Co-producing Crisis Response Pathways

Situation: Focus groups held to co-produce the development and improvement of crisis response pathways. The information gathered during the focus groups will be used to inform improvement work and acute crisis pathways.

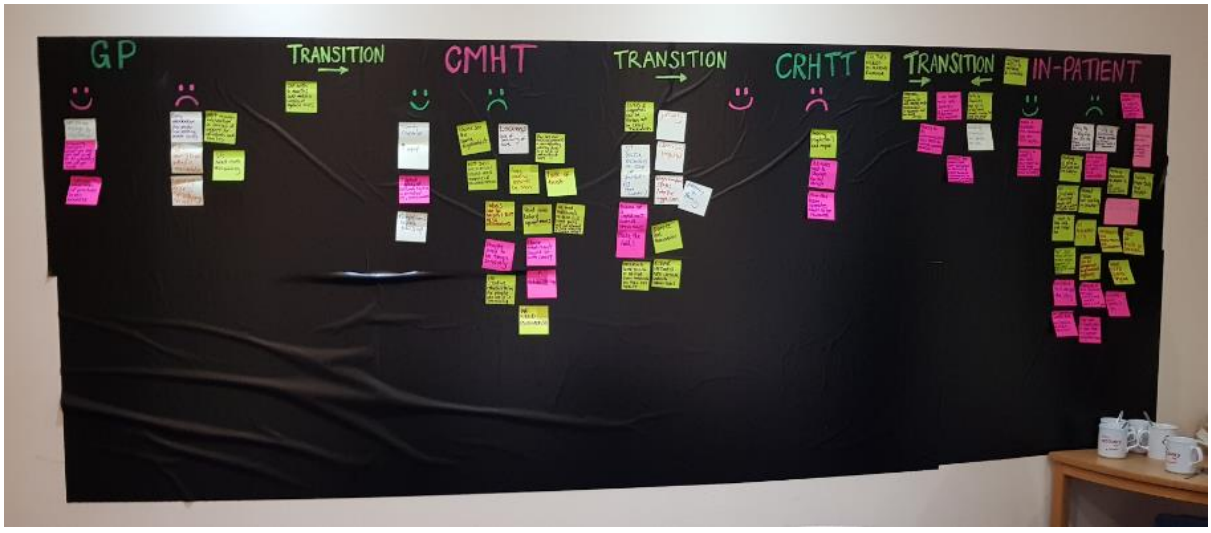
Location: Dundee Volunteer and Voluntary Action

When: Monday 3rd of February 2020

Participants: 8 Healthy Minds Network members

Facilitators: Lynsey McCallum (Co-ordinator HMN) and Linda Graham (Clinical Lead for Mental Health & Learning Disabilities)

Attendance: 5 people (focus group 1) 3 people (focus group 2)



Background: Our mental health services are delivered over a range of different settings and teams: In-patient care, Crisis Resolution and Home Treatment Teams (CRHTT) and Community Mental Health Teams (CMHTs). Over recent years, there have been a number of changes to

these services and not every area in Tayside has access to the same type of service.

Through the work of the Tayside Mental Health Alliance, they are currently reviewing the **pathways** between our crisis services. They need to truly understand what the journey from CMHT to CRHTT and/or in-patient care is like and what response people want when experiencing an acute mental health crisis.

