AIM

-> unmet need.
-> level of support
-> stensty model.
-> Alternative to Health / medical offer.
-> variable workforce to meet diversified needs.

Purpose / outcome. ->

- Safe space. (visible / verbal / tech.
- accessible.
- advice /
- preventative measures.
- Inter agency working - Vol / Prim / Sec. faith.

- Be part of the conversations
- Network +
- Open doors - collaboration
- improve pt experience
- Learn about other services (3rd sector, social care, other public sms) Trust
- Whats on offer for BME communities?
- Whats changed + where are we heading?
- Learning more about - crisis - what makes people go
- Whats on offer as an alternative?
- How do we not react but plan?
- Young people focus.
Put Pts at beginning of conversations.

Accessibility Criteria. – All

1st point of contact –

Multiple providers - holistic.

– Triage - Skills.

- Outcomes- develop skills / support across all daily functions. - Money management / Benefits.

- Crisis support. / +

Could get confused what

Instant Access – If the SU is able

Safe Place

Home outreach – Peer Support / Mentoring
– accompany / Relationships.

Wellbeing / Crisis – SU not accessing
familiarity. when in Crisis.

Preventative Support

Who can access – criteria, needs
open access.

Helpline?

Grow existing resource.

- Central Pathway into Crisis Services

* Peer support in community
* How police link into work, reduce risk, keep people safe.
* See how things will improve
* Clarity on pathway
* Bringing all together, new resources available
* Advocacy & how this links in

? use of sanctuary as a term.

café - evolves over in, informal support.

? network vs. physical space

"A place to feel alright"
learning from people's experience.

My own sanctuary? What could be commissioned

Sanctuary: domestic violence context.
Conflict of metaphors. Role of online telephone.
? outcomes. ? measurable.

Sanctuary too formal.

Practicalities: where located? Transport?
Does it have to be physical?

- Where are we, where do we fit in?
- finding out about developments.
- Connecting interconnecting agendas
- Better understanding of ICS's interventions
- Meet people.
- Look at development of crisis care pathway
- Understanding of BME groups' needs.
- role of voluntary sector.
- explore partners working together.
- practical day to day, least restrictive alternatives.
- mental health issues :- LGBT+
  - under 25's.
- connection to changes underway in CRHT, PCDU.

- Create 1 service.

- ? Same Staff - different inputs,

- accessibility to different groups. community, background.
- fills a current gap (MHA ~~at~~ amount ED attendance).
- instant / timely | response.
  - peer led
  - accessible
- barries to access.
- prevention. open door.
- accessing different communities
  - bigger reach to service users.

We think in terms of Services.

- what we know
- what we don't know.

flexibility required.

Issues of risk.

