Health and Adult Social Care Overview and Scrutiny Committee – Supplementary agenda

A meeting of the Health and Adult Social Care Overview and Scrutiny Committee will be held on:

Date: 20 June 2023

Time: 7.00pm

Venue: Meeting Room 9 - Level 3, Gun Wharf, Dock Road, Chatham ME4 4TR

Items

5 Section 136 Pathway and Health-Based Place of Safety Service Improvement **(Pages 3 - 56)**

Attached is a report from Better Decisions Together which provides an analysis of the responses received to the consultation on the above proposals – as referred to in paragraph 7.8 of the cover report for agenda item 5.

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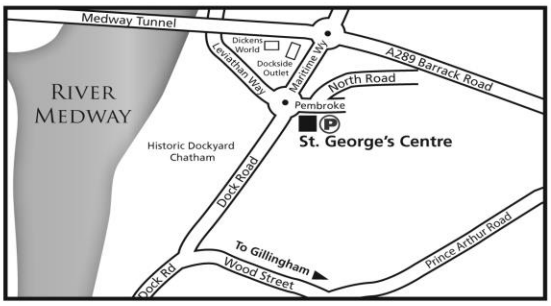
Date: 15 June 2023



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Improving Section 136 health-based places of safety in Kent and Medway

Consultation report

NHS Kent & Medway

JUNE 2023

Better Decisions Together

Document information	
Client	NHS Kent & Medway
Title	Improving Section 136 health-based places of safety in Kent and Medway
Subtitle	Consultation report
Date	13/06/2023
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Contents

Executive summary

NHS organisations in Kent and Medway are working together with partners to review and improve services for people who are experiencing mental health crisis and who are in need of emergency care and urgent support.

Part of this work is a programme of public engagement including a consultation, which ran from 21 February 2023 to 18 April 2023. The public consultation asked for views on proposals for new or improved services (including crisis houses, mental health patient transport, a Rapid Response Service and Enhanced Home Treatment), and for the proposal to move all three health-based places of safety (Section 136 suites) based at Kent and Medway NHS and Social Care Partnership Trust (KMPT) sites to a new-build single site in Maidstone.

Focus groups were held with 19 service user groups, reaching around 230 people. An online consultation survey was viewed by nearly 1,500 people and completed by 59 people.

The public consultation responses were analysed by an independent consultancy, Better Decisions Together. This is a report of the findings of the consultation.

How can we improve mental health urgent and emergency care services?

Responses to the specific proposals for new services were generally positive, particularly for crisis houses and mental health patient transport.

Overall, the main suggestions for improvements were:

- Expanding urgent and emergency mental health support;
- improved continuity of care, in particular discharge support;
- better information and communication about crisis support; and
- improving quality of care.

The positive role played by the voluntary sector was a significant theme, in particular peer support groups and similar community groups, and safe havens where people feel listened to and not judged.

A need for better preventative services was also raised, including a need for easier access to primary care.

Views on the proposal for a single site for health-based places of safety

Views about the single site proposal were mixed.

- Just over half of respondents agreed that the proposal would improve the **patient experience**, with just under one-third disagreeing.

- Two-thirds agreed that the proposal would improve the **staff experience**, with just under one-quarter disagreeing.

Reasons for **support** for the single site proposal were largely on the grounds that a new purpose-built facility would be better for both people being assessed and staff.

Concerns about the proposal included the impacts of a single site in Maidstone on increased travel times for some people needing assessment, and potential impacts on police and ambulance services. Isolation of users from services and support networks (such as family and friends) was also raised as an issue for people who will need to travel further. The risks of a single point of failure were also raised.

Suggestions included improvements to staff training and staffing numbers, more than one site, such as sites in the east and west. Suggestions were also made about the design and layout of the facility.

Health-based places of safety (HBPoS): What is important to people?

Respondents were asked what was important to them when thinking about HBPoS. The top three issues were:

1. Improving patient care;
2. People being assessed quickly and with fewer delays; and
3. Keeping the service open 24/7.

Equality, diversity, and inclusion in mental health urgent and emergency care services.

Respondents identified barriers and challenges relating to a wide range of **equality** issues in urgent and emergency mental health services, including barriers facing disabled people; digital exclusion; impacts of the cost of living; the need for culturally sensitive mental health support; mental health stigma, particularly in some ethnic minority communities; exclusion of people who experience literacy barriers; and support for carers and families.

People also commented on issues relating to services working together, including probation, addiction support services, and domestic violence services.

Overall, respondents would like to see significant improvements to mental health urgent and emergency services, including the HBPoS facilities, across Kent and Medway.

Whilst views on the single-site proposal were mixed, most respondents felt that any HBPoS facilities provided must address access and transport challenges, support better patient experiences and wellbeing, and improve quality of care.

1. Introduction

1.1. Background

NHS organisations in Kent and Medway are working together with partners to review and improve services for people who are experiencing mental health crisis and who are in need of emergency care and urgent support.

Part of this work is a programme of engagement including a public consultation, undertaken after a considerable period of pre-consultation engagement.

The consultation sought views on proposals for new urgent and emergency mental health services, and proposals for developing a single site health-based place of safety (HBPoS), sometimes called Section 136 suites.

HBPoS in this proposal refer to the facilities Kent and Medway NHS and Social Care Partnership Trust (KMPT) provide for police officers to take adults under a Section 136 Mental Health Act order for emergency care and assessment. (A&E and also a person's home can also be considered a place of safety, depending on the person's needs.)

Alongside proposals for new urgent and emergency mental health services, the consultation asked for views on a proposal to improve services by bringing together the HBPoS (which are currently split across three sites in Maidstone, Canterbury, and Dartford), into a new, large, fit-for-purpose, Section 136 suite on the Maidstone HBPoS site.

1.2. Aims

The aims of this public consultation were:

- to gather people's views;
- to hold sensitive and safe discussions about improving mental health urgent and emergency care services; and
- to particularly focus on proposals about urgent and emergency mental health services, including KMPT's HBPoS.

1.3. Proposals: Urgent and emergency mental health services

The consultation asked for feedback about other new, planned, or proposed services for 2023/24, including:

- **Crisis houses:** Two are proposed, one in Medway and one in east Kent. They would provide people experiencing mental health crisis with a 24-hour supervised but supportive therapeutic space as an alternative to admission to mental health hospital beds. This service would be available to any Kent and Medway resident in need.
- **Rapid response service:** The rapid response service is being developed from the Crisis Resolution Home Treatment Team (CRHT), which would be split in to two services – a 24/7 rapid response service that would respond within four hours from April 2023, and a home treatment service.
- **Enhanced home treatment:** KMPT is developing a home treatment service where the team's sole function is to provide planned acute care (treatment and care for people in crisis or experiencing acute mental illness) to keep people safe and well in their own homes.
- **Mental health patient transport:** A dedicated mental health patient transport provider is proposed to transport people who need urgent admission to a KMPT hospital bed or HBPoS. The service would also take people home following a Section 136 Mental Health Act assessment, where the decision is to discharge home.

1.4. Proposals: Health-based places of safety

KMPT currently has five HBPoS assessment rooms. These are divided between three Section 136 suites in Maidstone, Dartford, and Canterbury. The suites each differ in the number of rooms and space they provide.

Currently there are about fifty people a month who require assessment under section 136 of the Mental Health Act.[1]

Despite investment in their maintenance and updated layouts over the years, all KMPT's Section 136 suite HBPoS struggle to meet local and national standards. The Kent and Medway Crisis Care Section 136 Standard was produced in 2018 and based on national best practice (including the Royal College of Psychiatry Service provision for Section 136 of the MHA) and developed with system partners across Kent and Medway. There is a marked gap between the Standard and current provision[2].

[1] It should be noted that this is a reduction from 1,500 per annum in 2021, prior to transformation work on the mental health urgent and emergency care (MHUEC) pathway.

[2] The Pre-Consultation Business Case lists some of the deficiencies with current facilities including: lack of de-escalation space; access only to shared seclusion space with inpatient services and therefore not always available to meet clinical needs; inadequate assessment space for the assessing teams – currently using the bedrooms or lounge – and therefore not meeting support needs; lack of alarms on doors; low ceilings so that lighting and smoke alarms are easily damaged; vinyl floor tiling easily damaged. The above has resulted in increasing maintenance costs and reduced access due to maintenance on a regular basis.

This has resulted in several challenges that Kent and Medway NHS now want to address, including increasing the availability of HBPoS, reducing delays in assessments, staffing challenges providing adequate or safe staffing levels, and improving overall care.

Kent and Medway have been allocated £3.7m in government funding to make improvements. The money is capital funding, which can only be used to expand or renovate an existing facility, build a new one, or buy major equipment.

The proposal that was the focus of the public consultation was to centralise HBPoS onto a single site in Maidstone.

1.5. Preferred option

A consultation sometimes puts forward different options and asks for people's views on these. Sometimes a single option is presented, and this is called a 'preferred option.' This can happen when other options have been considered, but rejected because they do not meet particular, essential criteria.

This consultation presents a single, preferred option for HBPoS.

The preferred option presented by NHS Kent and Medway is to develop a new fit-for-purpose facility that brings together the five HBPoS on the existing site at Priority House in Maidstone.

The Consultation Document (Appendix A) explains the criteria and process through which this preferred option was selected, and the reasons that the consultation has presented a preferred option rather than a selection of options.

1.6. Method

1.6.1. Consultation methodology

The public consultation ran from 21 February 2023 to 18 April 2023. It sought views on mental health urgent and emergency care services, with a particular focus on proposals to develop a single site for HBPoS.

The consultation also sought views on the wider mental health pathway, including current provision and proposed enhancements, including crisis houses, enhanced home treatment, rapid response service, and mental health patient transport.

The approach centred on questions relating to the current provision and proposed changes. The questions were asked in an online and printed survey, and through structured, open conversations in focus groups with people with lived experience of using mental health crisis services.

Demographic information was collected wherever possible.

The engagement team from NHS Kent and Medway, with the support of system partners and voluntary sector providers, endeavoured to ensure that the consultation and engagement programme reached as wide an audience as possible, with a particular focus on reaching groups that are not usually engaged with, including people from minority ethnic communities.

The nature of this service change or development is a complex one in terms of engagement. It involves engaging with a cohort of people who needed assessment under the Mental Health Act, and their families – people who are likely to have been through extremely difficult and traumatic experiences.

The team wanted to ensure that they approached this in a sensitive way that did not re-traumatise people. To plan this engagement and consultation programme, they worked with the mental health trust KMPT and the voluntary sector, to work through existing trusted organisations, groups, and relationships, to try to ensure that the engagement happened in a safe and supportive environment.

Groups and potential cohorts for engagement were approached through communications and briefings via existing mental health support networks, working with support staff in the first instance, to raise awareness of the consultation programme. The team also attended mental health support groups to have informal, face-to-face discussions with people who have used services. This ensured that discussions were held in safe, known environments where people had support staff and other trusted people to help the de-briefing process after engagement sessions.

The team wanted to make sure that they also spoke with particular communities who are not often engaged with and who may be disproportionately affected by the changes. This included people with complex emotional difficulties or serious mental illnesses, who may be particularly impacted by the change; ethnic minority communities; communities in areas of deprivation; people with drug and alcohol issues or dual diagnosis; people who are homeless; people with cognitive impairments; neurodiverse people; people with learning disabilities; and young adults, particularly those in transition from children's to adults services, age 18 – 25.

The team therefore targeted specific support groups to ensure that these conversations could be held with as wide an audience as possible.

It should be noted that this approach, whereby voluntary sector groups act as trusted routes into engagement with service users and families, could result in a bias towards VCSE provision in the consultation results. Further work and evaluation would need to be developed to explore this in more depth.

For more information on the methodology, please see Appendix B.

1.6.2. Consultation questions

The main consultation survey, and wide engagement approach, was based around six core questions.

Likert scales were used for questions asking for sentiments around agreement or disagreement with key statements.

The full consultation survey can be found in Appendix A.

