The Crisis Project Workbook

A resource pack for service users and survivors on setting up innovative mental health crisis projects
The Crisis Project Workbook
Guidance on setting up innovative mental health crisis projects led by service users and survivors

This workbook has been produced as part of The Mental Health Foundation’s work on issues relating to the mental health of adults of working age. This programme is entitled Strategies for Living, and aims to promote and encourage the development of user/survivor empowerment through research, evaluation and information gathering. It seeks to influence a wider audience – of frontline workers, professionals, researchers, policy makers and service users – of the value and significance of ‘expertise by experience’ and of evidence gained through user-led research and initiatives. Everyone involved in the programme has some experience of mental distress and/or using mental health services.
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Preface

From 1997 to 2000, I was the facilitator of the learning sets which were designed to support the seven projects receiving funding from the Mental Health Foundation Crisis Service Development Programme (referred to throughout the workbook as the Crisis Programme or the Programme).

A learning set is a group set up to enable action-based training and shared learning for innovative services where there are no established training courses. I visited each project for a day every couple of months; meeting with those involved to discuss how things were going and to work out how to improve their practice. Each of these groups was known as a local learning set. Most members of each local learning set were directly involved in the project, as management committee members, staff or volunteers. Keen supporters of their projects who did not have any other formal involvement sometimes joined them.

We also had a national learning set made up of two representatives from each project, which met every couple of months.

Most of the crisis service projects were set up by small, service user/survivor-led organisations. We often found ourselves paying as much attention to the successful working of these organisations as we did to the crisis projects themselves. We also learned about some of the challenges for larger, more established organisations as they set up projects that did not fit with their usual ways of doing things.

This workbook is my attempt to share what we discovered through the learning sets and as the projects progressed. It is to let you know what we wish we had known before we started. However, the Crisis Project Workbook is not a set of instructions, as this would be neither possible nor desirable. Instead, my intention is to use the lessons learned by these projects to help you think about yours.

With their emphasis on listening, peer support, cultural sensitivity, recovery and service user/survivor-led solutions, the projects of the Mental Health Foundation Crisis Service Development Programme represent a significant part of the future of mental health services. I hope that this workbook will assist you to also become part of this future.

Jim Read

Jim Read is a former mental patient who has been a writer, trainer and consultant on mental health issues since 1983.
My interest in crisis services comes from my personal experience of being admitted to acute wards in 1972. In the early 1980s I began to meet other service users and we shared our vision of alternatives to hospital, where people experiencing a crisis for the first time, or caught in the revolving door of repeated admissions to unsatisfactory services, might find the support they needed. In the 90s I was on the advisory committee for the Drayton Park and Highbury Grove crisis houses in Islington, and began my PhD looking into users’ experiences of crisis and treatment.

My role with the Mental Health Foundation Crisis Service Development Programme began in 1996 when I joined the steering group, and I later became programme manager in 1999. This workbook distills the experiences all those who participated in the Crisis Programme and were involved in years of hard and often frustrating work, battling to realise their vision of user-friendly, non-medical alternatives to hospital for people in crisis.

I know how difficult this process was for many of those involved, and that the learning sets run by Jim Read were an important source of mutual support, information sharing and laughter that re-energised people and helped them stay on track. At the end of the Crisis Programme the services were, all but one, operational and successful, giving good services to people in crisis and an inspiration to many who hope to set up similar services in their areas.

It is vital that the lessons learned from this programme as outlined in this workbook are available to others wanting establish crisis services, so that some of the pitfalls experienced by these pioneering projects can be avoided and more alternative projects can be helped to get off the ground.

The projects which formed the Crisis Programme have shown that voluntary sector alternatives do work, and that service users can be centrally involved in running them. I hope the lessons of these projects can provide the basis for a much larger national programme supporting many more similar initiatives. The networking provided by the learning sets has been a vital part of their survival and success. This should always be a part of any similar national programme.

Services that work well for people in crisis can be provided; they need to be small, humane, people-centred and empowering. They need to allow the possibility that former users of services can offer help to others as volunteers, trainers, crisis workers, committee members and holders of the vision of recovery for others.
While it is not possible that voluntary sector projects can provide services for everyone in a crisis, they can show the way to a variety of different approaches. They model accessibility, minimal formality, the awareness of users’ need to be heard and the need for services that feel safe and welcoming for women, black, gay and lesbian people.

I also hope to see statutory services take on the message that collaboration with voluntary services works, and can create a mutual learning network that enhances and revives local service provision.

I want to pay tribute to the many current and former service users and mental health workers who have worked so hard to realise the dream that inspired this programme, particularly those who volunteered their time. Even those who were paid have generally worked way beyond the call of duty. I hope that they feel the success of the projects has been some reward for all they have done. I recommend them, as well as this workbook, as invaluable sources of practical knowledge and experience for others trying to do the same thing.

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This report is dedicated to the memory of Margaret Greenlees, a valued and popular member of GLOSS and the national learning set who died in December 2001.

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Introduction

The Crisis Project Workbook is for anyone who is interested in setting up innovative mental health crisis services led by service users and survivors. It is based on the experience of seven voluntary sector projects that were part of the Mental Health Foundation Adult Crisis Service Development Programme, which ran from 1997-2002. As part of its Adult Crisis programme, the Mental Health Foundation funded seven community-based crisis services in England: two residential services, two safe houses and three telephone helplines. Although the Foundation’s pilot crisis services were all based in the UK, the lessons learnt from these projects are relevant across the UK and more widely. Further information about the Foundation’s adult crisis programme can be found in its report Being There in a Crisis, published in 2002.

This workbook highlights key issues to be aware of when establishing a crisis service and suggests some of the ways they can be tackled. It is intended as a practical tool to help you with your work. It uses several methods of presenting ideas and information to help you to develop your project.

- Examples of experiences of the seven Mental Health Foundation-funded crisis projects to demonstrate the many issues that need to be considered when setting up a crisis project.
- Checklists to assist you to identify what you have achieved and what still needs to be done.
- Group exercises and Handouts to stimulate thinking and debate on key issues and to assist decision-making. There are notes with each group exercise on how it should be run.

However, the materials in this workbook can be used in many ways and exercises can be adapted to fit the needs of your group. Timings have generally not been included because most of the exercises are very participatory and therefore the amount of time you need to give them is dependent upon the size of the group but even with a large group (e.g. more than 10 people) none of the exercises should take more than an one and a half hours.

This workbook is designed to be used rather than be read from cover to cover, for example, by a group of people wanting to set up a crisis project, using it in a series of meetings, to clarify their ideas and steer their way through the inevitable challenges that arise. In this way a group working together can use the workbook as a resource pack. However some sections of the workbook require an independent facilitator to assist the group through exercises and decision making (please see Appendix 3 for details of how to run a successful meeting). A lead person may also be required to ensure the workbook is used most productively. This could be the chair of your group.

The names of useful organisations and publications are mentioned throughout the report. Details of these, along with other sources of support, are given in Appendix 5.
This workbook also provides information that will be of use to anyone with an interest in service user/survivor involvement or service user/survivor-led organisations. It provides information on issues such as service users/survivors and professionals working together and building the confidence of service users/survivors on management committees.