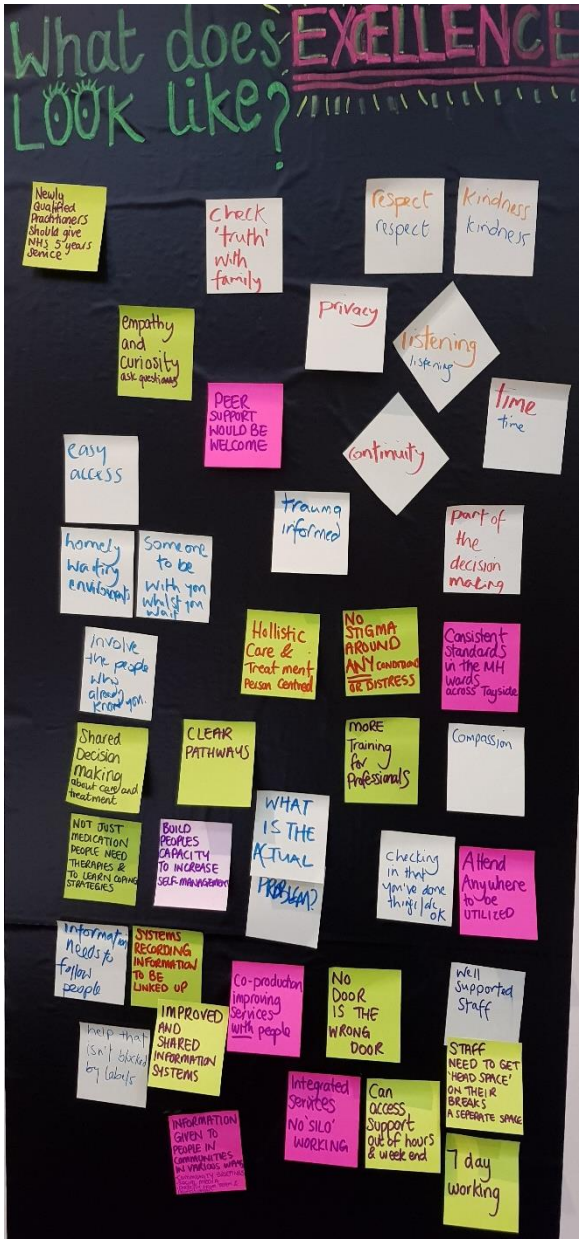
Analysis

When inviting people to be involved in discussions, we had some key criteria to ensure the most relevant voices were included and heard.

It was important to make the distinction between experiencing distress and acute mental health crisis. We wanted to hone in on lived experience of acute mental health crisis.

HMN held some small group discussions to listen to and learn about people's experiences. We brought together people with lived experience and carers/supporters perspectives who have experienced within the last 12 months – an acute mental health crisis and required a response from crisis services. In particular, CMHTs, CRHTT and In-patient services.

HMN asks that people's views, themes and recommendations are taken on board and used to co-produce crisis pathways in Tayside.



The main themes identified from the talking walls (Appendix 2 – Talking Wall) were as follows:

Culture change is required

a) "No door is the wrong door"
b) "Culture needs to improve and change"
c) "No stigma around ANY conditions and distress"
d) "Integrated services, no 'silo' working"
e) "Co-production, improving services with people"

Kind, Caring and Compassionate crisis services are required

a) "Compassionate response from staff"
b) "People need to be taken seriously"
c) "Listening"
d) "Respect"
e) "Nurses in Ward 1 are good, they treat you with more compassion and respect than Ward 2"
f) "Lacking people skills and respect" (CRHTT)
g) "How this team operates needs reviewed" (CRHTT)
h) "Attitudes need to change, far too abrupt" (CRHTT)

Environment (in-patient services)

a) "…Waiting area exposed, no empathy, no cuppy, no kindness"
b) "Homely waiting environments"
c) "Someone to be with you whilst you wait"
d) "Doesn't feel therapeutic"
e) "Nothing therapeutic for people to do, not a nice environment"
f) "I want to feel safe and cared for"

Creative care plans and person centred rehabilitation

a) "No creative rehabilitation for people who are ill in community"
b) "Not just medication, people need therapies and rehabilitation"
c) "Build people's capacity to increase self-management"
d) "Not just medication, people need therapies and to learn coping"
e) "Shared decision making about care and treatment"
f) "Early intervention stops people from entering severe crisis"
g) "Holistic care and treatment, person centred"
h) "No prep for home life when in-patient"

i) "not making progress in your recovery journey due to a lack of continuity of care"

Transitions

a) "Clear pathways are critical during transitions"
b) "Offering something is better than nothing, you feel set adrift"
c) "Follow up is important during transitions"
d) "Information needs to follow people"

Communication and information systems

a) "Systems recording information to be linked up"
b) "Improved and shared information systems"
c) "Checking in that you've done things OK"
d) "Nurses don't speak to you"
e) "Following through when you are going to do something like call you back"
f) "Information given to people in communities in various ways: community briefings; social media; directly from team & professionals"

Better trained staff and resources

a) "Not managing complex risk, not asking enough questions"
i) "Trauma informed"
b) "More training for professionals"
c) "GPs need more MH training"
d) "GPs don't know what is available"
e) "Labels can be dangerous, 'drug induced psychosis'"
f) "Specialists back in to GP practices, PAMS example"
g) "Third Sector resources to step up support (eg peer support)"
h) "Peer support would be welcome"

Including and informing 'named persons' and supportive family and carers

a) "'Named person' not working in practice"
b) "Involve the people who already know you"
c) "Carers and supporters can be frozen out by CPN/ psychiatrists"

d) "Whole families end up in crisis and unwell trying to cope and keep loved one safe"
e) "Check "truth" with family"