- **1.** Do you have any comments on how to improve mental health urgent and emergency care services?
- **2.** Please let us know how far you agree or disagree with the following statement: The proposed changes to KMPT's health-based places of safety (HBPoS), bringing them together on a single site at Priority House in Maidstone, will improve the experience of people needing assessment under Section 136 of the Mental Health Act.
- **3.** Please let us know how far you agree or disagree with the following statement. Bringing together the KMPT health-based places of safety on to a single site at Priority House in Maidstone will improve the working environment for health care and emergency services staff (NHS and the police) involved in Section 136 Mental Health Act assessments.
- **4.** Do you have any concerns about the proposal to bring together the KMPT Section 136 health-based places of safety on one site?
- **5.** Please let us know what is most important to you when thinking about Section 136 health-based places of safety.
  - Improving patient care
  - People are assessed quickly with fewer delays
  - Less time is spent in a HBPoS, before treatment, or referral and returning home
  - Keeping the service open 24/7
  - Making sure partner agencies like the police and ambulance staff can resume other duties more quickly
  - Having a facility that is safer, more comfortable and meets modern standards
  - Reducing the need for people to attend A&E in a crisis
  - Patients receiving crisis care closer to home
  - Staff teams having a positive experience
  - Having transport home following assessment
- **6.** Do you have any other comments or suggestions about how the Section 136 health-based places of safety can be improved?

1.6.3. Participation

Structured conversations were held with 19 service user groups, reaching around 230 people. A community health and wellbeing event (organised by Rethink and Kent Equality and Cohesion Council) was led by people with lived experience and was attended by a further 160 people: NHS Kent and Medway engagement team were in attendance with information about the consultation.

The online survey had a total of 1,800 visits, with 1,447 visitors viewing at least one page of the survey. The consultation document was downloaded by 87 people. The online survey was completed by 59 people.

Overall, including visitors to the online survey, we estimate that at least 2,000 people engaged with the consultation.

1.6.4. Analysis and reporting

Every online survey response and all notes from focus groups were read and analysed by independent consultants, Better Decisions Together.

A thematic coding framework was used to identify key themes, common narratives and perspectives, and sentiments across both surveys and focus groups.

Closed questions were analysed and reported, and all free text was analysed, coded and reported by theme, with a focus on the key questions in the consultation. All comments relating to equality and inclusion were also highlighted and analysed, to enable the equality impact assessment for this programme of work to be informed by the views and experiences of users of services, families, and other stakeholders.

1.7. How to read this report

Findings are reported according to the key consultation issues, themes that emerged in analysis and an additional focus on equality and inclusion. Some cross-cutting themes may appear throughout different sections.

Key issues are highlighted in **bold** throughout the report. This is to aid understanding when reading through the chapters.

In the titles of tables or charts shown in this report, we used the expression "**n=**" to indicate the number of people who responded to the particular survey question. The "n" is short for "number" and refers to the total number of respondents. So "n=50" means 50 people answered that particular question. That number is not the same for all tables and charts, because not every respondent answered every question.

1.7.1. Interpreting and extrapolating findings

As with any research method, it is important to consider what the engagement approach means for interpreting or extrapolating findings.

- This report is a snapshot in time: people's views may change in the future.
- This was a largely qualitative exercise, which did not aim to be representative of the UK population. As such, findings (particularly graphs and quantitative data) are not statistically representative of the wider public, nor generalisable.
- Most of the face-to-face engagement work was undertaken using voluntary sector-run groups. This could result in a bias towards VCSE provision in the findings.

1.7.2. Language and terms used (glossary)

We have used the term '**respondents**' to refer to the people who have shared their views in this consultation, whether that is through directly answering the survey or talking to the Engagement Team at face-to-face groups and events.

We have used the term '**users of services**' or 'service users' to refer to people who have used, or may use in the future, the services that are referred to in this report. Other terms that might be used would be patient, client, customer or, in the case of health-based places of safety, 'person being assessed.'

The issues that are the subject of this consultation are about mental health services that are there for people in a mental health crisis, who need urgent or emergency care. Some of the terms used may be quite specific and not in common usage or widely understood by the general public. Some of these terms are:

Approved Mental Health Professional (AMHP): AMHPs are responsible for carrying out a variety of functions under the Mental Health Act. This includes making applications for people to be detained (sometimes called 'sectionning') in hospital, and making sure that the Mental Health Act and its Code of Practice are followed. (The Mental Health Code of Practice can be found at: https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983)

Crisis Resolution and Home Treatment Team (CRHT): Crisis Resolution and Home Treatment Teams, sometimes called Crisis teams, help people who need urgent mental health support. They can provide help in hospital or at home. Crisis teams usually include several mental health professionals, such as a psychiatrist, mental health nurses, social workers and support workers.

Health-based place of safety or HBPoS: A health-based place of safety is where people are detained and managed safely while an appropriate mental health assessment is undertaken. They are health-based because they are based on health service premises. Sometimes they are called "Section 136 suites." A HBPoS may be A&E if this is appropriate for the person (for example if they need immediate medical treatment) but the proposals in this consultation considered changes to the HBPoS run by KMPT.

Section 136: Section 136 is a part of the Mental Health Act that allows the police to take a person to a place of safety, if they appear to have a mental disorder, are outside of the home, and police think it is necessary to do so to keep them or others safe.

A&E (Accident and Emergency): Accident and Emergency Departments or A&E are where people may be advised to attend in a mental health crisis. They are also called Emergency Departments or Casualty.

Kent and Medway NHS and Social Care Partnership Trust (KMPT): KMPT are an NHS provider trust: that means they are part of the NHS. They provide adult mental health and learning disability services to the population of 1.8 million people in Kent and Medway, as well as specialist services for adults in Sussex and Surrey.

Mental Health Act (MHA): The Mental Health Act 1983 (as amended 2007) is a law that tells people with mental health problems what their rights are and how they can be treated. It covers assessment, treatment in hospital or the community, and pathways into hospital.

VCSE: VCSE stands for Voluntary, Community or Social Enterprise organisation. These are organisations that deliver charitable or community interest objectives. These organisations are often charities. This is sometimes called the voluntary sector.

Patient experience: The phrase 'patient experience' is commonly used to refer to the environment where people receive services, and how those people experience those services. It is similar to the expression 'user experience.' We have used the expression 'patient experience' in this report, although it may refer to the experience of people needing assessment, service users, or their families.

1.7.3. Finding your way around

Quotes are used throughout the report to illustrate points, not replace narrative. When using respondents' own text, these are provided verbatim, without changes to spelling or grammar.

Summaries

Summaries are presented at the start of each chapter, in blue blocks such as this. These provide a brief overview of the key issues and take-aways for each chapter.

2. How can we improve mental health urgent and emergency care services?

Summary

The majority of feedback received related to respondents' experiences of mental health urgent and emergency services, and mental health support more widely.

Responses to the specific proposals for new services (crisis houses, Rapid Response Service and Enhanced Home treatment, and mental health patient transport) were a small part of the wider feedback. These responses were generally positive, particularly for crisis houses and mental health patient transport.

Overall, the main suggestions for improvements were expanding urgent and emergency mental health support; improved continuity of care (particularly discharge support); better information and communication about crisis support; and improving quality of care.

A significant theme was the positive role played by the voluntary sector, in particular community groups, such as peer-led support groups run by the voluntary sector, where people feel listened to and not judged.

A need for better preventative services was also raised, including a need for easier access to primary care.

A key area of feedback in the consultation related to people's views about how urgent and emergency mental health services could be improved, with reference to proposals for improvements to the pathway.

These improvements included proposals for crisis houses, developing a Rapid Response Service and Enhanced Home treatment service, and developing mental health patient transport. It also included improvements to existing services, such as Safe Havens and Crisis Cafes.

Overall, the majority of the feedback from respondents focused on general feedback about urgent and emergency mental health services as a whole, and mental health support more widely. This is particularly true of the face-to-face

feedback, where people were keen to share their experiences, raising concerns and offering feedback about how improvements could be made, as well as which services they valued.

As such, the feedback did not always pertain exactly to the new service proposals but also covered feedback for mental health support more widely.

This chapter considers all this feedback, which is broader in scope than the initial consultation question, in the spirit of respecting the experiences that people have generously shared about mental health services. It therefore considers the feedback received, for both the survey question: "Do you have any comments on how to improve mental health urgent and emergency care services?" as well as general suggestions captured elsewhere, and comments relating to mental health support from face-to-face engagement.

2.1. New service proposals: Crisis houses

There were very supportive comments about the proposal for crisis houses.

There were suggestions about what crisis houses should look like: **comfortable, cosy spaces** with a non-clinical feel.

There were suggestions that **more than two** crisis houses would be needed.

There was a suggestion that a psychiatrist would be needed at a crisis house.

> **"The crisis houses are a good idea: we need a safe place to go when you need to get everything out of your head. A place which is welcoming and is more accessible than NHS mental health services are. You are more likely to accept help and try new things in a welcoming and comfortable space where you are accepted.**

2.2. New service proposals: Rapid Response Service and Enhanced Home treatment

One of the new proposals is to develop the rapid response service from the Crisis Resolution Home Treatment Team (CRHT), which would be split into two services – a 24/7 rapid response service that would respond within four hours from April 2023, and a home treatment service.

There were very few comments relating to this proposal.

One respondent said that the current CRHT takes up to 72 hours to respond, so there was a need for a **more rapid response** service.

Respondents commented that the current CRHT spends **too little time** with patients (for example, an incident where they only stayed for ten minutes) and patients and families are then left without support.

Comments also included that people wanted **staff that they knew** on the crisis team, and that a rapid response service should be quicker than 4 hours, as people in crisis may not be able to wait that long.

> **The CRHT being split up is also a good idea. Maybe the enhanced support at home could follow up after the crisis house?**

2.3. New service proposals: Patient transport

Of all the new service proposals, mental health patient transport received the most responses. Respondents were generally **in favour** of the changes to patient transport, feeling that current patient transport had negative impacts on some peoples' mental health.

Respondents recalled experiences with current patient transport which they had found very **distressing**. They described their experiences of being put into a 'caged van' when in mental health crisis, that was dirty and smelly. They described the experience as frightening, and recall staff who were not supportive or sympathetic and were laughing or talking. One respondent recalled being put into the van after a serious sexual assault. The van was described as like a 'riot van'.

Respondents noted that dedicated patient transport would **free up police vehicles** and ambulances and be **less traumatising or stigmatising** for distressed people. Respondents felt that police vehicles can make people feel like criminals and not vulnerable people needing care.

Respondents felt that ambulances or police cars are **too stimulating** (lights and noise) or frightening and not calming. Respondents recalled feeling **guilty** that they were using ambulance time when they did not feel they needed an ambulance. Some described an obvious police presence as triggering.

Respondents suggested **calming elements** to incorporate into the patient transport, such as calming colours, calming music, and access to communication tools (like drawing or art), that may enable them to communicate with staff in other ways than talking. These issues may be particularly pertinent for **neurodivergent** people.

Another suggestion was to staff patient transport with one paramedic, rather than two, and a trained driver, which could enable veterans to gain employment and be trained 'on the job' as paramedics or similar.

Respondents also suggested that patient transport staff **do not have uniforms**, and that the car is **unmarked and without lights**.

One concern that was raised about patient transport is that it would need to be sufficient to meet demand.

> **Current patient transport is like a cage. I would want it to have both ambulance and police features, equipped and comfortable. It would be good to have a paramedic in the back with you and it's nice to have a non-judgemental person to talk to. Also – you don't know where you are going and want to be told – informing is important. There's a lot of stigma with police car.**

Respondents also raised the issue of people **returning home** with patient transport. This was important to people, particularly if the journey home is lengthy or they are being discharged late at night.

Respondents noted that some people may prefer not to use patient transport home, preferring to travel home with a family member or friend instead.

Respondents recalled having to return home by taxi with no support.

Respondents also suggested having patient transport, such as an agreement with a taxi service, to help people get to crisis houses and home again.

2.4. Urgent and emergency care mental health services: General themes

2.4.1. Expanding urgent and emergency mental health support

Overall, respondents' experiences of urgent and emergency care were **mixed**.

Respondents suggested a need for more accessible mental health services, including prevention services, peer support services, and services that provide out-of-hours support.

Some respondents felt that people needed to be **very ill** to get crisis support, but even when they had been very ill or suicidal, they did not feel that they were well supported by services, particularly when calling telephone lines for help and support.

It should be noted that there are several crisis lines run by different providers, and respondents were not always clear about which source of support they were referring to.

Overall respondents expressed a **lack of trust** in helplines, feeling distressed about the length of call-back **waiting times** or not hearing back at all. They described the wait for a call-back as extremely distressing and difficult.