Note on language

The terms ‘service user’ and ‘survivor’ have different meanings and are preferred by different people. To be inclusive, the term service user/survivor has been used. The exceptions are:

- when writing about a particular project (the term used by that project is used)
- extracts from material written by others (the author’s original term is used)
- when referring specifically to people who are clients of, or using a service.

(For a discussion about the terms ‘service user’ and ‘survivor’ see page 9.)

About the crisis projects

Each project is summarised briefly below. Appendix 1 summarises the practical details of each service. Contact details of the Crisis Programme services can be found in Appendix 2.

Asian Mental Health Helpline

This project is managed by Rethink and is the sister project of a Rethink English language helpline. It covers Kent, East Sussex, Brighton and the London Borough of Bexley. The helpline is staffed by volunteers with a paid co-ordinator. Languages spoken are Gujarati, Punjabi, Hindi and Urdu. Other languages can be offered. The helpline opens two evenings and two afternoons a week. It is open to people with mental health problems, carers and professionals, and offers both support and information.

GLOSS Group Crisis Line

This telephone helpline was run by the user-led group, GLOSS, in Glossop, Derbyshire to provide out of hours (evenings and weekends) telephone support for local users of mental health services. The helpline was staffed entirely by volunteers, managed by service users. It closed after 17 months because insufficient use was being made of the service.

WAND Telephone Support Line

This telephone helpline is run by Working Advocacy in North Devon (WAND) is a user-led organisation. It aims to provide support for people across Devon who have a mental health issue – from service users who may have severe and enduring mental health problems, to carers, friends and professionals.
The helpline offers listening and support, information and help to make choices and decisions. The service is managed by the WAND user group and operates 8pm to midnight Friday to Monday.

**Anam Cara**

Anam Cara (Celtic for ‘soul friend’) is a crisis house run by CHANGE, a small charity dedicated to providing crisis services that offer real alternatives to acute hospital inpatient admission in Birmingham. The crisis house started on different premises, where it was known as Skallagrigg House, in 1997. All staff have experienced mental health crises themselves, use a model of recovery and make use of complementary therapies.

Residents can stay up to three weeks. The service is staffed from 9am to 8pm on weekdays, and for four hours on Saturdays. Staff are on call for four hours on Sundays. A variety of self-help groups meet at Anam Cara and include current and former residents.

**Dial House**

Dial House is a crisis house run by the Leeds Survivor Led Crisis Service, open during the evening on weekends. It aims to offer a supportive place for people in crisis and to help people make choices about the kind of support that will help them the most. The Connect Helpline is part of the same service and operates every evening.

**The Nile Centre**

The Nile Centre was opened in 1997 to provide an alternative to hospital admission for African and Caribbean adults living in the London Borough of Hackney who experience a mental health crisis. It offers crisis response and outreach, short-stay accommodation (up to three weeks), and counselling and complementary therapies. The project is run by the Kush Housing Association.

**The Safe Haven**

The Safe Haven, Corby is a support service for anyone who is going through a difficult time, emotionally. It offers a safe and friendly environment and supportive company for anyone in distress, at times when other services are closed. It is open from 6pm-2am, Tuesday to Sunday. The Safe Haven is run by a user organisation, User Support Service.
The Mental Health Foundation is the UK’s leading charity working to promote mental well-being and the rights and needs of people with mental health problems and people with learning disabilities. We aim to improve people’s lives, reduce stigma and discrimination and to encourage better understanding. We undertake and support research and encourage improvements to local services. We provide information to the public and people working in relevant fields. We aim to maximise knowledge, skill and resources by working with service users, government and service providers.
Chapter 1
Service user/survivor-led projects and partnerships with professionals

Who are service users and survivors?

The term ‘service user’, usually abbreviated to ‘user’, is commonly used but seldom liked by the people it is intended to describe. Some object to it because they associate the term with users of illegal drugs. Others do not like it because it suggests the person takes but does not give.

‘Service user’ was introduced in the 1990s, when the government wanted public services to be more accountable to the people they were there to serve. Health and social services were expected to consult with ‘service users’ and ‘carers’, and involve them in monitoring existing services and planning new ones.

When current and former psychiatric patients started organising themselves in the mid-1980s, they adopted the term ‘mental health system survivor’, usually shortened to ‘survivor’. This gives a very different idea of how they view themselves and mental health services compared with the term ‘service user’. The ‘survivor’ movement was and is interested in the rights of mental patients, in speaking out about bad experiences and challenging the power of professionals. However this term does not appeal to people who do not think they have been badly treated by mental health services.

Terms like ‘service user’ and ‘survivor’ reflect different approaches to the mental health system that can broadly be described as reform or revolution. The term ‘survivor’ implies that the mental health system is something to be survived; the term ‘service user’ is more neutral about services. However, just as we tend not to fit neatly into diagnostic categories, we may not always choose to identify and act exclusively as a survivor or service user. In practice, many people involve themselves in trying to improve services, while also reserving the right to protest about them, and to set up alternatives.

In some countries, such as the US, there has been more of a split between people who identify as survivors (who also call themselves ex-inmates) and people who use the term ‘consumers’ (an equivalent term to service users). In the UK, we have tended to stick together. This has had the advantage of unity and inclusiveness but the disadvantage of a weak ideology. We have tended to shy away, individually and collectively, from sharply defining what we believe in and why.
Spending time thinking and talking about what we want to call ourselves, and why, helps us to work out our own positions, and to see what we have in common and where we disagree with others. It also opens us up to other points of view which we can learn from. Although it may expose differences, it has the potential for building real unity – based on finding common ground, rather than assuming or pretending that there are no differences between us because ‘we are all service users’ or ‘we are all survivors’.

This has important implications for setting up crisis projects. If we talk to each other about our experiences and viewpoints, we stand more chance of developing a project that has clearly defined values.

**Group exercise 1**

**Telling our stories**

**Purpose**
This exercise is intended for service users/survivors, and a facilitator should run it. It is to help service users/survivors to feel closer to others, better about themselves, and more energetic and purposeful.

**Notes for facilitator**
1. Allow enough time for this exercise so that there is time for each person to speak for around five minutes.
2. Ask the participants to agree to take it in turns to listen to each other without comment and to keep what they hear confidential.
3. Give each person a set time to tell his or her mental health story.
4. Allow time at the end for people to talk about what it was like being in the group. A ‘telling our stories’ group can meet once or many times.

**Group exercise 2**

**What’s in a name?**

**Purpose**
To decide what terminology to use in your service and how you will define it.

**Notes for facilitator**
This exercise is intended for a group of service users/survivors, however it could also be used with a mixed group of service users/survivors and professionals. Ask people to
suggest the different names that are used to describe people who have been diagnosed as mentally ill (not slang or insulting words). Make a list on flipchart paper.

1. Distribute Handout 1 and discuss it in relation to the terms already collected.
2. Get people into groups of three to discuss what they each think of these words and phrases.
3. Ask people to speak to the whole group in favour or against any of the terms mentioned in point 1 and 2.
4. Ask each person to vote on the term they like the most. The most popular is the agreed term for use in your service.

If this exercise is carried out with a mixed group (i.e. one that also has professionals) it is vital that service users/survivors should have the right of veto (especially if they are in the minority in the group) over any term that the majority of them disagree with.