Mental Health Safe space is broader than crisis

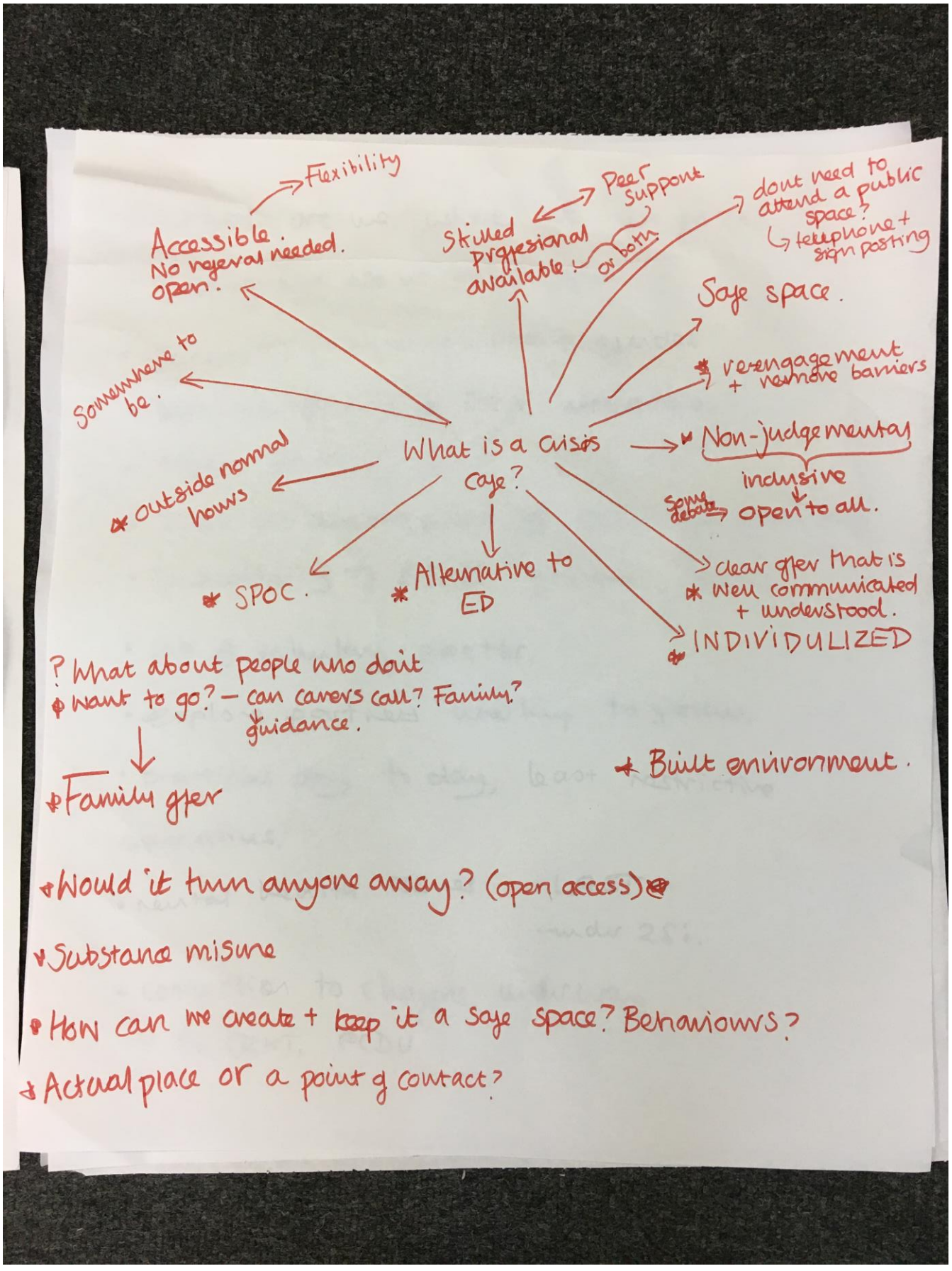
Is there a danger of being too broad? → over run?
→ no one accessing?

Before the point of getting to an 'A+E' crisis

'Not a place of Safety'

Suicide prevention → Men.
→ Where can services send people when they are worried?
↓ Is this the right service?
↓ What staff/ professionals would we need.

PS. Could we ask people who are attending ED and/or admitted to hospital what would have made a difference?


Flexibility
Accessible
No referral needed.
open.
Peer support
Skilled progressional available
or both
dont need to attend a public space?
↳ telephone + sign posting
Safe space.
Somewhere to be.
re-engagement + remove barriers
What is a crisis Cafe?
Non-judgementay
inclusive
open to all.
outside normal hours
SPOC.
Alternative to ED
clear offer that is well communicated + understood.
INDIVIDULIZED
? What about people who don't want to go? – can carers call? Family? guidance.
Family offer
Built environment.
Would it turn anyone away? (open access)
Substance misuse
How can we create + keep it a safe space? Behaviours?
Actual place or a point of contact?

- We were invited
- Keeping people out of hospital -
- Influencing discussions around pathways.
- Knowing what is out there
- Social care working more closely with mental health.
- 3rd sector - CVSS roles + other options / opportunities
- Strategy + cross working.
- What next? Plans for future.

(1)

High level of mh needs w/ survivors that support

→ barriers to AMH.

→ capacity w/in servics challenging.

→ pathways don't currently deliver servics that survivors need no smooth access in

→ waste of NHS resources calling cpg

→ survivors can become retraumatised.

mental health provision is inadequate - recognition of MH in equal terms to physical health

representing service users – advocating for service users.
Creating environments where people can stay well. – support people better w/ general health

Complexities

Housing can do a lot with wider determinants of health.

Access into services → baniers → multiple complex needs. Dual diagnosis.
hard to get patients into the right services.
Whose criteria do people fit!

What is Crisis Café / Sanctuary?

Physical space? Could be something accessed remotely.

'Café' → menu of services? interventions?
some are actual cafe's.

'Sanctuary' go somewhere I'll be kept safe.

See café & sanctuary as 2 different things.

