Evaluation of the Crisis Care Concordat implementation

Interim report

**Prepared by the McPin Foundation for Mind**

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# Background

In May, 2014, Mind commissioned the McPin Foundation to complete an evaluation of the work being undertaken to implement the national Crisis Care Concordat statement. The evaluation is guided by the core values within the concordat and aims to:

1. Assess the progress and impact of rolling out the local crisis declarations.
2. Begin to understand the success factors for local areas to sign up and embed agreements made through Local Crisis Declarations into their working practices and protocols, as well as the major challenges and obstacles.
3. Produce learning and recommendations for how local partners can effectively work together to improve the experience of people in mental health crisis in each and every locality.

This is an interim report covering the progress of the evaluation in the first seven months. A final report is due to be completed at the end of the evaluation in January, 2016. This report includes a description of the methodology followed so far, including changes to the original work plan. It also provides an overview of the findings so far, including themes arising from the observations with local sites and the first survey completed with people who have a mental health diagnosis and their families. The themes discussed in this report should be treated as tentative as they will be developed and reconsidered throughout the remaining months of the evaluation.

# Outline of methodology

The evaluation aims to use two approaches: a) Case studies of the local crisis declaration and action plans in a few of the localities which have signed up, and b) baseline and follow up surveys of all areas which sign up, to assess the impact of the concordat. We are using a mixed methods case study approach looking in detail at four areas which have signed up to a declaration. The aim of these case studies are:

1. To observe and evaluate the implementation of the declaration as it is put into practice locally, including gathering data on the local context and who does and doesn’t engage with this process, what it builds upon as existing practice, what new ways of working emerge;
2. To assess how effectively the concordat is working in relation to local practice and the challenges that arise;
3. To evaluate the impact for mental health service users in crisis, and their families.

Planned case study data consists of:

1. Routinely collected data, including use of police cells as a place of safety, detention in hospitals as a place of safety, length of hospital stay, inpatient satisfaction data. This will help us benchmark before concordat action plans nationally, and compare areas, and to look at later data as far as possible in the time frames.
2. Analysis of documents, including the declarations and local action plans for fidelity to the core principles of the concordat
3. Observations at key meetings where sign up and implementation are discussed to help understand decision making, joint working, leadership and problem solving as well as fidelity to the principles of the concordat
4. Telephone interviews with key stakeholders, including those who do not sign up to the local declaration
5. Two surveys with service users/carers asking about their experience of crisis care towards the beginning and towards the end of the evaluation period, with a small number of follow-up interviews.

# Progress so far

## Site selection

Four local areas were chosen as case studies for this project. The process of selection took longer than envisaged. While one site was quite advanced and eager to participate, other sites were more cautious. There were several apparent reasons for this.

First, the cross-agency nature of this work made it difficult for any one individual to commit to participation in the evaluation on behalf of the other organisations involved. In one site, a group already existed that was taking the cross-agency work on the crisis care concordat forward, and this seemed to make it easier for them to approve participation in the study. In the other sites approached, however, these groups were still being established. In one site, for example, the lead from the Police and Crime Commissioner’s office was eager to participate, but seeking and securing agreement from other partners took some time. In one other site, the length of time required to seek all the relevant approvals made it impossible to include them.

Second, there were some concerns about the motives for the evaluation and an apparent concern about being ‘assessed’. This was particularly the case where some of those involved locally anticipated barriers to implementation locally. This is not uncommon in evaluations, and through discussions, in general we were able to reassure the sites about the aims of the evaluation. In particular, we emphasised that the evaluation aimed to understand the barriers and facilitators for implementation rather than to assess whether or not the local work was being delivered ‘well’.

Finally, there were delays in some sites around agreeing the level and regional area for implementation. Specifically, in London, there were a number of groups with a potential role in implementing the crisis care concordat at a pan-London level, in addition to the mental health Trusts, local authorities and CCGs that had their own programmes of work. This caused some delays in agreeing the level at which our evaluation should operate. Ultimately, it was agreed that we would look at the work done at the pan-London level. The challenge of selecting the appropriate regions for implementation is one that we will look at in the overall evaluation.

Four sites were selected by late summer 2014. The sites provide a good geographical mix (one from the east of England, one from the South West, one from the North West and London) and a good mix of rural and urban sites (one densely urban, one rural, and two mixed). The sites also, as far as possible, represent different levels of progress with implementation. One site, Gloucestershire, was chosen because it was already advanced in developing a declaration and action plan. Other sites were still starting this work when the evaluation was beginning.