When they did receive telephone support, some respondents felt that they were not given enough time or received **inadequate responses**, such as suggestions 'to have a bath' or 'make a cup of tea.'

Respondents said that they had found NHS 111 to be a good service when they were in crisis, describing staff as calming and understanding.

Respondents also felt that **face-to-face** crisis support was extremely important, both for the person in crisis and for the staff to properly assess how someone was presenting in a crisis. One respondent stated that face-to-face services were important to them as they were deaf.

Some respondents expressed feelings that the NHS had failed to offer any helpful support, or had made them worse, or even suicidal. Some respondents felt that the lack of NHS response meant that the **voluntary sector was left to 'pick up the pieces'**.

> **"My personal experience of using the Urgent Mental Health Helpline was that it set off a series of hoop jumping exercises: the initial phone call with them, an assessment with them, a potential assessment with the CMHT, before getting any kind of appropriate support (or going on a long waiting list). On numerous times I was discharged from getting support because I couldn't take a phone call from them at a time they decided was good. While in principal it's a great idea, the reality and experience I had was very different.**

Respondents also raised concerns about the **processes for referral** and getting support, recalling experiences of complex and lengthy referral processes leading to slow access to support and a lack of consistent support staff.

Concerns were also raised about the current A&E provision and lengthy waits for assessment. Some respondents reported having to wait overnight to be seen and having to sleep on the floor, or having to stay in medical wards due to long waits for assessments. People also raised concerns that the waiting areas in A&E felt unsafe and too small.

2.4.2. Discharge and continuity of care

Concerns about discharge from crisis care were also raised (some of which related to discharge from secondary mental health services). Respondents felt that they had been discharged to teams or staff that they didn't know or felt left to 'fend for themselves' after being discharged.

Respondents spoke about bouncing back to inpatient care after not being given enough support back in the community.

> **"Maidstone (HBPoS) service is okay, but I did not get an outcome or support afterwards. I was sent back on the street. I kicked off and then ended up at the hospital from self-harm. I feel like I have to kick off to be seen.**

2.4.3. Information and communications about crisis care

Another key theme was the need to ensure that existing services, including crisis services and Safe Havens, are better promoted.

Respondents said they **did not know** what support was available, particularly community support such as Safe Havens, and felt it was not widely advertised or understood, either by service users or by partner services.

Respondents spoke of **communication between services being poor**, with services giving out-of-date information, including signposting to services that no longer exist. Respondents spoke about the need for information to be available in different formats and platforms, and not just digital, so that it was available to a broad audience, including those who do not have smart phones or internet access. It was noted that internet access was sometimes only available to people in a local library.

Respondents flagged that people in a mental health crisis in particular, may not be able to use smartphones or access digital information. Wider use and promotion of **Z-cards** was also suggested (pocket-sized information cards which signpost people to mental health support).

2.4.4. Improving quality of care

Suggestions included a need for more individualised care with known and trusted staff who provide continuity of care.

Staff attitude and **staffing levels** were raised as an area of concern, with concerns that staff were not always sufficiently compassionate and that suggestions from staff were often glib or inadequate. This included some staff from health services and some police officers.

Respondents suggested staff **training**, including specialist training in neurodiversity.

Concerns about staffing levels were also raised, particularly insufficient staffing for keeping HBPoS open.

Concerns were raised about the **staffing levels for Psychiatric Liaison** services in A&E departments, with respondents reporting long waits. Some respondents felt that some A&E staff were inconsiderate of people presenting with mental health crises or self-harm. People also felt that specialist mental health staff were not often available to support staff in the A&E.

> **"Far too often police are the first and only resort for those in mental health crisis, as the teams supposedly meant to be there for them are virtually non-existent and provide little.**

Examples of **positive staff interaction** were also given, including police officers who had been compassionate and supportive, and NHS111 staff who were singled out as helpful, understanding, and supportive.

Issues were also raised around a **lack of continuity** of care overall, including when moving area where services are different and offer different types of support.

A lack of **consistent trusted staff** or care coordinator was also raised, including having multiple social workers.

Changes to service providers can also lead to gaps in service provision, leading to feelings of abandonment.

2.5. Voluntary sector support

A significant theme was the positive role played by the voluntary sector. When considering this feedback, it should be noted that a significant amount of the face-to-face engagement was undertaken with groups run by the voluntary sector.

Respondents spoke extremely positively about the support they received from **community groups** run by the voluntary sector, where they feel listened to and not judged. Services that included one-to-one support from peer or support workers, as well as wider peer support groups, were highly valued.

VCSE services were described as feeling like a community, and a place where people trust each other and do not judge, but understand what others are going through. The informal nature of clubs, peer support groups, and smaller community groups was considered especially helpful as a source of trusted support.

Peer support was mentioned as important because peer supporters could relate to what respondents were experiencing.

> **"Take off is a peer led organisation, where previous members receive training and become peer support workers. That's helpful, not like professionals who are well educated and trained, they also have first hand experience. It helps working with someone who has had first hand experience.**

Respondents valued the opportunities that such groups gave them to **socialise**, and to participate in **activities** such as crafts, arts, sports (such as a table tennis), and learning about new things, for example through guest speakers.

The **leaders and staff** of community groups were singled out as being helpful in advocating for wider support for respondents. The groups were also considered trusted sources for information.

Positive feedback was consistent for Safe Havens. These were valued by people who had used them, but it was felt that they were not widely known about, and that

opening hours needed to be expanded – respondents said it was very hard to get support at night or at weekends. Respondents felt that Safe Havens offered a better experience than attending A&E.

There were concerns about the **pressure** that the voluntary sector was under, as it was having to 'mop up' where there are insufficient mental health services. Where health and social care services are not able to meet the needs of mental health support, voluntary sector services are having to deal with situations that are high-risk and complex. Local organisations are therefore left feeling overwhelmed.

> **"I work in a supported living scheme with people who have mental health difficulties and often CMHT services don't touch them, and so we end up back at Single Point of Access (crisis service). No one seems to want to help before they get into crisis, and our difficulty is that the community mental health is a no man's land.**

There were also concerns that VCSE services were under financial pressure and potentially facing cuts. It was noted that some voluntary sector organisations may wish to be involved in bidding for new mental health services but may lack the infrastructure and support needed.

2.6. Prevention: Primary care and wider preventative services

2.6.1. Primary care

Respondents had experienced **difficulties accessing a GP** for mental health support, with some saying they went to **A&E as an alternative** or were signposted to A&E by GP receptionists. One respondent said they were accessing a private GP because they had been unable to access their NHS GP.

Mental Health nurses in primary care practices were spoken of positively, although respondents noted that these are not available at all practices.

Concerns were also raised about a lack of **medication reviews** in primary care, or GPs prescribing medications when respondents felt that other support would be more appropriate. Some respondents felt that their GP prescribed medication without proper knowledge or understanding of the potential side effects, interactions, or contraindications with other medications.

2.6.2. Prevention

Respondents reported a need for more **preventative services**. They spoke of the challenges accessing support if you have a **dual diagnosis** or issues related to other

support services, including prison or probationary services and domestic violence support services.

Respondents raised issues relating to access to talking therapies, reporting that they were told their issues were too complex for talking therapies, or only being allowed a certain number of sessions.

Respondents felt that some people do not meet criteria to receive services such as talking therapies or Community Mental Health Team support, and therefore end up in crisis as there seems to be no other services that can take them at that time.

A lack of preventative services for people thinking about **self-harm** was also raised.

> **"The ideas are good, but more is needed for those in between: people not severe enough for one service, and too severe for another: this would prevent the need for crisis support.**

3. Views on the proposal for a single site health-based place of safety

Summary

When asked whether the proposal would improve the patient experience, **just over half of respondents agreed that the proposal would improve the patient experience**, with just under one-third disagreeing.

When asked about staff experience, **two-thirds agreed that the proposal would improve the staff experience**, with just under one-quarter disagreeing.

Concerns about the proposal included the impacts of a single site in Maidstone on increased travel times for some people needing assessment and therefore for police and ambulance services. Isolation of users from services and support networks (such as family and friends) was also raised as an issue for people who will need to travel further. The risks of a single point of failure were also raised.

Suggestions included improvements to staff training and staffing numbers, and having more than one site (such as sites in the east and west). Suggestions were also made about the design and layout of the facility.

The consultation explored several questions around the single site proposal for health-based places of safety.

Respondents were asked both closed and open questions. The closed questions related to whether they agreed or disagreed that the proposal would improve the patient and the staff experience. The open (free text) questions asked for concerns, suggestions, and any other comments about the proposal.

3.1. Will the single site proposal improve the patient experience?

The consultation survey asked respondents to give their views on whether the single site proposal would improve the experience of people needing assessment. This question was asked using a Likert scale (a five-point scale from 'strongly agree; to 'strongly disagree').

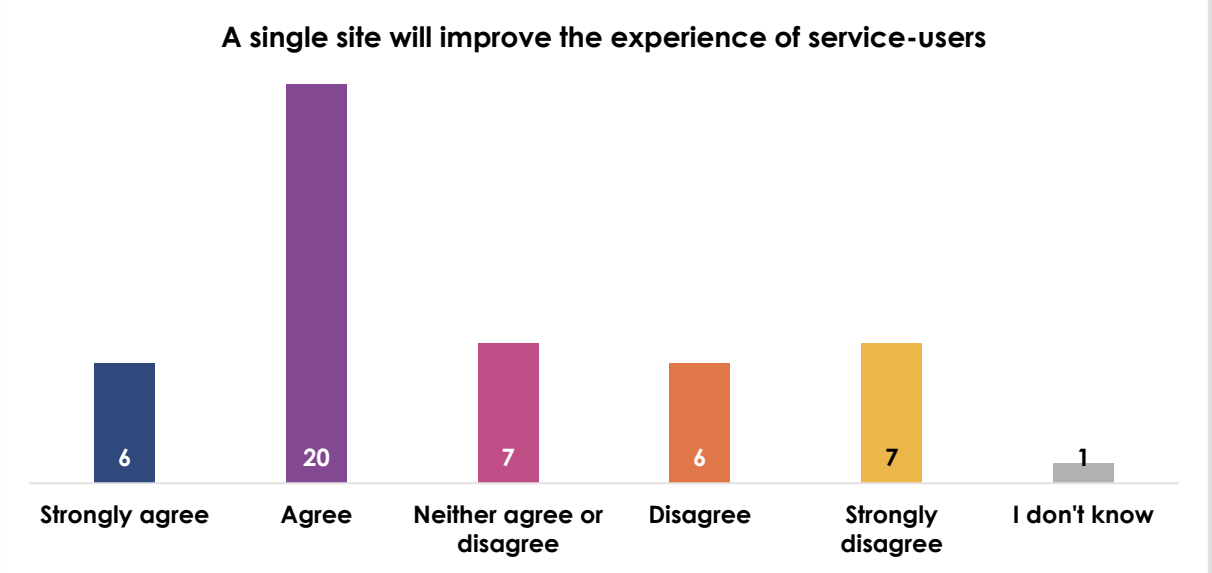


Figure 1: Respondents' views on the statement "The proposed changes to KMPT's health-based places of safety (HBPoS), bringing them together on a single site at Priority House in Maidstone, will improve the experience of people needing assessment under Section 136 of the Mental Health Act." (n=47)

Overall, of the respondents who answered this question, just over half (55%) agreed that the proposal would improve the patient experience, with just under one-third (28%) disagreeing, and just under one-fifth (17%) neutral about the proposal.

3.2. Comments in support of the single site proposal

Some respondents commented in support of the proposals. Reasons for support were largely that a new modern building would provide a better, fit-for-purpose facility that would benefit staff and people needing assessment.

Respondents noted that the current facilities are poor. Comments included the difficulty of finding an appropriate, quiet place to carry out assessments at the current time.

Respondents also saw the proposal as a solution to some staffing issues and police or ambulance waiting times, freeing up police and ambulance staff to focus on other call-outs. Respondents positively commented that the proposals would reduce the need for people needing assessment to wait in police vans.

Respondents commented that a modern facility would be fit-for-purpose and better than retro-fitting existing premises.

> **A new build facility is likely to be the best option. Fitting out older buildings, like the s136 suite at Canterbury (St Martin's) is never going to be as well-designed, especially for the safety of both service users and staff, as a new build designed based on best practice.**

3.3. Comments raising concerns about the single site proposal

Respondents' concerns about the proposed single site facility were generally around the themes of travel and transport, staffing, and concerns that the proposed facilities (in particularly the number of beds) are insufficient to cope with demand.