Experience of setting up Sober - based on café, safe space, open access. income generating, safe space 'The Brink' in Frodsham - Sanctuary behind the café.

café sanctuary

could people be supported to get to a Sanctuary?
different for different areas - modelled to the local population.
How do people access this?
What about the rural harder to reach areas? How do you get service users to engage with these services. Accessibility is an issue - Crisis doesn't just happen on a Wednesday.
How does it fit in with the local community - not something alien - how will it be welcomed? This can be a barrier too.
Development of peer support networks → for the Wednesday afternoon.
mobile Sanctuary team? Do they go to the person?
POW - after a Sanctuary, drop-in outreach in a van. Respect for all that's going on

different areas shop

Triggers at 1am → what is available OOH.
last support?
How will it need to be different for CTP?
Menu — would be the same for every community / group.

Need? Purpose? Outcomes?

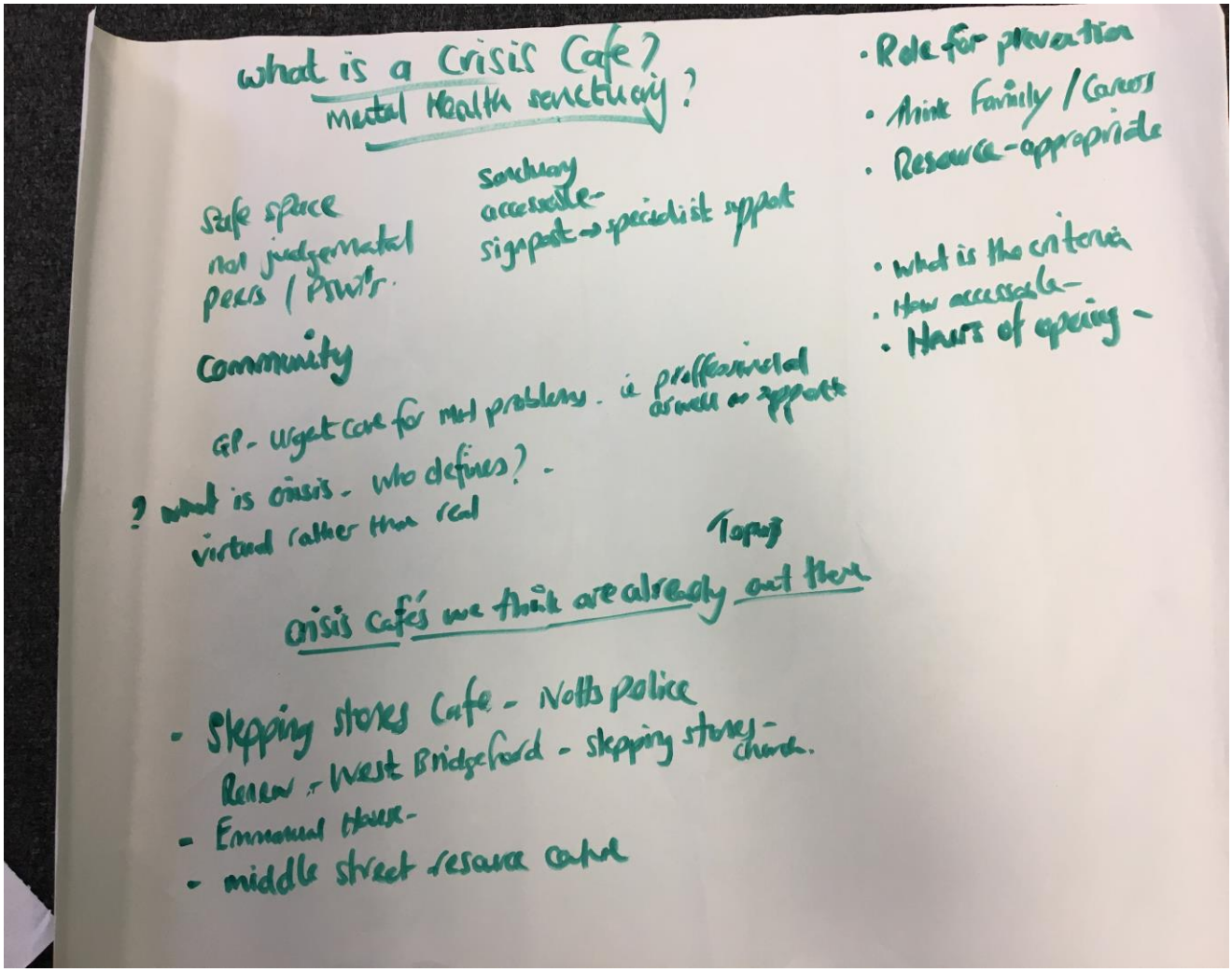
Rapid assessment or intervention — to reduce inpatient admissions ↓ (not signposting)
intervention at the right time.
not necessarily clinical but mental health expertise