Having come up with a definition for service user, we should have one for ‘professional’. One suggestion is ‘someone whose main role is as a paid mental health worker’. Of course, people can be service users/survivors and professionals at different times, or even the same time. Then, they have to decide in each situation, whether to identify as one or both of these.

People with other roles may be involved in service user/survivor-led projects. The main other group is sometimes called ‘carers’. They are more accurately and fairly described as friends and relatives, or family members of service users/survivors. There were virtually no people who primarily identified as ‘carers’ involved in the learning sets of the Mental Health Foundation Crisis Service Development Programme. This reflected the often difficult relationships between service users/survivors and ‘carers’. Some staff and volunteers were, however, motivated to do this work because of their family connections with service users/survivors. However, the principal working relationships in the Crisis Programme were between service users/survivors and professionals.

What is a service user/survivor-led service?

Another issue that needs to be clarified is what is meant when a project claims to be service user-led. Does that mean it is led by people who use or have used any mental health service, or people who use or have used the particular service provided by the project?

It is easier for a project to be run by its own service users if it is one where people meet face-to-face and where they stay involved for a long time, such a day centre or supported housing project. It is more difficult with telephone helplines and short-term crisis accommodation. However it is still worth thinking about how users of these services can be involved and have an influence.
Most of the projects in the Crisis Programme described themselves as ‘service user-led’ or ‘survivor-led’. Some were partnerships between service user/survivor groups and professional-led organisations. Either way, there was some kind of working relationship between service users/survivors and professionals. During the learning sets, working definitions were developed to clarify the levels of user/survivor involvement. These can be broken down into the following categories.

- **Service user/survivor-only**: No-one else involved.
- **Service user/survivor-controlled**: Others may be involved as allies or non-voting members.
- **Service user/survivor-led**: More of a partnership, but set up to ensure that service users/survivors have the greatest influence, for example by being the majority on the management committee.
- **Partnership**: This can be a mix of service users/survivors, professionals and anyone else, without any attempt to regulate power between them, or a mix of these groups where there are fixed power-sharing arrangements, such as the management committee having to be one third service users/survivors, one third professionals and one third family members.
- **Service user/survivor-involved**: The project is run and controlled by professionals but service users/survivors have input into decision-making.
- **Mainstream service**: Also run and controlled by professionals. Service users/survivors may be consulted but they do not have direct input into decision-making.

These references to levels of service user/survivor influence have focused on the organisation rather than the crisis project. In the learning set discussions, several additional terms were invented to describe service user/survivor involvement in actual service provision.

- **Service user/survivor-initiated**: A project that is planned by service users/survivors and keeps to their ideas but is run by professionals.
- **Service user/survivor-fronted**: A project that is set up by professionals but staffed by service users/survivors.

This list was useful in provoking discussion in several projects where confusion had set in. It enabled those involved in the crisis projects to identify areas of disagreement or ignorance. From there greater clarity could be achieved and the project could move on.

The list also has limitations. Some of these definitions are simplistic. For example, an organisation may have a constitution that makes it service user/survivor-controlled, but it may be running a project that is funded by a health authority, with certain conditions attached to the funding. Is the project still service user/survivor-controlled?
These distinctions matter. It is not just playing with words. Some of the difficulties that arose in the Crisis Programme because of confusion about the level of service user/survivor influence are outlined below.

- A project was supposedly service user/survivor-led but service users/survivors felt they had lost control because a social services manager was, with the best of intentions, doing most of the work. This was resolved by an outside facilitator drawing attention to the issue and creating some safety for it to be dealt with, and by the constructive spirit in which the key people involved tackled the problem.

- Service users/survivors felt that they had lost control of a project to the social services department. This was resolved by us locating long-forgotten papers, such as the business plan and constitution, that made it clear the project was intended to move towards being more service user/survivor-led. It was then planned how this would happen.

- Service users/survivors felt that they were not being given enough influence in a partnership with a service provider. When they became assertive about this, it became clear that the partnership was not going to work, and they eventually were able to have funding taken away from that service provider and given to a new one.

So what aspect of service user/survivor involvement matters most? Is it that the organisation is controlled or led by service users/survivors, the project is staffed by people who are open about having used services or had mental health crises, or that the project reflects the stated wishes of service users/survivors for something different from the mainstream?

Whether the people who make up the staff and volunteers are service users/survivors may be as significant or more significant than whether the project is managed by service users/survivor. After all, they are the people who are in direct contact with the users of the service.

Perhaps it matters more who you talk to when you telephone a helpline than who set up the project, and recruited and trained the volunteer. So why bother with setting up a service users/survivor-led crisis service?

The benefits and challenges of service user/survivor-led organisations

The provision of crisis services that offer an alternative to hospital treatment has been a central demand of the service user/survivor movement. Three of the projects in the Crisis Programme were set up by new, service user/survivor-led organisations and a fourth is run by an established service user/survivor-controlled organisation. It is fitting that these projects were set up by organisations led by service users/survivors. In each instance, it has undoubtedly helped the project to achieve a strong identity that distinguishes it from more mainstream services.
Why be a service user/survivor-led organisation?
The WAND group asked itself this question when some of its members temporarily lost sight of the reasons why it benefited from being a service user/survivor-led organisation. Some of the answers they came up with are outlined below and they could apply to any service user/survivor-led organisation.

1. Provides opportunity for individuals to empower themselves.
2. Gives positive message to other users.
3. Gives users opportunity to be equals with others in wider mental health forums.
4. Challenges professionals’ attitudes.
5. Gives users opportunity to pass their knowledge and experience on to professionals, etc.
6. A compromise between being user-only and users having no particular role.
7. Political statement – users have a voice.
8. Good PR – demonstrates to public that we can be responsible and capable.
9. Has worked in practice.
10. Has enabled non-users to be involved, including staff and volunteers.

The Crisis Programme projects have overcome many obstacles since they were first established and each organisation has had its struggles to function well. At times this has undermined the progress of the crisis service. More often, it caused a great deal of stress for the most active management committee members and the staff. However when difficulties were faced and overcome, people grew in confidence and optimism.

Many of these difficulties are common in voluntary organisations: confusion of roles between management committee and staff, not attracting enough active committee members, and so on. However some particular issues concerned with service users/survivors running organisations magnified these problems. In this respect, they reflected the national experience: that service user/survivor-led and service user/survivor-only groups often struggle to function well.

There are several difficulties that service user/survivors can have in managing projects.

- Many people have little recent experience of the world of work, and yet are attempting to recruit and manage staff.
- Service users/survivors may know very little about running an organisation.
- Some people have done well in careers or running their own businesses but then have difficulty with the participative and informal style of service user/survivor-led organisations.
- People sometimes become distressed and unable to carry out their responsibilities. Those around them find it difficult to know when and how to intervene. In their desire not to be disempowering, they tend to try to cope with the situation rather than deal
with it decisively.

• There is a reluctance to challenge oppressive or other destructive behaviour for several reasons including feelings of concern that the person’s mental health might suffer, intimidation and confusion about whether it is caused by the person’s distress, and if so, whether to be more tolerant of it.

• The effects of years of disempowerment can make it hard to feel that you are really in charge of an organisation, possibly with a budget of several hundred thousand pounds a year.

