Mental Health Crisis Care Provision Transformation Programme

Interim Evaluation Report

Report of the Mental Health Crisis Transformation Challenge Award Steering Group

September 2016

Contents

Executive Summary

a. This report presents the interim evaluation findings for the Mental Health Crisis Care Transformation Challenge Award (TCA) programme. It is intended to inform commissioning discussions and capture lessons learned so far from the Safe Haven and Healios carers' support pilot programmes.

b. In November 2014, partners in Surrey were awarded £1.5 million non-recurring funding from the Department for Communities and Local Government TCA 2015/16. The programme aims to provide accessible alternative care and support pathways for people in mental health crisis and their carers that focus on preventing crises before they happen.

c. The Single Point of Access (SPA) programme led by Surrey and Borders Partnership is excluded from the scope of this report as it is under development at the time of writing. A full evaluation report will be published in 2017 that will include the SPA along with the other TCA interventions.

d. The key questions this evaluation aims to address are:
    - **How have Safe Havens and the Healios carers' service transformed the way Surrey's health and care system operates?**
    - **What relationship do Safe Havens have with stakeholders in the wider public service system (e.g. Surrey Police)?**
    - **What are service users', carers' and other stakeholders' perceptions of the Safe Havens and Healios carers' service?**
    - **How are they affecting the outcomes identified in the original TCA bid?**

Safe Havens – headline findings

e. Five Safe Havens opened across Surrey from November 2015 to April 2016, loosely based on the service model piloted in Aldershot. The Safe Havens' locations are Camberley, Epsom, Guildford, Redhill and Woking.

f. There have been high levels of activity at the Safe Havens since they opened - there were over 4,000 visits to them countywide between November 2015 and July 2016. In financial terms, this translates to almost £1.2 million of potential estimated costs avoided in A&E and psychiatric liaison service resources. Most visitors tended to stay at the Safe Haven for three hours or more, which suggests they value them as a safe place for them to go. Results from the Safe Haven satisfaction surveys reinforce this as all respondents agreed that they provided them with places of safety.

g. 4% of visitors attended the Safe Havens with someone in a caring role. There is little evidence to explain why it appears few carers have attended the Safe Havens. However, data from the user satisfaction survey suggests most people that responded would have gone to family and friends had the Safe Haven not been open. This implies the service has a wider role to play to ensure people within wider informal networks for people with mental health issues are also supported.

h. Nearly half of visitors said they were visiting primarily for preventative reasons. This aligns with a key aim of the project to prevent the symptoms of crisis escalating. The second most popular reason for people visiting was for the social aspect. While the social function is an important part of how the service works, and socialising can play a role in prevention, it is important to ensure that people are visiting the Safe Havens for the purposes of managing their mental health and wellbeing.

i. 83% of users that completed the user satisfaction survey were very satisfied with their experience of the Safe Haven. Feedback from partners, such as GPs, has also been positive and recognised the value they added for people. While people said they were treated well by the service, some were unsure whether Safe Havens were able to help them to assess their treatment options or help them feel informed to make choices.

j. Safe Havens are potentially at risk of becoming victims of their own success. Service users and carers have said that the popularity of the service means they are at risk of coming under pressure should visitor numbers continue to rise. Commissioners and providers should jointly develop plans that explicitly address how to handle rising demand.

k. Safe Haven staff raised concerns about how they manage situations where their safety and those of other visitors could be at risk. Safety and security procedures should be reviewed for the Safe Havens, and common standards agreed to ensure consistency and clarity on how to respond to an unsafe situation.

Healios pilot – headline findings

l. The Healios carers pilot is an online-based programme of psycho-educational and skills training designed to increase the confidence and capability of carers that look after people with mental health needs. The pilot aimed to recruit 60 families to the programme to access support from a pool of 720 sessions with a qualified clinician.

m. Early evidence suggests Healios is having a beneficial impact on the families and the people with mental health needs themselves. Notably, the programme has made a difference to carers' wellbeing evidenced by them self reporting reductions in their distress and burden levels and improvements to their ability to function well day-to-day in their work and social lives.

n. Changes in carers' behaviour and the approach to their relationship with the person they care for was a key factor underpinning these improvements. Carers felt more capable in dealing with the challenges of caring, and that the service delivered a previously unmet need.

o. Carers were positive about how accessible and responsive the service was. 97% of the families referred to the pilot were contacted within two days of their referral, and 63% attended their first session within five days or less.

p. A review of the recruitment process has thrown up a key issue. Carer support organisations and Safe Havens were initially identified as key referral points for carers to

enter the pathway. To date, the majority of referrals have been through carer support organisations, although Safe Havens are now starting to make more referrals. Going forward, the recruitment process for the service needs to be clear about who the key referring agencies are and ensure those agencies are clear about their role.

q. A further issue to consider is long-term impact for the families and the people they care for. Any future specification should ensure a process for capturing medium to longer term impact of the Healios programme is explicitly set out. Commissioners can build an evidence base to assess whether the programme provides a sustainable solution for upskilling carers in Surrey and they use the techniques learned from their sessions to maintain their increased sense of wellbeing following the programme's completion.

Outcomes – headline findings

r. Early analysis of the outcomes identified by the programme shows a mixed picture in terms of demand. Outcome performance was compared for the period the Safe Havens were open for (November 2015 to July 2016) and with the same period in the previous year. Some services have seen a reduction in demand, while others have seen an increase, summarised as follows:

- 14% increase in the number of assessments and 23% increase in the number of admissions to section 136 suites. It is worth noting that Safe Havens and the Healios pilot were not primarily designed to address this issue – the Single Point of Access programme, currently in development, aims to reduce the numbers attending a section 136 suite;
- 22% increase in the number of missing persons incidents;
- 22% fewer police officer deployments to mental health incidents;
- 13% fewer specialist police units, e.g. helicopters, being deployed; and
- 84% reduction in incidents of people with mental health issues being detained in a police cell.

s. At this stage, the data has thrown up more questions than answers and does not provide conclusive proof of the impact the Safe Havens and Healios have had on the TCA outcomes. The number of variables involved makes it very difficult on current data to determine to what degree changes in demand can be attributed to the TCA interventions. Further work should be commissioned into what the mental health crisis care system in Surrey looks like and what influence Safe Havens and the Healios pilots have over this system.

Conclusion

t. Overall, Safe Havens and Healios have been well received by the intended service users. Service satisfaction is high and they feel the services meet their needs. Partners' determination and passion for the interventions have contributed to high usage and quality of service.

u. The impact on outcomes at this stage is unclear. Some services have been operational for a short time so are at an early stage of development, and there is room for improvement in the quality of data and partner understanding of how public agencies' response to mental health crises is working. A priority is for partners to build a collective

understanding of how mental health crisis services are responding in Surrey and identify where the TCA services can be deployed to best effect.

v. A full evaluation of the TCA programme, including the Single Point of Access, will be produced in 2017, which will cover a more comprehensive analysis of the impact the TCA's interventions have had on the outcomes and on savings for partners.

Recommendations table

Reference	Recommendation
Safe Havens	
S1	Commissioners and providers work together to ensure the crisis management and preventative aspects of the service are actively promoted.
S2	Commissioners and providers should work together with carers support organisations to raise awareness of the Safe Havens and review the service offer to ensure carers, friends and family can also receive the most appropriate support.
S3	Commissioners and providers continue to monitor activity levels and put contingency plans in place to help manage increased demand.
S4	Commissioners and providers should work together to develop plans to raise awareness with different Surrey communities, particularly those with protected characteristics under the Equality Act 2010.
S5	Providers and commissioners work together to develop a clear, consistent process and standards for all Safe Havens to enshrine their commitment to the safety of visitors and staff. New and existing staff should be briefed on the new policy as a priority.
Healios	
H1	Commissioners work with Healios to understand why referral rates from certain areas of Surrey are lower than average, and develop a plan to address this.
H2	Commissioners and Healios to co-design a systematic process for monitoring longer-term impact (six months plus) of the programme on carers.
H3	Ensure Healios awareness training and referral process is included as part of the standard induction for Safe Haven staff.
H4	Healios should agree a feedback process with Safe Haven managers so that they can monitor how many people are being referred to Healios and any inappropriate referrals identified.
H5	The TCA Steering Group would advise that commissioners develop a stakeholder engagement plan to increase awareness with partner organisations and potentially increase the number of access points into the Healios programme. It is of particular importance that this plan demonstrates how there will be engagement with communities more at risk of mental illness.
H6	The TCA Steering Group would suggest that commissioners consider reviewing different mechanisms for sustainable funding of the service.
Outcomes	
O1	The TCA Steering Group requests local Safe Haven commissioners pull together a countywide trend analysis to assess the difference made in local A&E attendances. This will include a breakdown for each acute hospital. This should then be fed in for discussion by the Steering Group at their meeting on 16 December 2016.
O2	The TCA Steering Group should request that Surrey Police review their data to understand the extent to which Safe Havens have made an impact on their outcomes monitored for the TCA programme. This should form part of an overall analysis of the outcomes where police have been deployed to deal with a mental health incident. They should then present an update report to the

	Steering Group at the meeting on 16 December 2016.
O3	The TCA Steering Group should request that partners work together to produce an analysis of police and ambulance data to assess the proportion of incidents where they brought people to a Safe Haven.
O4	The TCA Steering Group should request that customer journey maps should be developed to improve understanding of the user experience of Surrey's mental health crisis care system. The Steering Group should use the output of this exercise to inform how to improve the impact of the TCA interventions.

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Special thanks must go to the people who use the services and their carers who shared their stories. Their views have strengthened the evidence base in this report and will drive improvements that ensure they receive the high quality of service they deserve.

Thanks also goes to colleagues from different partners across Surrey for contributing to this report. Safe Haven staff, commissioners, GPs, police and other practitioners have contributed their views and insights, plus case study materials that add a human side to the story. The authors are also grateful for the input of the Performance and Change team at Surrey County Council. They helped set up the data collection and monitoring tools that enabled us to deliver the quantitative analysis for the report.

Gratitude is also owed to Emily Eisenstein of the now decommissioned Public Service Transformation Network formerly based in the Department for Communities and Local Government. Her expertise and advice on evaluation has been invaluable for pulling this report together.

Full responsibility for the text in this report rests with the authors. The conclusions and recommendations expressed do not represent the views of Surrey County Council.

Introduction

Purpose of the report

1.1 This is the interim evaluation report of the Mental Health Crisis Transformation Challenge Award (TCA) Steering Group for the Mental Health Crisis Care TCA programme. It has been produced to inform commissioning discussions and to capture the learning so far from the Safe Haven and Healios carers' support pilot programmes.

1.2 The Single Point of Access (SPA) programme is excluded from the scope of this report as the project is in development at time of writing. A full evaluation report will be produced in 2017 that will include the SPA so all TCA funded interventions are evaluated for their impact on the wider public service system in Surrey.

1.3 Production of this report has been led by Surrey County Council staff. The authors support the TCA Steering Group, and have carried out the research for this report. No consultancy or other external resource was involved in the report's production. The authors also do not have any formal clinical training or experience, therefore this report does not make recommendations on the clinical operations of the services.

1.4 The key questions this evaluation aims to address are:

1. **How have Safe Havens and the Healios service transformed the way Surrey's health and care system operates?** – How these interventions relate and integrate with the rest of Surrey's health and care system are critical to their success. Failure to do this could lead to lack of awareness of the service amongst partners, meaning fewer people can access the service and are delayed in getting help. Lack of interaction between services would also have an adverse effect on service quality.
2. **What relationship do Safe Havens have with stakeholders in the wider public service system (e.g. Surrey Police)?** – A key outcome from this programme is for other partners in Surrey's public service system to develop close relationships with these services. Surrey Police and South East Coast Ambulance Service are two intended beneficiaries of the programme, so the effectiveness of the services would be diminished if strong local relationships were not developed.
3. **What are service users', carers' and other stakeholders' perceptions of the Safe Havens and Healios service?** – Service users not only need to be happy with how they receive the service, they also need to perceive that there are tangible benefits to their wellbeing from using the services.
4. **How are they affecting the outcomes identified in the original TCA bid?** – The services have been designed to make a difference to the outcomes from the TCA bid. There needs to be evidence of progress towards delivery of these outcomes and the extent to which they are attributable to the new services.

1.5 This report will also make recommendations for commissioners and providers to consider implementing for future service development.

Background

1.6 In November 2014, partners were awarded £1.5 million non-recurring funding from the TCA 2015/16 administered by the Department for Communities and Local Government. This funding was designed to incentivise places that had ambitious plans to work in partnership across the public sector, voluntary and community sector and/or private sector to re-design services.

1.7 Colleagues from NHS Clinical Commissioning Groups (CCGs), Surrey and Borders Partnership NHS Foundation Trust (SABP), Surrey County Council (SCC), Surrey Police and South East Coast Ambulance Service (SECAMB) came together to form the partnership that would oversee delivery of the interventions proposed in the TCA bid. Representatives from these organisations form the TCA Steering Group – the governance body that is accountable for how the TCA funding is spent and reporting on outcomes.

1.8 The case for transforming the public sector response to people with mental health problems in crisis is a national issue and not exclusive to Surrey. Evidence is mounting both nationally and internationally that crisis services redesigned across whole systems would deliver a seamless service that supports recovery and resilience as well as reducing costs.

1.9 In Surrey, demand for mental health services is projected to grow. The population of 18-64 year olds in Surrey was 691,288[1] people in 2011, and is forecast to grow by nearly 5% by 2025. National figures show mental disorder accounts for around 5% of accident and emergency (A&E) attendances, 25% of primary care attendances, 30% of acute inpatient bed occupancy and 30% of acute readmissions[2]. A report from QualityWatch suggests that people with mental ill health attend A&E departments up to 3.2 times more than people without mental ill health[3]. Most patients who frequently re-attend A&E departments do so because of an untreated mental health problem. There is also an issue of people with mental health problems in crisis being in police cells because of a lack of 'health based place of safety' capacity in the system.

1.10 The TCA Programme aims to provide alternative care and support pathways for people in mental health crisis and their carers, friends or family. By establishing a SPA for people in crisis, setting up Safe Havens in each CCG area and implementing personalised skills and educational support for carers of people with mental health issues, the desired outcomes are these interventions reduce demand on high-cost public services, such as A&E and police, and facilitate a system of care where partners coordinate their response around the needs of service users.

1.11 The programme originally set out to achieve the following outcomes:

1. Reduction in use of hospital or crisis house beds;

[1] Census 2011
[2] Sourced from the original TCA bid
[3] QualityWatch – Focus on: people with mental ill health and hospital use, http://www.qualitywatch.org.uk/content/summary-people-mental-ill-health-and-hospital-use#

2. Reduction of mental health attendances and re-attendances to A&E;
3. More people receiving crisis intervention locally at a lower cost;
4. Reduction of police operational deployments – officers;
5. Reduction on police unit attendance, scene investigation etc.;
6. Reduction on specialist police services, including air support, dogs, specialist search, and negotiators;
7. Reduction on use of police custody suites for 136;
8. Reduction in hear and treat responses; and
9. Reduction in the number of ambulance deployments

The TCA Steering Group monitors performance against these outcomes on a regular basis.

1.12 There is also a clear financial case for transforming mental health crisis care services. For example, attendances at A&E are estimated to cost on average over £130 per attendance[4]. In the original submission to Government, partners estimated that the total potential cumulative financial benefit to them of the programme's interventions (including the SPA) would exceed £31 million by 2025. Surrey County Council is the only partner not to derive any direct financial benefits from the programme.

1.13 Nearly three quarters of the TCA money was allocated for the Safe Havens and Healios. A breakdown of the initial allocation is shown below:

Intervention	Launched	Allocated funding (£)
Healios pilot	September 2015	£60,000
Camberley Safe Haven	November 2015	£98,851
Woking Safe Haven	December 2015	£303,169
Epsom Safe Haven	March 2016	£218,940
Redhill Safe Haven	March 2016	£164,739
Guildford Safe Haven	April 2016	£203,642
TOTAL		**£1,049,341**

Theories of Change

1.14 To understand why Safe Havens and the Healios pilot were chosen as two of the intervention methods, transformation logic models were developed (see Appendices pp 45-46). In short, these models describe how a new service or policy will cause a transformation using a diagram and a few simple words. They map the causal connections between the identified needs, inputs and outputs for the intervention and intended impacts on individuals they are designed to serve[5].

1.15 The Safe Havens model illustrates how they have been designed to respond to the current context, such as an increase in detentions under the Mental Health Act, a projected increase in demand for mental health services and pressures on acute public

[4] NHS Reference Costs 2014/15 (https://www.gov.uk/government/publications/nhs-reference-costs-2014-to-2015) – Unit cost for emergency medicine (£131.92)
[5] Public Service Transformation: Introductory guide to evaluation, Public Service Transformation Network, March 2014

services, such as A&E. By procuring suitable facilities in the community and resourcing them with clinical support, the resulting outcomes and impacts are less demand on public services and improved health and wellbeing for people with mental health needs.

1.16 A similar logic model approach was developed for the Healios pilot. The demands of their role impacts their mental wellbeing. By supporting carers, not only are they able to care for people more effectively, the risk of them requiring future support from mental health services also reduces. They are equipped with the essential skills they need to feel more confident and capable in their caring role.

1.17 These logic models were used as the basis for deciding which data to use for this evaluation to test whether the desired outcomes from each theory of change was delivered in practice.

Evaluation of the Aldershot Safe Haven

1.18 The Surrey Safe Haven programme built on the work of the flagship service in Aldershot. This was formed on the back of national and local evidence that formed the drivers for the project. In 2011, Mind commissioned an independent inquiry into acute and mental health crisis services. People said they wanted:

1. To be treated in a warm, caring and respectful way.
2. A reduction in the medical emphasis in acute care and recognition of the benefits peer support and other third sector providers, in helping manage a crisis.
3. Services to respond quickly to prevent further escalation of the crisis.
4. A place to go for safety and respite.[6]

1.19 A report published in February 2015 found the project had developed significantly as an alternative care pathway to individuals managing a mental health crisis. People said the Safe Haven offered them somewhere safe to go and viewed the service as a lifeline. They were greeted with a friendly atmosphere where they felt understood.[7] It was on this basis, and some signs that the service was reducing admissions to A&E, that the Safe Haven was mainstreamed in North East Hampshire and Farnham with recurrent funding and was embedded in the work with partners to support the population with mental health needs.

Healios pilot

1.20 The TCA programme also commissioned a project to support people with caring responsibilities for people with mental health needs. The aim of this work was to enhance carers' quality of life and provide carers with new skills to support in their role caring for someone with a diagnosis of mental illness.

1.21 In Surrey, there were an estimated 108,433 carers of all ages as of March 2011, including young carers supporting their parents and siblings to older couples providing

[6] Mind, *Listening to Experience*, 2011
[7] 'The Safe Haven' Aldershot: Evaluation Report, 2015

support to one another. This equates to 9.8% of Surrey's population[8]. They are estimated to save the county nearly £1.6 billion a year.

1.22 There is strong evidence that care giving affects the mental health of care givers and distress can reach clinical thresholds - 27% of care givers providing over 20 hours of care a week had mental health problems compared to 13% of those providing under 20 hours of care per week[9]. Evidence also suggests that providing education, information and training for carers is the most effective means to support carers to become more confident and capable in their caring role.

1.23 Surrey's Emotional Wellbeing and Mental Health Strategy established that carers felt they were under-equipped to deal with the challenges of caring for someone with mental health needs. There was a clear gap in support to help carers develop the resilience and skills they needed to carry out their role.