The delays in selecting and recruiting sites have had some implications for the evaluation overall. In particular, it made it impossible to work with local user groups in the four areas to support the survey (see below). We were able to work to some extent with a user-led group in Gloucestershire, however the timings made it difficult to work with them in the way envisaged. We hope that this engagement can still take place before the second survey in autumn 2015. As a result, we decided to open the survey wider than the four areas as originally envisaged, to capture views from across the country. Though we targeted the four areas as much as possible, the numbers from these sites are low in the survey responses. The survey is therefore better at providing a wider snapshot of crisis experiences than the targeted local experiences we had intended.

## Observations in four local areas

We have attended and observed meetings in the four selected areas. The table below shows the observations completed:

Table

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Gloucestershire | Task and finish meeting | 22nd July, 2014 |
| Cambridgeshire | CCC regional event – South EastMental health concordat declaration group Concordat workshop | 4th July, 201427th August, 20148th October, 2014 |
| The Wirral | CCC regional event – Cheshire & MerseysideMental Health and Social Care Board | 7th July, 201420th October, 2014 |
| London | London mental health partnership boardCCC regional event – London | 8th October, 201427th October, 2014 |

The intention was to complete two observations for each site, however Gloucestershire was already at their last Task and Finish group meeting by the time the evaluation started. An additional observation was therefore completed in Cambridgeshire instead. In each site, except Gloucestershire, the observations included at least one local meeting in which implementation was being discussed, and one regional Crisis Care Concordat event.

The observations have provided valuable data in ascertaining some of the challenges discussed in relation to implementing the crisis care concordat, the participation of different organisations and the approaches being taken. They are, however, only a snapshot since each area had a long series of meetings (and are continuing to do so). The observations are therefore most valuable in identifying key themes to be explored in interviews with key people in each site. These interviews will be completed over the coming months.

The themes arising from these meetings are discussed in the section on findings below.

## Document analysis

As part of assessing how far the local declarations and action plans reflect the core principles laid out in the national Crisis Concordat document, we aimed to compare documents for the occurrence and relationships between key concepts using a Content Analysis and mapping method. As part of this analysis, the national crisis care concordat statement was analysed to create a matrix of the key terms used and their relationship to other key terms (through co-occurrence in a single paragraph). Table 2 shows the most common terms occurring within the Concordat statement.

Having completed this analysis, however, it became clear from the observations that all four sites planned to use the template declaration provided through the Crisis Care Concordat website. As a result, this analysis was not felt to be useful. Instead, we will analyse the action plans to compare how far they address the key themes arising from the Concordat statement. At the time of writing this report, only Gloucestershire and parts of London had completed an action plan. This analysis will therefore take place in the latter half of 2015.