Of course, many service users/survivors are reasonably confident and have the experience and ability to run organisations well. But they would not want to exclude people who are newer to this work and for whom it is more of an opportunity. It has to be possible for people to get the right assistance to ‘grow into the role’.

The service users/survivors in the Crisis Programme projects demonstrated many times that difficulties can be overcome. Sometimes they showed a remarkable determination and resilience in doing so. Thoughtful support from allies also made a crucial difference and the learning sets were another useful forum for moving things forward.

The teams of staff and volunteers who ran the crisis services benefited from a certain level of organisation. They were all carefully selected for their jobs, whether paid or unpaid. They received necessary training. If there was a senior staff member, they were responsible for providing the other paid staff with supervision and support. Paid co-ordinators provided supervision and support to volunteers. There were arrangements for coping with staff absence.

In comparison, the arrangements for management committee members were more haphazard. Even though they carried a great deal of responsibility, they were simply expected to get on with it. This is a common problem for voluntary organisations but one that was particularly serious for people who really needed opportunities to learn and gain in confidence.

As the difficulties became apparent, steps were taken to build in more support for management committee members, including:

• paying for an external supervisor for the chair
• using the learning sets for training about management committees
• employing a part-time administrative assistant to work for the management committee
• the management committee going away on a residential training course.

All these helped, and it would have been even better if they had been in place from the beginning. Therefore it would be useful for you to think about these factors when setting your budget.
Service users/survivors and professionals working together

Among any group of people working together, there are tensions and conflicts. When service users/survivors and professionals work together on a crisis project, these problems may arise from preconceptions each group has about the other. To avoid these problems and ensure effective working, several factors must be considered.

Good facilitation
If meetings are well chaired or facilitated it brings out the best in people.

Being clear about roles
In a service user/survivor-led project what is the role of professionals? It may be to:
• support service users/survivors to run the project
• bring specific expertise to the group
• contribute in any way that seems useful.
Developing a common understanding of which of these roles is appropriate will help.

Acknowledging the potential for difficulties
Partnerships between service users/survivors and professionals benefit from a positive attitude and a willingness to seek common ground, as people who care about mental health. However, when tensions surface, as they often do, goodwill is not enough. It is also necessary to acknowledge the different experiences of the people in these two groups and the effect that may have on their relationships and views of the project.

The situations of service users/survivors and professionals are sufficiently different that they need to be acknowledged and dealt with. This is best done by each group meeting separately and then together.

Professionals as allies
What do we mean when we talk about professionals being allies? It is about backing service users/survivors to do what they want to do, rather than pursuing their own goals. Some examples from the crisis projects are below.
• This is how a service user/survivor described two managers in social services: ‘They could have had much easier lives but instead have persistently, for decades, supported users trying to figure out their own ways of doing things, with cash and resources when they could.’
• One professional invited someone who had used the project he managed to join him in delivering some training to GPs.
• Several professionals worked hard, in the background, to help service users/survivors deal with all the feelings that came up for them as they took on responsibilities in their projects. This included assisting them to resolve disputes with other service users/survivors.

• Another aspect of being an ally is giving credit to service user/survivor-led services for being able to offer something that you cannot. A worker at Anam Cara told me about a psychiatrist who encouraged a service user/survivor to come off her medication and make use of the Reiki healing and flower essences that Anam Cara offers.

Being an ally is a vital role. The progress that service users/survivors have made in influencing services and attitudes has been aided a great deal by the time and effort put in by thoughtful allies. An example of such an ally included a psychologist who put in a lot of effort to help Survivors Speak Out get off the ground, even though it was to become an organisation controlled by survivors. It is also a challenging role and people who take it on may benefit from participating in the kind of activities described in Group exercise 1: Telling our stories.

**Roles and expectations**

It is helpful for everyone if there is clarity about the role of professionals. Within a partnership or a service user/survivor-led project, it may be perfectly reasonable for professionals to express their own views and argue for what they think is right. But if the service users/survivors are expecting them to be there simply to back them up, they will be disappointed. It is worth talking about these things.

**Group exercise 3**

**Making your partnership succeed**

**Purpose**

To ensure that people involved in the project have a common understanding of the roles of service users/survivors and others. To identify any work that is needed to improve these aspects of the project.

**Notes for facilitator**

1. Collect together any papers that may help to answer the questions in Handout 2. These may include your organisation’s articles of association, constitution and business plan.

2. Give each person a copy of Handout 2. It may also be useful to refer to Handout 3 and provide it to the group. This is optional.

3. Divide the participants into groups of three and ask them to answer the questions on Handout 2 checklist as well as they can.
4. Get everyone back together and go through the questions with them. You can expect, broadly, three types of response:
   • everyone is in agreement
   • all, or some people do not know factual answers. See if these can be answered from the papers you have with you. If not, decide how they can be answered.
   • There are differences of opinion.

5. Where there are differences of opinion attempt to resolve them through discussion.

6. You can consolidate this piece of work in a later session by asking for volunteers to prepare a short talk and handout on the service user/survivor-led and partnership aspects of the organisation. They can then make a presentation to the rest of the group to deal with any outstanding concerns your group may have.

It may also be useful for service users/survivors to discuss in a group what they like and dislike about working with professionals as colleagues. If you have not completed Group exercise 1 it may also be useful to do this at this stage.

Useful things for professionals to do in a group together include:
   • telling stories of why they became mental health workers and what it has been like – the good and bad things
   • sharing what they have learned about the mental health system
   • discussing what they like and dislike about working with service users/survivors as colleagues.

Useful things for service users/survivors and professionals to do together include:
   • sharing the collective results of their discussions on what they have learned about the mental health system
   • discussing similarities and differences in the conclusions of the two groups
   • establishing what agreement there is about the project being set up, and any differences of opinion.
Chapter 2
Setting up a service user/survivor-led organisation

Several of the projects supported by the Mental Health Foundation Crisis Programme were set up by newly formed service user/survivor-led organisations. In the learning set programme, we found that we had to pay at least as much attention to developing these new organisations, as we did to their crisis services.

Some of the challenges were simply those facing any group of people who establish a new organisation. Others arose because of the lack of confidence and experience of many of the service users/survivors who were taking the lead in these projects. As problems were overcome, the gains in confidence and skills were especially significant for the service users/survivors involved.

This section is not a comprehensive guide to running a voluntary organisation. Instead, it focuses on five significant lessons for service user/survivor-led organisations that were identified in the learning sets.

This is what we learned through the learning set programme.
1. There is a lot of help available, but you have to know how to find it.
2. If you set up a steering group, think carefully about how it will work.
3. The involvement of service user/survivors on management committees creates additional planning issues that must be dealt with.
4. All management committees need training.
5. Attention needs to be paid to roles and relationships, especially between management committee members, staff, volunteers and people using the service.