1.24 A company called Healios[10] was commissioned to deliver this work. They are an organisation that provides focussed support specifically designed to help care givers of people with mental health needs. The pilot supported people who were caring for individuals diagnosed with psychosis, schizophrenia or bipolar disorder, depression, anxiety, post-traumatic stress disorder and adjustment disorder, using the internet as a mechanism to access National Institute for Clinical Excellence (NICE) approved therapeutic interventions and awareness raising approaches to up-skill carers for their caring role.

1.25 Healios aimed to recruit up to 60 families for the pilot. This would cover up to 90 carers, with the aim of at least 10-12 young carers being recruited. The service was open to all carers regardless of the number of years they had been providing their caring role. 720 sessions were on offer, lasting approximately 40 minutes per session. This equated to an average of 12 sessions per family, recognising that some families required more and others less.

[8] JSNA Chapter: Carers, Surrey-i website, http://www.surreyi.gov.uk/ViewPage1.aspx?C=resource&ResourceID=668
[9] Ibid
[10] www.healios.org.uk

Methodology

2.1 This evaluation combined quantitative and qualitative methods to build up a comprehensive picture on the impact of Safe Havens and Healios since they were launched. As a starting point, the authors reviewed the Aldershot Safe Haven evaluation report from February 2015 and service specifications for the Safe Havens and Healios to understand the original objectives and delivery models for each service and analysis completed to date.

2.2 The TCA Steering Group also receives a performance monitoring dashboard on a quarterly basis tracking the high level outcomes identified in the original bid. This data provides important information to assess whether the TCA's interventions are having any impact on the wider public service system in Surrey.

2.3 Data on the impact of the programme on services provided by SECAMB is currently unavailable as the outcomes originally identified are under review.

Outcomes data

2.4 The outcomes dashboard collects the following data:

- Section 136 admissions – Monitoring forms are completed for each Section 136 assessment by each place of safety – these are Blake, Fenby, Frimley Hospital and Wingfield services. The completed form and police warrant are then faxed to the Mental Health Act office and collated in a quarterly report. Both attendances for assessment and resulting admissions are reported.
- A&E attendances and re-attendances – This compiles data from Ashford and St Peters, Epsom and St Helier, Frimley Park and Kingston acute trusts. Data for Royal Surrey County and Surrey and Sussex acute trusts are missing from this data. Locally sourced data from Surrey Heath CCG has also been collected to provide a local example that tracks overall attendance by people with psychiatric conditions and the attendance records of those on the Camberley Safe Haven link worker's caseload.
- Police operational deployment - This refers to the number of times police officers are deployed to respond to an incident flagged as a "mental health incident". Data is extracted from the police incident system ICAD monthly and relies on operators in the Call Handling Centre adding a mental health "flag" to the incident report.
- Police missing persons - This captures all incidents reported to the police and recorded as 'missing person' where the reporting establishment is a hospital or MH establishment. This data is extracted from the police occurrence management system (Niche) on a monthly basis.
- Police specialist units - This follows on from the police operational deployment and identifies whether in addition to an officer being dispatched, a firearms, dog or helicopter unit is also dispatched. This is also extracted from the ICAD system where the incident has both a mental health "flag" and a specialist unit call-sign.
- Use of custody suites (Police) – Used to identify where a person is taken to once Section 136 powers have been invoked. This is collected through a Section 136

form officers are required to complete and where the outcome is detention in custody and reasons why.

Notes for interpreting the data

2.5 It is important to note the following when interpreting the outcomes data.

- Crisis House admissions data is being monitored but has not been included in this report as data was only available up to September 2015. SABP are currently migrating their reporting system from the Trust Information Management tool to a new Data Analysis Reporting Tool, which has meant the reporting of Crisis House data has been on hold since last year. It is hoped further data will be collected on this for the full evaluation report in 2017.
- In addition to missing data from certain trusts as mentioned in paragraph 2.4, there has been a historical issue with recording A&E attendances for people with mental health needs. A national initiative being lead by NHS England through its 'Commissioning for Quality and Innovation' (CQUIN) initiative. One of the indicators focuses on attendance and re-attendance at A&E, which some of Surrey's acute trusts are signed up to. Better recording of attendances means the data will show an increase in the number of people with mental health needs attending A&E, so caution will be needed when interpreting the figures.
- Recording of police data for operational deployment and specialist units are reliant on staff in the contact centre using the mental health 'flag' when logging the incident. This could be flagged differently or not at all.
- Data on missing persons only includes people who fit the criteria for 'missing'. This does not include people who are 'absent' or people for whom there is a 'concern for safety' call.

Safe Havens

2.6 CCG commissioners and voluntary sector providers, supported by SCC, developed performance monitoring dashboards for the Safe Havens. Partners use these to monitor key performance indicators monthly covering activity volumes, service satisfaction and quality.

2.7 Data on activity volumes is collected using a paper registration form that service users and/or their carers complete when they arrive at and leave the Safe Haven. Data captured on the form includes the service user's name, the time they arrived and left the Safe Haven, the reason they visited (Crisis/Preventative/Social/Other) and whether they were visiting with a carer.

2.8 Data on user satisfaction is collected using a standardised questionnaire uploaded onto survey software hosted by the CCGs (e.g. Survey Monkey). Staff at the Safe Havens are on hand to help service users to complete the surveys should they need it. The data is collected monthly and reported quarterly to the TCA Steering Group.

2.9 In addition, where they add further insight to understand operational delivery, further datasets were requested from partners not captured by the high level dashboards, for example, outreach worker data in Camberley and Guildford. Given time constraints, this

report uses only existing data already collected by the Safe Havens.

2.10 To complement this, qualitative feedback was gathered from commissioners and providers involved in the design and implementation of the Safe Havens. Feedback was also received from carers' support groups, service user representative groups, GPs and police. Methods used included focus groups and one to one discussions. Discussion guides were produced to help the report authors steer the conversation to gain insight. These were also occasionally used as feedback forms where stakeholders wanted to submit a written response.

2.11 Case study templates were also circulated to stakeholders to gather individual stories on the difference Safe Havens made for service users and their families. These were collected to demonstrate the individual impact of the Havens that was not reflected in the quantitative data. Pseudonyms were used for the individuals in the case studies to protect their identities.

Notes for interpreting the data

2.12 Some Safe Havens had not asked every visitor to sign out on the registration form once they had finished their visit. This means the data on visitor arrival times and data on the length of their stay may not tally.

2.13 Completion of the user satisfaction questionnaire was voluntary. Participants for the questionnaire were therefore self-selecting, and represent a small proportion of the views of those visiting the Safe Haven. In total, 123 responses to the survey had been collected county-wide between November 2015 and July 2016.

2.14 Providers have not supplied data on the number of unique visitors, only the number of visits. This was for information governance reasons, and the registration form did not contain personally identifiable information (such as postcode data) to differentiate between individuals who were visiting the Safe Haven.

Healios carers' pilot

2.15 Different methods have also been used to gather data on the impact of the Healios carers' pilot. Healios use a number of survey methodologies to assess carers' wellbeing (included in the Appendices pp. 56 – 64), and they have provided the quantitative data to represent changes in outcomes. Scale methodologies have been used to track the impact of the programme on outcomes. These are:

- Involvement Evaluation Questionnaire (IEQ) – a measure of care giver burden and its impact on families. The questionnaire consists of 29 items across four domains. Each domain has a varying number of items between six and nine;
- Hospital Anxiety and Depression Scale (HADS) – a tool to identify carer distress that has been both validated in psychiatric and general populations and is sensitive to change. It is a 14 item scale rated on a four point Likert scale;

- Work and Social Adjustment Scale (WASAS) – measures carers' ability to do certain day-to-day tasks in their daily lives. It measures self-reported impairment on an eight point Likert scale;
- Client Satisfaction Questionnaire (CSQ-8) – a validated scale measuring client satisfaction with the service provided;

The measures above are the primary success indicators for the Healios pilot. Qualitative questions were also used to determine how the families moved forward. A pre- and post-session survey was used with all carers. Activity data, such as referral numbers, was also collected and reported on a quarterly basis to the Healios Steering Group.

Notes for interpreting the data

2.16 The latest available outcomes data reported is up to March 2016. This accounts for the difference in the attendance and referral figures, which are reported up to the end of July 2016.

2.17 Data on the difference made to carers' wellbeing was collected after the families had completed eight sessions, so families had not completed the course when they responded to the survey. This means the data reported does not reflect any medium to longer term impact of Healios on carers' wellbeing.

Safe Havens: findings and analysis

3.1 This section reviews evidence on the effectiveness of the Safe Havens. It explains how the services work, activity in terms of visitor numbers and their reasons for visiting and a review of the quality of service they received based on stakeholder feedback.

Service operational models

3.2 The Safe Havens are designed to act as alternative care pathways for people when they are managing a mental health crisis. They provide an alternative to A&E. They:

- Are staffed by service professionals to support active intervention, and give people the opportunity to talk to someone who has also lived with a mental health problem;
- Provide access to a range of community information on mental health and wellbeing; and
- Provide peer support which promotes integration into the community.

3.3 There are five Safe Havens in Surrey in total located in Camberley, Epsom, Guildford, Redhill and Woking. Camberley acts as a satellite site to the Safe Haven in Aldershot, and is open two days a week (Monday and Friday). The other Safe Havens are open seven days a week between 6pm and 11pm, except Woking which also opens 12:30pm to 11pm on weekends and bank holidays.

3.4 They are jointly run by Surrey and Borders Partnership and Community Connections providers – Mary Frances Trust; Cornerhouse Woking; Catalyst; Oakleaf Enterprise; Reigate Stepping Stones; and The Richmond Fellowship. Surrey and Borders Partnership staff deliver intensive one-to-one clinical support and Community Connections staff provide a social support role, for example, talking through issues with visitors.

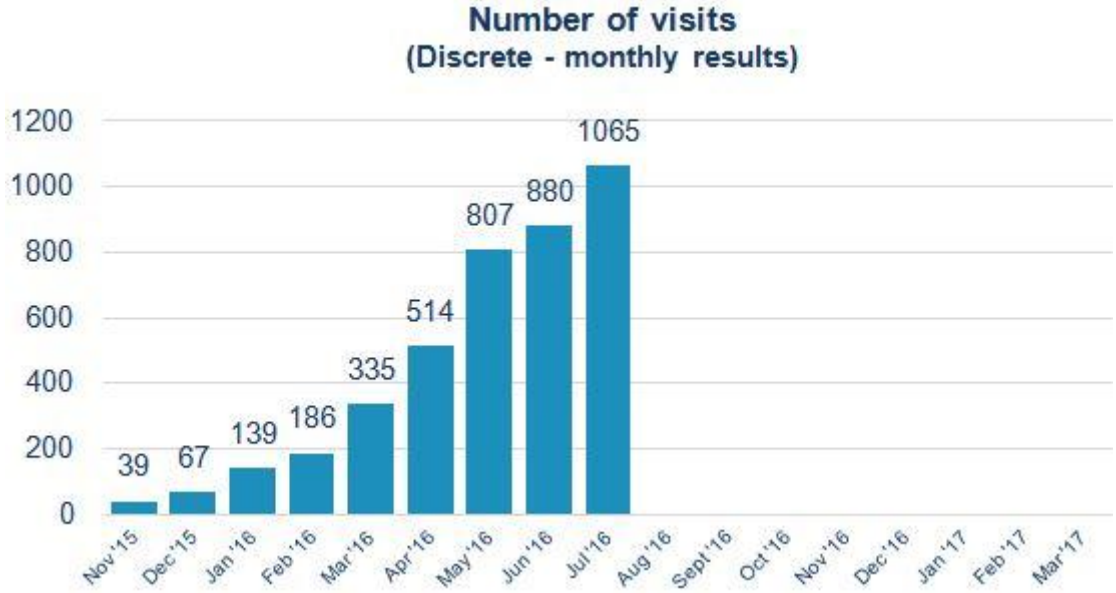
3.5 Two of the Safe Havens (Guildford and Camberley) employ assertive outreach workers. Their role is to engage with those people who frequently access A&E or other public agencies such as the police. They seek out and intensively engage with these people to enable them to find different coping strategies for their mental health needs and improve their outcomes while reducing the use of public services.

Activity

3.6 Since the first Safe Haven opened in Camberley in November 2015, visits to all five county-wide have increased as more people have become aware of them and as they have opened. They have received over 4,000 visits since they started opening. To illustrate the impact in financial terms, if it is assumed that, had the Safe Havens not existed, all visits could have resulted in attendance at A&E and being referred to psychiatric liaison services, this translates into estimates of over £1.2 million of potential

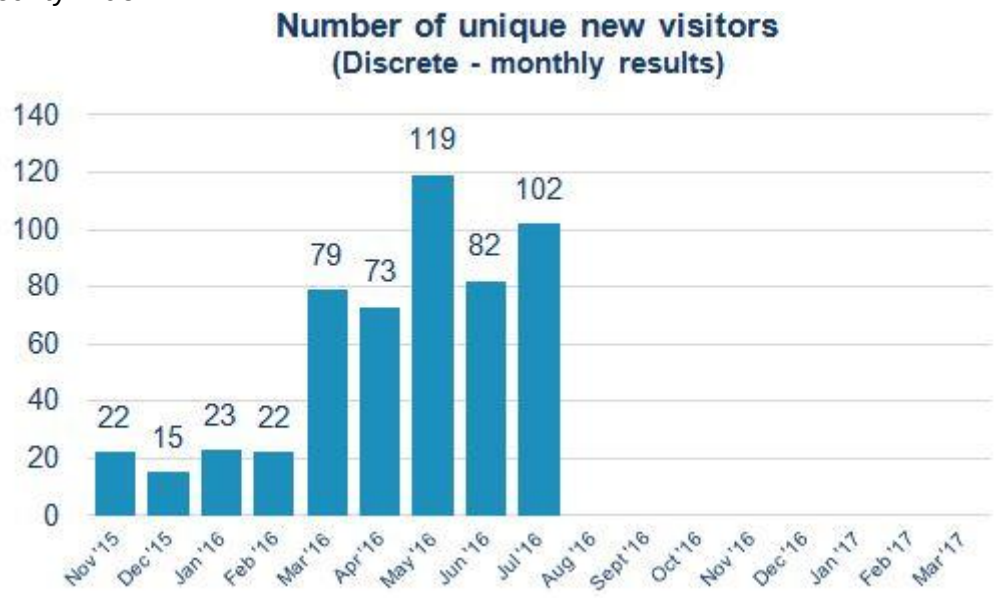
costs avoided[11] (£531,000 for A&E attendances alone).

3.7 The highest levels of activity seen by the Safe Havens were in July 2016 with 1,065 visits – approximately 34 visits per day on average for the county as a whole.



The highest number of visits received in a single month was at the Epsom Safe Haven, with 347 visits in June 2016.

3.8 As new Safe Havens opened, they continued to attract new business. The highest number of new visitors to the Safe Havens was in May 2016, with 119 new visitors county-wide.



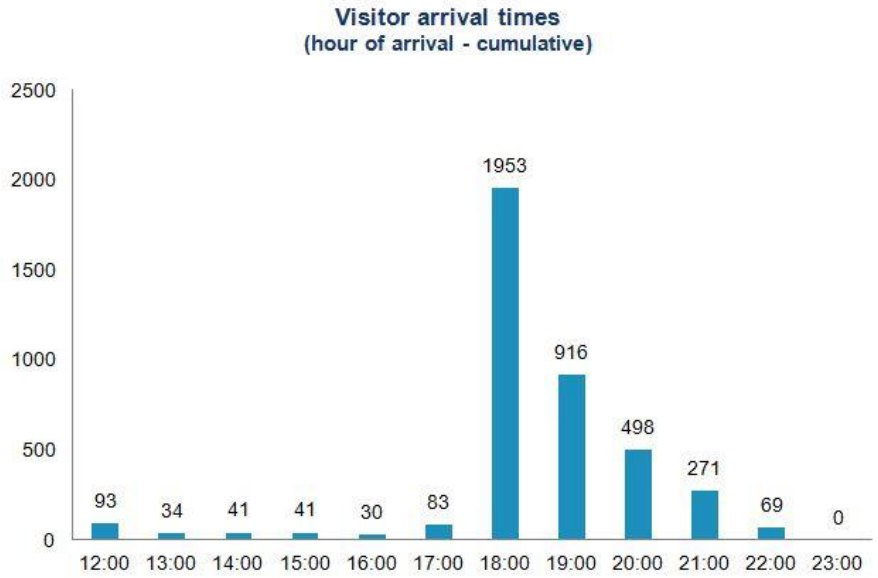
Once again, Epsom saw the most activity, with 35 new visitors coming to the Safe

[11] NHS Reference Costs 2014/15 (https://www.gov.uk/government/publications/nhs-reference-costs-2014-to-2015) national average unit costs for A&E attendance (£131.92) and adult attendance at A&E Mental Health Liaison Services (£187.45) multiplied by 4,032 visits = £1,287,699.84 (£531,901.44 for A&E attendances alone).

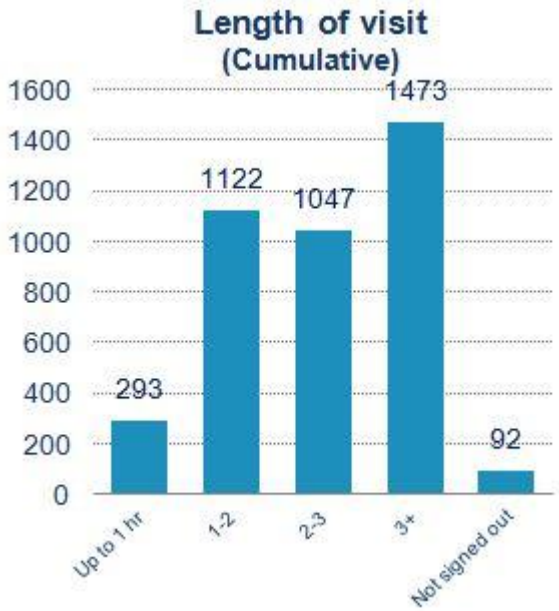
Haven in May 2016.

3.9 When asked how they first found out about the Safe Havens, the majority of survey respondents said they had found out either through existing NHS Mental Health services or through existing Community Connections provider services. Few respondents indicated they had found out about the service through their GP or A&E services.

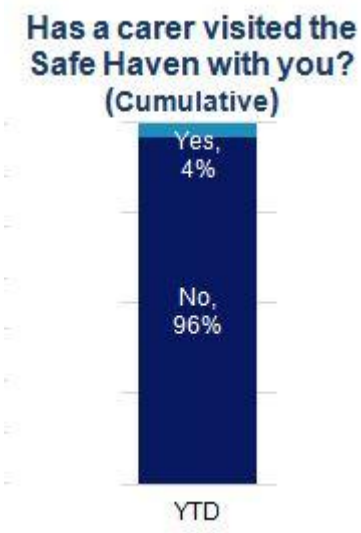
3.10 Service users tended to arrive when the Safe Havens open in early evening. The most popular time period for arrivals is between 6pm and 8pm.