Table : The most frequently occurring terms in the national concordat statement

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Concept** | **Search term** | **Includes** | **Manual exclusions** | **Number** |
| Mental health | “mental health” | Only “mental health” as full phrase |  | 275 |
| Services | Service\* | Service; services | “Service user” | 240 |
| Crisis | Cris\*s | Crisis; crises |  | 206 |
| Care | Care | Care |  | 150 |
| Police | Polic\* | Police; policing | Policy; policies | 116 |
| Support | Support\* | Support; supports; supporting; supportive | Supporters (as in supporters of the concordat) | 101 |
| Commission | Commission\* | Commission (*n* & *v)*; commissioner(s); commissioning; commissioned |  | 97 |
| Response | Respon\* | Response; responsive; respond; responds | Responsibility; responsibilities  | 83 |
| Safety | Safe\* | Safe; safety; safely; safeguarding |  | 78 |
| Improvement | Improv\* | Improve; improves; improving; improvement |  | 65 |
| Emergency | Emergenc\* | Emergency; emergencies |  | 51 |
| Partnership | Partner\* | Partner; partners; partnered; partnership(s) |  | 48 |
| Access | Access\* | Access; accessibility; accessible |  | 40 |
| Information | Inform\* | Inform; informative; information; informing; informed |  | 37 |
| Urgency | Urgen\* | Urgency; urgent; urgence |  | 36 |
| Assessment | Assess\* | Assess; assessed; assessing; assessment |  | 34 |
| Training | Train\* | Train(s); trained; training |  | 34 |
| Quality | quality | quality |  | 33 |
| Planning | Plan\*  | Plan(s) (*n* & *v)*; planning; planned  |  | 31 |
| Children | Child\* | Child; children |  | 31 |
| Outcomes | Outcome\* | Outcome; outcomes |  | 30 |
| Prevention | Prevent\* | Preventative; prevent; prevents; prevention |  | 28 |
| Vulnerable | Vulnerab\* | Vulnerable; vulnerabilities |  | 28 |
| Section 136 | 136 | Section 136; s. 136 |  | 25 |
| Joint | Joint\* | Joint; jointly |  | 24 |
| Risk | Risk\* | Risk; risks; risky |  | 24 |
| Ambulance | Ambulance\* | Ambulance; ambulances |  | 23 |
| Criminal justice | Crim\* | Criminal; crime |  | 23 |
| Hospital | Hospital\* | Hospital(s); hospitalise(d); hospitalisation |  | 21 |
| Misuse | Misuse | Substance misuse; drug misuse; alcohol misuse | Misuse where it occurs not in conjunction with substance, drug or alcohol | 19 |
| Strategy | Strateg\* | Strategy; strategies; strategic |  | 19 |
| Psychiatry | Psychiatr\* | Psychiatry; psychiatric; psychiatrist(s) |  | 18 |
| Hours | Hour\* | Hour; hours; 24-hour |  | 17 |
| Social Care | “Social care” | Social care |  | 16 |
| AMHP | AMHP | AMHP |  | 16 |
| Family | Famil\* | Family; families |  | 15 |
| Early intervention | Early | Early intervention; intervene(s)(d) early | Early where it does not occur in conjunction with intervene/intervention | 15 |
| Contact | Contact\* | Contact; contacts; contacted |  | 14 |
| BME | BME OR ethnic\* | BME; ethnicity; Black and Minority Ethnic |  | 13 |
| Acute | Acute | Acute |  | 12 |
| Recovery | Recover\* | Recover; recovery |  | 11 |
| Cells | Cell\* | Cell; cells |  | 9 |
| Nurse | Nurs\* | Nurse(s); nursing |  | 9 |
| Respect | Respect\* | Respect; respected; respectful | “in respect to” – as in concepts, rather than respect for people | 9 |
| Protection | Protect\* | Protect(s); protected; protection | “data protection” | 9 |
| Suicide | suicid\* | Suicide; suicidal; suicidality |  | 9 |
| Transport | Transport\* | Transport; transportation | “Transport Police” | 8 |
| Restraint | Restrain\* | Restrain; restraint; restrained |  | 7 |

## Survey of crisis care experiences

As described above, the survey was originally intended to focus only on the four areas selected as case studies for this evaluation. However, due to delays in confirming the study sites, we decided to do a broader survey capturing experiences across the UK.

The survey was developed alongside three people with experience of using mental health crisis services – two as people with mental health problems themselves and one as a family carer. The topics and question wording were developed and agreed across these peer advisors and the researchers. The questionnaire was then presented to a user-led group in Gloucestershire to gather feedback.

The survey was administered during October and November and was primarily available online. It was promoted through online networks, including Mind’s and McPin’s twitter and facebook pages, as well as those of various other third sector organisations. It was included in various newsletters and email distributions. In the four case study areas, we identified as many local voluntary sector networks as possible and asked them to promote the survey. In only one site (Gloucestershire) were we able to engage with a local sector to actively support people to complete the survey. Since NHS ethics approvals were not sought for this study, we were not able to go through NHS services or distribution lists.

Findings from the survey are reported later in this report.

## Analysis of routinely collected data

The evaluation included a plan to analyse routinely collected data that could be used as proxies to measure the standards of crisis care in each area. A number of sources are available to access data, including the Mental Health Dementia and Neurology Intelligence Network, and the Mental Health Minimum dataset.

However, in the early stages of the evaluation, a similar piece of work has been undertaken and published by the Care Quality Commission. They have used a pathways approach, looking at data in relation to presentations at A&E, support from specialist mental health teams and s.136 detentions. The data covers the period from April 2012 to March 2013. It provides a valuable baseline and is available at a local authority level which can be mapped against our four evaluation sites.

The Care Quality Commission is not anticipating doing this form of data analysis next year. We will therefore use the CQC’s data as a baseline and follow up with comparable data analysis towards the end of the evaluation in order to allow for data releases. Where possible, we would look to compare with data covering the year April 2014 to March 2015, but data release timescales may make this impossible. In that case, we will compare with data from 2013-4. Since minimal change is expected in that time, we will, as far as possible, set things up to make a further analysis after this project easy and cost-effective, should Mind wish to do this. It should also be noted that not all of the indicators used in the CQC data are available every year. Some are based on Freedom of Information requests, some are from surveys or reports which may not be produced regularly. We cannot, therefore, guarantee that a follow-up measure will be available for all the indicators listed below.