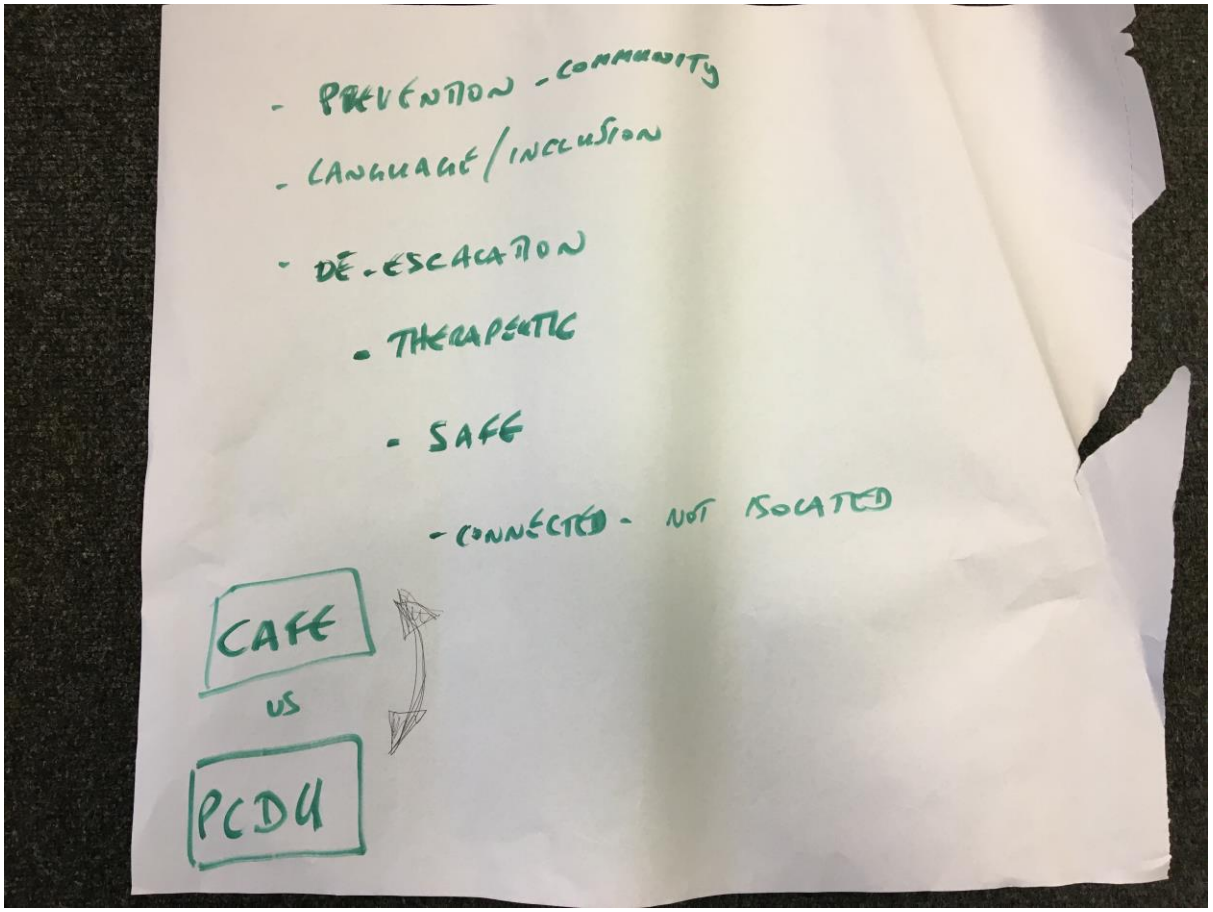
Open to everyone — not just because of the service you are already under.
Person centred — accessible to everyone.
service users have nowhere to go → almost homeless — can be a vicious cycle if patients are discharged from services.
not everyone will go to the same places as everyone else — different safe spaces within this model. Gender only spaces?
Need to recognise that people have different needs or different nervousnesses about accessing services or others.