They also commonly stay for three hours or more – this happened on 37% of all visits. This reflects the perception of users that the Havens offer a place of safety. All users surveyed agreed or strongly agreed that the Havens offered a place of safety, which may account for why service users opted to stay for long periods of time as the chart below illustrates:

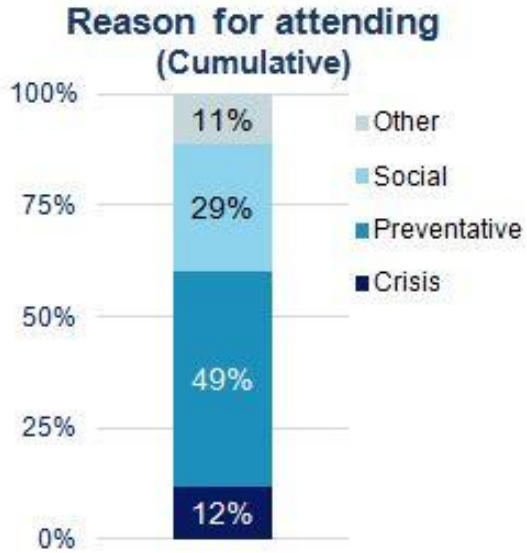


3.11 The Safe Havens also collected data on whether service users visited with a carer. This could have been, for example, a support worker, family member or friend. Just 4% of visitors county-wide declared they had visited with a carer.



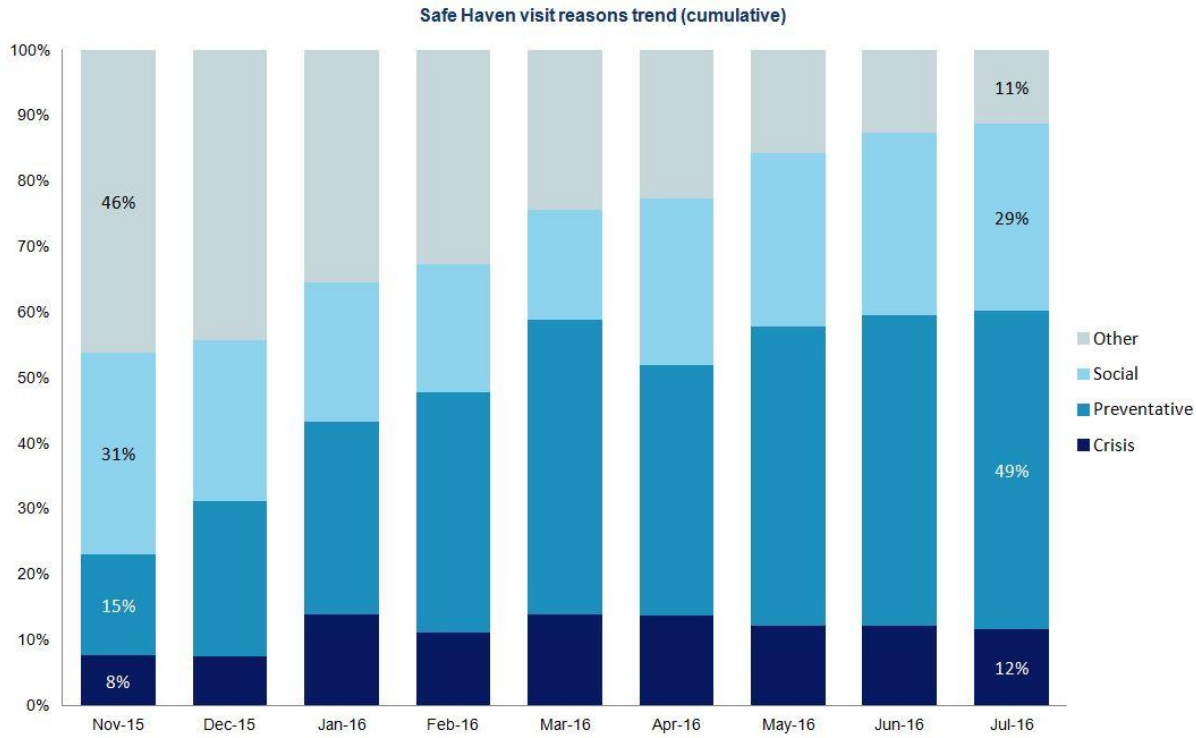
Safe Havens have a role to provide support to carers as well as people with mental health needs. There are over 108,000 unpaid carers in Surrey[12], with 27% of them providing over 20 hours of unpaid care per week. This role places demands on the emotional wellbeing and mental health of carers, so Safe Havens have a role to support them. Further research may be needed to understand the reasons why it appears so few carers visit the Safe Havens.

3.12 As part of the registration process, service users were asked what their main reason for visiting the Safe Haven was. 49% of people that visited the Safe Haven said they used the Safe Haven for preventative reasons to stop their symptoms developing into a full crisis episode. The second most popular reason was to socialise with their peers and staff (29%). Only 12% of those attending said they visited to manage a current crisis.



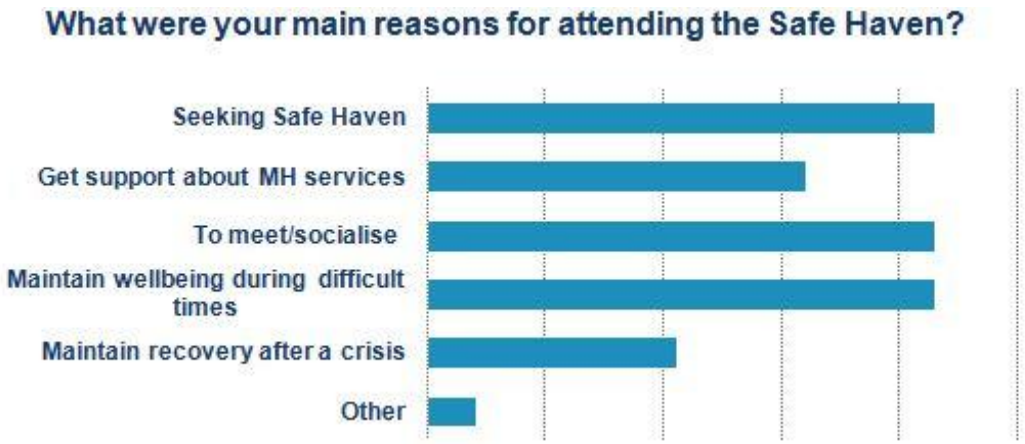
[12] JSNA Chapter: Carers, Surrey-i website, http://www.surreyi.gov.uk/ViewPage1.aspx?C=resource&ResourceID=668

Over time, a pattern has emerged for the primary reason people choose to visit the Safe Havens:



As visitor numbers and visits to the Safe Haven have increased as they opened, and as recording practices have improved, the pattern has shifted to show that the majority of people visit for preventative reasons, and fewer people are choosing to visit for “Other” reasons. The number of recorded visits for people in crisis has remained relatively static over time, reflecting the role people see the Safe Havens having in preventing crisis.

This aligned with the survey responses, with the main reasons for people visiting the Havens being to seek a place of safety, maintain their wellbeing during difficult times or to meet and socialise with their peers.



The reasons for visiting cited by service users align with the original objectives for the Safe Havens for their role as a preventative resource. De-escalating the signs of a crisis before it occurs improves the wellbeing and resilience of the service user and lessens their dependence on acute services such as A&E.

3.13 While an important function of the service is to provide a space where people can socialise and talk through their issues, the Safe Havens were commissioned to help people with crisis management to prevent the symptoms of crisis from escalating. There is a risk that individuals could use them for reasons other support for their mental health needs. Commissioners will need to work with providers to develop strategies to mitigate this and ensure Safe Havens continue to be used primarily as facilities for preventative purposes.

3.14 The high use of the service has led to concerns about the Havens becoming a victim of their success. Feedback from service users[13] suggests demand will continue to increase as word of their existence spreads and that staff would be unable to accommodate this. It will be important for the Safe Havens to continue monitoring activity levels if they are re-commissioned to ensure they are able to handle demand and can be resourced appropriately during peak times.

3.15 Safe Haven staff also shared their experiences. They were asked about what they thought the successes of the project had been and any lessons learned. Below are some of the comments on the successes:

"*We have been able to support young people who were vulnerable and at high risk of becoming severely mentally unwell. Additionally we have been able to signpost many people to other agencies for support and treatment focussed on signposting away from A&E whenever possible.*"

"*Working in collaboration with other professionals (such as police and ambulance services) to ensure continuity and consistency of care and treatment of clients who use our service.*"

"*The Safe Haven gives me a chance to address an issue 'now'.*"

"*People can turn up in floods of tears and in a lot of distress and after two or three hours leave with a smile on their face.*"

3.16 Staff also shared they had learned lessons on the need for the service to be flexible in how it responds to peoples' needs and that links with local services were strong:

"*We have learned that people often present very differently at different times with different people and this needs the team to always be informed and supportive in its communication to ensure that we continue to provide a consistent service to our public*."

"*I learnt that one pathway doesn't fit all. It takes an experienced practitioner to assess*

[13] Feedback from focus group session of Surrey Independent Mental Health Network 15 July 2016

and make a plausible decision/or exercise flexibility on way forward."

"*We get referrals from the police and they are very supportive when their assistance is required*."

Some staff raised concerns about the safety of service users and themselves when dealing with challenging situations:

"*My main concerns are risks to staff and to others when dealing with potentially violent situations*."

"*I have dealt with a young lady who chose to go to a toilet to wrap a jacket around her neck. We cannot offer one to one nursing care to those requiring constant observation and care as they would receive on an acute psychiatric ward*."

"*I have learnt to ensure safety of all involved – this has been hard on occasion as we have had to exclude some service users due to their behaviour. This has led to disruption and sometimes confrontation, however when faced with difficult situations, it is imperative that the safety and wellbeing of everyone involved is thought about.*"

User feedback

3.17 Service users were given the option to complete an online user satisfaction survey while they visited the Safe Haven to give their feedback on the quality of service. Questions in the survey were based on variables measured in the Care Quality Commission report on peoples' experiences of help, care and support during a mental health crisis[14].

3.18 Visitors were given the option to complete an online survey to ask them for their views on how well the Safe Havens served their needs and their overall satisfaction with the service. As of 30 June 2016, there have been 123 responses to the survey.

3.19 83% of respondents said they were very satisfied with their experience. 16% said they were satisfied and no-one indicated they were dissatisfied overall with their experience.

[14] Care Quality Commission: *Right here, right now: People's experiences of help, care and support during a mental health crisis*, June 2015

3.20 To learn more about why satisfaction with the Safe Havens was so high, the survey also explored different aspects of their experience. The results are summarised below:

3.21 The majority of respondents were mainly positive across the range of questions. The feedback suggests the staff provide a compassionate environment to help people through a difficult time, and that they make time to listen to peoples' concerns. It also suggests that the Safe Havens meet the demand for a physical place of safety for people in a crisis to go to.

3.22 Comments from service users reinforced this[15]:

"*I socialised with other people and played board games which is a great distraction.*"

"*It has helped me to understand about a difficult time I went through and came out the other side smiling.*"

"*It's just been absolutely brilliant and I can't thank everyone enough for their help"*

3.23 GPs and acute trust providers also fed back on the Safe Havens, whether they benefited their patients and how, if at all, it altered their role. Below are some examples of the feedback:

"*I have advised two to three patients about it so far. It gives a valid, well-functioning alternative service to recommend to certain patients filling a previous provision gap*"

3.24 The case study overleaf exemplifies that value that staff offer visitors:

[15] Sourced from survey responses to the Safe Haven user satisfaction survey

Case Study: Supporting a couple to find the right solution for them to support recovery

Callum attended Safe Haven when he was in crisis. He stated that he had heard of Safe Haven from a friend and wanted to come as he felt he could no longer cope. His partner had kicked him out of the house due to chaotic and challenging behaviour and self harm - he had been dealing with a psychotic illness for some time and had not identified his relapse triggers. He had stopped going to work as he was paranoid about work colleagues, was anxious all the time and had been aggressive to others, and felt "lost".

A member of staff worked with Callum to develop a crisis plan. They agreed he was to go to the doctor and request medication, to change GP as he was based outside the borough, and he was referred to local mental health services.

Safe Haven staff met with Callum and his partner to discuss relapse prevention, signs and symptoms of relapse and put a robust plan in place. They also worked on the relationship between Callum and his partner and developed house rules for them to both follow.

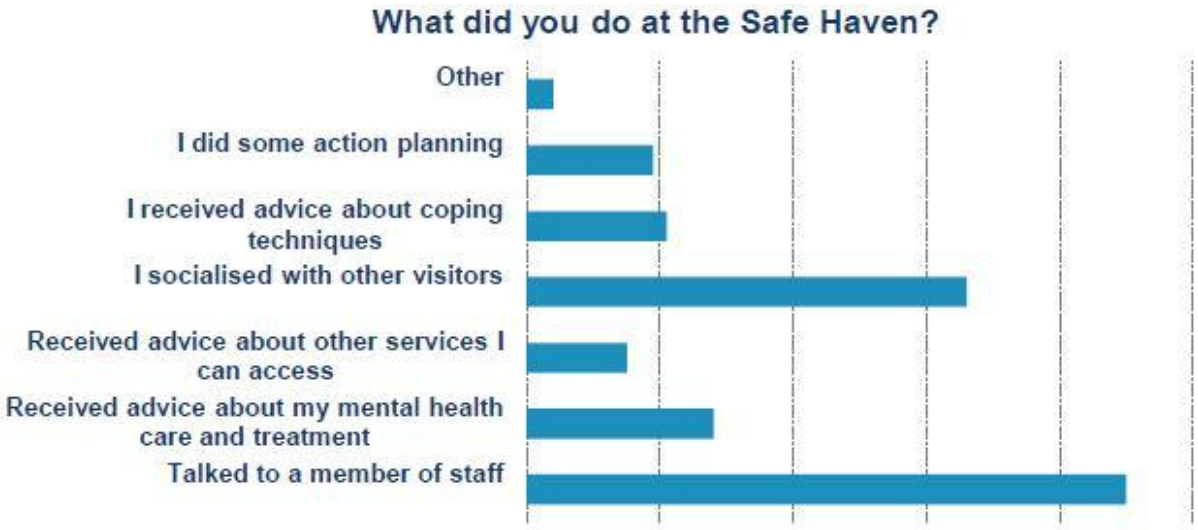
Callum returned to the Safe Haven weeks later stating that he had managed to "get my life sorted". His partner who had benefited from the session had allowed him back to the house and they were continuing the work on his crisis plan and following the "rules" that we had discussed in session. Having "house rules" and a crisis plan meant Callum's partner felt they were more aware of relapse signs and he felt more in control of his mental state, symptoms and more able to talk about how he was feeling without being scared of potential negative reactions. He had gone back to the GP and managed to have his medication reduced to a more therapeutic level and managed to get up early to attend to his job.

He was very grateful for the Safe Haven's input and felt that finally he had managed to return to work and manage his symptoms.

*Case study supplied by Surrey and Borders Partnership staff. A pseudonym has been used to protect Callum's real identity.

3.25 The survey results showed there was a significant minority that were unable to confirm whether the Havens prevented crisis or provided the information they needed to help to self manage their conditions. For those people that answered 'Neither Yes or No', the reasons why they answered this way are unclear. For people that attend the Safe Havens primarily to prevent symptoms of crisis escalating, the staff will benefit by collecting feedback on the materials and processes used to help people manage crisis. Improving this will help people have a clearer understanding of their options and feel they are getting expert medical support for their condition/s.

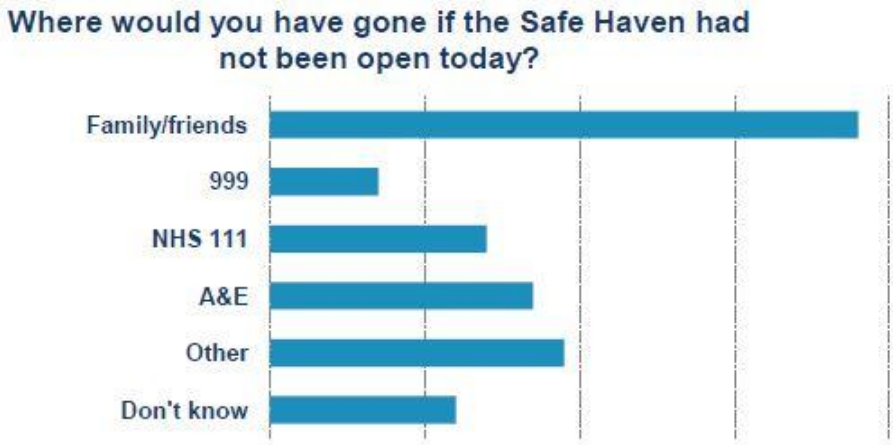
3.26 A clue to why fewer people indicated the Safe Havens prevented their crisis and informed their ability to make choices could be derived from the activities people said they did while they were at the Safe Haven:



Most respondents indicated they used the Safe Havens to talk through their problems with members of staff and their peers. People value the opportunity to talk to others about their issues, which would account for the higher satisfaction levels around 'dignity', 'compassion' and 'being listened to'. Fewer people said they received medical advice on their care, advice about other services and action planning.

3.27 This raises questions about what users believe the Safe Havens are for. They see the benefit of using the services for peer support and the informal atmosphere they provide, but questions remain over whether the majority of people are aware of the services they offer, or whether they choose not to use these services because they see the peer support and social interaction as enough to help them manage.

3.28 A fundamental question asked of service users was where they would have gone had the Safe Haven not been open. This was important because a fundamental assumption of the programme is Safe Havens would relieve pressure on acute services such as A&E. The findings from the survey are shown below:



Most people said they would have relied on friends and family for support if the Safe Havens had not been open. The second most responded to category 'Other' included services such as Crisis Line or the Samaritans. A&E was the third most responded to category.

3.29 Safe Havens have a responsibility to not just consider the wellbeing of the people they see, but also to think about support they can provide to friends and family members that may take a caring role. While there are real benefits for services to see demand taken out of the system, it is important to remember the role of wider personal networks in the wellbeing of people with mental health needs, so the Safe Havens could play an enhanced role in delivering whole family support.

User profile

3.30 Safe Havens routinely collect equalities monitoring data as part of the survey to ensure that services are accessible to all communities in Surrey. The headline findings are:

- 91% of respondents classed themselves as White British. 3% of attendees were Asian, 2% Mixed Race and 1% Black. The rest were either 'Unknown' or 'White Other'.
- Just over half of respondents (51%) were aged 26-44. The next highest proportion of those that responded were aged 45 – 64 (27%), then 19-25 (14%), then over 65s (6%). The remaining 3% were either aged 18 or under or were 'Unknown'.
- The gender split between respondents was fairly even with 53% of respondents being female compared to 47% male.

3.31 It is noteworthy that there are lower numbers of attendees to the Safe Havens who are not 'White British'. This indicates there is more to do to engage with Black, Asian and Minority Ethnic (BAME) communities with the Safe Havens as a place for them to come to help manage any mental health issues they have.

3.32 A further point to note is users of the Safe Havens could also have other issues that interact with, and possibly exacerbate, their mental health issues as the case study below demonstrates:

Case Study: Supporting individuals with complex needs

Alex was homeless when he attended his local Safe Haven. He used to make use of a local night shelter. One of the clients that use the Safe Haven told him about it and he started to attend. Alex had some mental health issues and also struggled with alcohol misuse.

In January 2016, he attended Safe Haven one evening and wanted to have a chat. He was really down and said he had had enough of struggling and wanted to make a change. He referred himself to the Welcome Project and the ISIS team (drug and alcohol team) and looked into one to one support with his mental health issues as well as his benefits.

He wanted to join the Job Club which he attended a few times. He got offered advice and support at the job club and also attended one to one sessions where the Safe Haven staff supported him to sign up with the Job Centre. For his alcohol misuse he was seen in drop in sessions and was supported around his housing by the team.

He was signed up with Jobseekers' Allowance while actively looking for employment and engaging with the services around him. He still attended Safe Haven on a regular basis as well as the night shelter.