3.3.1. General opposition

Some respondents were strongly opposed to the proposal for a single site facility. They felt it would have a negative impact on people needing assessment and families, who may have to travel further to be assessed, which would be distressing in a crisis.

Concern was raised that a single site model may have a greater impact on deprived communities, and the disproportionate impact of Section 136 detainments on ethnic minority communities was raised as an issue that respondents felt needed more attention.

Respondents also felt that it may not help the staffing crisis, which was a problem throughout the NHS, and may exacerbate this as staff may resign rather than travel further to work.

Some respondents felt it would not achieve an improved service, but would just move existing problems onto a single site.

> **I am astounded that you are now suggesting to take what little support there is out there for seriously unwell people and concentrate it in a town miles away from where people live. Unbelievable. When my family member has a crisis and is sectioned, they need a place of safety that is near home and can be got to quickly.**

3.3.2. Travel and transport

Concerns around travel and transport centred on the proposal to centralise services in Maidstone, which would mean that some people needing assessment have further to travel due to increased distances their home or local area.

> **Kent is a large county - but reducing the coverage across the county will become more challenging for people to access services when they need them.**

Concerns were raised that some people needing assessment may be **further from their homes** and from their **support networks**, which may increase the **isolation** that they feel. Long journeys for people needing assessment – and for family and carers – were raised as a concern.

Concerns were raised about how people needing assessment and their families would **get back home**, after assessment in a centralised venue.

> **That's a long way to go for some people in crisis and families that may want to visit family in crisis.**

Concerns were also raised that people needing assessment may travel a significant distance to Maidstone only to be admitted to a ward back across the county in East or North Kent – the long travel times may be difficult and distressing.

Respondents commented on the difficulties of this for people needing assessment and for staff. Concerns were raised that the staff who may be travelling long distances with people needing assessment (particularly police) would find it very **difficult to manage**.

Concerns were also raised that longer journeys would mean that **more police time** was needed to transport people.

3.3.3. Risk of single point of failure

The lack of alternative locations and the **reliance on one location** was raised as a concern as there would be a single point of failure. Concerns were raised that if there were problems on the premises, a centralised model would not allow for alternative venues to take over as a back-up. Concerns were also raised that the reliance on one location may be a problem if major transport routes are closed.

> **Savings can be made with centralisation of this nature, but in the event of an issue with the suite, you have no back-up option. Staffing must be resilient to this, or this will see an increase in going out of county for beds which obviously results in a detriment for the patient in travel time and unnecessary distress, a detriment to the ability of the police to handover and carry on with their core function, and an unnecessary expense.**

Suggestions included having more than one HBPoS – for example, one in the west of the county and one in the east of the county.

3.3.4. Staffing

Comments about staffing generally centred on concerns that there would not be sufficient staffing to ensure the HBPoS was resilient. Concerns were raised that current staffing levels are insufficient and staff are not adequately experienced.

There were concerns that if there are more people needing assessment in one location, then the staff there may be stretched and under pressure.

> **The site should be able to realistically accommodate all admissions with safe staffing levels.**

Concerns were also raised about staff who may lack training or experience, particularly from past service users who raised concerns that staff came across as rude and uncaring and did not provide a quality service. Other concerns included whether staff would be properly trained and suitably experienced.

Concerns were raised that in the longer-term, staff would be reduced due to ongoing pressure for cost savings, and this may result in increased waiting times and a reduction in available beds/suites.

3.3.5. Facilities insufficient for demand

Concerns were raised that the proposals would not lead to improvements but would result in a perception of a reduced service, with current challenges continuing to persist. There were concerns that centralising may also increase assessment times, particularly if the facility was busy.

Concerns were raised that five HBPoS were not sufficient at the current time, and that centralising them would not address this insufficiency.

> **Bringing staff into one place means that you can concentrate expertise, but to the lay person, it just looks like a reduction in service availability.**

3.4. Suggestions about the single site proposal

Respondents felt that a HBPoS should be warm, friendly, and safe, and made many suggestions about how this could be achieved, including increasing the workforce, improved staff training, and more locations and more beds (for example, sites in the east and west to better balance transport distances). Suggestions were also made about the design and layout to improve the patient experience, such as a discharge lounge.

3.4.1. Staff and staffing

Increasing staff levels was a common theme in respondents' suggestions. Employing more staff, especially out of hours, to ensure that the facility was fully staffed to enable all beds to be used. Suggestions also included having trained staff available at A&E, rather than relying on police or nursing staff.

Suggestions included employing specialist staff or training staff in areas such as minor physical injury (to avoid A&E attendances), alcohol intoxication and working with carers, as well as improving communication skills with people in crisis.

Other suggestions included investing in apprenticeships, or working with younger people to encourage them to consider careers in mental health services.

Consideration of how Advocates can be used was suggested, to help people get the support they need and explain the process.

Better partnership working was suggested, particularly with the homelessness service or for people leaving foster care. A suggestion was made of a single point of access for local authority homelessness and leaving care services.

> **"Yes more experienced staff working there, listening to carers as well as the patients as they are the ones who understand and know what is really going on regarding patient at crisis point.**

3.4.2. More than one site

Suggestions included having more than one site, local sites, or one in the east and one in the west. Suggestions also included having a HBPoS on site at A&E. Local hubs are also suggested.

Some felt that some of the challenges of a single site could potentially be mitigated by better communication around travel and transport options for people needing assessment and their families.

> **If this were two sites then the distances between a patient's home and the site would be reduced, not only for them but also the emergency staff. Look at the current situation regarding hospitals, where some have to travel three-quarters of the way across Kent to be seen. For an unstable person this would reduce the likelihood of them volunteering for help.**

3.4.3. Increased number of beds/suites

Some respondents felt that the number of beds/suites needed increasing from the current five, which was described as inadequate and contributing to long waiting times for police services.

> **There must be more spaces created at S136 suites. Hours and hours of police time is wasted waiting for these spaces. The NHS and ambulance services simply must take more responsibility for what is their remit. Police must not be used to supplement a lack of resources by the NHS and local services.**

3.4.4. Building design

Respondents suggest that the building must be built to a high specification, prioritising patient and staff safety. It should be able to withstand intentional damage, with full anti-ligature furniture, isolation suites for covid or otherwise, 'airlock' entry and exit, and remote patient monitoring in seclusion rooms.

Spaces built with autistic people in mind, or for people who need sensory reduction was suggested: quiet spaces where people can retreat. Some respondents suggest that detaining autistic people in a HBPoS should be avoided at all costs, using the home or a familiar environment for assessment instead.

Suggestions included ensuring separation for aggressive or agitated people, and sensitive design of mixed gender environments, especially considering the management of people who are sexually disinhibited.

Several respondents shared their experiences in Section 136 suites as being detrimental due to the design of the suites, which contributes to a feeling of being disempowered, imprisoned and an increase in distressing feelings. Respondents described being left scared and alone, in rooms with a padded chair or a mattress in the corner, with nothing on the walls, mesh wire over closed windows and locked doors. They recall not being allowed a watch, a phone, book or newspaper or anything to distract them or occupy their time. These respondents felt that more consideration needed to be given to the impact of decisions around removing such items and leaving people without any distraction or means of relaxation.

Other suggestions included bean bags, outside space and garden furniture, pictures on the walls and sunbeds.

Suggestions were also made to consider how tradespeople would work when repairs are needed, and how the facility would be designed to avoid closure in such situations.

A discharge lounge was suggested to avoid increasing waits.

Using a pre-fabricated building to save costs was suggested.

> **"Don't keep me locked up like I was in a prison. Having access to fresh air, getting a walk; having access to music and something to read. While you're in there you need something, otherwise it'll make you worse. You go in with a problem and they take everything away from you and that makes your problems worse.**

3.5. Will the single site proposal improve the staff experience?

The consultation survey asked respondents to give their views on whether the single site proposal would improve the experience of healthcare and emergency services staff (NHS and police) involved with Mental Health Act assessments.

As with the question about patient experience, this question was asked using a Likert scale (a five-point scale from 'strongly agree; to 'strongly disagree').

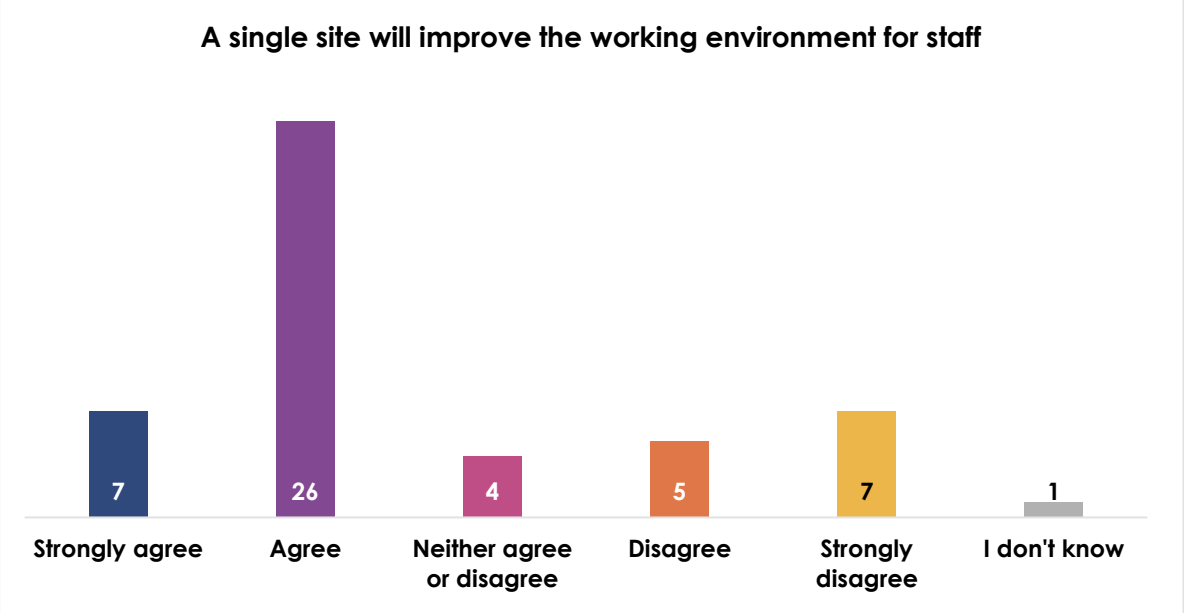


Figure 2: Respondents' views on the statement "Bringing together the KMPT health-based places of safety on to a single site at Priority House in Maidstone will improve the working environment for health care and emergency services staff (NHS and the police) involved in Mental Health Act assessments." (n=50)

Overall, of the 50 respondents who answered this question, two-thirds (66%) agreed that the proposal would improve the staff experience, with just under one-quarter (24%) disagreeing, and one-tenth (10%) neutral.

3.5.1. Impact on staff and staffing

Concerns were also raised about the impact of centralisation on staff; that the workload may be stressful and that role clarity may be an issue for centralised teams. Concerns were raised that staff may resign and this could compound staff shortages.

> **"Management should greatly think about the welfare of staff who would be looking after 4 to 5 patients that may be having serious mental health challenges in a single unit. Having to deal with one patient is very challenging and can be very exhausting for staff. How much more looking after 4 -5 patients with the most challenging mental health problems in a single unit.**

3.5.2. Comments on improving the staff experience

There were very few comments on whether the single site proposal would specifically improve the experience of staff.

Respondents who commented generally thought that the improved working environment would benefit staff. However, it was also commented that police time may be wasted with additional transport hours.

> **"It's good to improve working environment for health care and emergency services staff, especially if this then facilitates a better service for users.**

3.6. Comparison of sentiment of staff responses and all other responses

It is useful to compare the staff sentiments about proposals with the sentiments of people who are not staff, as staff may have a different perception and understanding to other respondents. This is particularly pertinent when one driver for the proposal is to improve the staffing of the HBPoS.

The closed questions in the consultation survey are the simplest way of comparing the views of both groups.

Respondents on the survey had the option of indicating whether they were a partner staff member, or a voluntary, community or social enterprise staff member. Comparing these responses with all other respondents', shows that all respondents

show a broadly similar pattern of sentiment about the proposals when considering both the staff experience and the patient experience.