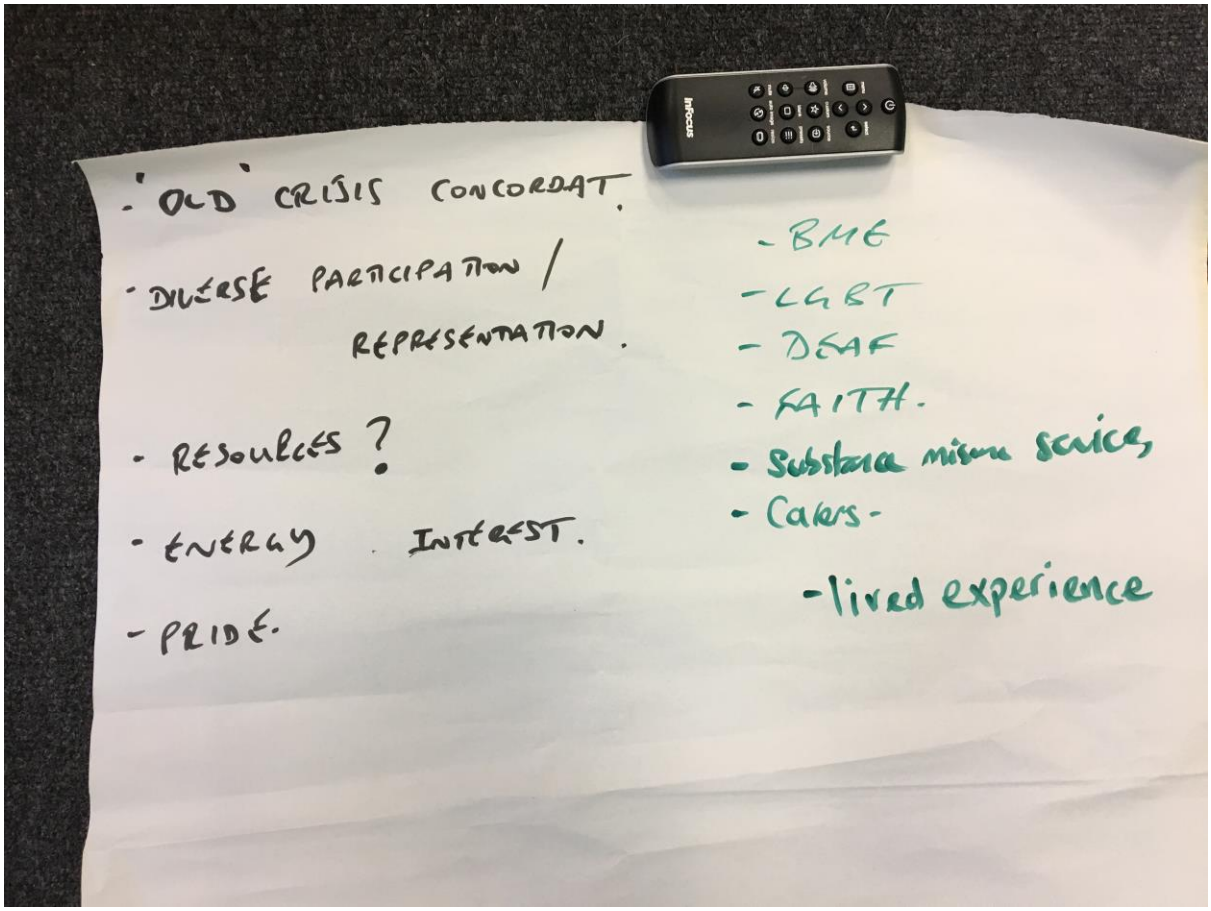
Some services are already doing this. Different communities could set up according to need.
Clinical input could be needed - signposting not appropriate - provide for the full range of mh. needs.

Outcome - person engages w/ a volunteer/ clinician depending on their individual need to get what they need.