Robust discharge process and protocol required

a) "No discharge planning, people left without care or support plans"
b) "Needs to be individualised sign posting during discharge process"
c) "Address the knowledge gap between in-patient and everything in community to improve discharge planning"
d) "Made a referral for Dundonald, this has been helpful"

Improved access required

a) "They try to diagnose you over the phone without face-to-face assessment"
b) "Easy access"
c) "Can access support out of hours and weekends"
d) "Attend anywhere to be utilised"
e) "7 day working"
f) "Speedy response"
g) "Long waiting lists to be seen"
h) "Help that isn't blocked by labels"

Recommendations

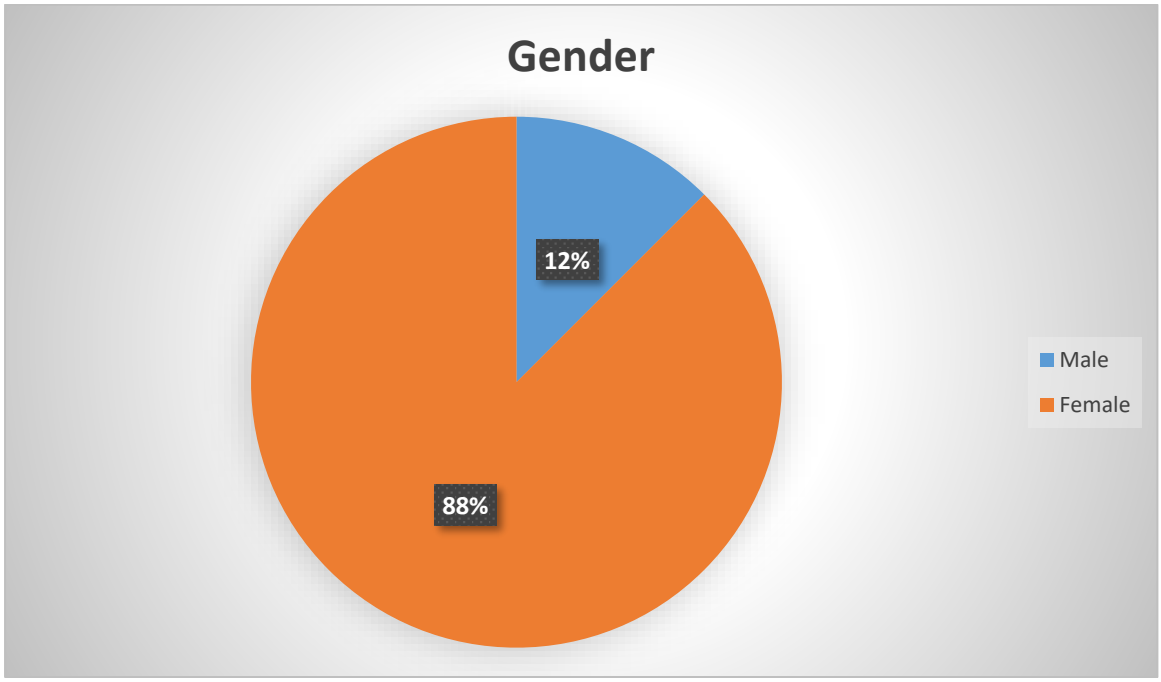
1. Develop clear clinical pathways for crisis services that are easy to understand for both professionals and service users
2. Culture change in crisis services will require continued listening to a range of voices (service users, lived experience, family, community services, and third sector) not merely NHS perspectives
3. "No door is the wrong door" with people being linked to the right support at the right time no matter where they present
4. Crisis service must ensure that people experience a kind, caring compassionate response at all times and at every stage of a person's recovery journey