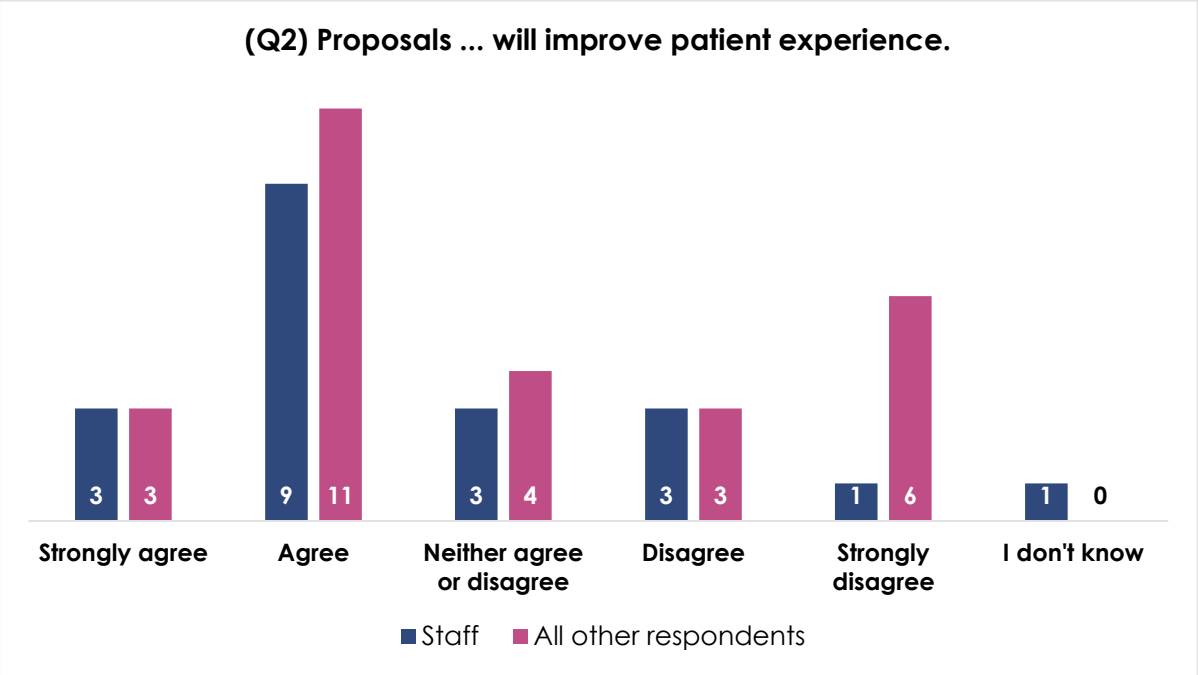


Figure 3: Responses showing agreement/disagreement with the statement that the proposed (single site) changes will improve the experience of people needing assessment under Section 136 of the Mental Health Act, showing staff responses and all other responses.

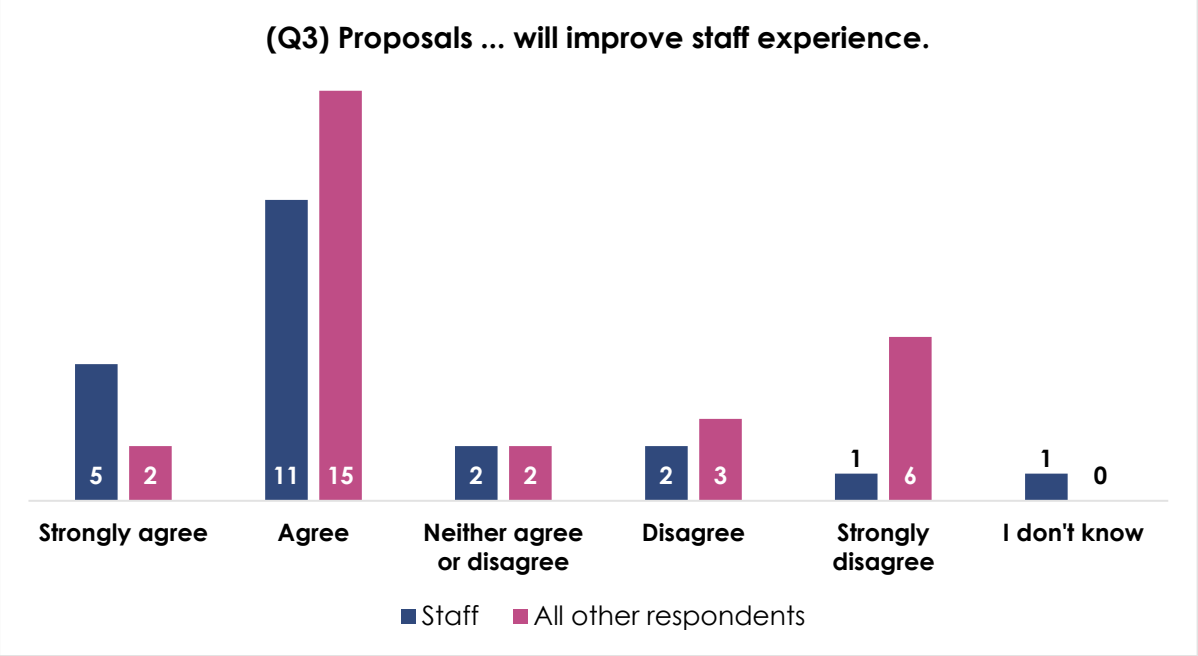


Figure 4: Responses showing agreement/disagreement with the statement that the proposed (single site) changes will improve the working environment for health care and emergency services staff (NHS and the police) involved in Mental Health Act assessments,' showing staff responses and all other responses.

4. HBPoS: What is important to people?

Summary

Respondents were asked what was important to them when thinking about health-based places of safety. The most commonly chosen issues were:

1. Improving patient care;
2. People being assessed quickly and with fewer delays; and
3. Keeping the service open 24/7.

In the consultation survey, respondents were given a list of ten key issues and asked what were important to them in relation to HBPoS.

Respondents could select how important these things were to them using a Likert scale (five options from 'very important' to 'not very important').

Respondents were asked: 'Please let us know what is most important to you when thinking about Section 136 health-based places of safety.'

- Improving patient care.
- People are assessed quickly with fewer delays.
- Less time is spent in a HBPoS, before treatment, or referral and returning home.
- Keeping the service open 24/7.
- Making sure partner agencies like the police and ambulance staff can resume other duties more quickly.
- Having a facility that is safer, more comfortable and meets modern standards.
- Reducing the need for people to attend A&E in a crisis.
- Patients receiving crisis care closer to home.
- Staff teams having a positive experience.
- Having transport home following assessment.

The most commonly chosen issues were:

1. Improving patient care;
2. People being assessed quickly and with fewer delays; and
3. Keeping the service open 24/7.

It is perhaps notable that while transport and distance from home were frequently raised as concerns in relation to a single site HBPoS, these were the issues that were chosen less frequently in the prioritisation question.

Responses to the prioritisation question are shown in the chart and table below, where they are ordered by the importance that respondents assigned to each issue.

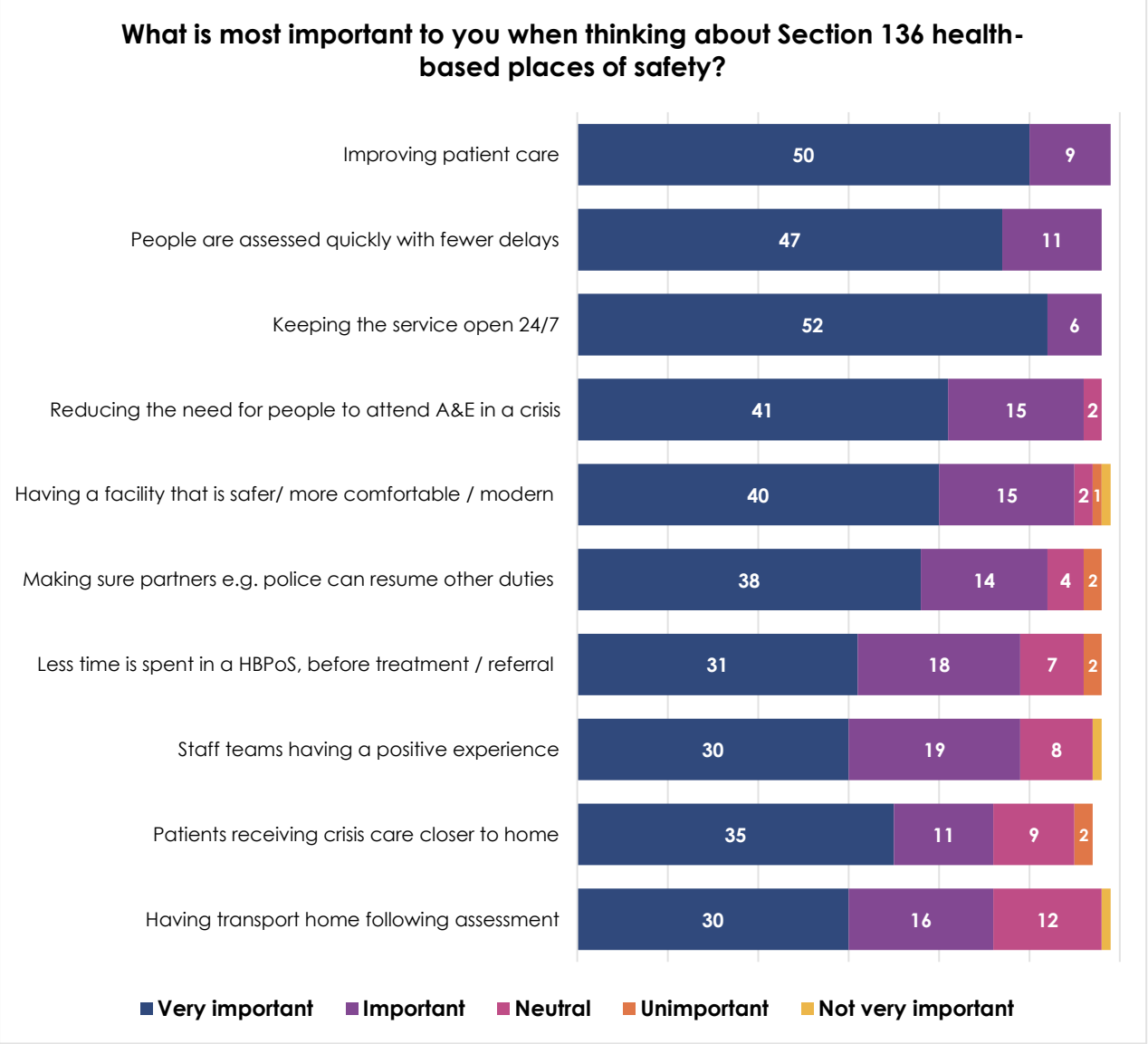


Figure 5: Responses to the question: 'Please let us know what is most important to you when thinking about Section 136 health-based places of safety.'

Most of the respondents consider all of the issues to be important (either very important or important), but the number of respondents who selected the top three issues as 'very important' indicates that respondents considered these to be the three key issues. The breakdown of numbers in the table below shows this in more detail.

Table 1: Responses to prioritisation question

What is most important to you…	Very important	Important	Neutral	Un-important	Not very important
Improving patient care	50	9	0	0	0
People are assessed quickly with fewer delays	47	11	0	0	0
Keeping the service open 24/7	52	6	0	0	0
Reducing the need for people to attend A&E in a crisis	41	15	2	0	0
Having a facility that is safer/ more comfortable / modern	40	15	2	1	1
Making sure partners e.g. police can resume other duties	38	14	4	2	0
Less time is spent in a HBPoS, before treatment / referral	31	18	7	2	0
Staff teams having a positive experience	30	19	8	0	1
Patients receiving crisis care closer to home	35	11	9	2	0
Having transport home following assessment	30	16	12	0	1

5. Equality, diversity, and inclusion in mental health urgent and emergency care services.

Summary

Respondents commented on issues relating to inclusion and equality in mental health support.

This included identifying barriers and challenges relating to a wide range of equality issues. These include barriers facing disabled people; digital exclusion; impacts of the cost of living; the need for culturally sensitive mental health support; mental health stigma, particularly in some ethnic minority communities; exclusion of people who experience literacy barriers, and support for carers and families.

People also commented on the segregation of services and the issues relating to services working together, including probation, drug services and domestic violence services.