* Use existing community spaces - that's the model that works
↳ contracts in the clinical support.
take the service to the communities that are already there.


what is a Crisis Cafe?
Mental Health sanctuary?
Safe space
non judgemental
peers / PSW's.
sanctuary
accessible-
signpost → specialist support
Community
GP - Urgent care for mental problems - ie pre/referral as well as support
? what is crisis - who defines? -
virtual rather than real
Taping
Crisis Cafés we think are already out there
- Skipping stones Cafe - Notts police
Renew - West Bridgeford - skipping stones church.
- Emmanuel House -
- middle street resource central
• Role for prevention
• Think Family / Carers
• Resource - appropriate
• what is the criteria
• How accessable -
• Hours of opening -


- PREVENTION - COMMUNITY
- LANGUAGE / INCLUSION
- DE-ESCALATION
- THERAPEUTIC
- SAFE
- CONNECTED - NOT ISOLATED
CAFE
VS
PCDU


'OLD' CRISIS CONCORDAT.
- DIVERSE PARTICIPATION / REPRESENTATION.
- RESOURCES ?
- ENERGY INTEREST.
- PRIDE.
- BME
- LGBT
- DEAF
- FAITH.
- Substance misuse service,
- Carers -
- lived experience

FEEDBACK FROM TABLES

WHAT IS IT

- Safe space
- peers as essential
- In the community
- accessibility
- moving on if nec.
- How to learn from existing part manned eg. retained police etc
- preventative role.
- working a whole social syst. not just ind.
- Non-judgmental individualised
- Single point of contact
- What exactly offer is clearly understood

SIMILARITIES

- use of communal for therapeutic + safety
- home like rather than clinical
- covers all times crisis can occur.
- must be determined by ind rather than central personal something diff to commissioned
- Must be measured outcomes
- Need to address transport
- Concern that large orgs can't get to everywhere.
- Wellbeing not
- grow existing community assets
- push away from point crisis point.
- how to avoid - not ill enough / too ill

DIFFERENCES

- meaning of "crisis" for "MH" problems only.
- ? Virtual vs. real ? network vs physical ? professionals vs. peer.
- Criteria
- accessibility
- practical details
- any exclusion - turn away?
- Subst misuse → how to maintain safe space.
- ? sounding or wider names - stigma. "crisis" "MH"
- ? tying into existing spaces → ? like dementia friendly
- Safe vs sanctuary ? place to feel alright ? venue.
- drop in
- outreach vs. central point.
- meaning of "sanctuary"
- wellbeing/prev. vs crisis
- eligibility
- ~~how to~~

DIVERSE WORKFORCE

ACCESSIBILITY

SAFETY - VIRTUAL + PHYSICAL.

MULTIPLE PROV - HOLISTIC CARE

TRIAGE SKILLS + PATHWAYS
+ STRONG SIGNPOSTING + PATHWAY

ABILITY TO PREVENT UNNECESSARY
MAU/ED

HOW TO REACH PEOPLE WHO WOULDN'T
CURRENTLY ACCESS

HOW TO USE EXISTING COMM. SPACE

PEER SUPPORT WORKERS WITHOUT BARRIERS

ENSURE PRIOR TO A+E/CRISIS NEED

HOW TO MANAGE SUICIDAL IDEATION/PREVENTION

CONNECTED NOT ISOLATED

? WHAT IS DIFF. BETWEEN THIS + CDU - CLARITY
OF PATHWAY.

ACTIONS.

KEY PRINCIPLES - QUESTIONS

→ ↳ DRAFT SPECIFICATIONS

4 - 6 WEEKS NEXT MEETINGS TO START DEVELOPING SPEC.

→ KAZIA WILL DISTRIBUTE LTP.

→ ↑

→ NEXT MTG.

MODEL BINGO & PRIN.

PEER WORKER EXPANSION

TABLE INTO BACK BUT BUILD ON

+ PEER VIEWS

→ ? COULD THEY PRESENT IT.

? OTHER AREAS/MODELS

MAKE SURE WIDER COMM THEN BACK TOG. FOR MODEL CONV.

JONATHAN TO TAKE FORWARD CONVERSATION BUILD ON EXISTING CHARITY QUEST + METHOD.

ANYONE ELSE

- SERVICE USERS / CARERS
  - HEALTHWATCH
  - SELF HELP UK
  - PEER SUPPORT IN EXISTENCE
  - CONNECTS PARTNERSHIP UK.