Table : Data from CQC thematic review of mental health crisis care[[1]](#footnote-1)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | National | Gloucestershire | Cambridgeshire | Wirral |
| **% of GP patients on severe mental illness register** | 0.8% | 0.7% | 0.7% | 1.0% |
| **% of GP patients (aged 18+) on depression register** | 5.8% | 5.5% | 5.6% | 6.7% |
| **% of people with severe mental health illness with a comprehensive care plan in place** | 81.3% | 79% | 81.1% | 82.2% |
| **Ratio of the number of people entering talking therapies to the estimated number of people with depression and/or anxiety disorders** | 9.8% | 9.4% | 4.2% | 10.1% |
| **Ratio of observed to expected number of emergency acute admissions for:** **Self-harm****Schizophrenia****Mood disorders****MH conditions resulting from alcohol misuse** |  | Expected8431530177 | Observed931814168 | Expected8041632180 | Observed7853741138 | Expected7061020206 | Observed7571127340 |
| **% of patients admitted to an acute hospital via A&E for a MH condition** | 4.8% | 4.9% | 5.1% | 7.3% |
| **% of patients admitted to an acute hospital via A&E for a MH condition who had attended A&E multiple times in the preceding 5 years** | 3.5% | 2.8% | 2.8% | 2.5% |
| **% of patients attending A&E multiple times prior to admission that have had previous specialist MH contact and/or acute hospital admission for MH condition** | 66% | 63.9% | 76.6% | 83.9% |
| **% of patients admitted to an acute hospital via A&E for self-harm at times when attendances for these conditions are nationally at their highest (11pm to 5am)** | 6% | 7.8% | 6.7% | 9% |
| **% of emergency admissions via A&E for a MH condition (for patients with a history of previous MH contact) that returned to A&E within 30 days (for any reason)** | 25% | 21.5% | 24.3% | 23.2% |
| **% of emergency admissions via A&E for a MH condition (for patients with NO history of previous MH contact) that returned to A&E within 30 days (for any reason)** | 13.5% | 11.3% | 13.6% | 12.9% |
| **6 month mortality rate (from all causes) among patients admitted to an acute hospital for a MH condition (not including self harm or undetermined injury)** |  | Expected31 | Observed26 | Expected52 | Observed47 | Expected60 | Observed62 |
| **6 month mortality rate from self-harm or undetermined injury among all patients admitted to an acute hospital (for any reason)** |  | Expected- | Observed- | Expected- | Observed7 | Expected- | Observed- |
| **MHMDS recording - % of Care Programme Approach (CPA) spells with a crisis plan recorded** | 23.4% | 27.1% | 0.5% | 0.8% |
| **Ratio of home treatment episodes by crisis resolution home treatment teams to people using secondary MH services** | 76 per 1000 | 84 per 1000 | 43 per 1000 | 83 per 1000 |
| **Referral rate to crisis teams per 10,000 population[[2]](#footnote-2)** | 107 | - | 42 | 430 |
| **% of crisis team referrals with face to face assessment2** | 72.1% | - | 95.9% | - |
| **Hospital admissions as a % of crisis team referrals2** | 18.3% | - | 31.4% | 10.5% |
| **Ratio of crisis resolution home treatment staffing to caseload (benchmark is 0.56 staff per case)2** | 0.47 | - | 0.25 | 1.98 |
| **% of emergency admissions to specialist MH provider that are NOT the main provider commissioned by the CCG** | 4.4% | 2.1% | 12.9% | 7% |
| **Estimated annual bed occupancy levels compared to expected standard (85%** | 88.1% | 88.7% | 90.9% | 78.8% |
| **Number of deaths within 30 days of MHMDS care spell ending** |  | Expected272 | Observed339 | Expected280 | Observed181 | Expected139 | Observed139 |
| **Number of suicides within 30 days of MHMDS care spell ending** |  | Expected- | Observed- | Expected- | Observed- | Expected- | Observed0 |
| **Number of deaths of people on a CTO** | 1 | - | 0 | 0 |
| **Number of S136 detentions by local authority of residence** |  | 74 | 8 | 105 |
| **Number of S136 detentions by MH provider (MHMDS)** |  | 75 | 20 | 296 |
| **Number of S136 detentions by police force boundary** |  | 444 | 191 | - |
| **% of all S136 detentions that result in individual being taken to a health based place of safety (HBPoS)** | 65.4% | 77% | 15.2% | - |
| **% of <18 year old S136 detentions that result in individual being taken to health based place of safety (HBPoS)** | 57.5% | 81.8% | 22.2% | - |
| **Number of S136 detentions admitted to hospital following assessment** |  | Expected21 | Observed- | Expected- | Observed7 | Expected31 | Observed25 |
| **Number of S136 detentions that are re-detained under S136 within 90 days** |  | Expected11 | Observed- | Expected- | Observed0 | Expected14 | Observed8 |
| **Number of S136 detentions that take their own life within 180 days** |  | 0 | 0 | 0 |