While working with other agencies, he received support by the 'Team Around Family' team with accommodation for ex forces personnel. In March 2016 he moved out of the area. He is doing really well and is attending training courses.

*****Case study supplied by member of Safe Haven staff. A pseudonym has been used to protect Alex's real identity.

3.33 The case study reinforces the importance of the Safe Havens joining up with other local organisations. People with mental illness could also have other issues in their lives that hinder their recovery, such as unemployment, social isolation, substance misuse and homelessness. It is therefore vital that Safe Havens establish strong working relationships with organisations that focus on these issues so they can work around peoples' needs.

Conclusions and recommendations

3.34 Overall, the Safe Havens have seen promising levels of activity in their opening months and, with effective and sustained communications and engagement, will continue to be a vital community resource that many people will use. High satisfaction levels indicate visitors are pleased with what the Safe Havens provide. They particularly value the role of Safe Havens as places of safety, and the opportunities they allow for people to share experiences and provide peer support.

3.35 This is reinforced by the increase in visits since the Safe Havens opened, and the length of time visitors stay in them. Talking through their issues with staff or peers helps the visitors to manage their conditions during difficult times and expands their informal support networks.

3.36 A further primary reason for commissioning the Safe Havens was to help people prevent the symptoms of crisis from escalating. A risk of over-emphasising the social aspect of the service is that there may be visitors that could use them for reasons other than support for their mental health needs. Commissioners will need to work with providers to develop strategies to mitigate this and support visitors to move on to other services where appropriate.

Recommendation S1: Commissioners and providers work together to ensure the crisis management and preventative aspects of the service are actively promoted.

3.37 To date, people with mental health conditions have felt well served by the Safe Havens. However, there is little evidence to explain how carers and others in those individuals' wider networks are being supported by the Safe Havens. Registration returns show that only 4% of people county-wide that visited a Safe Haven were accompanied by a carer. There is little evidence to explain why carer attendance is so low. It will be important to offer support to those that make up informal networks for people (e.g. carers, friends and family) particularly as people with mental health needs rely on them if the Safe Havens are not open.

Recommendation S2: Commissioners and providers should work together with carers support organisations to raise awareness of the Safe Havens and review the service offer to ensure carers, friends and family can also receive the most appropriate support.

3.38 It will be key that the Safe Havens are resourced adequately to cope with future demand. If the services' success continues and they attract more visitors, there is a risk that staff will be unable to cope with increased visitor numbers, which could lead to people seeking support from other routes such as A&E. This was a concern voiced by both users and carers. Commissioners and providers will need to assume that demand will continue to grow if the Safe Havens continue to be successful.

Recommendation S3: Commissioners and providers continue to monitor activity levels and put contingency plans in place to help manage increased demand.

3.39 Specific communities are known to be more vulnerable to experiencing a mental health crisis, for example, BAME communities. Through their regular monitoring of activity levels, commissioners and providers should ensure that different communities, particularly those with protected characteristics as defined by the Equality Act 2010, are aware of the service and actively engage with them to raise this awareness.

Recommendation S4: Commissioners and providers should work together to develop plans to raise awareness with different Surrey communities, particularly those with protected characteristics under the Equality Act.

3.40 Feedback from the Safe Haven staff is they are clearly committed to the safety of the people they serve and their colleagues. They highlighted the need for clarity and consistency in how to deal with challenging situations where peoples' safety is at risk and this should be reflected in their operational policies and staff training programmes.

Recommendation S5: Providers and commissioners work together to develop a clear, consistent process and standards for all Safe Havens to enshrine their commitment to the safety of visitors and staff. New and existing staff should be briefed on the new policy as a priority.

Healios pilot: findings and analysis

4.1 This chapter reports on the findings from the Healios pilot. It reviews who uses the service, an overview of service delivery including recruitment processes, and the impact of the service on the lives of carers' and the ones they care for. It also suggests recommendations for improvement should the service be re-commissioned.

Service operational model

4.2 To understand the experiences of carers' use of the service, it is important to know how the delivery model works:

- A Healios researcher holds an intake interview with the family to determine eligibility and contact details. There is also an overview of the scales interviews, log-in and IT setup phase so carers are fully able to participate in the sessions.
- Carers receive an overview of the Healios service including how to access the service, confirmation of who the clinician is and start time and date of the first appointment.
- Carers receive texts and email alerts to confirm weekly appointments. They are given a username and password to access the system.
- Carers have access to an online portal that included a "My Healios" space to review material and to communicate with their clinician to be able to book or cancel a session and continue their learning in between sessions to increase the chances of successful outcomes.
- The content of the sessions are tailored around psycho-educational and skills training that met the individual needs and goals of the family.

4.3 Carers need to have internet access, ideally equipped with a computer that has a webcam and microphone and have a moderate level of IT skills. If access or knowledge of technology was an issue, carers support workers would assist carers to overcome these barriers. As a last resort, a telephone intervention would be offered.

Service delivery

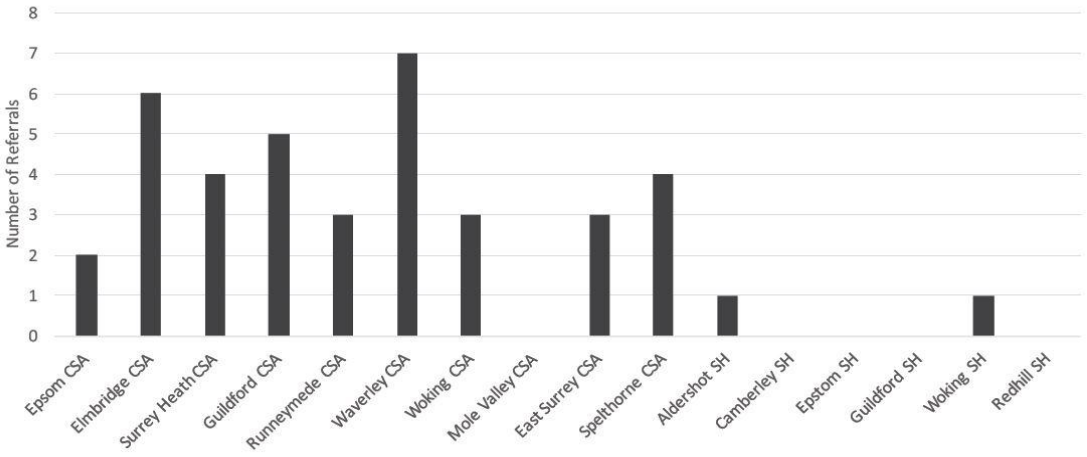
4.4 Since the Healios pilot was launched in September 2015, they received 38 referrals out of a target of 60, which equates to 63%.

4.5 The majority of families referred to the service (97%) were contacted in two days or less to discuss their requirements. 63% of those referred attended their first session within five days or less of their initial referral. The remaining 37% attended their first session in six days or more because either it was more convenient for the carer or the start date was not available within five days.

4.6 The high proportion of carers seen in under five days demonstrates the responsiveness and accessibility of the service. It also takes account of the needs of their clients as demonstrated by the flexibility to start sessions when convenient for the client.

4.7 The majority of recruitment was carried out through carers' support organisations. The largest number of referrals came from Waverley (7), whereas the lowest number of referrals came from Mole Valley (0). Safe Havens were also encouraged to refer carers

to Healios. At the time of writing, the Safe Havens have made two referrals to the programme.



Nearly 10% of all people providing unpaid care in Surrey are based in Waverley (9.9%). However, referrals in those areas with the highest proportion of people providing unpaid care are low to average. 10.4% of Mole Valley's population provide unpaid care – the highest in the county[16]. Commissioners should consider how they can increase referrals from areas with lower than average referral rates, in particular where the number of unpaid carers is higher than the county average.

4.8 From the pool of 720 sessions available on the pilot, 312 were delivered, which means 408 sessions were still to be used. This means there has been uptake of 43% of the sessions.

User profile

4.9 Carers that have attended the sessions were more likely to be a family member of the person with a diagnosed mental health need. Over two-thirds of those carers that attended (67%) were a parent providing care for their child. 21% of those providing care were a partner, and 12% were other (e.g sibling, neighbour, friend, etc.).

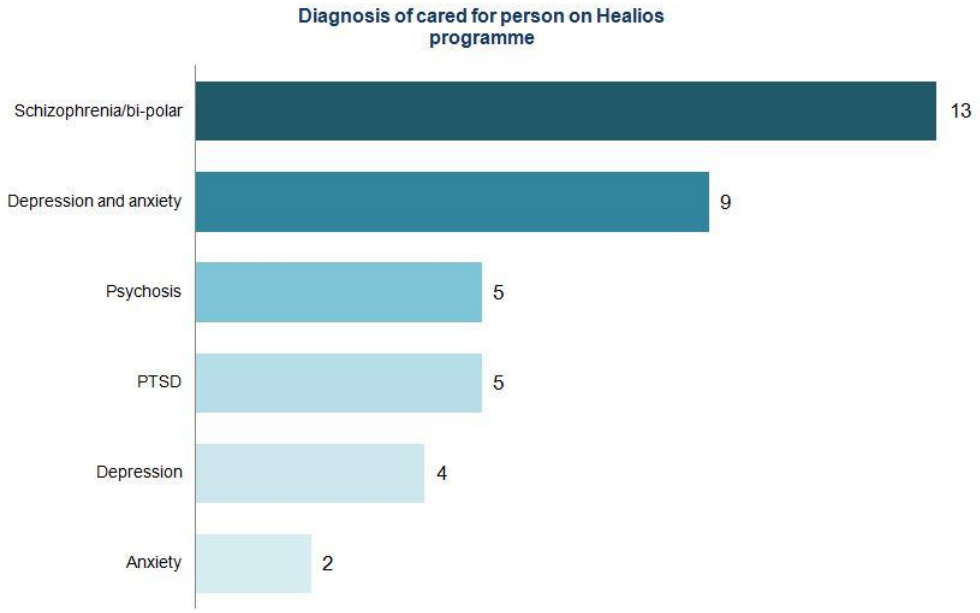
4.10 The mean average age for a family member was on the higher side of working age (50.4 years), with the average age of the individual being cared at 35.9 years. No young carers had been recruited into the pilot. The Young Carers Support Service has undergone a reconfiguration since the start of 2016. This was recently completed, so efforts are increasing to recruit young carers into the programme. There is value in considering expanding the offer to them to include wider family members.

4.11 70% of carers taking part in the pilot were female and 62% of those being cared for were male. This reflects the gender demographics for carers in Surrey where the

[16] Census dataset – Number of people providing unpaid care in Surrey, Surrey-i website, http://www.surreyi.gov.uk/Viewdata.aspx?P=Data&referer=%2fViewpage.aspx%3fC%3dbasket%26BasketID%3d269

majority are female (58.3%)[17].

4.12 A significant minority of people with mental health needs referred to the pilot had been diagnosed with anxiety and/or depression (15). Other clients had diagnosed conditions of psychosis (5), schizophrenia/bipolar disorder (13) and post-traumatic stress disorder (5).



4.13 The majority of people accessing the service were the families of people with mental health needs only. Only one family accessed the service where the person they were caring for also took part.

Impact

4.14 Before they participated in the sessions, carers were asked to complete questionnaires that covered a range of aspects of their wellbeing. After they completed eight sessions, the families were surveyed again across these variables to measure whether the programme was having any effect on the families' wellbeing. The data below was reported in March 2016 covering the 35 families referred to the programme at the time.

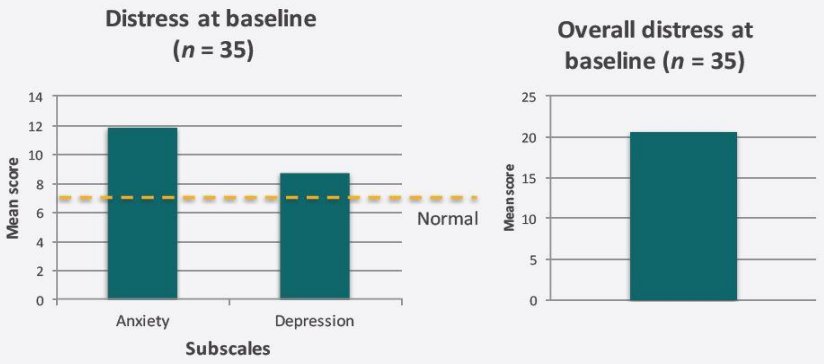
4.15 The chart overleaf demonstrates that families showed on average a mild to moderate level of distress before they started the sessions[18]. Distress could take the form of carers finding it difficult to maintain a positive frame of mind, sudden feelings of panic or anxiety, or concern that an awful situation was about to befall them. It provides an insight into the mental state of the carer.

[17] JSNA Chapter: Carers, Surrey-i website, http://www.surreyi.gov.uk/ViewPage1.aspx?C=resource&ResourceID=668

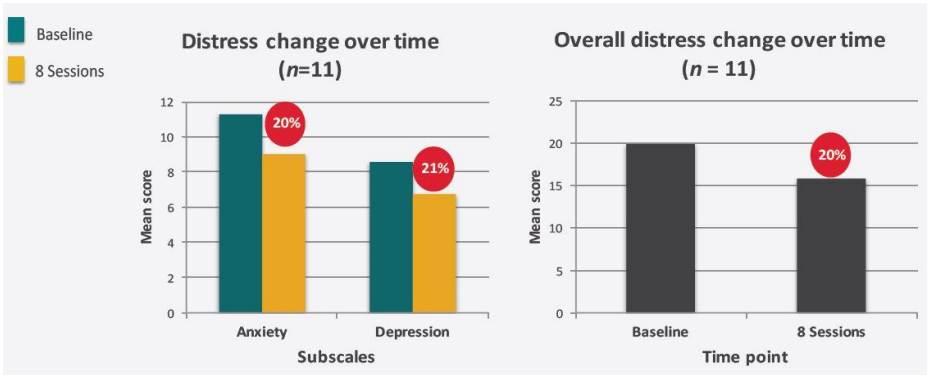
[18] Overall distress score range 0 – 42.

Severity	Cut-off
Normal	0-7
Mild	8-10
Moderate	11-15
Severe	16-21

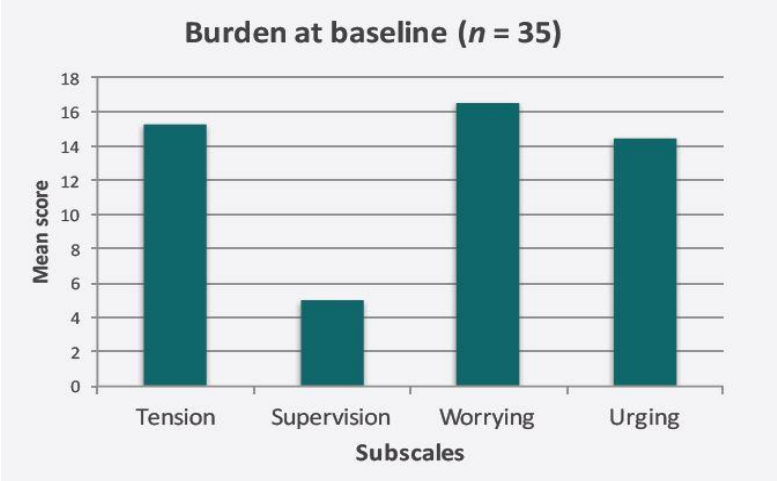
(Snaith & Zigmond, 1994)



4.16 After eight sessions, the families reported an improvement to their distress levels with an overall average improvement of 20%. When looking at the results for families by different conditions, similar levels of improvement were observed.

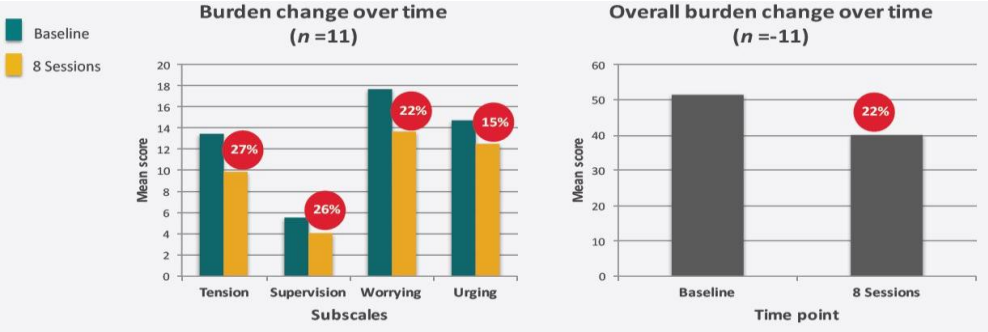


4.17 Across the four domain areas for burden[19], the families reported average scores. Burden is defined across domains of 'Tension' (for example, relationship difficulties between carer and cared for), 'Supervision' (for example, ensuring the cared for person did not harm themselves), 'Worrying' (for example, worrying about the cared for person's health, safety, finances, etc.) and 'Urging' (for example, encouraging the cared for person to look after themselves).

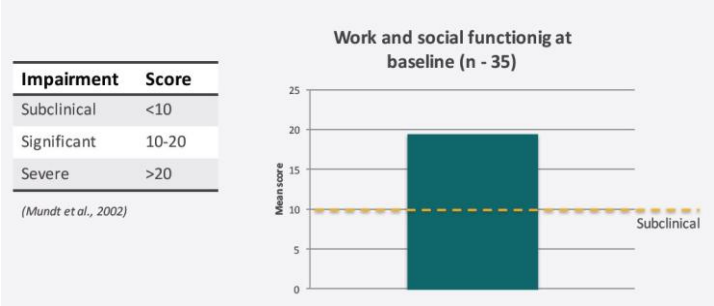


4.18 After eight sessions, there was an improvement across all domain areas for burden. The greatest reduction was in 'Tension' (27%) and the smallest reduction was for 'Urging' (15%). Overall, there was a 22% reduction in the level of burden families experienced.

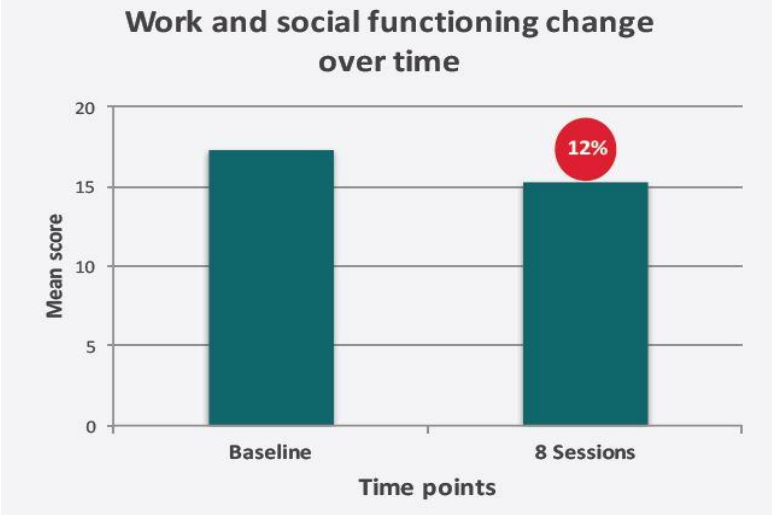
[19] The four domain areas are 'Tension', 'Supervision', 'Worrying' and 'Urging'. Each domain has a varying number of between six and nine items. Max score for each item; Tension max score=36, Supervision max score=24, Worrying max score=24, Urging max score=32.



4.19 On average, families reported significant impairment on work and social functioning activities due to their caring responsibilities[20] before they started the Healios programme. This could have been impacts on general household tasks (cleaning, cooking, etc.), leisure activities (going to parties, reading, gardening) or work.