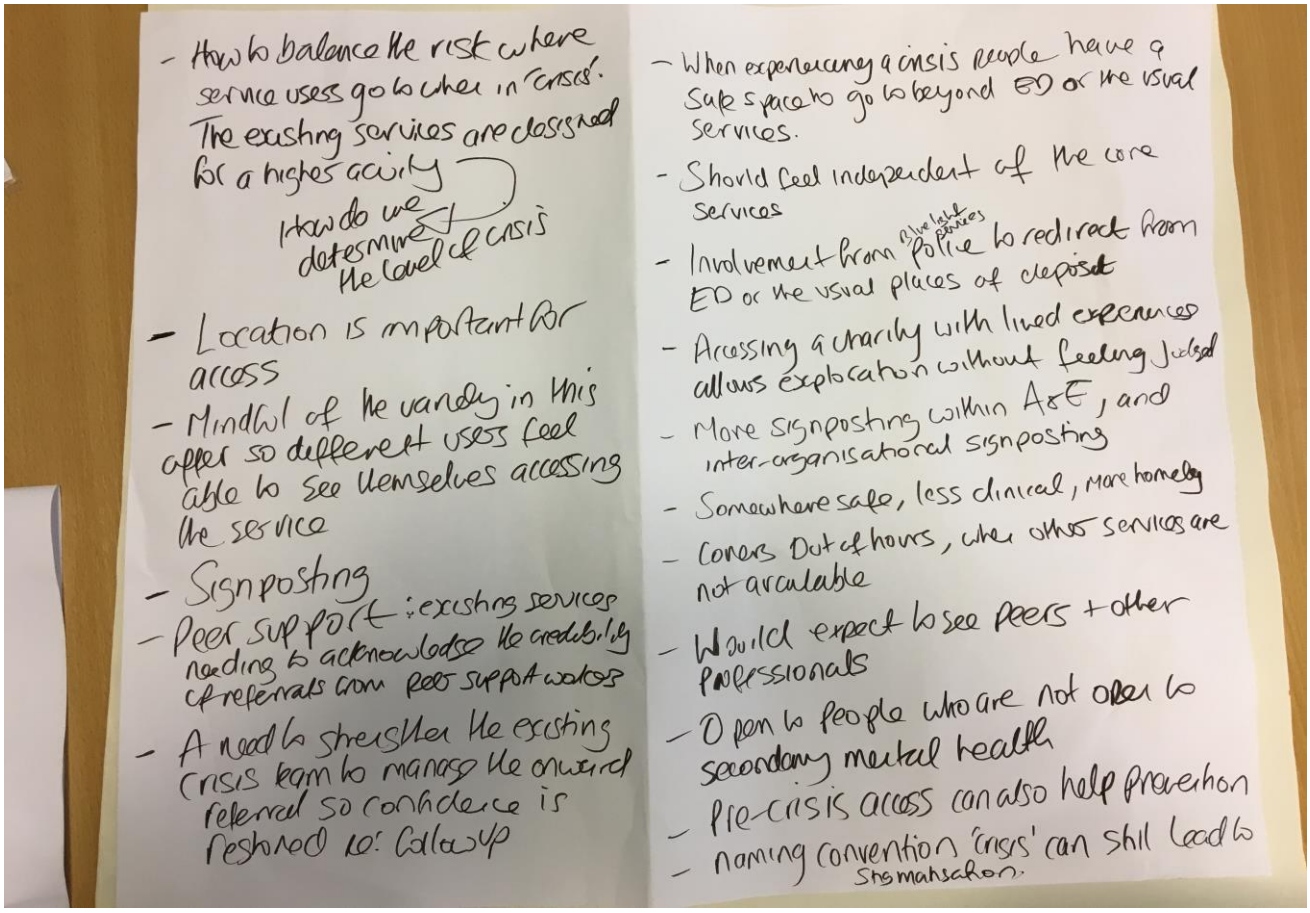
FAMILY THERAPY - FAMILY INT. ON IT.

CRISIS WORKERS.