Lesson one: there is a lot of help available

If you decide to register your crisis project as a charity, you will be one of nearly 150,000 registered charities across the UK (The UK Voluntary Sector Almanac, NCVO, 2002) so, although your project may have little previous experience to draw on, your organisation certainly will. There are local and national organisations whose sole purpose is to assist people like you. There are also many publications, websites and training courses that you may find helpful. Contact details can be found in Appendix 5 Sources of support, advice and information.
Organisations
There are many organisations that provide information, advice and support to charities, voluntary and community groups across the UK. There are hundreds of local councils for voluntary sector (often called Councils of the Voluntary Sector or Services (CVS) although some may use other names such as Voluntary Sector Council or Voluntary Action). These local voluntary sector councils support local voluntary organisations and community action. In England alone there are around 300 local voluntary sector councils. These councils vary in character and size, although they usually work to the same geographical boundaries as the local authority. You can find your local CVS through the telephone book, or in England through the National Association of Councils for Voluntary Service (see Appendix 5.)

In addition to the local voluntary sector councils, there are also four national voluntary sector councils in the UK, which provide more strategic support to the voluntary sector as a whole in England, Northern Ireland, Scotland and Wales. These national councils (see Appendix 5) also provide information, advice and support and also seek to represent the views of their member organisations to government and policy makers.

The Directory of Social Change also offers publications, training course and conferences. It is especially strong on providing advice on fundraising. DSC provides information on how to raise money, how to manage your resources, what your rights and responsibilities are and how to plan and develop for the future.

The United Kingdom Advocacy Network (UKAN) is the national federation of patients’ councils, user/survivor forums, advocacy projects and user/survivor-led groups operating in the field of mental health. It produces a newsletter, The Advocate.

Publications
In addition to those published by the organisations listed above, you may also find the following publications useful.


The most comprehensive publication you will find is Croner’s Management of Voluntary Organisations. It covers setting up a voluntary organisation, general management (including employment), finance, fundraising, publicity and further information. It is in a ring binder and a subscription service enables you to keep it up to date. It is expensive but may be worth it. Alternatively, you may have access to it through your local CVS.
Lesson two: if you set up a steering group think carefully about how it will work

Some people have an idea for a new project. If it does not have an obvious home in an existing organisation, usually somebody will suggest setting up a steering group. A steering group decides the priorities or order of business of a project or how the general course of operations of a project will managed. Lessons learned from the learning sets show that at this point you should:

• pay attention to how the steering group is going to work, from the beginning
• model it on the proposed, more formal structure that you are planning to adopt later
• move towards adopting a more formal structure such as a management committee as soon as you can.

Taking these steps at the initial stages will help avoid the following problems:

• there is no shared vision of the project
• decision-making is a muddle, leaving some people disempowered
• no one is clear who is a member of the steering group
• service users/survivors are feeling their project has been taken over by professionals.

Lesson three: the involvement of service user/survivors on management committees creates additional planning issues that must be dealt with

Joining a management committee may offer service users/survivors opportunities that they would not otherwise have. As a result they may be inexperienced in participating in structured meetings and lack confidence. Therefore these factors may need to be taken into account. This emerged very clearly from a service user/survivor-only session facilitated in Leeds for people who were interested in joining the management committee. A follow up session on confidence building helped them to develop a stronger sense that they had something to offer. You may need to allow for a similar process when planning your project.

Some of the practical aspects of participation may need to be paid attention to, if service users/survivors are to be recruited to the management committee. Just expecting people to turn up is not enough. One person may not have the cash for a bus fare and need money in advance. A single parent may need help with baby sitting costs. Another person may appreciate a lift or want the meeting to end in daylight so that they can travel home in safety.

Another issue to be considered during the planning stage is that service users/survivors are more likely to experience times of crisis than the population as a whole. These may be
directly about mental health and use of services but can also be about trying to keep their life together (family, housing and finance). Service users/survivors have a lot to offer, but may not always be the best at making and keeping a commitment over a long period of time.

Service user/survivor groups have learned, usually the painful way, to try to anticipate the possible sudden withdrawal of a key member for a period of time. Several groups have got into difficulties when the group treasurer was admitted to hospital, leaving the chequebook and accounts locked in their house. One solution is to have shadowers for each of the officers (an officer is someone who holds a position in your group, such as chairperson, secretary or treasurer). This helps with continuity in a crisis, spreads responsibility and helps to train up possible future replacements. Like much good practice in the service user/survivor involvement, it is also good practice for any group as none of us are immune from the possibility of a crisis of one sort or another.

**Lesson four: all management committees need training**

All management committees need training, but they do not always get it. You can get training for your management committee if you budget for it in your funding application. There are different benefits to be had from participating in external training and from having your own, in-house, training. It is also possible to make a start by working through the group exercises below.

**Group exercise 4**

*How well are we doing?*

**Purpose**

To identify priorities for improving the working of the management committee.

**Notes for facilitator**

1. Distribute Handout 4 towards the end of a management committee meeting, allowing enough time for everyone to complete it and return it to you.

2. Be prepared to explain the role of an officer (a member of the management committee with a particular role e.g. chair, treasurer, etc.), an elected member (someone on the committee who has been voted onto it by the membership of the organisation), and an advisor (someone who has been invited to join the committee because they have particular expertise that the committee needs; they may, or may not be full members of the committee i.e. they may not have voting rights).

3. Collate the results and present them at your next meeting.
4. At your next meeting you can then focus on:
   • what is going well and why
   • where there is disagreement and attempt to resolve it
   • what is not going well and how to improve it.
   You can move forward through brainstorming and small group discussions in your meetings.

5. If there is a lot not going well, you may get bogged down in negativity. One way of keeping positive is to look at examples of when something did go well. For example, when there was a good discussion at a meeting or a time when the staff and management committee members worked well together. Then you can try and identify why it went well and how to build on the success.

The following group exercise was one the learning sets found particularly useful. It is reproduced from *How to be a Better Trustee, Part 1*, by Kevin Ford, by kind permission of the publishers, The Directory of Social Change, 24 Stephenson Way, London NW1 2DP. (Out of print.)

**Group exercise 5**

**The jobs of the officers**

**Purpose**
To clarify the roles of chair, treasurer, secretary and the other officers on a management committee.

**Notes for facilitator**
1. Photocopy Handout 5 and cut into strips – one job to each strip.
2. Write on flipchart paper the following headings: chair, secretary, treasurer, committee, members, staff, professional and other advisers. Make sure the whole group can see these.
3. Distribute the strips of jobs equally among the participants.
4. Ask each participant to read out in turn the name of a job and propose under what job title (for example, chair or staff) it should be put.
5. If everyone agrees, it should be put under that heading, unless you want to challenge the decision, based on the explanatory notes in Handout 6.
6. If there is disagreement, after a discussion, you should read out the relevant part from Handout 6 and suggest placing the job accordingly.
7. Eventually, all 40 jobs will be allocated under the headings outlined in point 2.
8. You should then take the group through the lists and participants should be asked to comment about what they have learned.
Lesson five: attention needs to be paid to roles and relationships, especially between management committee members, staff, volunteers and people using the service

At their best, service user/survivor-led services are friendly and informal. Talk of ‘professional boundaries’ is a big turn-off for many service users/survivors, who see it as excuse for keeping them at a distance. Walking in to a building and not immediately being able to tell who are the staff, volunteers and service users/survivors could be one test of a good project.

When service users/survivors start setting up services, relationships can get quite multi-dimensional. For example, a management committee member may be responsible for employing staff and also work under their direction as a volunteer. This can work but some of the Crisis Programme projects learned, from painful experience, that there can be too many overlapping roles.