5. Improve access to crisis services including; face-to-face assessment, reduced waiting times, 24/7 support and utilising Attend Anywhere technology
6. Ensure there is follow up for patients, particularly during transitions
7. People said that the Crisis Resolution and Home Treatment Team should be reviewed due to "staff attitudes" and being "too abrupt". Conducting a review of this team and other crisis services would be a good way to 'take stock' and to identify key priorities and outcomes for improvement work
8. To aid the co-production process, services can use quality improvement tools (facilitated annually by someone independent of the NHS) which explore healthcare services through the eyes of service users, carers and stakeholders. This is a collaborative process and will help staff, service users and others to work together to identify improvements that can be made to enhance the service user experience. An example of a quality improvement tool is 'THE FIFTEEN STEPS CHALLENGE' which has a mental health services toolkit
9. Mental health professionals could be offered a range of training. Examples include: active listening skills, inequalities training, demonstrating empathy, Psychological First Aid, de-escalation skills, trauma informed practice, rights-based support and motivational interviewing skills
10. Training opportunities for staff should also include warning against overuse of or overreliance on psychotropic medications. Mental health care should take account of social and political contexts (poverty, inequality, loneliness and isolation) that contribute to a high prevalence of poor mental health and distress. Psychosocial and other social interventions are crucial for mental health recovery. Third sector services and those offering peer support can provide additional resource to step up support
11. People require "not just medication" but "capacity building" to learn about their condition, their triggers, coping strategies and "self-management". People should be connected to psychosocial interventions such as talking therapies, green prescriptions, self-help groups, third sector services and peer support. In order to build creative support/rehabilitation plans for individuals
12. People must have person centred care/rehabilitation plans in place whether an inpatient or being supported in the community. Individuals, and where appropriate 'named

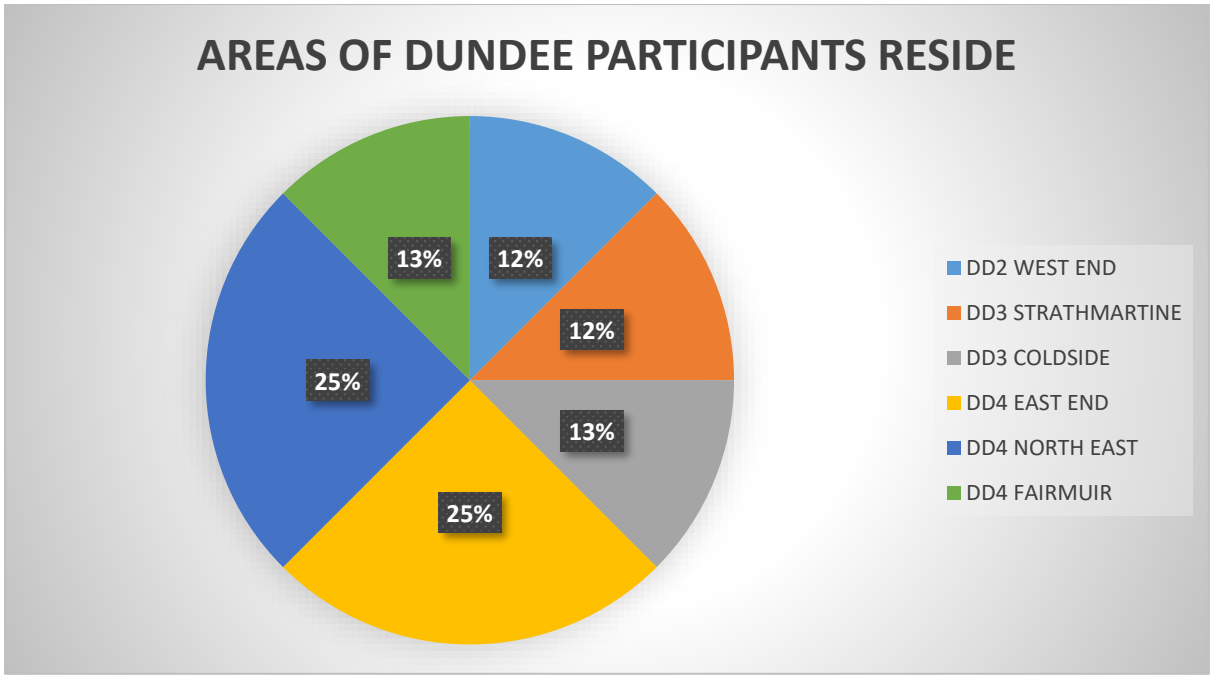
persons' and supportive family should be aware of care plans and rehabilitation goals in place

13. Include, inform and listen to 'named persons' and supportive family and carers. Power irregulations in mental health care, such as not appropriately including, listening to and informing 'named persons' is a systemic issue which must be addressed in NHS Tayside's policies, procedures and practice
14. Improve discharge process including; mapping agreed rehabilitation goals, supporting people to create an advanced statement, signposting, writing referrals and connecting people to on-going support and social opportunities in the community
15. Improve IT communication and information systems by ensuring systems are integrated "shared information systems" and that people's information follows them appropriately on their journey
16. Communicate people's feedback about the physical environment of crisis services to the appropriate teams, services and mental health transformation program

Appendix 1 – Participants



The table above shows that 1 male and 7 females participated.