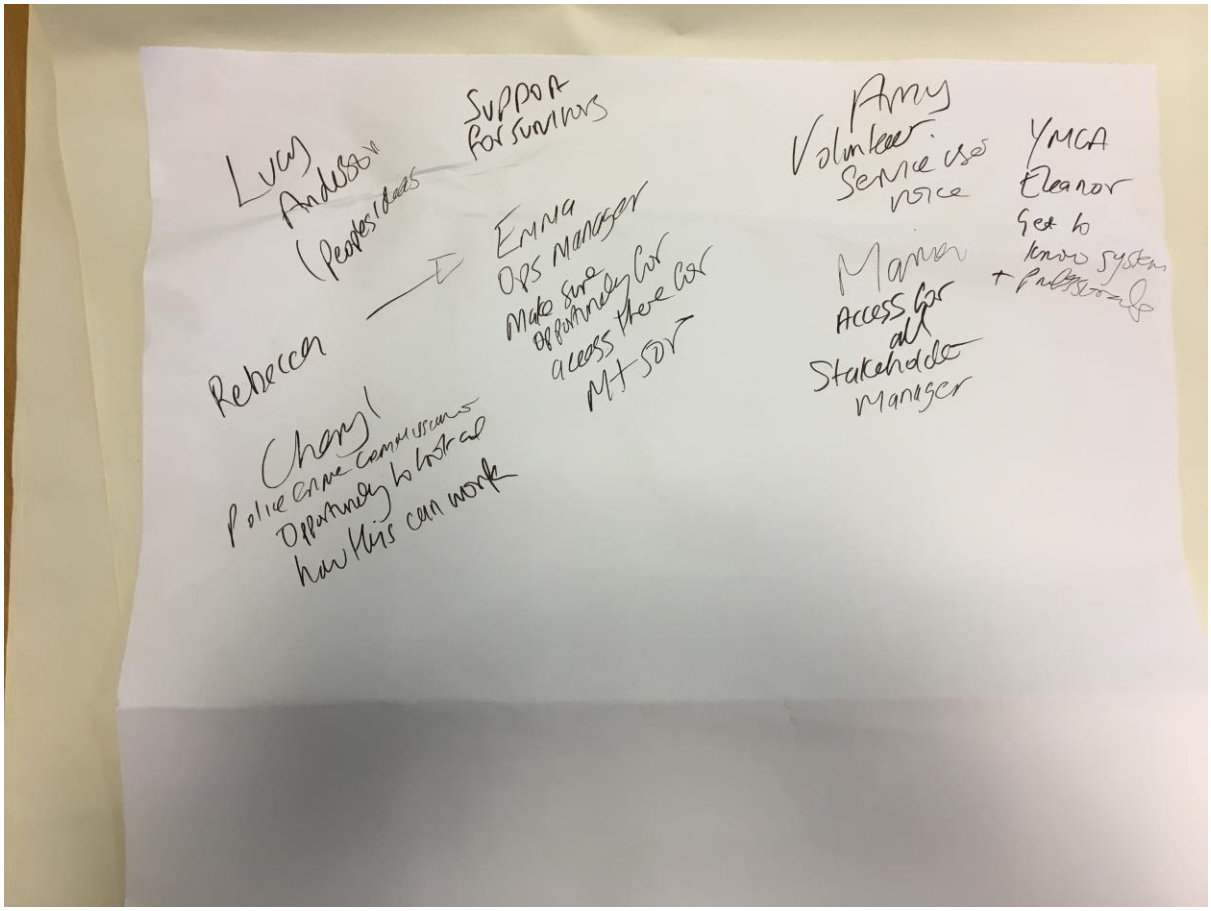
CHURCHES + FAITH GROUPS.

OTHER INFRASTRUCTURES
- CVS - WHERE COUNTY

DISTRICT COUNCILS
- H + WBEING OFFICERS.



- How to balance the risk where service users go to when in 'crisis'. The existing services are classified for a higher acuity
  - How do we determine the level of crisis
- Location is important for access
- Mindful of the variety in this offer so different users feel able to see themselves accessing the service
- Signposting
- Peer support: existing services needing to acknowledge the credibility of referrals from peer support workers
- A need to strengthen the existing crisis team to manage the onward referral so confidence is restored re: follow up
- When experiencing a crisis people have a safe space to go to beyond ED or the usual services.
- Should feel independent of the core services
- Involvement from blue light services Police to redirect from ED or the usual places of despair
- Accessing a charity with lived experiences allows exploration without feeling judged
- More signposting within A&E, and inter-organisational signposting
- Somewhere safe, less clinical, more homely
- Covers Out of hours, when other services are not available
- Would expect to see peers + other professionals
- Open to people who are not open to secondary mental health
- Pre-crisis access can also help prevention
- naming convention 'crisis' can still lead to stigmatisation.


Lucy
Andrew
(Peoples ideas
Support for survivors
Rebecca
Emma
Ops Manager
Make sure opportunity for access these for MH SDR
Amy
Volunteer
Service use voice
Manager
Access for all
Stakeholder
Manager
YMCA
Eleanor
Get to know system