- A friend of a member of staff of a crisis house became a volunteer. He later became distressed and was admitted to the crisis house as a resident. He then had sex with a female resident. She had gone against the religious beliefs of her family and they were angry that someone who they saw as being part of the staff group had acted unethically.
- A member of staff was unhappy with the conduct of a management committee member who was also a volunteer on the telephone helpline. As a supervisor on the line, she felt obliged to challenge the way this person had responded to a call, but she was anxious about them reacting badly and complaining in the management committee meeting.
- A former resident in a crisis project was so pleased with the way she had been treated, she wanted to give something back. With the agreement of the staff, she started visiting as an informal advocate. Later, she was readmitted as a resident. But in her confused state, she kept insisting that she was an advocate and was unable to accept her role as a resident who was in need of support.

As a result of these sorts of difficulties, the Crisis Programme projects decided that they needed policies to regulate potentially tricky situations. It should be possible for a volunteer or management committee member to make use of the project they are involved with, but policies need to be in place to keep roles distinct. One proposal considered by a Crisis Programme project is outlined here:

If a management committee member or volunteer becomes a user of the service, they are immediately considered to have stepped down from their position and will not take it up again for at least six months after they have stopped using the service.
To further clarify the situation you must state who is responsible for what in your project. The simple way of describing the division of responsibilities is that the management committee makes strategic decisions; the staff make operational decisions. The following two group exercises are designed to help you work out the appropriate relationship between staff and the management committee in your crisis project.

However, remember that while training, procedures and policies are all necessary, they are not a substitute for good relationships. Taking time to pay a compliment, listen to a worry or share a joke all help to build trust and respect. This will give you a sound basis for dealing with the inevitable difficulties that will arise.

**Group exercise 6**

**The management committee and staff working together**

**Purpose**
To identify and resolve any difficulties the management committee and staff have in understanding and agreeing their respective roles.

**Notes for facilitator**
1. Give a copy of Handout 7 to everyone present.
2. Divide them into groups of three and ask each group to read through Handout 7 and identify:
   - which stage their management committee is currently at
   - which stage their management committee should be at
   - any ways it is fluctuating between stages.
3. Ask each group to report back. See if their responses suggest there are difficulties A, B or C, as described in the handout.
4. If so, aim to resolve them through a discussion involving the whole group.

**Group exercise 7**

**Clarifying roles and responsibilities**

**Purpose**
To consolidate the work done in Group exercise 6 by checking that there is a common understanding of roles and responsibilities between the management committee and staff team in your organisation.
Notes for facilitator

1. Think up a number of scenarios that may present dilemmas about how they are handled, for example:
   - a letter arrives, addressed to ‘The Manager’ requesting that they make a presentation about your project at a conference
   - there is only going to be one member of staff available to work in the crisis house at the weekend and your policy is for there to be two.

2. Present these to the group and ask them to consider what should happen next.

3. Divide them into small groups to decide on their answers.

4. When they report back if each group has not come up with a similar answer then you have highlighted an area of confusion regarding the roles and responsibilities of those involved that needs to be clarified through discussion.
You have an idea for a crisis project but what do you do next? This section takes you through the process of developing your initial idea into a practical, well-thought-out project to present to potential funders.

**Generating ideas**

The idea for an innovative crisis project has to come from somewhere. It could be from a negative or a positive experience, perhaps someone hearing an inspiring talk at a conference or from a disastrous experience with traditional services. The origin of some of the Mental Health Foundation Crisis Programme projects are described here:

- **Asian Mental Health Helpline**
  There was obvious gap in the provision of helpline services as non-English speaking Asian people were unable to use the existing, English language, line run by Rethink.

- **Anam Cara**
  It was inspired by Soteria House, a successful Californian experiment in assisting people through the journey of psychosis. (See References for sources of information about Soteria House.)

- **GLOSS Group Crisis Line**
  The idea came from someone who was alone and suicidal at a weekend and with no-one to turn to. She wanted to prevent anyone else from being in that position.

- **The Nile Centre**
  Research, much of what can be found in *The Fundamental Facts* (The Mental Health Foundation, 1999), had established that people of African heritage had bad experiences of psychiatric services. This inspired further specific research into the needs of people of African heritage in the London Borough of Hackney. The idea for the Nile Centre emerged from this research.
Group exercise 8

Help in a crisis

Purpose
To come up with ideas for innovative crisis projects.

Notes for facilitator
1. Ask the group to draw on any personal experience of mental health crisis or a situation where they or someone they know has been unable to cope. This could be described as:
   • being overwhelmed by bad feelings such as fear or despair
   • losing their usual ability to function in the world
   • finding the world very confusing, not knowing what is real and what is not real
   • people around you becoming very worried and saying you must get help.
2. Ask each person to spend a few minutes writing down where they would like to be, who they would like to be with and what they would want these people to do if they were in a crisis.
3. Put the headings ‘where’, ‘who’ and ‘what’ on a flip chart and ask each person to say where they would like to be and write the main points on the flip chart. Repeat this for ‘who’ and ‘what’ with each participant.
4. Look at the results together. Ask if local mental health services offer the help people say they want. If not, then what could?

Research
To further develop your idea for a crisis service you will have to do some research. This does not have to be a mammoth project carried out by people who have lots of letters after their names, although it could be. It may simply involve, for example, phoning organisations that provide telephone helplines to find what opening hours work best for them.

Research can be a dynamic activity that brings results. Handout 8, entitled Someone to get me through the night, describes a fine example. However research can also be a substitute for action. How many surveys of service user/survivor views have been carried out only to be filed away? Some research is necessary, but we do not need to go back to basics every time. In general, we know what service users/survivors want from services. This extract from a report by the Audit Commission in England (Finding a Place, 1994) is a good summary of what services people want:

In the community people want more community supports and aftercare in general, more 24-hour crisis facilities, out-of-hours contact, the option of non-hospital crisis centres, crisis cards, more help with finding employment, more help with benefits and finances, and more support for carers. Sensitivity to
ethnic and cultural needs is particularly important. Services run by voluntary
groups or by users themselves are often the most highly valued.

**Service users/survivors as researchers**

Service users/survivors have a lot to offer as researchers into service users/survivors views and experiences. They may be especially good at thinking of the best questions to ask and in putting interviewees at their ease. An example comes from *Openmind* (Rose, 2001):

One piece of research, which was orientated towards the rights of black users, asked them ‘do you think your medication dose is too high?’ Most of the users interviewed said ‘I do not know, I do not know what the right dose is.’ When service users themselves framed a question about this, they asked ‘do you think you are overmedicated at all?’ This may seem like hair-splitting, but because the second question used the vocabulary of ordinary service users, the question was meaningful. In response to it, 30 per cent of those interviewed said ‘yes’ and only a handful said they did not know.

The Mental Health Foundation’s Strategies for Living Project has produced *The DIY Guide to Survivor Research* and is dedicated to supporting service user/survivor researchers through a network, training days and publications. Strategies for Living can be contacted at the Mental Health Foundation (see Appendix 5 for contact details). Handout 8 outlines the experiences of one such user researcher. It may be useful to distribute this to your group in preparation for Group exercise 9.

**Group exercise 9**

**Research brainstorm**

**Purpose**

To generate ideas for research to be carried out.