# Themes arising

Through observations in the four sites, we have identified a number of themes that we will explore further in the interviews during 2015. These are briefly outlined below:

## Leadership

The organisations taking a lead have varied across the four regions observed. In one site, the Task and Finish group is co-chaired by a CCG representative and someone with personal experience of a mental health crisis. In a second, co-chairs were from the CCG and the local police force, with considerable drive from the Police and Crime Commissioner’s office. In a third, leadership was through the police with CCGs leading action planning for their areas. In the fourth region – London – leadership was still under discussion at the events observed, with several existing groups potentially well-placed to drive the concordat work forward.

In the interviews, we will explore these variations in the approach taken to leading the Concordat implementation work. In particular, we will consider how these decisions came to be made, how they may have changed over the course of the implementation work, and how effective people feel that these approaches were. This links closely to the next theme, Partnership working.

## Partnership working

The Crisis Care Concordat explicitly requires different agencies to work together in producing a declaration and action plan that contains commitments from a number of different organisations. At the meetings we observed, representatives attended from the following organisations:

* Local constabulary
* Office of the Police and Crime Commissioner
* Local Clinical Commissioning Groups
* Local Mental Health Trusts
* Local Ambulance Trusts
* Local authorities
* Accident and Emergency departments
* British Transport Police
* Prisons
* Third sector providers
* Probation
* Crown Prosecution Service

The history of partnership working varied from area to area. In one site, for example, a board including partners from virtually all of the key organisations for the Concordat had been in existence for 3 – 4 years and had been addressing issues related to crisis care during this time. This meant that there was a solid base for continued partnership working, and excellent existing relationships at this management level. In other sites, this way of working appeared to be much newer. In one area, attendees commented on the benefits of having an opportunity – apparently not there previously – to discuss provision of care and services across these different agencies. At several points, it became clear that new information was being revealed about the way other agencies worked, the pressures on their systems and the data they managed. One basic aspect was the frequency with which specialist terms and acronyms had to be explained to colleagues from other organisations, highlighting how far the language used was different.

While it clearly opened up some fantastic opportunities, there were also suggestions that tensions existed in the early stages of such partnership working. Incentives to change the systems and release pressure for some partners were not there for others. In the interviews, we will explore how these partnerships worked, what the challenges were and how they were overcome, and how (if at all) they envisage these partnerships being sustained beyond the crisis care concordat implementation work.

## Regional boundaries

One of the apparent challenges to partnership working is the lack of co-terminosity for different agencies. The key partners – police, mental health trusts, local authorities and CCGs – all have different geographic boundaries. One effect of this is that some agencies – for example the larger police forces – had to be involved in a number of crisis care concordats. Equally, it required all CCGs in a given region to engage in the process while managing different local pressures and contexts. In London, as an extreme example, the Concordat declaration was signed by two police forces, six mental health trusts, 33 CCGs and London Councils on behalf of 32 local authorities and the City of London. This contributed considerably to challenges around who should take responsibility for the Concordat work and at what level.

In one site, a further issue was raised about those things that were in local control and things that were decided at a national level, including legal requirements and aspects such as GP training.

In some areas, the regional variation was also an issue that arose in implementation meetings. Some of the sites are large and contain diverse populations and needs. The need to understand these variations across the area through good quality data was raised in observed meetings.

In the interviews, we will explore how these challenges have been experienced and overcome (or not) by the different agencies involved. This will provide an opportunity to understand in more depth the concerns that individuals had during the process and whether these have changed over time.

## Competing priorities

Again linking to partnership working challenges, various agencies faced different pressures – both relating to crisis care and to broader care delivery issues. A major theme that arose frequently in the observed meetings was the challenge of resource. Many of the agencies involved have been under considerable financial pressure. In some sites, particular financial issues were pressing in the concerns discussed. This meant that while some agencies were talking about investment in new ways to improve crisis care, others were warning of the potential for further cuts in services.