4.20 After eight sessions, families reported this impairment had dropped. A 12% reduction in work and social functioning impairment was observed.



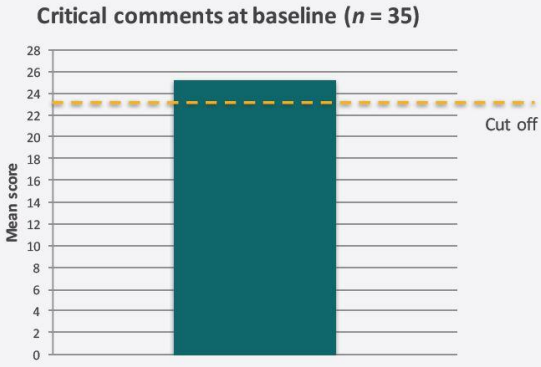
4.21 Healios also assessed the frequency with which carers used critical language with the person they cared for. These could be expressed as feeling a lack of appreciation from the cared for person, annoyance at the demands cared for people place on them or

[20] Scale score range = 0 (no impairment) to 40 (very severe impairment), Total max score=40.

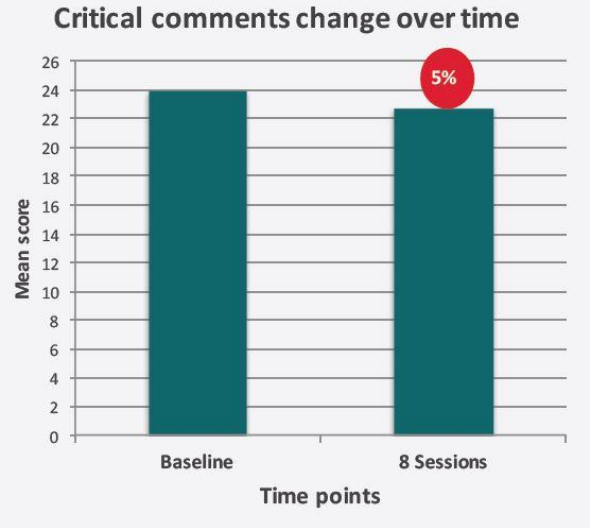
feeling angry with the cared for person often. Data before the start of the session showed there was a high level of criticism on average.

Level of critical comment	Cut off
High	>23
Low	≤23

(Wiedemann et al. 2002)



4.22 After eight sessions, while the level of criticism was still high, there was a 5% self-reported drop in critical comments by clients.



4.23 Carers' feedback on the service has been very positive. They have referred to tools that they found helped them to improve their relationship with the person they were caring for[21]:

"*I found vicious circle mapping really helpful and has helped me reflect on patterns of communicating with my daughter.*"

Carers also appreciated the flexibility of the service to work around their needs:

"*I appreciate that you're working at my pace and giving more time between sessions.*"

Overall, the feedback has emphasised the changes in the families' situation for the better as reflected in the comments below:

"*I am amazed that such small changes have created such a dramatic change in how we*

[21] Carer comments sourced from combination of feedback collected by Healios directly from clients and independently by the report authors through carers support organisations.

communicate with each other."

"*I'm feeling positive and proud that I'm doing something to help us change.*"

"*I can cope now and know how to manage my stress, whereas before I was at crisis point and feel had no direction in life with regards to my caring role or own life.*"

"*I'm beginning to notice the good things again – now we focus on them, we're tackling the difficult times better.*"

"*This service was an absolute god-send for me and my sanity*."

"*It's changed my thinking, given me coping strategies and a different way of looking and dealing with a crisis and daily caring role.*"

4.24 The case study gives an example of how Healios' work has transformed the lives of one of the Surrey families:

Case Study: Improving communication as a basis for moving forward

Graham's wife, Janet, experienced severe bouts of anxiety and depression. These resulted in her feeling frustration, panic, insomnia, suicidal thoughts and feeling overwhelmed. She also suffered with extreme physical ailments. Janet's anxiety could escalate to a point where she had a complete meltdown, and resulted in both her and Graham feeling unable to know the best solution to help alleviate things. Graham said they were both emotionally drained and extremely tearful. He said he wanted to improve his communication and felt he often did not say the right thing.

Healios delivered family support and psycho-education. These sessions initially began with Graham, however, he later requested that Janet join him after they spoke about the benefits. The couple learned new skills and coping methods. They explored anxiety and depression in greater detail which enhanced their understanding, gave them a sense of greater control and confidence and gave them a platform from which to move forwards.

Both Graham and Janet completed their sessions with a far greater sense of positivity and confidence. Their outlook for the future was filled with optimism and excitement. They expressed their appreciation of each other's efforts and felt proud at how far they had come. The couple gained a sense of achievement by using their new skills.

Graham said:

"*Our lives were filled with negative emotion and I could not see that it would ever change. We now have a new lease of life.*"

Janet said:

"*I felt guilty all the time that I was ruining mine and my husband's lives. Now that I know how, I've taken back control and feel excited for our future*."

*Case study supplied by Healios. Pseudonyms have been used to protect Graham and Janet's real identities

4.25 To validate the data, a focus group session was held on 13 July with carers and care practice advisors. They explained that the service had met a previously unmet demand for carers. Before the Healios pilot, carers felt “in the dark” about how they could best support the people they cared for, with common fears cited about “saying the wrong thing at the wrong time”.

4.26 The discussion group also noted the benefits for the programme, not just for the impact it had on improving relationship dynamics, but how it also translated into improved wellbeing for the people with mental health needs they were looking after. The group also commented favourably on the responsive and personalised nature of the service. One example was the majority of referrals being seen in under five days from their first referral, and how families were accommodated should the suggested start date for the course not suit them.

4.27 The group considered how the service could be opened up to include wider groups. Currently, it offers support to carers where the people with mental health needs they look after have a narrow set of mental health conditions. The group considered whether in future the service could open up access to carers supporting people with conditions on the Autistic Disorder Spectrum and physical disabilities.

4.28 The group also considered how the service could be expanded for people with specific characteristics to participate, for example, prisoners or military veterans.

Conclusions and recommendations

4.29 The initial evidence presented suggests the tools and responsiveness to customers that Healios provides are delivering significant improvements for the wellbeing of carers and their ability to deliver their caring role. Changes in behaviour, and the way the families and those they care for relate to each other, are a key positive difference that the programme has made.

4.30 Improved communication between the carer and the person they were caring for was reflected as a key factor in this change. In addition, working constructively to meet specific, manageable goals has been key in improving their relationships.

4.31 Positive changes across the wellbeing indicators provide further evidence the programme is meeting a need among carers to enhance their resilience and effectiveness to deliver care for people with mental health needs. Simultaneously, the programme carries out a preventative role to halt deterioration of the mental health of those carers. This relieves pressure on the health and care system and the need for carers to access high demand acute services. The programme could act as one of a range of support pathways carers can access to help them deliver their role.

4.32 Recruitment to the pilot from some areas has been highlighted as an issue, particularly low numbers of referrals for parts of Surrey where the proportion of local populations providing unpaid care are higher than average, for example, Mole Valley.

Recommendation H1: Commissioners work with Healios to understand why

referral rates from certain areas of Surrey are lower than average, and develop a plan to address this.

4.33 To measure whether the service is having a longer term impact, follow-up research should be commissioned with a sample of the families to assess whether the learning and techniques picked up on the course continue to be practiced and improved wellbeing has been maintained. Although a follow-up process after three months is in place, commissioners may wish to discuss extending this to at least a six month follow-up process with the families to assess the impact of the changes over a longer time period.

Recommendation H2: Commissioners and Healios to co-design a systematic process for monitoring longer-term impact (six months plus) of the programme on carers.

4.34 Recruitment through carers' support organisations has been effective, but there has been limited success with referrals through the Safe Havens. They can be vital referral points in the system as there are occasions where carers attend the Safe Havens with the person they care for. The low referral levels from Safe Havens are starting to be addressed, but there are further practical steps they can take to foster a culture where staff consider the needs of carers by default rather than as an add-on.

Recommendation H3: Ensure Healios awareness training and referral process is included as part of the standard induction for Safe Haven staff and for local carers' support organisations.

4.35 It will also be important for Safe Havens to have processes in place to track how many carers they are referring to the service to evidence how they are supporting carers. There should also be clear feedback channels between Healios and the Safe Havens to ensure people are not being inappropriately referred, and where this happens, address the issue with their staff.

Recommendation H4: Healios should agree a feedback process with Safe Haven managers so that Safe Havens can monitor how many people are being referred to Healios and any inappropriate referrals identified.

4.36 It is also worth exploring how wider organisations within the health and care system and beyond could help raise awareness of the service. For example, engaging with Home Treatment Teams and outreach workers would mean community-based services can provide a crucial access point for carers to access the service. Work could also be done with organisations such as Citizens Advice and registered social landlords to develop further access points to the service.

4.37 There are also certain groups that are known to be more at risk of suffering from mental health issues, for example, black and minority ethnic groups (9.6% of Surrey's

population), military veterans (over 7,800 in Surrey) and the prison population[22]. It is recommended commissioners consider how they attract people from these groups and take account of their needs in the design of a recruitment process and communications plan.

Recommendation H5: The TCA Steering Group would advise that commissioners develop a stakeholder engagement plan to increase awareness with partner organisations and potentially increase the number of access points into the Healios programme. It is of particular importance that this plan demonstrates how there will be engagement with communities more at risk of mental illness.

4.38 In value for money terms, the uniqueness of what the service provides is reflected in the high costs for the sessions – the average cost for a family using 12 Healios sessions is almost £1,000[23]. This does not include the time spent by the family between sessions to practice what they learned on the course. Assuming the service is re-commissioned, commissioners may want to explore different funding options for the service to ensure sustainability, including whether clients should pick up some of the costs through, for instance, the carers' prescription.

Recommendation H6: The TCA Steering Group would suggest that commissioners consider reviewing different mechanisms for sustainable funding of the service.

[22] JSNA Chapter: Adult Mental Health, Surrey-i website, http://www.surreyi.gov.uk/ViewPage1.aspx?C=resource&ResourceID=667

[23] Average cost for family to access 12 Healios sessions – 720 sessions were purchased for £59,000. This means each session costs £81.94, and the financial equivalent of 12 sessions is £983.33 per family.

Outcomes

5.1 This section aims to establish if there is any early evidence that the interventions, particularly the Safe Havens, have had any impact on the desired outcomes that the TCA programme aimed to influence.

5.2 Below is a reminder of the nine outcomes partners originally identified that they wanted the programme to impact on:

Mental Health Crisis Care Transformation programme – desired outcomes

1. Reduction in number of people in crisis and resulting in use of hospital or crisis house beds;
2. Reduction of mental health attendances and re-attendances to A&E;
3. More people receiving crisis intervention locally at a lower cost;
4. Reduction of police operational deployments – officers;
5. Reduction on police unit attendance, scene investigation etc.;
6. Reduction on specialist police services, including air support, dogs, specialist search, and negotiators;
7. Reduction on use of police custody suites for 136;
8. Reduction in hear and treat responses; and
9. Reduction in the number of ambulance deployments

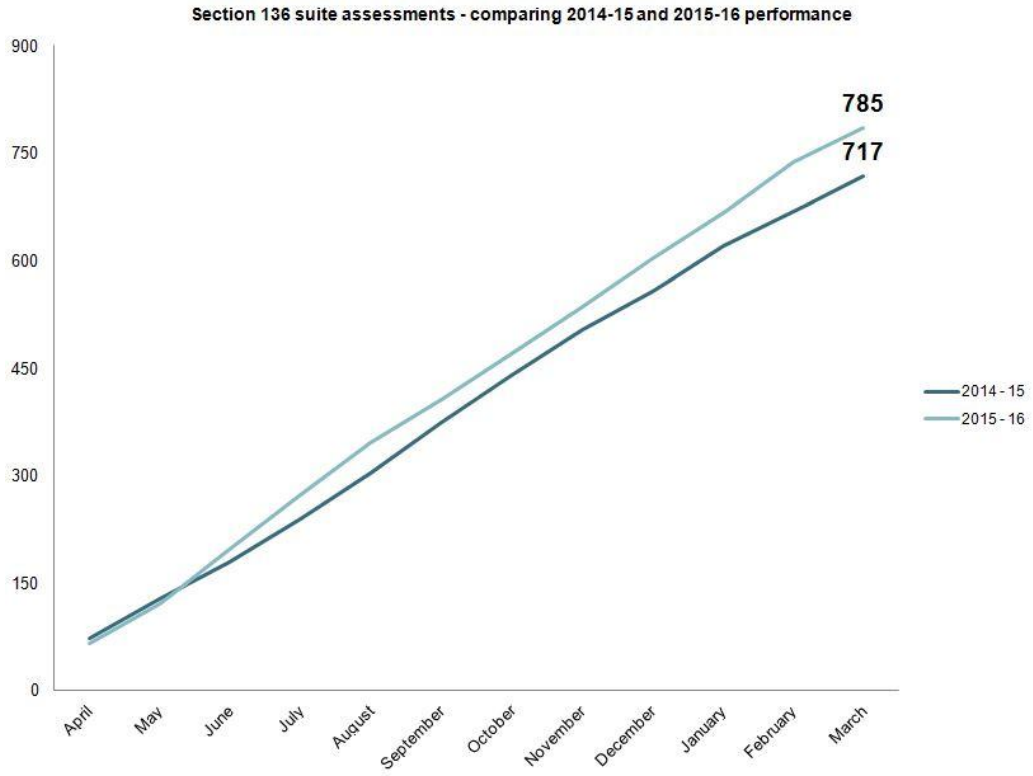
5.3 The final two outcomes are currently under review, therefore there is no data on them presented in this report.

5.4 At this stage, while some of the interventions have only been in place for six months at the time of writing this report, some of the recommendations will focus on commissioning further research to establish the degree to which they have affected the outcomes.

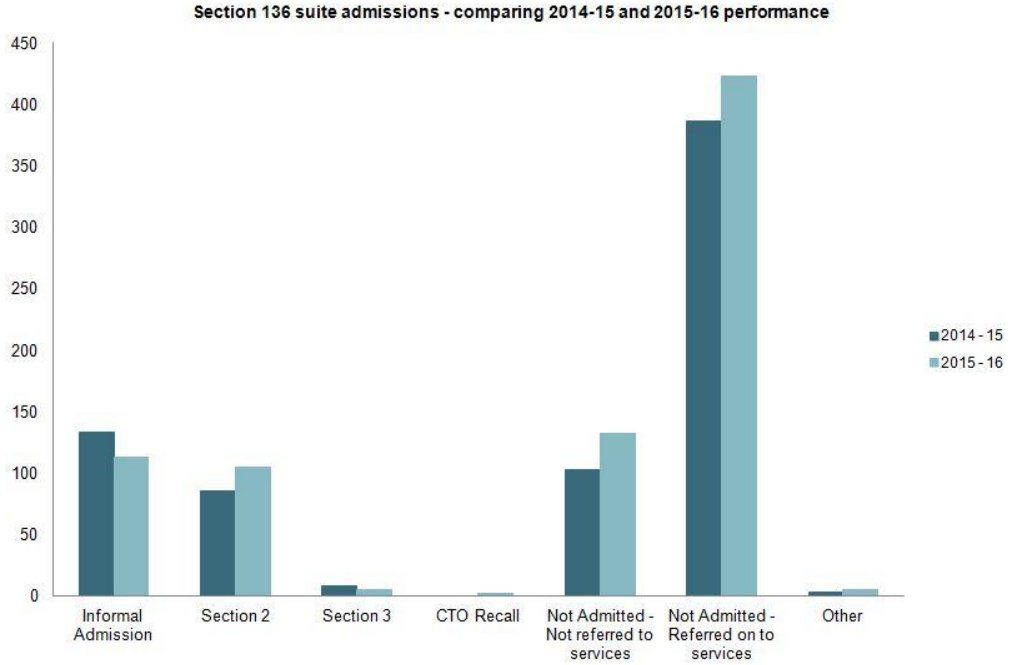
5.5 The report will also not be reviewing savings at this stage. This will need to be reviewed and reported on in the full evaluation in 2017 once the Single Point of Access programme has been implemented.

Section 136 health-based places of safety

5.6 Data on assessments and admissions of section 136 patients were reviewed. These covered the Blake, Fenby, Frimley Hospital and Wingfield services. The chart overleaf illustrate the comparative levels of demand for the 2014/15 and 2015/16 financial years:



5.7 The chart above shows that overall use of the section 136 power has increased, and more people on average each month were brought to a health based place of safety for an assessment - 65 on average per month compared to 59 the previous year. There was a 9% increase in the number of assessments (785 against 717). The admissions rate to the 136 suites was also monitored, and the outcomes were compared across the financial years.



The data indicates that overall, fewer people were admitted to a facility. In 2014/15, 68% of those brought for a section 136 assessment were not admitted. This increased to

71% in 2015/16, and people were more likely to be referred on to other services for further support. It is however also worth noting that the number of admissions under Section 2 (where a person can be detained under the Mental Health Act for up to 28 days) increased from 12% to 13.5% of all people assessed.

5.8 Anecdotal evidence from service managers suggest that they are still heavily used because they are open 24 hours a day. This is widely known to agencies, such as police, that come into contact with them on a regular basis. However, it is unlikely that numbers attending would reduce if the Safe Havens were open in parallel

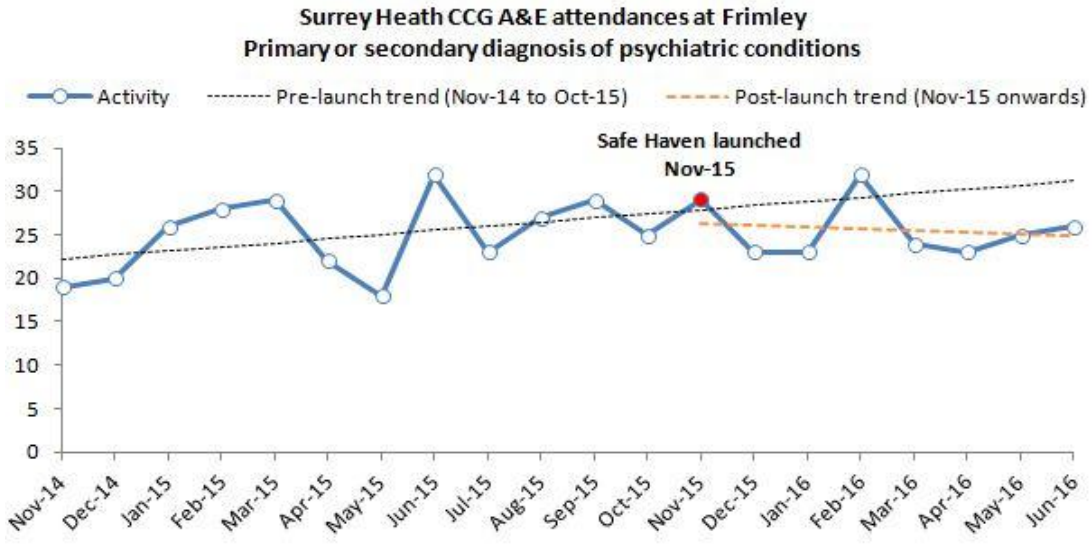
5.9 The data provided for this report assessed the high level assessments and outcomes of those assessments. However, the dataset was limited in being able to explain the reasons who brought service users to the suites and to validate the assumption that it is because of the 24 hour access. Further in-depth research is needed to understand the different factors that influence the decision to bring someone to the service instead of referring them to other mental health services.