This chapter highlights the findings that have emerged that look at the issues through an intersectional lens, focusing on inclusion and inequality.

Comments related both to urgent and emergency mental health support but also prevention and mental health support more widely.

5.1. Disability exclusion

Respondents commented that when ill or in a crisis, crisis services often had too high **expectations** of what people in crisis could do, as they may be unable to undertake tasks that they were usually able to do, such as communicating, completing paperwork, answering the phone and holding telephone conversations, and accessing the internet.

Disability adjustments such as the need for face-to-face appointments, including GP appointments, was raised by a respondent who was deaf: this respondent also said

they had not been offered counselling services. One respondent was unable to attend a community support group because they had oxygen tanks.

Concerns were raised about **patient transport provision for disabled patients**, or patients who need adjustments for transport, such as carers accompanying them to the HBPoS.

> **Ensure your staff have thorough and good, co-produced and co-delivered training in neurodiverse minds and their needs, particularly autism but also learning disabilities, ADHD and any others, to avoid misdiagnosis and mis-medication. Ensure there are community mental health services for autistic people, as these are currently lacking.**

5.2. Access inequalities

Digital exclusion was also mentioned, with some respondents without access to the internet. Access for people who are unable to read or write, or who do not have English as a first language, was also raised.

> **[After discharge from a mental health inpatient ward] I did a lifeline group online course – but could not load it onto my phone and couldn't get connected. I was viewed as failing to attend. If you are not mentally well and in a crisis – who do you go to? Face to face is better.**

Inequality of provision ('postcode lottery') was raised regarding a lack of local services in some areas, noting that some patients could find travel stressful. Swale and Dover were specifically mentioned as areas without much local support.

Some respondents raised the issue of mental health support services being segregated by age, and suggested that inter-generational peer support may be valuable.

The cost of living and economic hardship was mentioned as an issue that resulted in some people being unable to access services, particularly if they are on benefits. Services such as peer support activities are often charged for, but even nominal sums may be too much for some people; some groups also require membership fees. The cost of travel to activities and support groups was a further issue raised.

Suggestions included offering free travel cards.

Access for people in vulnerable situations: The issue was also raised of the difficulties accessing support for people who have come out of prison services, or who have been the victim of domestic abuse or violence.

> **You get no help in prison at all, since I came out no agencies will take me on as condition of my license not to be near vulnerable people – that's who services mainly deal with, so there is no help available for me at all. They can't see me.**

Suggestions also included **mapping patient's home locations** to ensure that the centralised HBPoS was sited in the right part of the county, appropriate to demand.

5.3. Culturally sensitive mental health services

The issue of mental health stigma was raised as a particular barrier by some respondents from diverse cultural backgrounds, particularly black African backgrounds.

> **You have to understand for our communities it is very difficult to admit people have a mental health need, its still very stigmatised in our communities. Especially in the African culture we keep such issues within the family; we don't discuss these things or ask for outside help.**

There is particular stigma associated with seeking help outside the family group, so people may present in a crisis due to a lack of earlier, potentially preventative interventions.

> **From a Nigerian perspective we don't have the awareness of services and wouldn't think to go to a psychiatrist or seek mental health help. People are still called 'mad'. If an individual deteriorates and the family can't cope, they can end up on the street, naked, having never been treated.**

This may be a particular issue for young black people, who may be dissuaded by their families from seeking help. There is a risk that such young people may become especially isolated at home and unable to seek help.

People from some ethnic minority communities may seek pastoral support from their church or faith leaders, however, some respondents noted that spiritual or community leaders may not have the relevant training or experience to manage people with mental health support needs.

People from some communities may also not want to seek mental health support because of a fear that their children may be taken away from them.

It was suggested that community and faith events may be good places to raise awareness and promote mental health support services.

> **Not being able to speak up is one of the cultural issues – people don't want to be seen as weak, or mad; these are taboo issues for people with African heritage.**

5.4. Carers' support

Support for families and carers was also raised, with respondents saying that training was no longer available for carers. The need for support for young carers was also raised.

It was also noted that carers themselves, when they are in a mental health crisis, may be unable to leave their caring responsibilities to seek help.

> **I phone my family, I get more help and support from them than from the professionals. But when you are ringing them all the time to get help, you feel like a burden to them, they have no one to support them.**

6. Conclusion

People who have used mental health services, their families, partner staff and wider stakeholders have shared their views and many personal experiences of mental health urgent and emergency support. Respondents expressed their experiences, concerns, and suggestions for improvement.

Views on proposals

Centralisation of HBPoS: Views about the proposal to centralise HBPoS on the Maidstone site were mixed, but overall, more positive than negative. Overall, just over half of respondents to the survey agreed that the proposal would improve the patient experience, and two-thirds agreed that the proposal would improve the staff experience.

Crisis houses: The proposal for crisis houses received very supportive comments. Respondents emphasized the importance of having safe, welcoming, non-clinical spaces that are perceived as more accessible than statutory mental health services.

Mental health patient transport: This proposal received many positive responses. Respondents generally supported the changes, highlighting the negative impact of current patient transport on mental health. Experiences of being transported in uncomfortable conditions, such as "caged vans," were shared. Suggestions included using dedicated patient transport to reduce trauma, incorporating calming elements, and having non-uniformed staff and unmarked vehicles.

Rapid Response Service and Enhanced Home Treatment: Feedback on these proposals was limited. Some respondents expressed the need for a more rapid response than the current Crisis Resolution Home Treatment Team. Continuity of care between crisis houses and Enhanced Home Treatment was also suggested.

Priorities

When asked what was important to them when thinking about HBPoS, respondents' priorities were: improving patient care; quicker assessments; and a service that was open 24/7. These priorities can be used to inform commissioner and providers' decision-making when developing and improving mental health urgent and emergency services.

Other key insights

Expanding Urgent and Emergency Care: Respondents called for more accessible mental health services, prevention services, and peer support services. Lack of trust in helplines, long wait times for call-backs, and inadequate responses were shared. Face-to-face crisis support was deemed important.

Discharge and continuity of care: Concerns were expressed about discharge from crisis care, inadequate support after discharge, and bouncing back to inpatient care. Referral processes, A&E provision, and lengthy waits for assessment were also highlighted as areas of concern.

Information and communications: Respondents emphasized the need for better promotion of existing services, improved communication between services, and accessible information in various formats. Digital accessibility was a concern, particularly for individuals in a mental health crisis who may not have access to smartphones or the internet.

Improving quality of care: Individualised care, compassionate staff, and adequate staffing levels were identified as areas for improvement. Staff training, including neurodiversity training, was suggested. Concerns were raised about staffing levels for crisis services, Psychiatric Liaison services in A&E, and the lack of continuity of care during transitions.

Voluntary sector services: The voluntary sector was highly praised for providing trusted, non-judgmental support through services such as community groups, peer support, and Safe Havens. Respondents valued the informal nature of these services and expressed concerns about the pressure and potential financial cuts faced by the voluntary sector. When considering these findings, we should bear in mind that much of the face-to-face engagement was undertaken with groups that are supported and run by the voluntary sector, and this may result in a bias in the feedback.

Prevention: Difficulties in accessing mental health support through primary care were reported. Respondents called for improved availability of mental health nurses and medication reviews. There was a perceived need for more preventative services, especially for individuals with dual diagnoses and related issues.

Equalities and inclusion

Respondents identified barriers and challenges to accessing urgent and emergency mental health support, including barriers facing disabled people; digital exclusion; impacts of the cost of living; the need for culturally sensitive mental health support; mental health stigma, particularly in some ethnic minority communities; exclusion of people who experience literacy barriers, and support for carers and families.

This wider understanding can help inform equality impact assessments for mental health services going forwards.

Next steps

Overall, the conclusions drawn from the data highlight the importance of improving urgent and emergency mental health services, providing better patient experiences when conveying people to HBPoS, promoting accessible information, and addressing gaps in support, discharge processes, and continuity of care. The important role played by the voluntary sector in mental health support was widely understood and appreciated.

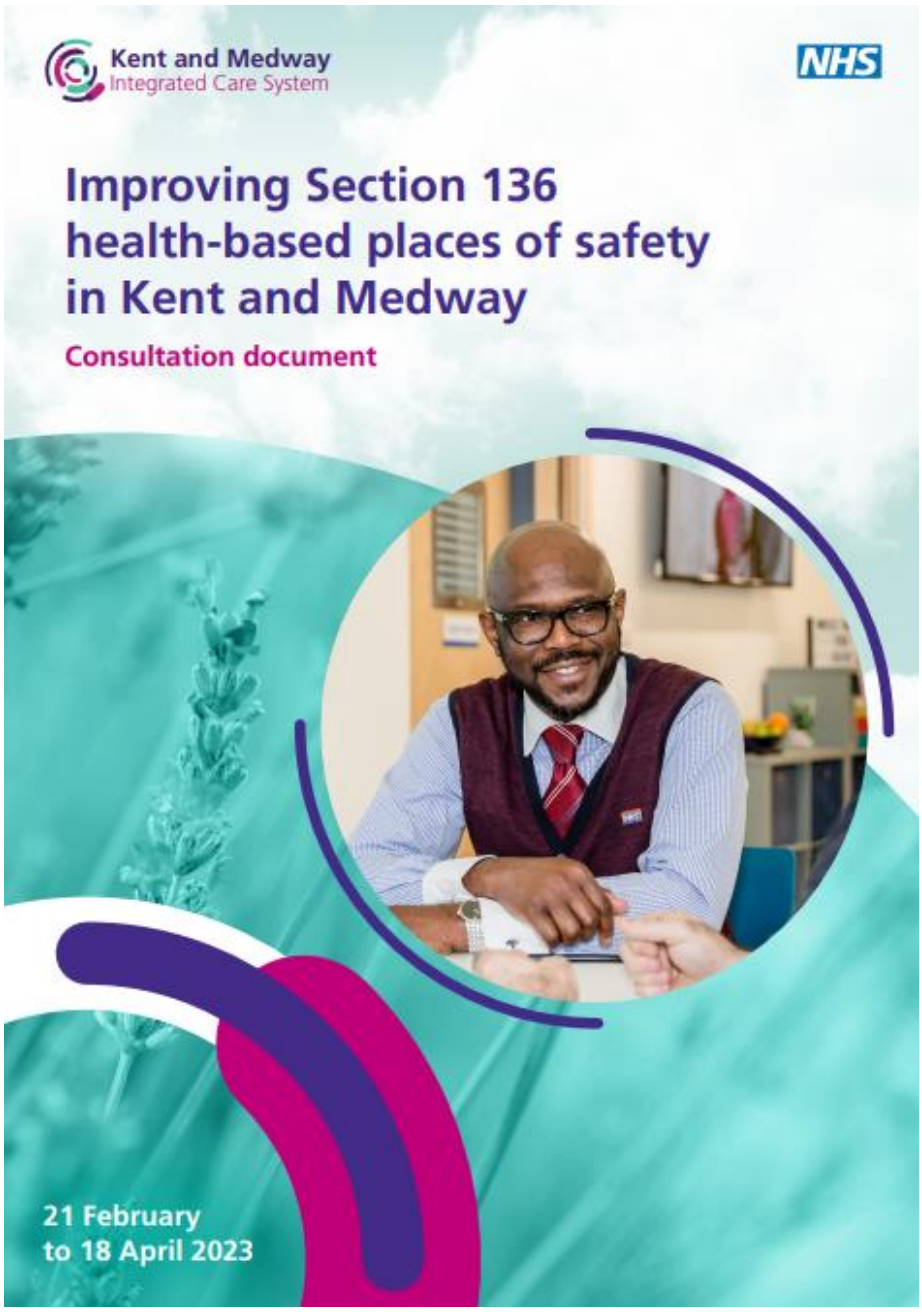
The experiences and views shared through this consultation are extremely valuable in moving towards improved services coproduced through the lived experience of patients, service users, families and carers – as well as staff and partners.

Further engagement and coproduction with groups and communities can ensure practical and achievable actions are taken to improve equitable access to mental health support.

Continuing to develop the relationships and processes for this shared journey will ensure that Kent and Medway urgent and emergency mental health services are designed to help meet the needs of the local community now and in the future.