**Notes for facilitator**

1. Get the group to brainstorm together on ‘what we want to know’.
2. Put the ideas into categories, such as service users/survivors views or local services, on a flipchart.
3. Discuss what is known already in these areas.
4. What does that leave? What is most important to find out?
5. Ask for suggestions for how to do the research and who could do it. Record this on the flipchart.
6. Take your ideas to a decision-making meeting.
Group exercise 10

Making some basic decisions

Purpose
To assist the group reach consensus about basic features of its proposed crisis project.

Notes for facilitator
1. Distribute Handout 9 to your group and in small groups ask them to answer the questions on this handout.
2. Return to the larger group and get the feedback from each group, identifying
   • what people agree on easily
   • where there are minor disagreements
   • where there are not yet answers
   • more significant disagreements.
3. You then work through where there are minor disagreements, followed by where there are not yet answers and then where there are more significant disagreements. Handout 10 may be useful and can be distributed to the group.
4. When the group has reached agreement on all points, ask someone to write up what has been decided. Then take the document to the decision-making forum of the group for ratification.
5. These descriptions of the crisis project should then be reproduced, to look as attractive as possible, and given to anyone who shows an interest in the project.

Group exercise 11

What accommodation do we need?

Purpose
To identify what accommodation your project will need.

Notes for facilitator
1. Give each person a piece of flipchart paper and some felt tip pens.
2. Ask them to draw a floor plan of the accommodation they think is necessary. Allow five minutes for this part of the exercise.
3. Ask each person to then present their plan to the rest of the group, explaining why they have drawn what they have.
4. Ask what people have noticed about the similarities and differences in their plans, and write them on a flipchart.
5. Discuss and decide what is necessary to agree on at this stage in relation to accommodation needs and what can be left for the time being (though ensure a record is kept of outstanding issues for future reference).

**Getting real about money**

Now you have made some basic decisions about your project, you need to think about how much it is going to cost. It is useful to divide the money you will need into two categories:

- **capital expenditure**: money spent on things that will last, such as a building or telephone equipment
- **revenue expenditure or running costs**: money for recurring expenses, such as staff salaries.

When working out the costs of your project, some important points to remember are:

- **inflation** – costs go up each year
- however hard you try, you will probably not think of everything. Be generous in your estimates so that you have a bit left over to pay for any extras. One Crisis Programme project forgot about the cost of employing a cleaner, another did not allow for the cost of the launch of its helpline
- it is easy to underestimate the hours of staff time you will need to keep the project open for the hours that you want. You will need to allow for staff meetings, training and supervision, holidays, time off sick, maternity and paternity leave and compassionate leave if your policies allow for it.

Also remember what you are required to offer by law. Contact ACAS for further information on your obligations as an employer (see Appendix 5 for contact details).

**Group exercise 12**

*Estimating the cost of your project*

**Purpose**
To make an attempt at estimating the cost of your project.

**Notes for facilitator**
1. Put the headings Capital and Revenue on different sheets of flip chart paper.
2. Explain to the group what they mean using the descriptions above.
3. Get the group to brainstorm every item of expenditure which the project would incur that they can think of. Group the smaller items together under headings such as office expenses or refreshments.
4. Identify the major items of expenditure and ask the group to try to estimate the approximate costs. If they cannot, decide how they can find out. Handout 10 is an example of the costs associated with a Mental Health Foundation Crisis Programme project and is a good reference for this exercise.

5. Move on to the lower cost items and repeat point 4.
Chapter 4
Making progress with your crisis service

You may have a well-thought out project, but there is still a lot of work to do before it will be ready to welcome its first callers, guests or service users.

Some of the work facing you is fairly standard for voluntary organisations: fundraising and employing staff, for example. You can get advice and assistance on these and other issues from the organisations and publications mentioned in Chapter 2: Setting up a service user/survivor-led organisation.

This chapter is designed to help your project through the areas of policy and the issues that the Mental Health Foundation Crisis Programme projects found difficult.

Inclusion and exclusion

Issues of inclusion and exclusion understandably stir up strong feelings. We all have experiences of being left out, rejected, and possibly abused because other people do not like who we are. Some of us may trace the origins of our mental distress to such experiences.

We may also find these experiences being reproduced in mental health services. We may be told we are not distressed enough to qualify for one service but too distressed for another, or have the wrong kind of distress altogether. We may find our cultural background is misunderstood, leading to misdiagnosis and mistreatment. We may have no way of communicating or are being physically excluded from a building. We may feel it is physically unsafe to make use of a service.

All this makes it likely that people involved in creating and developing your project will be highly motivated to be as inclusive as possible. But what does that mean in practice? How do you be inclusive and what are the limitations?

Issues of inclusion and exclusion apply to every aspect of your organisation. An equal opportunities policy and programme is your plan for making sure everyone involved (or potentially involved) in your project is treated fairly, including staff and management committee members. It is about fulfilling your legal obligations.
An equal opportunities policy should contain the following characteristics.

1. A statement of intent.
2. Policies relating to users of the service.
3. Policies relating to recruitment, training and promotion of employees.
4. Conditions of service for employees.
5. Policies relating to volunteers.
6. Complaints, grievance and disciplinary procedures.
7. Training for equal opportunities.

An equal opportunities programme should contain the following stages.

1. Research and review
2. Priorities
3. Targets
4. Action
5. Monitoring
6. Budget
7. Publicity and dissemination.

These frameworks are extracted from *Guidelines on Equal Opportunities and Mental Health*, by Jan Wallcraft and Jim Read. A fuller version appears in that publication.

**Group exercise 13**

*Identifying issues and priorities for inclusion*

**Purpose**
To identify the key issues for inclusion that require action.

**Notes for facilitator**

1. Get the group to brainstorm all of the possible types of people who could face obstacles in using their service.
2. Divide into small groups and split the types of people identified in point 1 equally among the groups.
3. Ask each group to write the name of one type of person at the top of a piece of flipchart paper, putting the heading ‘obstacles’ underneath and half way down, the heading, ‘solutions’.
4. Participants should then write on flipchart paper their thoughts about the obstacles facing this type of person and the solutions of how to include them. They should repeat these steps for each type of person they were given in point 2.

5. There are two ways this work can be presented back to the main group and commented upon:
   • each sheet is displayed and read out and comments and further suggestions are invited
   • the sheets are all displayed on the wall, with participants moving around, reading them, and adding their own comments.

6. There are two ways of looking at the priorities identified earlier in this exercise.
   • What needs to be done now, to avoid missing an opportunity? You may be about to move into a building that cannot be made accessible to people with a physical disability. You may be about to appoint staff. Do you want to make a special effort to recruit people from minority ethnic backgrounds?
   • What are the key issues for your project regarding inclusion? This may relate to particular aims that you have, such as reaching out to a minority group that is not served by other services.

7. Divide participants into different small groups to try to answer these questions. Report back to the larger group and see what emerges from the discussions.

Exclusion policies

However much you may want to include everybody, there will have to be exceptions. The key principle is that if someone is excluded, it is for a necessary reason, and not because of prejudice or inflexibility. Like most of your policies, you will need something in place when you open, but it should be reviewed in the light of experience.