These competing priorities emerged in a number of ways. First, in some sites there were agencies who did not feel that this was the right time to focus on changes in crisis care, or that they had the time to work on it alongside other pressures. Second, and linked to the theme of regional boundaries, where multiple agencies delivering the same services were involved in a single declaration, concerns sometimes arose about how changes in crisis care delivery might increase demands on some agencies and not others.

Related to priorities were the different cultures of the organisations involved. These were observed, though not generally discussed explicitly at local meetings. In regional events, however, these sometimes came to the fore in relation to the different approaches from health services and from the police. Several of the police at regional events voice the view that health services appeared to be less mandated by national policy than they felt they were themselves. This difference may not exist in reality but was certainly a view that created tensions for police who often felt that they were spending more time in crisis related activities than they should be because of a lack of capacity in the health system.

In the interviews, we will explore with participants the different priorities they were managing throughout this process and how far they felt that these impacted on their ability to deliver the crisis care work alongside other agencies.

## Co-production

This theme was identified early in the evaluation as an issue of particular interest to Mind. Co-production refers to the extent to which people receiving (or potentially receiving) mental health crisis care were involved in the local work being done to implement the concordat.

In fact, this theme did not arise much through the observations, though it was raised by people at several of the regional events where it was felt to be very important. One notable exception in the local groups was the co-chairing of the Gloucestershire Task and Finish group by someone who had used local crisis care services in the past. This model was not repeated elsewhere, however. There was some discussion in one of the other sites about how people using mental health services might be consulted about plans to improve crisis care.

We will explore this issue in the interviews to identify participants views about whether co-production would have been valuable in the process and what approaches were taken to include the voice of service users in the decisions being made.

# Survey of crisis care experiences

## Background

A total of 732 survey entries were received. Of these, 129 had to be removed because they contained insufficient data for inclusion.[[3]](#footnote-3) The total sample size for this survey is therefore 603.

Of the whole sample, 399 were people with personal experience of a mental health crisis, 153 were family or other carers of someone with experience of a mental health crisis, and 51 were people with a mental health condition who had not experienced a mental health crisis. Where participants indicated that they had a mental health condition but had not experienced a mental health crisis in which they needed urgent help, they were asked only 3 questions since the majority of the survey was not relevant to them.

In the data below, the number of people completing each question is given as the ‘n’ in each graph or table. This number varies as people skipped some individual questions.

Open text responses were provided by many participants. These require further analysis work and will be included at a later stage.

## Demographics

Table : Demographic profile

|  |  |  |
| --- | --- | --- |
|  | People with personal experience of crisis care | People with experience of crisis care – family responses |
| Gender MaleFemaleTransgender | (n=391)75 (19%)313 (80%)1 (0.3%) | (n=150)77 (51%)73 (49%)0 (0%) |
| Age16-2526-3536-4546-5556-65Over 65Rather not say | (n=385)52 (14%)86 (22%)113 (29%)83 (22%)43 (11%)5 (1%)3 (1%) | (n=146)38 (26%)38 (26%)22 (15%)28 (19%)11 (8%)7 (5%)2 (1%) |
| EthnicityWhite BritishWhite otherWhite (not specified)British (not specified)IrishAsian/British AsianAustralian/New ZealanderBlack/Black BritishMixedRather not say | (n=385)233 (61%)5 (1%)43 (11%)37 (10%)7 (2%)10 (3%)5 (1%)3 (1%)5 (1%)37 (10%) | (n=145)90 (62%)1 (1%)9 (6%)18 (12%)1 (1%)3 (2%)01 (1%)022 (15%) |
| Fluent English speaker?YesNoRather not say | (n=389)385 (99%)1 (0.3%)3 (1%) | (n=149)145 (97%)1 (1%)3 (2%) |
| Physical disability or long-term health condition?YesNoRather not say | (n=390)195 (50%)179 (46%)16 (4%) | (n=145)61 (42%)78 (54%)6 (4%) |
| Carer’s relationship to the person they supportSon/daughterFriend/neighbourParentSiblingSpouse/partnerOther | NA | (n=150)11 (7%)12 (7%)74 (49%)11 (7%)31 (21%)12 (8%) |
| Diagnosis\*Schizophrenia or schizoaffective disorderPsychosisAnxietyDepressionBipolar disorderSubstance misusePersonality DisorderPTSDEating disordersNo diagnosisDon’t knowRather not sayAverage number of diagnoses per participant | (n=389)35 (8%)61 (15%)196 (50%)239 (61%)116 (30%)17 (4%)101 (26%)26 (7%)21 (5%)5 (1%)9 (2%)9 (2%)2.1 | (n=135)36 (26%)31 (20%)60 (39%)62 (41%)30 (20%)9 (6%)23 (15%)5 (3%)2 (1%)6 (4%)4 (3%)2 (1%)1.8 |

\* Participants could tick multiple options for diagnosis, reflecting multiple diagnoses received. Percentages stated are of participants who responded to the question.