Appendix A: Consultation document

The consultation document can be found online at:
https://www.haveyoursayinkentandmedway.co.uk/public-consultation-improving-section-136-health-based-places-of-safety



Appendix B: Consultation methodology

AUTHORS: Sara Warner & Julia Walsh, NHS Kent and Medway

NHS Kent & Medway communications and involvement approach

Concerns were raised during pre-engagement that seeking the views of the relatively small number of people in Kent and Medway who have been, or could in the future be, cared for and assessed at a health-based place of safety could trigger the recall of difficult memories for people with lived experience of mental health crisis.

The aim of the communications and involvement plan was two-fold: to inform people with an interest in mental health crisis care and health-based places of safety (HBPoS) in Kent and Medway about the public consultation on proposals to improve services by bringing together HBPoS on a single site in Maidstone, enabling people to feel able to share their views in ways sensitive to their personal situations; and to share publicly to the wider audience of stakeholders, people and communities the information and means to contribute their views should they wish to anonymously and safely.

Objectives

The objectives were to:

- Create a one-stop online information resource to support the delivery of the consultation on Improving section 136 health-based places of safety public and the MHUEC pathway from its launch (21 February '23) to decision (September 2023).
- Provide information about the consultation in a range of accessible formats, including online, print and an animation, with other languages and formats available upon request.
- Enable sensitive conversations in safe spaces throughout the consultation period (21 February to 18 April 2023). Working with trusted voluntary and community sector organisations to host bespoke discussions or invite us to existing groups to hold safe conversations with individuals or in groups.

- Provide multiple feedback methods: online or print survey, meeting, by phone, email, or post.
- Inform identified audiences of the launch of the consultation, the proposal being consulted on and how to get involved, the closing date, next steps and decisions.
- Work with system partners and mental health networks enable health and care partners, and interested stakeholders, to share information about the consultation on their internal and external channels as appropriate; encouraging people to participate and share their views.

Considerations

- Considerations for communication and engagement during the consultation period included but not limited to:
- Local elections meant active promotion was only permitted before and not during pre-election period.
- National industrial action by ambulance staff, nurses and junior doctors during consultation period.
- Infection prevention and control measures remain in some settings, preventing distribution of documents for public to pick up on off chance.
- People affected by serious mental illness are not the only ones who struggle with their mental wellbeing, many people are unknown to mental health services before they attempt to harm themselves or commit suicide: a publicly accessible website and regular cascade of information was essential to reach a broad audience.

There are a number of communities of interest which research shows are repeatedly suffering from health inequalities and more likely to have poor mental health and be at risk. So a targeted approach was needed to reach people within those communities of need through VCS support organisations; with support from two strong networks of individuals and organisations involved in working together for better mental health and suicide prevention.

The communities we intended to reach and involve were people with complex emotional disorders and serious mental illnesses, those in BAME communities, those in areas of deprivation, people with drug and alcohol issues or dual diagnosis, the homeless, those with cognitive impairment or autism/LD, veterans and young adults particularly those of transition age 18 – 25.

Delivery

The main approach was to share information via identified health and care system partner channels and networks. Information, including content for use internally and externally, was shared with health, local authority and voluntary, community and social enterprise (VCSE) system partners, with a request to support the consultation by spreading the word as appropriate on their own channels.

Specific channels included but were not limited to:

- Kent and Medway NHS and Social Care Partnership Trust's website, engagement pool (140) and social media
- Kent and Medway Better Mental Health (membership 500+) and Suicide Prevention Newsletter (714 membership), KCHFT newsletter to 900 stakeholders and 3,650 public members with a 35% read rate on both
- Kent Police's staff intranet and social media
- Kent and Medway ICB: community bulletin (7,645 members), stakeholder news (780) and GP bulletin (1,600), MP briefing, articles, main websites and project page on Have Your Say in Kent and Medway
- ICB social media - launch via ICB social media - Twitter 13 retweets, seven likes, zero comments and 5,126 views, Instagram 10 likes, zero comments and 183 views
- Targeted mail out to 166 VCS organisations, all NHS Trusts, and councils likewise
- Media release shared with local media outlets, Health Care Partnerships, and stakeholders.

Involving people

- MHEUC partnership workshop – alternative to crisis care 30 people
- Healthwatch website article, two newsletters membership 830 and 804 read rate of 43% and 60% and attended seven local area health networks Ashford, DGS, Maidstone, SKC, Swale, Thanet and Medway 89 people/organisations attending
- Attended peer support groups with NK MIND in Dartford and Medway, Speakup CIC in person in Thanet and online for east Kent, and Mid Kent Mind in total heard from 107 people who attended.
- Went to Safe havens in Thanet, Canterbury and Maidstone speaking to individuals and families 18 people took part.
- Attended community meeting in Dartford with Youth Ngage young people and family 13 people, attended health and wellbeing conference hosted by Rethink and Kent Equality Cohesion council had two speakers with lived experience who spoke about mental health peer support and the impact of suicide we shared information and discussed community's response 160 people in attendance.
- Met with Armed forces veterans' association representative who agreed to cascade information to people who would be interested.
- We had one meeting cancelled and one postponed due to snow.
- We sent documents to those who requested them, responded to queries, and replied to one letter.

Communications signposted people to the Have Your Say in Kent and Medway HBPoS public consultation page (Public consultation: Improving Section 136 health-based places of safety | Have Your Say In Kent and Medway).

It includes details on:

- Why we need to change.
- What's proposed.
- How to find out more and get involved.

- How to respond and share views
- How to request information in different formats
- Consultation and summary consultation documents
- A short animation, simply and succinctly explaining the proposal and how to get involved.
- The online consultation survey.
- Frequently asked questions.

The consultation and Have Your Say project page were promoted through: posters in appropriate venues, emails to networks partner organisations and stakeholder distribution lists, NHS Kent and Medway's three newsletters and those of our partners, social media, online news items and media releases to local media, partner organisations' websites and intranets.

There were 1,000 visitors to the Have Your Say consultation page within days of the launch. However, evaluation carried out two weeks post launch showed that while people were visiting the Have Your Say site, relatively few were choosing to complete the survey.

Recognising that this is a difficult and complex topic for many people to comment upon, unless they have direct experience, and even then, revisiting or sharing feedback on such a difficult time in their lives is hard.

Messaging was amended in subsequent reminder communications for the consultation, widening the messaging from the launch of the public consultation on the proposals for HBPoS to encouraging people to take part to share their thoughts on mental health urgent and emergency care services in general.

A round of reminder communications was distributed during the week prior to the start of the pre-election period to give the messaging a boost at the latest possible opportunity before the pre-election period began.

Our thanks to all the community and voluntary organisations who facilitated the safe and supportive conversations to take place.

Appendix C: Who we spoke to – events

Table 2: Focus groups and other events attended by the Engagement Team

Event date (2023)	Organisation	Participants
21-Feb	Dartford NK Mind	16
22-Feb	Medway NK Mind	14
28-Feb	Speak Up CIC Thanet	10
3-Mar	Youth Ngage	13
7-Mar	Speak Up Thanet Group	11
10-Mar	Thanet Safe Haven drop-in	2
10-Mar	Thanet Safe Haven drop-in	3
22-Mar	South Kent Coast Mind group	12
3-Apr	Healthwatch Ashford	10
3-Apr	Porchlight Canterbury	12
3-Apr	Canterbury Safe Haven	7
5-Apr	Maidstone Safe Haven	6
4-Apr	Porchlight Dover drop-in	26
11-Apr	Healthwatch DGS group	18
12-Apr	Local Mental Health Network South Kent Coast	16
13-Apr	Local Mental Health Network Swale	14
13-Apr	Porchlight meeting in Folkestone, St John's Church	6
14-Apr	Thanet Local mental health network hosted by ek360	15
17-Apr	EK360 Local MH network meeting Medway	16

Appendix D: Who we spoke to – demographics

The online consultation survey included demographic questions to capture the range of people responding to the survey.

People were asked demographic questions about themselves (or, if they were completing the survey on behalf of another person, that person).

It should be noted that these demographics only reflect respondents' answers to the demographic questions in the online survey. The face-to-face engagement at groups reached a broader demographic, in particular mental health service users and carers, and people from ethnically diverse communities. However, the demographic information of attendees at these groups was not captured due to the potential sensitivities of asking personal demographic of public groups for mental health support.

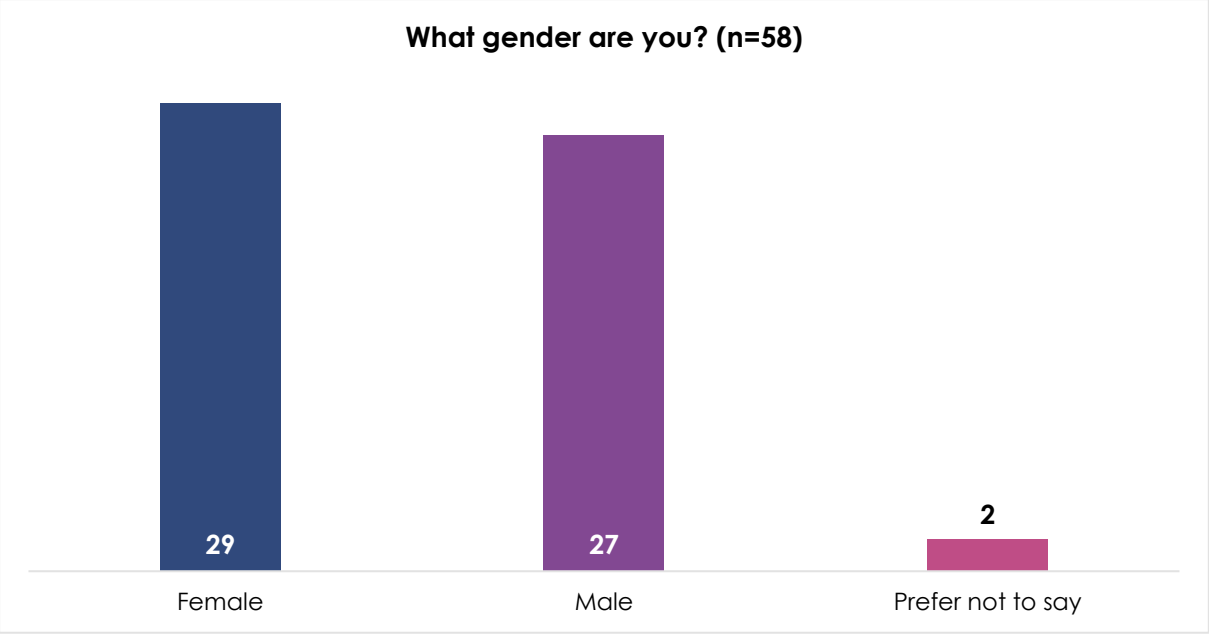


Figure 6: Respondent answers to the question 'What gender are you?' (n=58).

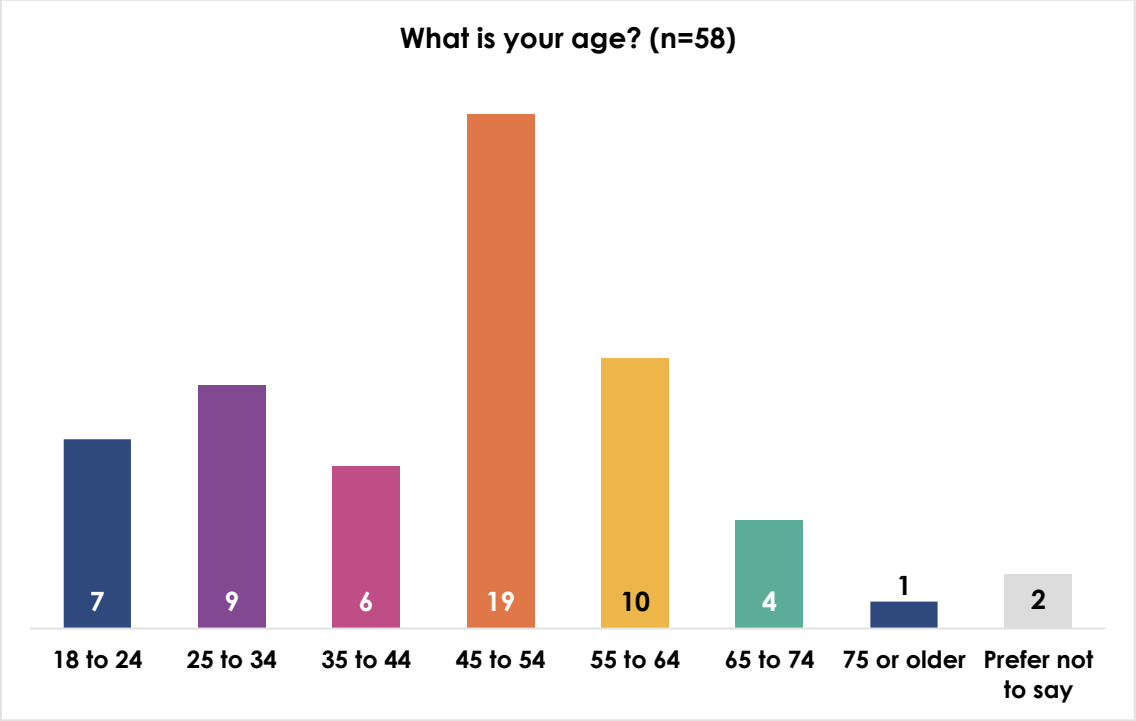


Figure 7: Respondent answers to the question 'What is your age?' (n=58).