5.10 It is worth noting that the Safe Havens and the Healios pilot were not primarily designed to address the demand levels on section 136 suites. The Single Point of Access programme, which is currently in development, aims to address this. In spite of this, it is still important to note the latest position as one of the key outcomes this programme aims to influence.

Local impact on A&E attendances

5.11 To examine whether Safe Havens are making a difference to the number of mental health attendances at A&E, it is worth reviewing their impact at local level.

5.12 Surrey Heath Clinical Commissioning Group carried out some analysis on whether their Safe Haven had affected the numbers of people attending A&E. The chart overleaf captures their analysis[24]:



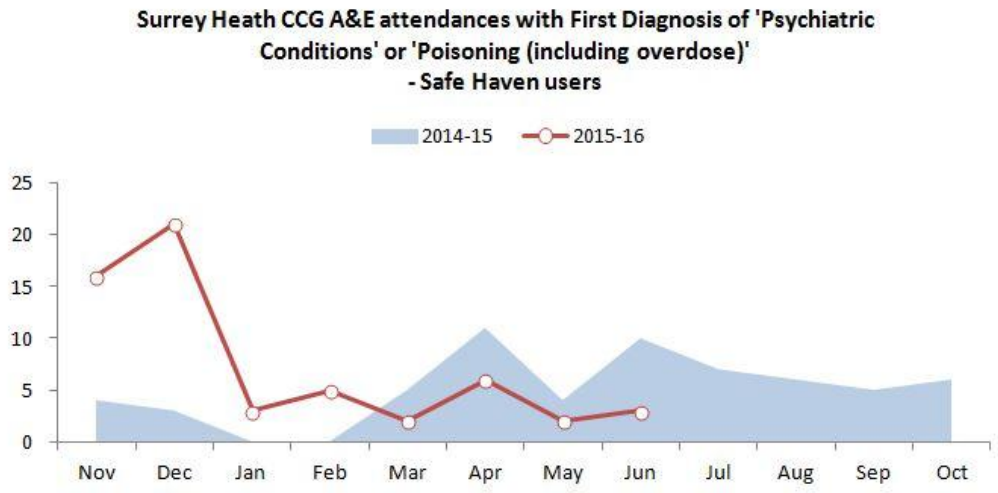
[24] Chart reproduced with permission from Surrey Heath Clinical Commissioning Group.

5.13 This shows that before the Safe Haven opened, Frimley hospital was experiencing an increasing trend in attendances. Comparing the periods of November 2014 to June 2015 and November 2015 to June 2016 allowed them to see what would have happened had the Safe Haven not opened.

5.14 Overall, mental health attendances had increased by 5.7% on the same period last year – 205 attendances compared to 194. However, if the number of attendances had followed a similar growth pattern to that of the 2014/15 financial year, there would have been 31 additional attendances at Frimley A&E from November 2015 to June 2016, meaning there would have been 236 attendances in total.

5.15 This means there has been a 13% reduction on the expected numbers attending A&E and downward trend in attendances during the period as represented by the orange dotted line on the chart. This indicates the Safe Haven potentially had a mitigating effect on attendances between November 2015 and June 2016.

5.16 To test this further, Camberley's Safe Haven also employs a link worker whose role is to maintain contact with Safe Haven users who are also frequent users of acute services, such as A&E. The chart overleaf assesses use of Frimley A&E over this period by people on the link worker's caseload:



5.17 Although there was a spike in attendances in November and December 2015 when the Camberley Safe Haven had just opened, the overall trend shows a consistently lower number of attendances at A&E of people on the link worker's caseload between March and June 2016 – 13 attendances compared to 30 in the previous year.

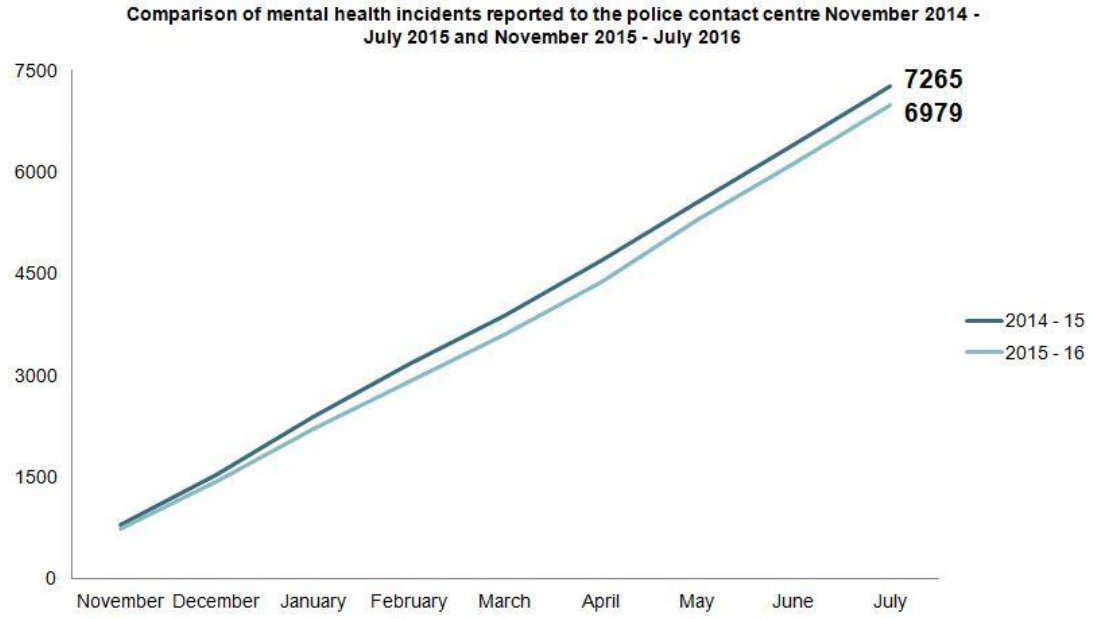
5.18 Early indications are this is having a positive effect on the numbers of people attending A&E with numbers consistently lower than those reported in 2014/15. Link worker activity will continue to be monitored to identify the longer term trend.

Police outcomes

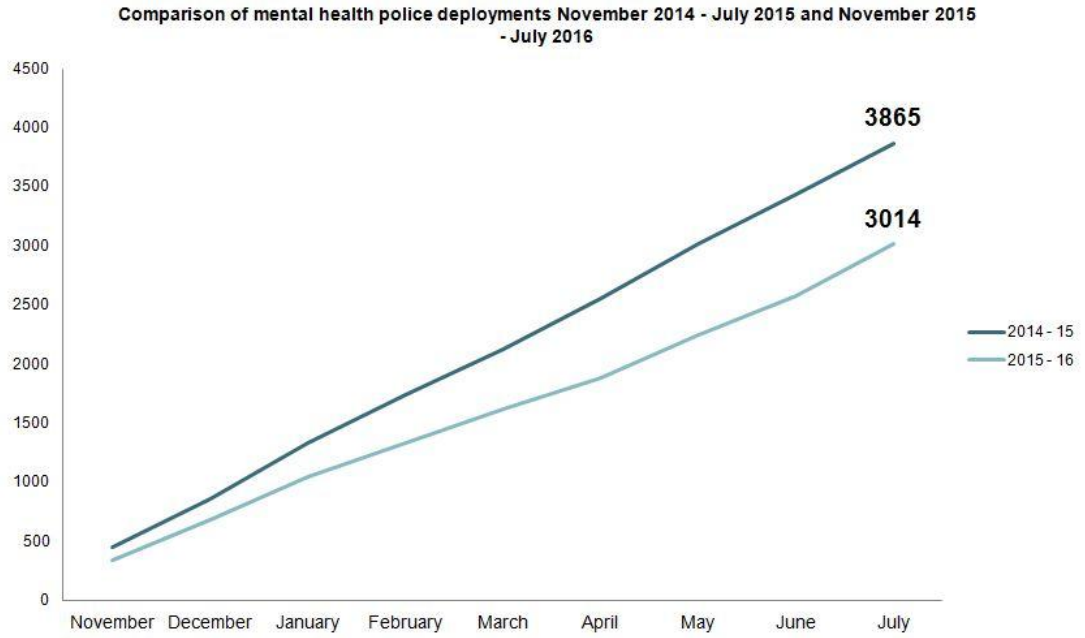
5.19 To assess if the interventions have made a difference to outcomes for the police, the nine month period in which the Safe Havens have been open (November 2015 to July 2016) was compared to the same period in the previous year to ascertain the direction

of travel across the indicators.

5.20 The authors started by reviewing the number of times where police officers had to attend in response to a reported mental health incident. This was cross-referenced with the number of incidents reported to the police contact centre. The charts overleaf illustrate the changes in demand:

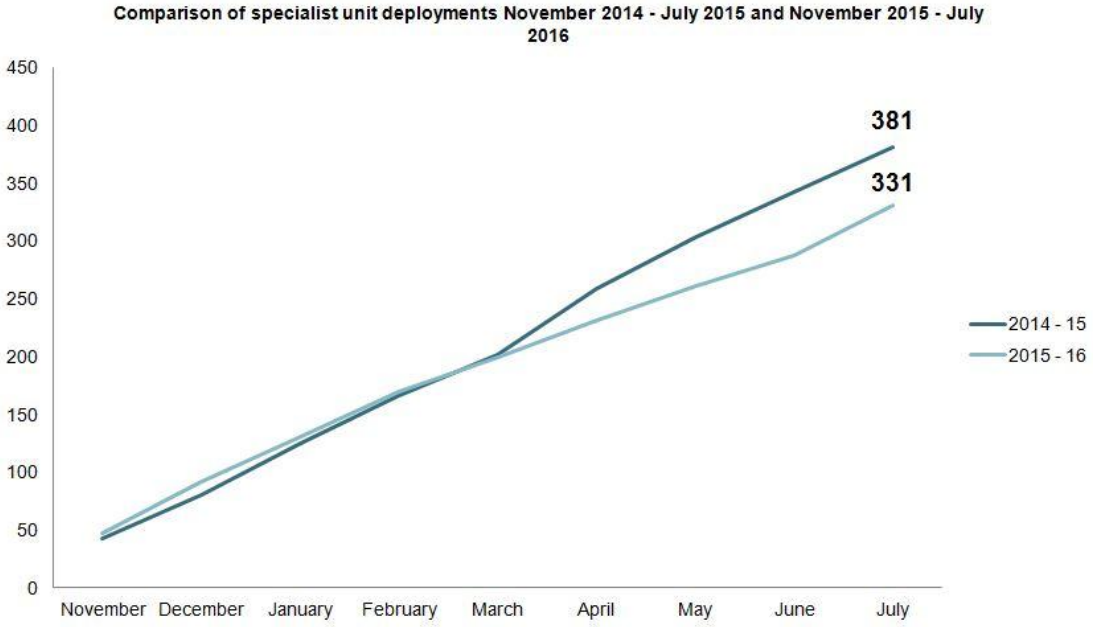


5.21 From November 2015 to July 2016, there were 6,979 instances where police have received a call expressing concern about the welfare of an individual's mental health. This represents 286 fewer calls than during the same period the previous year, equivalent to a 4% reduction. In spite of this reduction, demand has remained relatively static. However, there is a more significant deviation when reviewing deployment of officers to these incidents.



5.22 From November 2015 to July 2016, there were 3,014 mental health incidents attended by police. The represents 851 fewer incidents that officers attended, equivalent to a 22% reduction on the same period the year before. Officers attended 43% of reported incidents compared to 53% the previous year.

5.23 A similar trend can be seen on the number of specialist units deployed, for example, helicopters or dog units. The chart below illustrates demand for specialist units for mental health incidents:



This shows there were 50 fewer incidents where specialist units needed to be deployed – a 13% reduction.

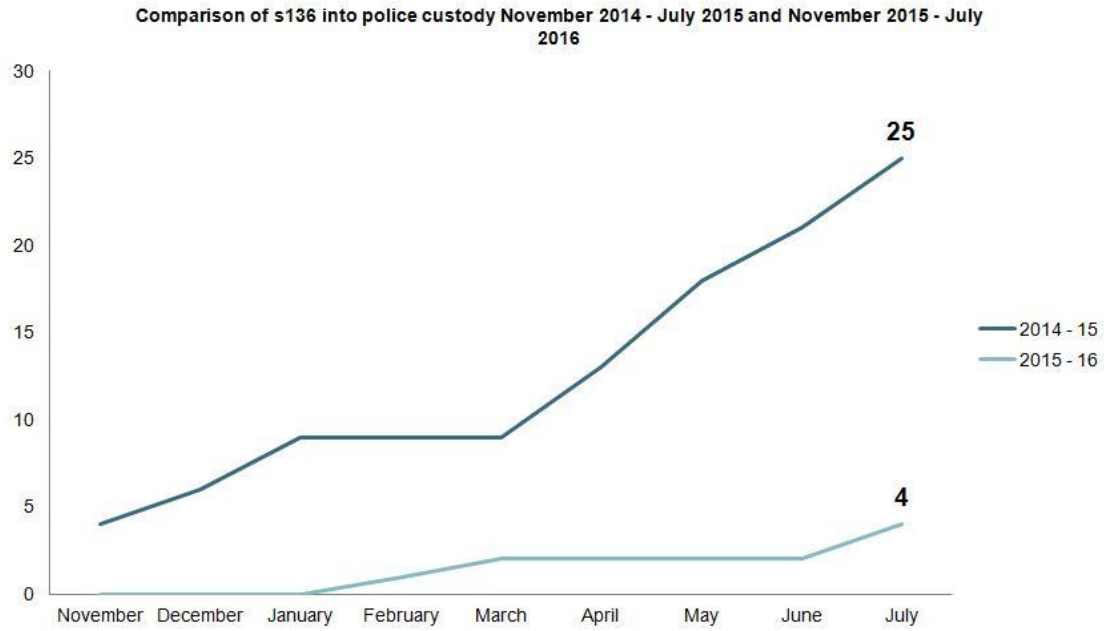
5.24 There are many different factors that could account for reductions in demand. Officers have received in-house training on the conditions under which invoking section 136 of

the Mental Health Act is appropriate. Surrey Police have also worked closely with mental health services to find better ways to accommodate the needs of people with mental health needs. In addition, the presence of a mental health specialist in the police contact centre has helped decision making on whether to deploy officers or not.

5.25 One of the outcomes where demand has increased is with the number of missing persons:

There were 45 more incidents of people reported missing during the period compared to the previous year – a 22% increase. Police data suggests that hospitals have been reporting this more frequently to the police contact centre. There have also been multiple incidents with certain individuals factored into this data that have increased demand pressures.

5.26 The final outcome Surrey Police monitor regarding the TCA bid is section 136 detentions in custody. The chart below reflects performance across the comparison period:



There were four instances of people in mental health crisis being detained in police custody, which is 21 fewer than the period in the previous year – this represents a reduction of 84%.

5.27 The extent of the influence of the Safe Havens on these outcomes is currently unclear. There are other variable to consider in the performance of these indicators, such as changes in police culture and approach to dealing with people in crisis. For example, custody sergeants have adopted a strict approach with officers, challenging them on the appropriateness of using a police cell for individuals in crisis. If no section 136 suites are available, officers are still being encouraged to take people in crisis to other locations, such as A&E.

5.28 Overall, the police have seen a general reduction across the outcomes they identified as key to the success of the bid. There are questions around the extent to which this was achieved through the introduction of the Safe Havens given the other programmes happening in parallel.

5.29 Changes in police practices and culture, coupled with awareness training, have all played a role in reductions of demands on officer time and use of police custody. For example, officers have been educated to deal with people in mental health crisis in the same way someone may be suffering a medical emergency, and are being encouraged to convey people to medical or mental health establishments. Officers will also try and use other means to de-escalate a crisis, such as talking with a family member or encouraging someone to present at A&E to have a voluntary mental health assessment.

5.30 In spite of these initiatives, levels of demand, as demonstrated by the number of mental health incidents reported to the police contact centre, at this stage appear to be relatively static. Feedback from police partners suggests the data in its current form makes it difficult to ascertain the role Safe Havens have played in the demand reductions. Further research into the role Safe Havens in changes to police practice would be a useful means of isolating this.

Conclusions and recommendations

5.31 This section has uncovered a mixed picture on whether the TCA programme is heading towards the desired outcomes it set out in the original bid. Some parts of the system for dealing with mental health crises have seen increases in demand for services, such as section 136 suites, while others have seen a reduction, such as police deployments.

5.32 It is notable that section 136 suite usage has increased over the period the Safe Havens have been operational. The lack of data around the motivations for people being brought to these suites instead of other services will require more in-depth exploration to identify how to reduce demand. It will be important to continue monitoring section 136 suite activity once the new Single Point of Access is launched in 2017 to assess if this is having any effect on demand.

5.33 The local example on A&E attendances provided by Surrey Heath CCG has provided useful analysis on the impact the Safe Haven has made at a local level. Early signs show that, in the case of the Camberley Safe Haven, it has made a difference to the number of people attending Frimley Park A&E. While this report's authors were unable to secure individual data for each CCG area, a helpful exercise for Safe Haven commissioners will be to develop a full picture of the county-wide trend.

Recommendation O1: The TCA Steering Group requests local Safe Haven commissioners pull together a countywide trend analysis to assess the difference made in local A&E attendances. This will include a breakdown for each acute hospital. This should then be fed in for discussion by the Steering Group at their meeting on 16 December 2016.

5.34 While there has been a clear reduction in demand on police services to respond to mental health incidents in Surrey, there are a number of factors, such as changes to police practice, which may or may not have played a more prominent role in this than Safe Havens. Data on the impact of Safe Havens has been difficult to obtain, but it would be useful for the TCA Steering Group and Surrey Police to have a greater understanding of police interaction with Safe Havens. Where people have not been taken to a Safe Haven, it will also be useful to have analysis on the outcomes where police have been deployed to deal with a mental health incident.

Recommendation O2: The TCA Steering Group should request that Surrey Police review their data to understand the extent to which Safe Havens have made an impact on their outcomes monitored for the TCA programme. This should form part of an overall analysis of the outcomes where police have been deployed to deal with a mental health incident. They should then present an update report to the Steering Group at the meeting on 16 December 2016.

5.35 A further complication has been the absence of data on the number of occurrences where the police or ambulance services have brought people in crisis to a Safe Haven. This has made it difficult to assess the frequency with which these services engage with the Safe Havens.

Recommendation O3: The TCA Steering Group should request that partners work together to produce an analysis of police and ambulance data to assess the proportion of incidents where they brought people to a Safe Haven.

5.36 Overall, due to the number of variables involved in the performance of these outcome measures, and the absence of the Single Point of Access service, it is extremely difficult at this stage to isolate the effect of the Safe Havens and Healios on these measures.

5.37 To understand the relationship between the outcomes, and the extent to which the current system works towards achieving these outcomes, partners may find it beneficial to develop a picture of how Surrey public agencies respond to people in crisis. This would primarily be through the means of customer journey maps to capture the user experience of interacting with public agencies. Doing this will help partners to identify the key points in the system where the TCA interventions can make maximum impact.

Recommendation O4: The TCA Steering Group should request that customer journey maps should be developed to improve understanding of the user experience of Surrey's mental health crisis care system. The Steering Group should use the output of this exercise to inform how to improve the impact of the TCA interventions.

Conclusion

6.1 To conclude this report, this section reflects on the questions it aimed to address. At this early stage, the evidence on the effectiveness of the Safe Havens and Healios in affecting the outcomes identified by the TCA programme is limited, and therefore this report is unable to provide anything conclusive. Longer term monitoring of these services by partners and the full evaluation in 2017 will provide a more robust picture of developments.