There are some key differences between participants responding about their personal experience and family members responding about the person they support. Respondents with personal experience were overwhelmingly female (80%), while the people family carers responded about were evenly split by gender. The median age of people responding about their own crisis experience was 36-45, with a normal distribution across the age categories. Family responses were skewed to the younger age group, with a median age of 26-35. This probably reflects the large proportion of parents who responded about their son or daughter (49%).

Participants were asked to describe their ethnicity. 61% described themselves as White British, a further 11% as White, and a further 10% as British. Only 5% of people with personal experience of a mental health crisis described themselves as a non-White ethnicity, and only 3% of family participants.

There was also a difference in the pattern of diagnoses between people with personal experience and family participants. The proportion with a diagnosis of schizophrenia or schizoaffective disorder was higher among the family participants (26% compared to 8%), and the same was true for psychosis (20% compared to 15%). In contrast, higher proportions of anxiety, depression, bipolar disorder and personality disorder were reported by people with personal experience of a crisis. This was anticipated, since people who are living with diagnoses of severe mental illness such as schizophrenia or psychosis – particularly those with recent experience of a crisis – were felt to be less likely to respond to a survey themselves.

Family participants were asked to specify their relationship to the person about whom they were responding. Nearly half were parents and around a fifth were partners or spouses. The other category included grandparents, nieces and nephews and other relations.

In the section below, responses from people with personal experience and from family/friends are reported separately. The text compares the two groups to highlight similar patterns or substantial variations. Unless otherwise stated, the numbers refer to numbers of participants, not percentages.

## People with personal experience of a crisis and family carers

***How long ago was the experience of crisis?***

In the survey, we gave the following definition of a crisis: “*A mental health crisis is when you need urgent help because of a mental or emotional state. It might include times of being, or feeling, out of control of your body, mind or behaviour, or being at risk of hurting yourself.*” We asked participants to answer only about their *most recent* experience of a mental health crisis.

Of people with personal experience, 65% had experienced a crisis within the last year, and 90% had experienced a crisis in the last 5 years. A similar pattern was reported by family, with 67% supporting someone who experienced a crisis in the last year, and 93% supporting someone who had experienced a crisis in the last 5 years.

**Initial contact with services in a crisis**

For both personal and family responses, the most common first point of contact was the person’s GP or a mental health professional who was already involved in their mental health care. In a sizeable minority of cases, people had initial contact with A&E (SUs - 12%; family – 11%) or with police (12%; family - 11%). The specified other categories included voluntary sector organisations, housing support, child and young people’s services and individually named centres or services.

**Result of the mental health crisis: hospital admissions**

Among people with personal experience of care in a crisis, the majority of participants’ most recent mental health crises did not result in a hospital admission. Of the 41% that did, 60% were voluntarily admitted (24% of the whole sample) and 40% were admitted under a section of the Mental Health Act (17% of the whole sample). Family respondents reported that the person they care for was admitted to hospital in roughly half of cases, with 36% of those being admitted voluntarily (18% of the whole sample) and 64% being admitted under a section of the Mental Health Act (32% of the whole sample). This is a sizeable difference across the two samples and may reflect a greater severity among the people being supported by family and carers, compared with people responding about their own experiences.

**Experiences of care in a crisis**

We asked participants to rate how far they agreed with a number of statements about their experience of care in a crisis. These statements were adapted from the ‘I statements’ developed by Mind and included in the Crisis Care Concordat. People with personal experience and family and carers gave a similar pattern of responses, though family and carers were less likely to agree that they were able to access an appropriate service or professional as quickly as needed (34% compared with 43%). Family and carer respondents were more likely to agree that the person had been offered the chance to have a friend, family member or advocate present (56% compared with 39%). This may reflect the sample, in that family respondents may be more likely to openly identify as carers and be actively involved in the person’s care. If so, professionals may be more likely to include, or offer to include them than other family members and friends.

**Overall quality of crisis care**

Sadly, 50% of participants rated their overall experience of care received in a crisis as ‘not very good’ or ‘poor’. Only 30% rated their experience as ‘excellent’ or ‘good’.