The table above shows the different localities where participants reside:

1 person DD2 West End; 1 person DD3 Cold Side; 1 person DD3 Strathmartine; 1 person DD4 Fairmuir; 2 people DD4 East End; 2 people DD4 East End.

Appendix 2 – Talking Wall

Talking Wall									
GP		Transition	CMHT		Transition	CRHTT	Transition	Inpatient	
☺	☹		☺	☹		☹		☺	☹
GP cared enough to call back Following through when you are going to do something like call you back Specialists back in to GP practices, PAMS example Early intervention stops people from entering severe crisis	GPs don't know what is available Cannot access GP listening services Not enough information on sources of support for individuals and families GPs need more MH training	Outwith 6 months can't make a complaint against NHS	I speak highly of Alloway Centre in particular OT, duty workers Speedy response ↑ input Compassionate response from staff	Locums, lack of continuity of care Not just medication, people need therapies and rehabilitation No creative rehabilitation for people who are ill in community Home treatment should sit with CMHT Long waiting lists to be seen Lack of trust	Clear pathways are critical during transitions Offering something is better than nothing, you feel set adrift Follow up is important during transitions Third Sector resources to step up support (eg peer support) Carers and supporters can be frozen out	Lacking people skills and respect How this team operates needs to be reviewed Attitudes need to change. Far too abrupt	Whole families end up in crisis and unwell trying to cope and keep loved one safe Needs to be individualised sign posting during discharge process Address the knowledge gap between in-patient and everything in community to improve discharge planning	Nurses in Ward 1 are good, they treat you with more compassion and respect than Ward 2 Made a referral for Dundonald, this has been helpful	Culture needs to improve and change Criteria: "mental disorder" In-patient services tweak to suit themselves Assessed as "not suicidal enough". Waiting area exposed, no empathy, no cuppy, no kindness Lacking people skills and respect Named person not working in practice

				Never see the same psychiatrist We need psychiatrists ↑ Rehabilitation People need to be taken seriously Labels can be helpful but ALSO dangerous Read notes before appointments We need professionals to take full time posts and not allowed to keep collecting a locum's wage You are not making progress in your	by CPN/ psychiatrists Make the call! Doesn't feel therapeutic High emotional states labelled aggression Patient + family Decisions imparted Privacy		and sign posting Extremely poor experiences with mental health professionals is traumatic and can cause PTSD I no longer trust MH services so I won't access professional help anymore Lack of resources for people to use Culture needs to improve and change		They try to diagnose you over the phone without face-to-face assessment Third Sector support in health services in community in-patient setting Bank nurses are used and told not to report being understaffed Bullying <u>is</u> going on and good staff are suffering Nothing therapeutic for people to do, not a nice environment No discharge planning, people left

				recovery journey due to a lack of continuity of care					without care or support plans I want to feel safe and cared for No accountability Not just medication, people need therapies to learn about condition and coping skills Labels can be dangerous, drug induced psychosis Inadequate risk assessments and documentation No prep for home life when in-patient

									Lack of trust in services Not managing complex risk, not asking enough questions The food in Carseview is very poor, it is better in Murray Royal Nurses don't speak to you Differences in care standards between Ward 1 and Ward 2, Ward 2 isn't good Inconsistent care despite the setting Label EUPD carries stigma

Appendix 2 – Talking Wall

What does excellence look like?
Newly qualified practitioners should give NHS five years' service
Empathy and curiosity, ask questions
Privacy
Someone to be with you whilst you wait
Shared decision making about care and treatment
Check "truth" with family
Peer support would be welcome
Listening x 2
Homely waiting environments
Involve the people who already know you
Kindness x 2
Respect x 2
Time x 2
Easy access
Not just medication, people need therapies and to learn coping strategies
Can access support out of hours and weekends
Information needs to follow people
Help that isn't blocked by labels
Checking in that you've done things OK
Attend anywhere to be utilised
Integrated services, no "silo" working
Information given to people in communities in various ways: community briefings; social media; directly from team & professionals
What is the actual problem?
Co-production, improving services with people
Build people's capacity to increase self-management
Trauma informed
Continuity
Clear pathways
No stigma around any conditions or distress
Holistic care and treatment, person centred
Part of the decision making
Consistent standards in the MH wards across Tayside
Compassion
More training for professionals
Systems recording information to be linked up
Well supported staff
Improved and shared information systems
7 day working
No door is the wrong door
Staff need to get "head space" on their breaks, a separate space