How have Safe Havens and the Healios service transformed the way Surrey's health and care system operates?

6.2 There is strong evidence that the partner organisations involved in the TCA programme are working more closely together to deliver these interventions. In spite of cultural differences between agencies, partners are determined to make them work for service users. Partners have fed back that relations are positive, potential service users are being referred to them and links are being made with other agencies within the community to ensure there are joined up approaches with other people.

6.3 The Healios service has proved a useful addition to the package of support for carers and addresses a previously unmet need. It has been well received by the carers that have used the service and there is strong evidence that using the service has played a role in the reduction of distress and burden for carers. However, other than carers support organisations and Safe Havens, there is little knowledge of this service by other partners, for example, GPs. There is also little evidence on the extent to which carers use of the service has reduced the need for the people they care for to use high demand acute services. This will need to be considered as part of a process for longer-term monitoring of the benefits carers have received from the programme.

6.4 Based on evidence gathered so far, there is more to do to understand how the system for dealing with people in mental health crisis operates. Developing a picture of this will help partners think of ways to maximise the impact of the TCA's services. It will enhance their role as preventative solutions for a service user at the right time. In short, further data needs to be gathered so partners have a comprehensive understanding of the system, its relationship to demand and the points the TCA interventions can come in to help manage this.

What relationship do Safe Havens have with stakeholders in the wider public service system (e.g. Surrey Police)?

6.5 As mentioned in paragraph 6.2, Safe Havens have a good relationship with wider stakeholders in the public service system. They have developed effective relationships with local police officers, are sharing information where possible with local acute trusts and are able to work with other agencies, such as homelessness charities, to join up around peoples' needs. This should not lose momentum, and there is a role for commissioners and providers to continue to engage with local groups to embed Safe Haven services within their communities.

What are service users', carers' and other stakeholders' perceptions of the Safe Havens and Healios carers' service?

6.6 The feedback from various stakeholders on the interventions has been overwhelmingly positive. Safe Havens have an overall satisfaction rate for service users of 99% (83% saying they were very satisfied). They feel they are respected and that they play a part in helping to manage the symptoms of a crisis before they escalate. Perhaps most importantly, they feel safe being there. The case studies also provide concrete individual examples of what impact Safe Havens can have. Other stakeholders, such as GPs, have commented on the value that these services add for people.

6.7 The popularity of the service means that commissioners and providers need to ensure that they do not become victims of their success. Safe Havens need to be clear about what support they will need to deal with increasing demand as awareness of their existence grows across Surrey.

6.8 There is also work to do to ensure the wider informal networks (carers, friends, family) around service users understand that the service is for them as well. Caring for someone with mental health needs can be a very challenging job, and they will also need support to help them care effectively and prevent them from suffering mental health issues.

6.9 Like the Safe Havens, the Healios service has received a similarly positive reception. Carers fed back how they had felt more positive about caring for someone, and that they were more able to carry out their caring role. To them, the service was responsive and flexible to their needs. A beneficial side-effect is increased carers' wellbeing means they are less likely to need to access high demand acute services for their own mental health needs.

How are they affecting the outcomes identified in the original TCA bid?

6.10 Performance across the outcomes monitored by the TCA Steering Group presents a mixed picture. Demand has reduced on certain services, with Surrey Police in particular seeing a significant drop in demand on some of their services. However, demand on other service areas, such as section 136 suites, has increased in spite of the presence of the Safe Havens.

6.11 Improving understanding of how the mental health crisis care system in Surrey operates is a logical next step in working out the points where it makes sense for the Safe Havens and Healios services to intervene. Data will also need to start being collected on the benefits produced by the introduction of the Single Point of Access programme.

6.12 Overall, there is strong evidence that people that have used these services value the individual difference it has made for them and there are benefits to the agencies involved from increased partnership working , but there is further work needed to assess whether over a longer time period, Safe Havens and the Healios services are affecting demand on the system and to better understand what is happening within the system to

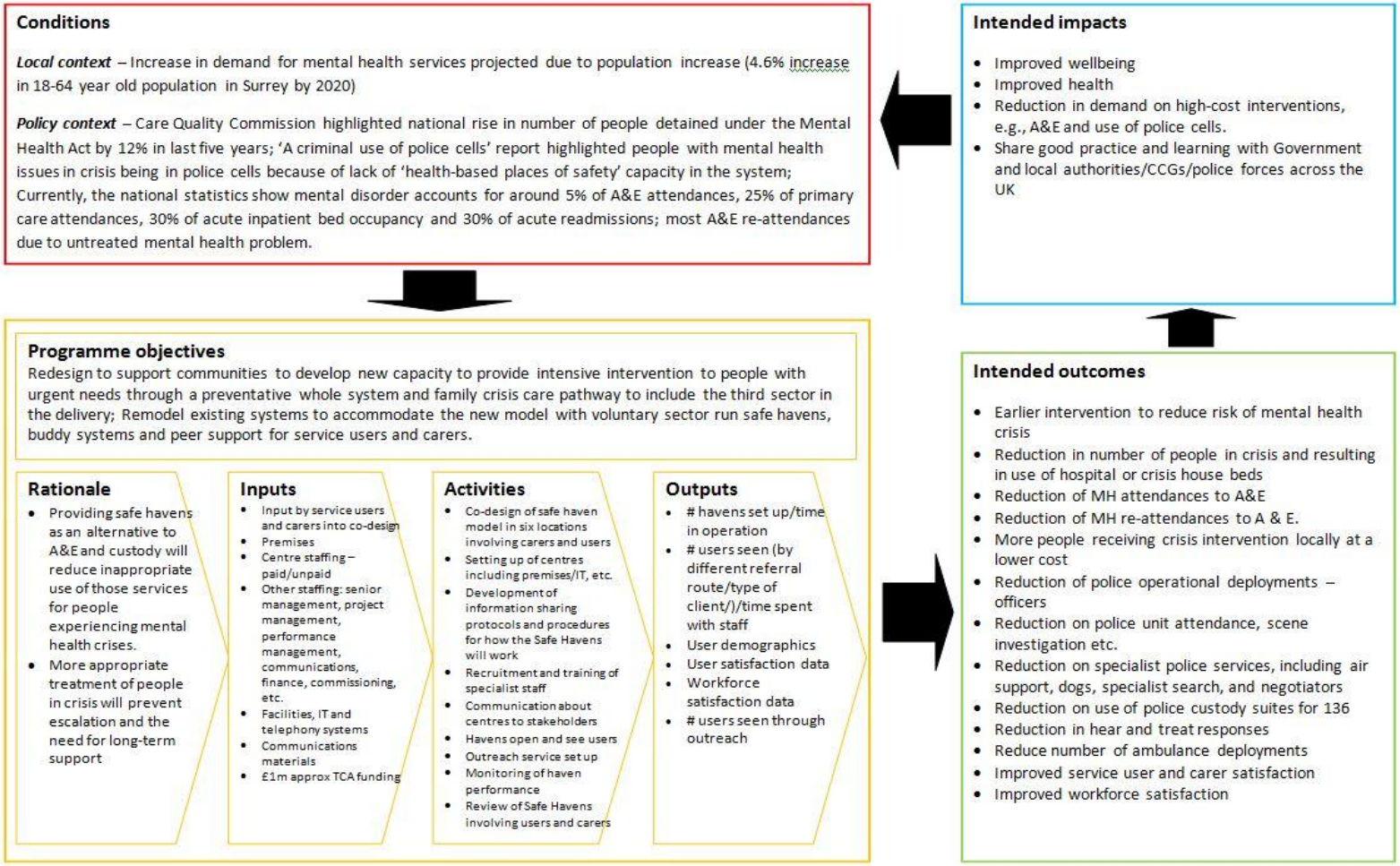
ascertain whether these interventions are providing the right support at the right time.

6.13 A full evaluation report on the TCA programme along with the Single Point of Access service will be produced in 2017 that will provide a more comprehensive picture of the effect of the TCA interventions along with an assessment of the savings generated.

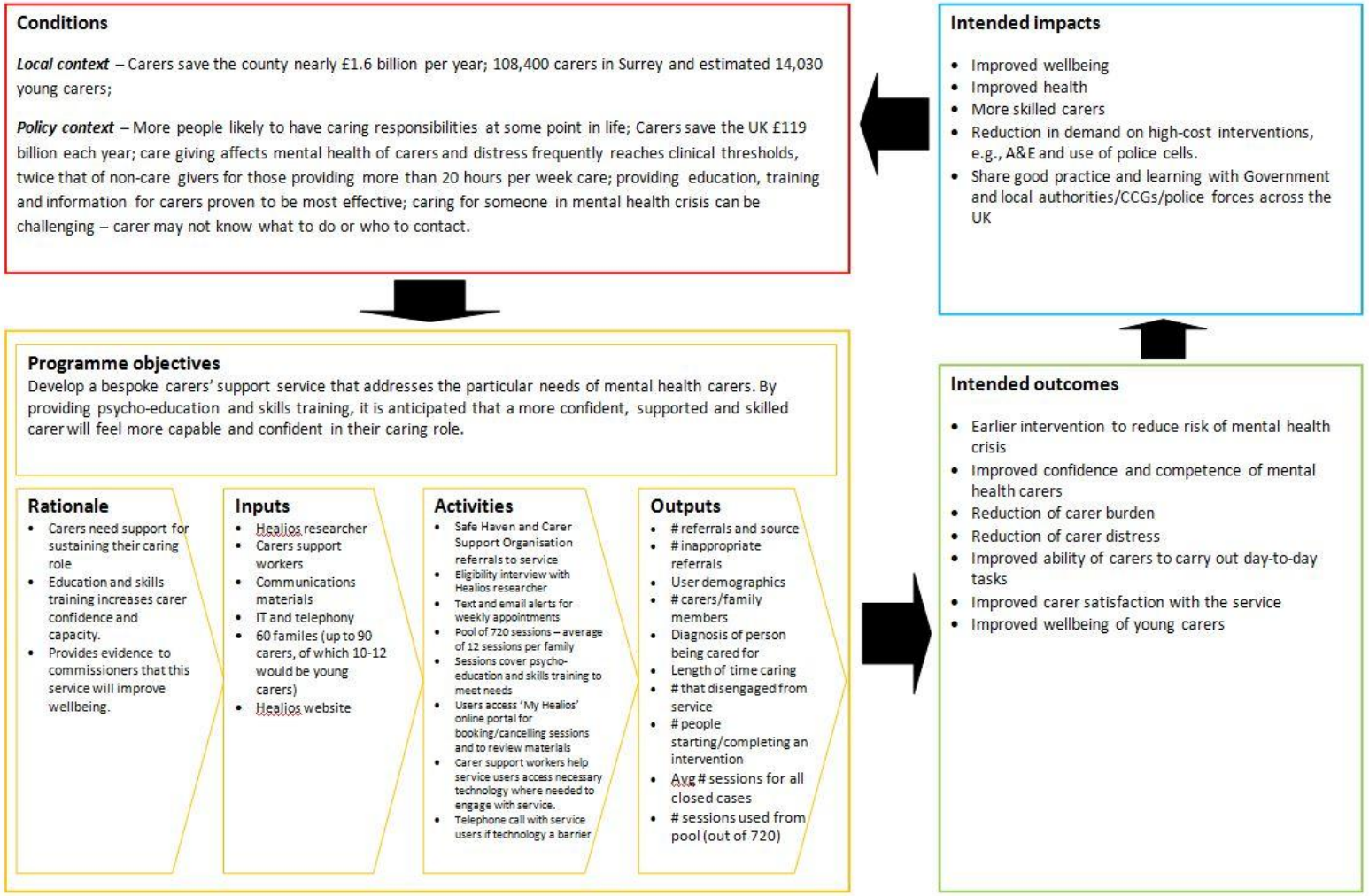
Appendices

Logic models

Safe Havens logic model



Healios pilot logic model



Summary of feedback from Safe Haven clinical staff and support workers

This summarises some of the key points gathered from the feedback provided by staff working in the Safe Havens.

Successes

- Clients feel truly safe in them.
- The wide scope of issues dealt with and range of clients from different walks of life is testament to their importance.
- Staff and regular service users provide a welcoming atmosphere.
- Dealing with patients with different diagnoses is rewarding.
- Seeing how people have benefited from visiting the Safe Haven to reduce their isolation and improve their wellbeing.
- Helps people feel more informed about local services and more empowered to ask for support.
- Service users know they have quicker access to out of hours care minus the long waits at A&E.
- It has been a wonderful experience to promote health and wellbeing to a client group who may never before had enough support to have moved forward with their problems.

Lessons learned

- Focus on getting the core service right.
- Clients are willing to provide support for each other.
- Learned about facilitating positive, constructive discussions between clients and managing tensions.
- One pathway does not suit everyone – an experienced practitioner is needed to advise on the best way forward for individuals.
- System One has shown a decrease in the use of Crisis Line.
- Should redirect people away from A&E unless they are medically unwell.
- I have learnt to always ensure the safety of all involved.
- My main concerns are risks to staff and others when dealing with potentially violent situations. We are not a ward in the community. We do not have enough quick back-up and security.
- I have learned never to be surprised by who arrives at the front door of a Safe Haven!

Relationships with external partners

- GPs and care coordinators have referred people to Safe Havens and speak highly of the service.
- Had a couple of referrals from police, although criteria for admission may need to be clarified (e.g. no under 16s).
- Project's relationship with external agencies is positive although communication is limited because of different work patterns.
- Work with the psychiatric liaison nurse with the local hospital. She refers people to the Safe Haven as part of their aftercare support.
- Links with GPs through the trust recording system could be improved to ensure faster transfer of knowledge through service users.
- Police must not think of the Safe Haven as a place for section 136.

Safe Haven Case Studies

All names in the case studies are pseudonyms to protect the identities of the individuals involved.

Jane's story

Jane is a twenty year old female undergraduate student. She first visited Safe Haven in early July 2016. She had been sexually assaulted by an acquaintance two weeks prior to attending Safe Haven for crisis support. She spoke with a client support worker and was directed to the CPN on duty. Her immediate distress was supported and she remained at Safe Haven for the rest of the evening, finding additional support from talking with other clients.

She returned to Safe Haven a week later and on this second visit started socialising with other clients. She asked to speak with a client support worker privately, describing her intrusive thoughts and memories of her experience, persistent insomnia, low mood and inability to engage with her studies.

She talked about her feelings and intrusive unresolved questions that were distressing her. She remained at Safe Haven and spoke with other visitors for the rest of the evening. She has since returned several times a week and has made friends with other clients. She has found this peer support very helpful and therapeutic.

In a follow up conversation with a support worker she reported that her insomnia had been relieved, that her 'sparkle' was returning and she was re-engaging with her studies. She continues to regularly attend Safe Haven for ongoing support.

*Case study supplied by Community Connections

Sam's story

Sam came to her local Safe Haven shortly after losing her job due to depression and anxiety. She had a history of overdosing and in the past suffered from mental health problems.

Sam finds evenings especially difficult as her partner works. She said this was when she felt mostly at risk when she struggles with negative thoughts and emotions, and feels alone and isolated.

Sam started to come to the Safe Haven most evenings where she socialises with the group or spend time doing mindful colouring.

She says that coming to Safe Haven is a lifeline for her where she has made new friends and feels she can get some relief from her isolation, as well as advice from the staff with any issues she may be struggling with. Since coming to the Safe Haven, Sam has also referred herself to Oakleaf to further fill her days with activities and learn new skills. Sam feels the Safe Haven has had a real positive impact on her life and emotional health.

*Case study supplied by Community Connections

David's story

David presented at Safe Haven having been living in a local hostel as he had become homeless. He had travelled down from Scotland to live in Surrey to care for his grandfather who was suffering from dementia, and had lived with him for four years. His grandfather then became too unwell and was taken into long term care. The property was sold and David had nowhere to live. He did not feel that he could go back to Scotland to live with his mum as she had severe mental health problems and he had been in care since he was 12.

He presented at the Safe Haven in a restless and agitated state. He was worried that the following week he would have nowhere to live and land up on the streets. He had been seen by his GP and been prescribed medication to help with his anxiety. The GP had made a referral for him to be seen by the Community Mental Health Recovery Services (CMHRS).

The CHMRS did not manage to engage with him, and advised he needed to engage with groups to help with the anxiety. He felt that he needed somewhere to live before he could concentrate on any support.

The Safe Haven made contact with Barnardos in Scotland and confirmed David was a looked after child and, as he was still only aged 20, he should be able to receive support locally. We were able to contact the council and support him with this. He was given accommodation locally with a support worker and was then able to accept the offer of group support from the CMHRS. The young gentleman is now doing well and is being supported to find paid employment.

*Case study supplied by Surrey and Borders Partnership staff

Shu-ling's story

Shu-ling is a 31 year old Taiwanese student who presented at a Safe Haven accompanied by her landlord and his daughter. They were referred by the crisis team. Initially, she was suspicious, but she engaged after counselling and reassurance. She lives in a rented accommodation and her family were acting as her main carers.

She gave moderate eye contact and her mood was objectively euthymic with incongruous affect. She said she was 'ok' but her speech lacked spontaneity and showed evidence of paucity. She was disturbed by her thoughts and internal experiences. She was able to attribute the way she was feeling but wasn't sure how to deal with her current situation and didn't see a way forward. She did not believe she had mental illness and was unable to make a rational decision in relation to her mental wellbeing.

Safe Haven staff recommended she and her family were referred for the following:

- Carer reported difficulty coping with Shu-lings's current presentation
- She had poor sleep hygiene and not eating properly.
- She presented with acute psychotic symptoms that would warrant an acute pathway.
- She was vulnerable and at risk of further mental health decline if symptoms persist without intensive intervention.

Following referral by the Safe Haven, Shu-ling was supported by the home treatment team for about four weeks. According to the notes it appears that she was treated with medication and this prevented him from being admitted into hospital.

This was an example of how the Safe Haven project has helped so many others who

previously had no option but to present at A and E.

*Case study supplied by Surrey and Borders Partnership staff

Tom's story

Tom accesses Safe Haven at the weekend every Saturday and Sunday and will often spend the day and into the evening with us there. He is 65 years old and lives alone in warden assisted accommodation. He is a very proud gentleman and struggles to accept support from carers.

He has a diagnosis of severe depressive episodes with suicide attempts and has spent lengthy periods of time in hospital as a result.

He spends £70 to get to the Safe Haven over the course of the weekend which he finds very difficult to find but says the benefits to him outweigh the cost of transport.

Various discussions have been had as a team and some staff believes that he is using the safe haven purely as a social resource and is therefore not appropriate.

Having looked at his notes and history, it was clear that Tom is socially isolated at the weekend and it has always been at these times that have proven most difficult for him to manage. He would often fight with voices in his head and would self-harm as a result. This mainly happened late evening at the weekends.

Since coming to Safe Haven, Tom has managed with staff support to problem solve at these particularly difficult times and as a result he reports not to have self-harmed at night and is beginning to have better sleep hygiene also. The team also recognised that for Tom, this was the right support package for his needs at the time.

*Case study supplied by Surrey and Borders partnership staff

Tanya's story

Tanya arrived at Safe Haven after calling the Crisis Line. She was distressed – pacing around the sitting area and wringing her hands – running her hands on occasion through her hair. She appeared dishevelled and malodorous indicating poor self -care and preoccupation. She was also unable to sit still for very long -- on two separate occasions banged her head on the wall of the small sitting area. She came alone and indicated that she had no carer or family she could rely upon.