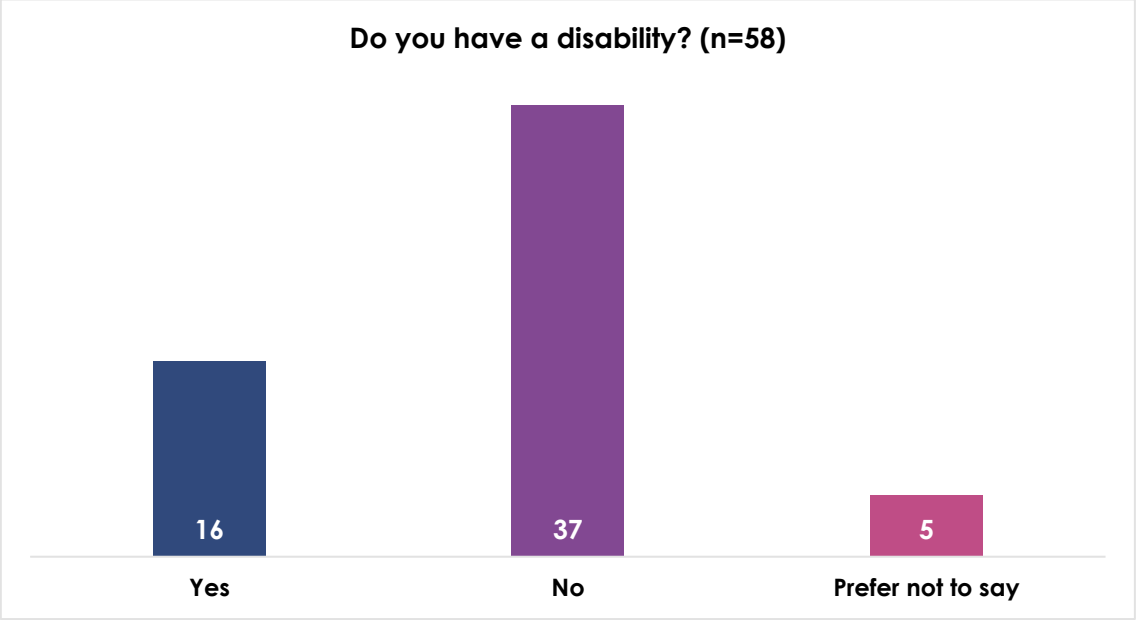


Figure 8: Respondent answers to the question 'Do you have a disability?' (n=58).

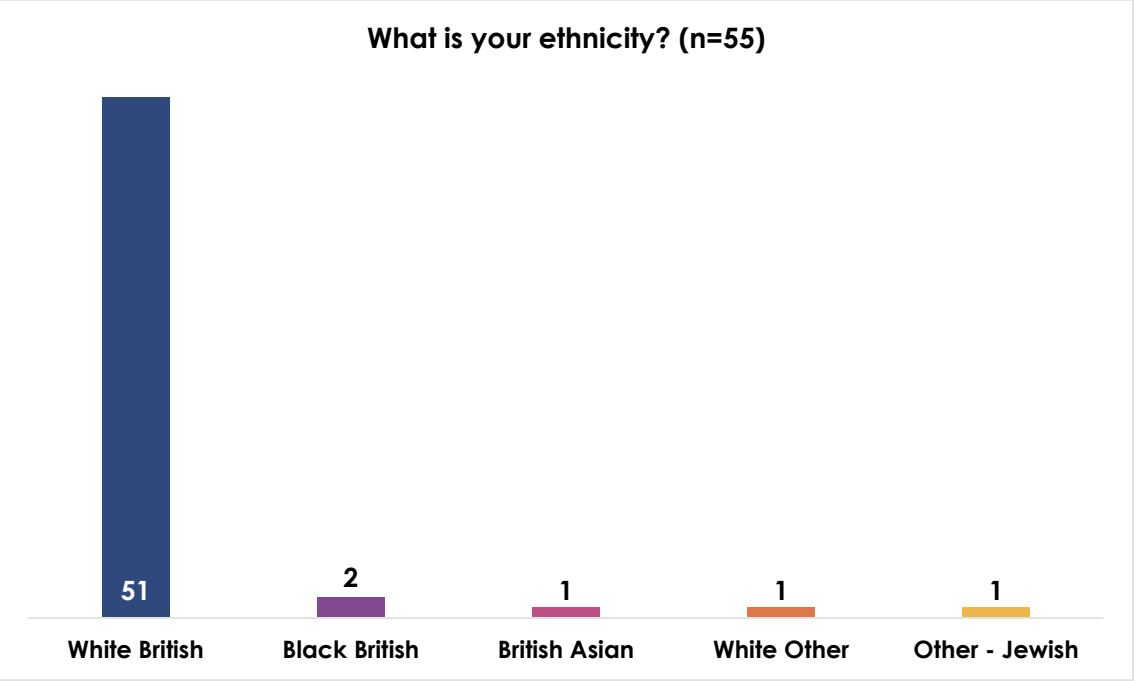


Figure 9: Respondent answers to the question 'What is your ethnicity?' (n=55).

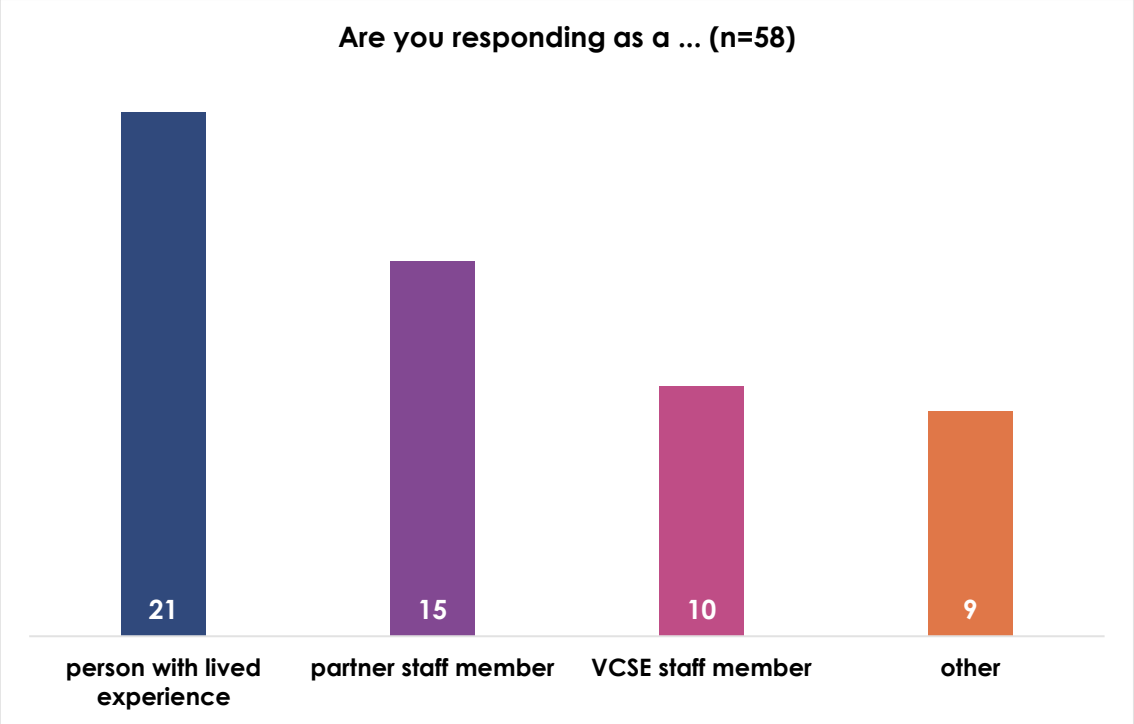


Figure 10: Respondent answers to the question: 'Are you responding as a...' (n=58). People could select more than one option, so the total in this table adds up to more than the total number of people who responded to the question.

Respondents were asked to share part of their post code. Figure 11 below provides an overview of the location of survey respondents. Whilst 49 respondents answered this question, only 43 of the postal codes appeared to be correct and therefore mappable on the heat map.

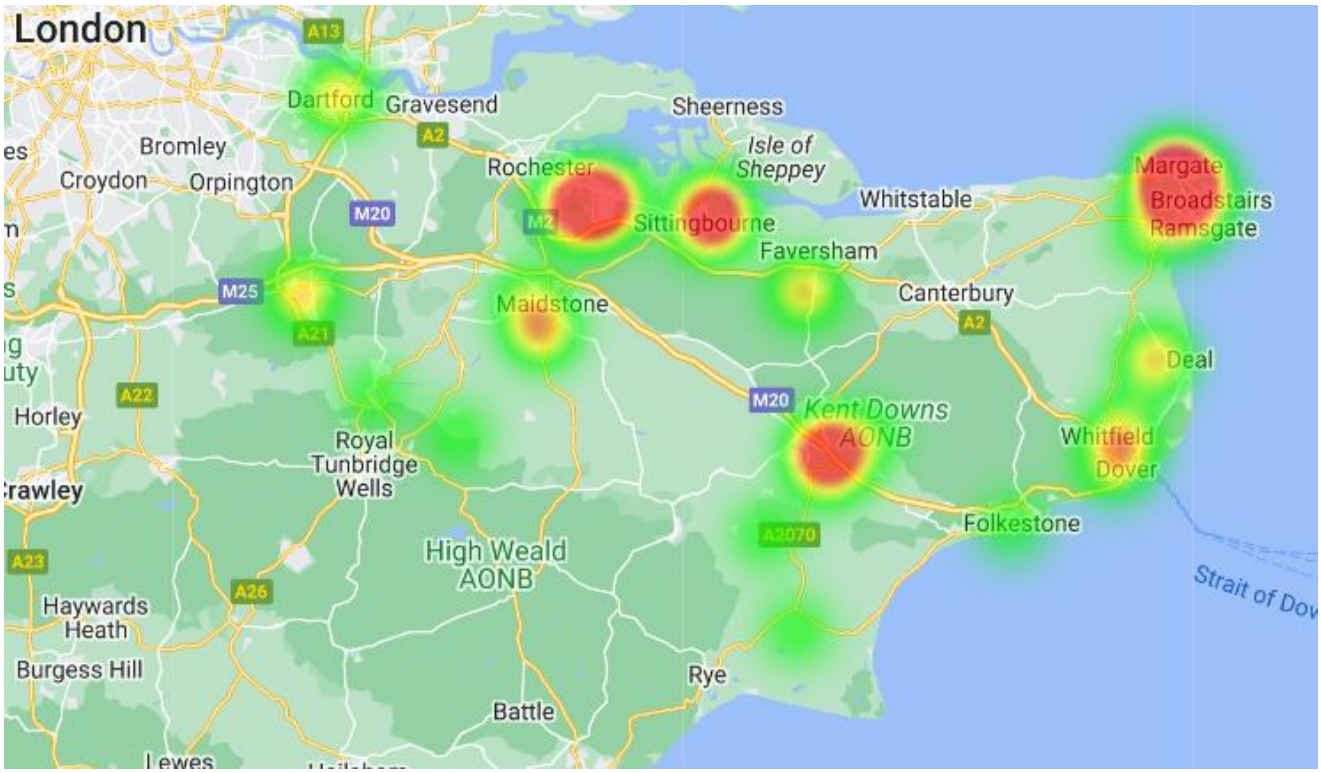


Figure 11: Heat map showing responses to the question 'Please tell us the first four digits of your post code' (n=43).

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