Due to an error in the online survey set-up, only family members who said that the person they cared for had been admitted into hospital were asked to rate the care they received. This means that these responses are not comparable with those from people with personal experience. Nonetheless, 54% of these family respondents rated the experience as ‘not very good’ or ‘poor’.

**Support to avoid a crisis**

We asked participants to tell us whether they had received support to prevent another crisis in the future. 45% of participants agreed or strongly agreed that they had this support, while 49% disagreed or strongly disagreed. Family respondents were less likely to agree with this statement with 34% agreeing or strongly agreeing, and 56% disagreeing or strongly disagreeing.

**Future contact in a crisis**

We asked participants whether they would know who to contact, at any time of day or night, if they needed urgent help in a crisis again in the future. A little over half (52%) of participants with personal experience of care in a crisis agreed or strongly agreed that they would know who to contact in a future crisis. 43% disagreed or strongly disagreed. For family respondents, slightly fewer agreed (47%) and the same number disagreed.

This question was also asked of people with personal experience of living with a mental health condition but who had not needed urgent help in a crisis. The pattern is slightly different for this group, with people more likely to disagree than strongly disagree. However, the combined proportions who agreed and strongly agreed were similar (52%).

This group of participants were also asked how confident they were that they would receive appropriate support if they ever experienced a mental health crisis in the future. Participants were asked how far they agreed that they felt confident they could access appropriate help as quickly as they needed it, and that they felt confident that services would know how to help.

This suggests that people were more concerned about appropriate access than they were about the quality of care in a crisis.

## Exploring the data further

For the following section, we combined data from people with personal experience of a mental health crisis with data from family and friends. This provides a combined sample size of 552 participants.

*Changing experiences of crisis over time*

The data in the four graphs below suggest that experiences may have improved over time, with more people agreeing with the statements in relation to the last 5 years than before that. However, these differences are generally small and the number of people responding for the earlier period is much lower (more than 6 years = 51 participants; fewer than 6 years = 499). The small numbers in the earlier categories suggest caution should be taken, as they may be less typical of people experiencing a crisis in that period. There does, however, consistently appear to be a worsening of the experience of crisis care in the last year compared to 1-5 years ago.

This pattern was also reflected in the overall experience of care in a crisis.[[4]](#footnote-4) In general, experiences appear to be better in the more recent time categories than in the earlier ones. Again, experiences seem to have worsened slightly in the last year.

*Experiences in different areas*

We were particularly interested in responses from four areas in England where further evaluation of the Crisis Care Concordat is taking place. We therefore asked people to tell us if they had experienced their crisis in one of these areas. The numbers responding from each area are low, however: Cambridgeshire, 34; Gloucestershire, 12; London,55; The Wirral, 11. We would therefore be hesitant about drawing conclusions from these findings. Nonetheless, the data available suggests that more people reported excellent or good experiences in Cambridgeshire compared to the average, while fewer people in the Wirral and Gloucestershire reported excellent/ good experiences. Cambridgeshire was the only area in which more people reported good experiences than poor ones.

*Admitted to hospital*

Overall, experiences of care in a crisis appear to have been more positive when the crisis resulted in an admission to hospital. 32% of those who were admitted rated their overall experience as excellent or good, compared to 26% of those who were not admitted. This may reflect a view that hospital admission is the desired, or appropriate, response to a mental health crisis. However, those who were admitted under a section, rated the experience as less positive (28% rating excellent/good, compared to 37% of those voluntarily admitted).

*Demographics*

We compared overall rating of care in a crisis across age groups, gender and diagnosis. There were insufficient numbers of non-White British to compare by ethnicity. Ratings appeared to be worse among the younger and older age groups. The pattern among men and women was very similar, though women were slightly more likely to rate their care as OK, and men more likely to rate it as poor.

The pattern across the six most commonly reported diagnoses is similar, though fewer people with schizophrenia and bipolar disorder rated their experience as poor compared to the other diagnoses. These differences are small however.

1. Data is published at a local authority level. As a result, data for London requires further work to combine. We will do this for the final report but have not been able to do so at this stage. [↑](#footnote-ref-1)
2. This data was obtained through a FOI request made by Mind. We would look to work with Mind to repeat this request if possible, ensuring that the wording of the request is kept the same to allow comparison. [↑](#footnote-ref-2)
3. Data was insufficient if no responses were given to any items rating the experience, and no qualitative data was given. [↑](#footnote-ref-3)
4. Note, this data is incomplete for family and friends due to an error in the online questionnaire. [↑](#footnote-ref-4)