Tanya said that as a young child she experienced the trauma of seeing her younger brother murdered by her father, and this had impacted on her mental health. She had been admitted to the ward several years ago with a diagnosis of bi-polar disorder, but had been well maintained by her GP.

She had a complicated background of using drugs and overeating as a form of self- harm and was currently finding things very difficult. Her GP had reduced Quetiapine by 100mg and she had also had a nasty fall fracturing her shoulder – leading to her having to alter her lifestyle dramatically.

The Safe Haven staff spent considerable time with this client over three months - initially we

discussed referral to the Home Treatment Team. Tanya did not want to receive community services. She was not psychotic having capacity to make decisions around her care and treatment. Small recovery goals were agreed with Tanya - then she discussed with GP around medication changes. She also spent time with Safe Haven staff doing basic problem solving, reflecting on her strengths and setting goals for each day.

As a result of the Safe Haven's intervention, Tanya has returned to her Fine Art course and swimming. She remains currently taking full dose of Quetiapine also continues to use PRN.

*Case study supplied by Surrey and Borders Partnership staff

Kim's story

Kim came to the Safe Haven after she had attended A&E. She was a regular client - she cuts very deeply several times a week. She was open to Community Mental Health Recovery Services (CMHRS) but found evenings and weekends extremely difficult. She was clearly anxious and was unable to talk to Safe Haven staff on arrival by ambulance on first occasion. A series of flashcards were used to communicate her concerns//worries. She did not make eye contact and could not verbalize her needs.

Kim had been diagnosed with Aspergers, Bulimia, Obsessive Compulsive Disorder and Emotionally Unstable Personality Disorder. She did not have a social friendship group and spent most of her time not sleeping or attending A&E due to severity of her cutting. She said she cuts to distract from the pain inside – "whilst I'm there, cleaning up, my thoughts don't keep going round and round".

Her constant thought about suicide all the time meant her risk marked as "High" as she lives alone.

Safe Haven staff spent considerable time with client "just sitting", reflecting back her concerns and offering support. We discussed referrals to the eating disorder service and her associated worries around this. She was offered time to reflect on her concerns around making changes and issues were discussed that she wanted to talk to her care manager about

Over six months, Kim started talk to other visitors about her worries. She now regularly attends the Safe Haven as a diversion from her current life choices, and sometimes joins in games and sits with others which is a huge step forwards in her recovery journey. She also talks to staff when she is particularly worried.

*Case study supplied by Surrey and Borders Partnership staff

Safe Haven service user and carer questionnaire

Camberley Safe Haven SERVICE USER / CARER questionnaire

Introduction

1. **When you visited the Safe Haven today, did you: [Skip logic question]**
   - Visit as a service user
   - Visit as a carer

2. **How did you first find out about the Safe Haven ?**
   - GP
   - Friend or family member
   - Someone who has previously visited a Safe Haven Cafe
   - NHS Mental health services
   - A&E
   - Other (please state)

3. **If the Safe Haven had not been open today, where would you have looked for support?**
   - Family or friends
   - 999
   - NHS 111
   - A&E
   - Other (please state)
   - Don't know

Attendance

4. **How many times have you been to the Safe Haven ?**

   Options: First time, 2, 3, 4+,

5. **What are your main reasons for attending the Safe Haven? (Choose up to 3)**
   - To seek a 'safe haven' during my crisis
   - To get support and advice about mental health services
   - To meet / socialise with other people like me
   - To maintain my wellbeing during a difficult time
   - To maintain my recovery after a crisis
   - Other (please state)

Carer question:

What are your main reasons for attending the Safe Haven?
(Choose up to 3)

- To get support and advice about my wellbeing, as a carer
- To get support and advice about mental health services
- To meet / socialise with other people visiting the cafe
- To help the person I care for during a difficult time
- To help the person I care for maintain their recovery after a crisis
- To maintain my wellbeing during a difficult time
- Other (please state)

Activities

6. **What did you do today at the Safe Haven ? (Tick all that apply)**
    - I talked to a member of staff about how I am feeling
    - I received advice about my mental health care and treatment
    - I received advice about other services I can access [housing, financial, employment]
    - I socialised with other people visiting the Safe Haven
    - I received advice about coping techniques I can use to help me manage my distress
    - I accessed, or was referred to the Healios online support programme
    - I did some action planning with a member of staff
      Other (please state)

Carer question

What did you do today at the Safe Haven ? (Tick all that apply)

- I talked to a member of staff about how I am feeling, as a carer
- I talked to a member of staff about the person I care for
- I received advice about mental health care and treatment
- I received advice about other services [housing, financial, employment]
- I socialised with other people visiting the Safe Haven
- I accessed, or was referred to the Healios online support programme
- Other (please state)

Experiences

Benefits / Outcomes

7. **Thinking about your visit to the Safe Haven , please state how much you agree with the following statements:**

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Not applicable
The staff treated you with dignity and respect							
The staff treated you with warmth and compassion							
The staff listened to you and your concerns were taken seriously							
The safe haven cafe offers a safe place for you to go							
Visiting the cafe has prevented you or the person you care for, from being in a crisis							
Visiting the cafe has helped you manage a difficult time							
The advice and support you were given was right for you							
You are better equipped to manage your mental distress							
You are more informed to make choices							

8. **Overall, how satisfied are you with your experience at the Safe Haven today?**
    - Very satisfied
    - Fairly Satisfied
    - Neither
    - Fairly unsatisfied
    - Very unsatisfied

9. **What has the Safe Haven helped you with the most?**

10. **Is there anything the Safe Haven could do better?**

About You (Census Question format)

11. **Age**
    - Under 15
    - 15-18
    - 19-25
    - 26-44
    - 45-64
    - 65+

12. **Gender**
    - Male
    - Female

13. **Ethnicity**
    - White British
    - White Other
    - Asian
    - Black
    - Mixed
    - Other
    - Unknown

14. **Religion**
    - Christian
    - Buddhist
    - Hindu
    - Jewish
    - Muslim
    - Sikh
    - Other religion
    - No religion

Healios pilot questionnaire scales

Below are the questionnaires that families undergoing the Healios pilot were asked to complete before they started the course and again after eight sessions to assess any impacts in outcomes for them.

1. Involvement Evaluation Questionnaire (IEQ)

This questionnaire has 5 choices of response:

1 = never; 2 = sometimes; 3 = regularly; 4 = often; 5 = always

When you are thinking about how to answer I would like you to think about how things have been in the last four weeks, please ignore the time before that.

How often during the **past four weeks**:

Tension subscale	Never	Sometimes	Regularly	Often	Always
has your relative/friend disturbed your sleep					
has the atmosphere been strained between you both, as a result of your relative/ friend's behaviour					
has your relative/friend caused a quarrel					
have you been annoyed by your relative/friend's behaviour					
have you heard from others that they have been annoyed by your relative/friend's behaviour					
have you felt threatened by your relative/friend					
<<does X live with you?>> have you thought of moving out, as a result of your relative/friend's behaviour					
have you worried about your own future					

have your relative/friend's mental health problems been a burden to you					

How often during the **past four weeks**:

Supervision subscale	Never	Sometimes	Regularly	Often	Always
have you guarded your relative/friend from committing dangerous acts					
have you guarded your relative/friend from self-inflicted harm					
have you ensured that your relative/friend received sufficient sleep					
have you guarded your relative/friend from drinking too much alcohol					
have you guarded your relative/friend from taking illegal drugs					
has your relative/friend disturbed your sleep					

How often during the **past four weeks**:

Worrying subscale	Never	Sometimes	Regularly	Often	Always
have you worried about your relative/friend's safety					
have you worried about the kind of help/treatment your relative/friend is receiving					
have you worried about your relative/friend's general health					

have you worried about how your relative/friend would manage financially if you were no longer able to help					
have you worried about your relative/friend's future					
Has X's mental health problems been a burden to you					

How often during the past four weeks:

Urging subscale	Never	Sometimes	Regularly	Often	Always
have you encouraged your relative/friend to take proper care of her/himself					
have you helped your relative/friend to take proper care of her/himself					
have you encouraged your relative/friend to eat enough					
have you have you encouraged your relative/friend to undertake some kind of activity					
have you accompanied your relative/friend on some kind of outside activity, because he/she did not dare to go alone					
have you ensured that your relative/friend has taken the required medicine					
have you carried out tasks normally done by your					

Urging subscale	Never	Sometimes	Regularly	Often	Always
relative/friend					
have you encouraged your relative/friend to get up in the morning					

Themes not included in a subscale:

	Never	Sometimes	Regularly	Often	Always
How often during the past 4 weeks have you been able to pursue your own activities and interests?					
Have you got used to your relative/friends mental health problems?					
How often have you felt able to cope with your relative/friend's mental health problems?					
Has your relationship with X changed since the onset of the mental health problems?					

2. Hospital Anxiety And Depression Scale (HADS)

Now we will move on to the next questionnaire. This scale is slightly different as it has **4 options** that are different for each statement so I will read each of them to you as many times as you need. You should give an immediate response and don't think too long about the answer. Please answer based on how it **currently** describes your feelings e.g. last week/ two weeks.

A (3)	**I feel tense or 'wound up'**	Most of the time	A lot of the time	From time to time, occasionally	Not at all
D (0)	**I still enjoy the things I used to enjoy**	Definitely as much	Not quite so much	Only a little	Hardly at all
A (3)	**I get a sort of frightened feeling as if something awful is about to happen**	Very definitely and quite badly	Yes, but not too badly	A little, but it doesn't worry me	Not at all
D (0)	**I can laugh and see the funny side of things**	As much as I always could	Not quite so much now	Definitely not so much now	Not at all
A (3)	**Worrying thoughts go through my mind**	A great deal of the time	A lot of the time	From time to time, but not too often	Only occasionally
D (3)	**I feel cheerful**	Not at all	Not often	Sometimes	Most of the time
A (0)	**I can sit at ease and feel relaxed**	Definitely	Usually	Not often	Not at all
D (3)	**I feel as if I am slowed down**	Nearly all the time	Very often	Sometimes	Not at all
A (0)	**I get a sort of frightened feeling like 'butterflies' in the stomach**	Not at all	Occasionally	Quite often	Very often
D (3)	**I have lost interest in my appearance**	Definitely	I don't take as much care as I should	I may not take quite as much care	I take just as much care as ever
A (3)	**I feel restless as I have to be on the move**	Very much indeed	Quite a lot	Not very much	Not at all
D (0)	**I look forward with enjoyment to things**	As much as I ever did	Rather less than I used	Definitely less than I used to	Hardly at all

			to		
A (3)	**I get sudden feelings of panic**	Very often indeed	Quite often	Not very often	Not at all
D (0)	**I can enjoy a good book or radio or TV program**	Often	Sometimes	Not often	Very Seldom

3. Work and Social Adjustment Scale

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a qualified health professional. If you're retired or choose not to have a job for reasons unrelated to your problem, tick here

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

Because of my [problem] my ability to work is impaired. '0' means 'not at all impaired' and '8' means very severely impaired to the point I can't work.

Because of my [problem] my home management (cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired.

Because of my [problem] my social leisure activities (with other people e.g. parties, bars, clubs, outings, visits, dating, home entertaining) are impaired.

Because of my [problem], my private leisure activities (done alone, such as reading, gardening, collecting, sewing, walking alone) are impaired.

Because of my [problem], my ability to form and maintain close relationships with others, including those I live with, is impaired.

4. Family Questionnaire (FQ – Critical Comments)

This questionnaire lists different ways in which families try to cope with everyday problems. For each item please indicate how often you have reacted to the patient in this way. There are no right or wrong responses. It is best to note the first response that comes to mind. Please respond to each question, and mark only one response per question.

1 = Never/Very Rarely 2 = Rarely 3 = Often 4 = Very often

1. I have to keep asking him/her to do things
2. He/she irritates me
3. I have to try not to criticize him/her
4. It's hard for us to agree on things
5. He/she does not appreciate what I do for him/ her
6. He/she sometimes gets on my nerves
7. He/she does some things out of spite
8. When he/she constantly wants something from me, it annoys me
9. I have to insist that he/she behave differently
10. I'm often angry with him/her

5. Client Satisfaction Questionnaire (CSQ-8)

Please help us improve our program by answering some questions about the services you have received.

We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions.

1. How would you rate the quality of service you have received?
    a. Excellent
    b. Good
    c. Fair
    d. Poor

2. Did you get the kind of service you wanted?
    a. No, definitely
    b. No, not really
    c. Yes, generally
    d. Yes, definitely

3. To what extent has our program met your needs?
    a. Almost all of my needs have been met
    b. Most of my needs have been met
    c. Only a few of my needs have been met
    d. None of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to him or her?
    a. No, definitely not
    b. No, I don't think so
    c. Yes, I think so
    d. Yes, definitely

5. How satisfied are you with the amount of help you have received?
    a. Quite dissatisfied
    b. Indifferent or mildly dissatisfied
    c. Mostly satisfied
    d. Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?
    a. Yes, they helped a great deal
    b. Yes, they helped
    c. No, they really didn't help
    d. No, they seemed to make things worse

7. In an overall general sense, how satisfied are you with the service you have received?
    a. Very satisfied
    b. Mostly satisfied
    c. Indifferent or mildly dissatisfied
    d. Quite dissatisfied

8. If you were to seek help again, would you come back to our program?
    a. No, definitely not
    b. No, I don't think so
    c. Yes, I think so
    d. Yes, definitely

<u>The following scales are used for Young Carers (12-18 years of age)</u>

6. Brief Multidimensional Students' Life Satisfaction Scale (BMSLSS)

	I would describe my satisfaction with …	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
1	My family life as:							
2	My friendships as:							
3	My school experience as							
4	Myself as:							

5	Where I live as:							

The next section is about how you have been feeling over the last week. There are 5 options for each statement (do you want to write these down):

Not at all, Occasionally, Sometimes, Often, Most/All of the time.

For each statement I would like you to think how often you have felt like that in the last week and then let me know which answer best fits.

YP-CORE

		Not at all	Occasionally	Some-times	Often	Most/All of the time
1	I've felt edgy or nervous					
2	I haven't felt like talking to anyone					
3	I've felt able to cope when things go wrong					
4	I've thought of hurting myself					
5	There's been someone I felt able to ask for help					
6	My thoughts and feelings distressed me					
7	My problems have felt too much for me					
8	It's been hard to go to sleep or stay asleep					
9	I've felt unhappy					
10	I've done all the things I wanted to					

Healios case studies

Sandra and Esther's story

Sandra cared for her daughter, Esther, who had bi-polar. She felt stressed and anxious when trying to cope with Esther's extreme mood changes. Esther called Sandra a dozen times each day and this caused Sandra stress as she had a demanding job. Sandra found it hard to divide her time and often felt guilty that her attention was being directed elsewhere.

Sandra said she was a pragmatic person used to solving things and struggled when it came to empathy and sympathy. Esther was in need of constant comfort.

Healios provided skills and education on the subject of bipolar. Sandra said she wanted to focus on the following goals:

- Learn to be a little more empathic when speaking and listening to Esther; and
- To educate other family members on how to cope and help. This included understanding symptoms, behaviours and coping methods in anxiety, bipolar and depression.

Healios focused on anxiety, bipolar, communication, low levels of activity, problem solving and grounding in PTSD.

Sandra felt completely supported by the course. It helped her to validate and clarify what was helpful and what was not. Her relationship with Esther had become far stronger and they injected a sense of fun into their practice, resulting in less pressure, guilt and anxiety.

Sandra said:

"*This has been the most marvellous intervention. Healios has provided me with a new way of approaching my relationship with my daughter and has made me feel less responsible and guilty. My son-in-law is also in the programme and I think this may be saving their marriage. We both now have some shared lessons that we encourage each other in.*"

*Case study provided by Healios. Pseudonyms have been used to protect Sandra and Esther's real identities.

Ellie and David's story

David was going through periods of depression and self-harm. The family were struggling to cope with his self-harming behaviour. Ellie, David's mother, and David were both working, but the increased pressure meant that they were both in danger of losing their jobs.

Ellie felt helpless. She had tried to encourage her son to get help and support, but he would not engage with services. Ellie realised they were in a negative spiral. David was isolated from his family as they were unable to cope with his self-harming.

Healios provided carer support and psycho-education. Ellie learned new communication skills to help her understand David's behaviour and engage him more effectively. She also learned problem solving skills which enabled her to encourage David to begin to think more for himself.

Healios supported Ellie to identify shared goals with David and she was able to work collaboratively with him to resolve some key issues. This gave them both the confidence

they needed.

Both Ellie and David are more positive about the future. David has returned to work after a period of illness and is due to start a course of individual therapy. Ellie feels stronger and more able to cope with everyday life. This change was reflected in a 39% reduction in her distress levels. She is more understanding of David's behaviour and they are able to have conversations about his symptoms and early warning signs. David is now treated more inclusively by the rest of the family.

Ellie said:

"*I am more relaxed...I have learnt to take each day as it comes. I am more honest with my son and he is much more positive about life.*"

*Case study provided by Healios. Pseudonyms have been used to protect Ellie and David's real identities.

Sophie and Adam's story

Adam had been diagnosed with schizoaffective disorder. He has a previous history of inpatient admissions under the Mental Health Act. Sophie, his mother, expressed concerns that he was stuck in a pattern of sleeping most of the day, spending many hours at night watching TV or playing computer games and rarely leaving the house.

She felt this left him isolated with little opportunity to make friends or become involved in a life outside his bedroom. She felt helpless to know how to talk with him about these things or her concerns about his future.

Healios helped Sophie to reflect on alternative ways to engage with her son. Using new communication skills, she was able to engage with Adam more effectively. They worked together to identify some activities he would like to share with her and she was able to provide positive feedback when this happened.

Healios also provided psycho-education to help Sophie and Adam understand the impact of mental illness on motivation and energy levels, and how to manage this more effectively.

Sophie was happy that she and Adam were communicating more openly and frequently, working on their issues together. This was reflected in a 27% reduction in her burden scores. They are now regularly enjoying walks and other activities and he is spending much less time in bed during the day. Adam is also going to the gym and attends an activity group independently. He has recently begun engaging with a support worker to enable him to access a voluntary work placement.

Sophie said:

"*I am more optimistic...I found problem solving with my son helped us both find activities that he was motivated to do. Now he seems much happier.*"

*Case study provided by Healios. Pseudonyms have been used to protect Sophie and Adam's real identities.

Agnes and Peter's story

Peter had significant mental and physical health needs. Agnes, his mother, cared for him and identified two main issues.

She was finding it very difficult to spend meaningful time in Peter's company and he was often distressed by delusions and voices. She was also concerned that communication with staff from different teams involved in Peter's care was less effective than it could be. She wanted to find a way to be better informed about how they worked together to support all his needs, and to feel more involved.

Healios helped Agnes put new communication approaches and skills into practice. Psycho-education about delusions and hallucinations gave Agnes a better understanding of her son's experiences and behaviours. Healios provided a problem-solving approach that enabled her to identify when her son was less distressed. In turn, this helped her plan different activities to share with Peter.

Reviewing her own coping strategies enabled Agnes to prioritise some of her own needs.

Agnes is now more confident in her communication with services and Peter, and feels more involved with both. She worked with Peter to identify new activities and supported him to get his own personal computer.

She also feels better in herself as was indicated by a 20% reduction in her distress levels. She felt more able to prioritise her own needs and to plan a holiday.

Agnes said:

"*I enjoyed improving my understanding of delusions and I liked the interactive exercises that were used in the work.*"

* Case study provided by Healios. Pseudonyms have been used to protect Agnes and Peter's real identities.