Some behaviour, if tolerated, is going to result in other people excluding themselves. If, for example, sexual harassment is accepted, the victims will stay away. If staff have no way of protecting themselves from aggression, they will leave and your service will close down. Telephone helplines avoid some of the difficulties that can arise when people are sharing the same physical space, but even they have polices for terminating calls.

You will not be able to offer a service that includes absolutely everyone, but you can develop a policy on exclusion that:
   • is based on principles of equal opportunities
   • is consistent, open and fair
   • gives potentially excluded people the opportunity to change their behaviour
   • gives people who have been excluded, the opportunity to make a fresh start

There are many different reasons for excluding people from your service and not all of them are negative. These reasons can be broken down into the following three categories.
Category A
1. The individual does not fit the basic criteria you have set for your service. For example, your service might be for women only.
2. The individual does not fit the criteria set by your funders. For example, they may specify that you only see people from a particular area.
   The reasons in this category are fairly straightforward, but the next categories are less clear cut.

Category B
3. The individual cannot make use of the service you offer. For example, they have been drinking and do not really know what they are doing.
4. The individual makes inappropriate use of the service. For example, although you run a crisis service, they turn up all the time.
5. The individual behaves in ways that are offensive to other service users. For example, they make personal and insulting remarks.
6. The individual has a history of dangerousness. For example, they have hit a member of staff.

Each of these reasons for exclusion requires a lot of thought about where you draw the line. The reasons for exclusion in the next category are ones that reflect badly on your service. You will want to be able to change them, though this may take time.

Category C
7. The individual does not feel physically safe in your building. For example, because offensive behaviour is tolerated
8. The individual does not feel welcomed by your service. For example, in an ethnically mixed area, a Black person may notice that all the staff and other users are white.
9. The individual cannot access the service. For example, a deaf person might want to call your helpline but you do not have the equipment to enable them to communicate.

Group exercise 14

Grounds for excluding someone from using your service

Purpose
To agree on fair reasons for excluding people from using your service.

Notes for facilitator
1. Give each person a copy of Handout 11.
2. Ask them to tick any of the reasons for excluding someone from your service that
they agree with. Ask them to put a question mark next to any reasons they are not sure about, and a cross where they believe someone should not be excluded for this reason. This part of the exercise should be done quickly, within a few minutes.

3. Write the reasons listed in Handout 11 up on flipchart paper.
4. Take the group through each reason, seeing who has given it a tick, cross or question mark. Add the results to the list on the flipchart.
5. Ask if there are any other reasons to exclude an individual. Vote on those suggested and add the results to your list.
6. Where there is disagreement discuss each reason as a group. Feelings tend to run where there is divided opinion so do not necessarily expect to deal with all disagreements in one go, and remind people of any ground rules you have agreed for the group.

Some of the possible reasons for exclusion in the list above have been chosen to draw attention to the possibility of excluding people you do not mean to exclude (for example, ‘is deaf’). When discussing these, it may be useful to refer to categories A, B and C on page 36. See Handouts 12 and 13 for example exclusion policies to further stimulate discussion.

**Thinking about violence**

This is a challenge for crisis projects. No one wants to fall into the trap of stereotyping people in crisis as being violent, but ignoring the issue does not make it go away. Why do some people become violent when in crisis?

1. They are angry at what is happening to them.
   According to the experience of one Crisis Programme project: ‘One woman stayed with us several times and was fine, but after her children were taken away, she came to us again and punched someone in the face.’ They may also be reacting to a violent situation. This can include compulsory detention and compulsory treatment. This may occur if force is used or threatened.

2. They have learned to get attention by being violent.
   This behaviour may have been learned on hospital wards, even though the actual attention it attracts may not be very welcome. ‘We had difficulties with some people who behaved as if they were on a ward. We realised that they were not deciding for themselves to come here, but were giving in to the wishes of their relatives. We learned to be more thorough about checking that people really wanted to be in the crisis house, and use what we could offer,’ reported one crisis project.
3. They become confused and attack someone because they think the person is someone else in a different place or time, or that the person is going to attack them. This is probably the least common reason, but is a possibility. One project described an incident where: ‘The staff member was from the same country, the same tribe and spoke the same language [as the service user]. I think she reminded him so much of disturbing events from long ago that, in his confused state, he thought she was someone else, who had scared him.’

**Learning from experience**
There have been several incidents of violence at the Nile Centre. It should be expected that this project would be more likely than others to have experienced such incidents as it has been open the longest, takes the greatest number of clients and is the most intensively staffed of all the Mental Health Foundation Crisis Programme projects, allowing it to take people in severe states of crisis who might be excluded from other projects.

However, no member of staff has left because of a violent incident. One said: ‘I’m more worried about being attacked on the street than here’. This does not mean the incidents of violence are regarded as trivial. Some people have gone off sick after being hit and have needed a lot of support to come back to work.

The Nile Centre team leader believes something can always be learned from these incidents, and used in the future. For example, she thought one incident could have been avoided if staff coming on to a shift had been better briefed and had paid more attention to someone who was very distressed.

The learning set discussed the therapeutic benefits of letting out angry feelings in a safe way. It would be good for crisis houses to have a room where people could rage, in safety. Perhaps it would have a punch bag, and some cushions that could be thrown around. It would probably be quite popular with the staff as well.

There have been very few incidents of violence in the crisis houses involved in the Crisis Programme. No one is forced to be there or forced to have treatment. This must make a significant difference, compared with psychiatric wards. Also, the staff firmly believe that by offering a friendly, accepting environment, they are greatly reducing the tensions that create violence. Giving people the opportunity to ‘let off steam’ safely could also make aggressive behaviour towards other people less likely and benefit service users. However your project does need to think about how it can best avoid violent incidents and how it should deal with them if they do occur.
Dealing with opposition

Opposition from neighbours and communities
Unfortunately, opposition from neighbours and local communities is all too common when
new mental health facilities are being set up. Three out of the four projects in the Crisis
Programme that provided face-to-face contact experienced opposition. The Nile Centre was
the exception, but the building had already been used for a project with the same client
group. The Leeds and Corby projects both had to look for alternative accommodation after
local people objected to the site, causing delays in opening the service. Anam Cara had a
more positive result. A petition against the service was abandoned when neighbours took it
into a GPs surgery and were given a lecture on what a valuable resource Anam Cara would
be for the local community.

There are two basic approaches to dealing with potential opposition.
1. Do not tell neighbours about the project
   This approach acknowledges the principle that we do not have the right to choose
   our neighbours and it protects the privacy of the residents or service users. However
   neighbours may still find out about it through rumour and gossip, fuelling their fears
   of the danger of the project.
2. Inform neighbours and be prepared to meet with them and answer their questions
   This gives you the opportunity to give accurate information and can create goodwill.
   However it may also stir up opposition that otherwise may not have occurred.

If there is opposition that cannot be quelled, again there are two possible approaches:
1. Go ahead anyway
   You have a right to be there and should not have to give in to prejudice. A survey into
   neighbourhood opposition to community mental health facilities (Repper et al, 1997)
   found that opposition rarely continues once a project has opened, so it may be worth
   persevering.
2. Give up and try somewhere else
   This is a more pragmatic approach that recognises the benefits to residents or service
   users of moving into a friendlier neighbourhood.

This survey found that there is no approach that guarantees success or failure. Each
situation is unique. However, as a general rule, it suggests it is best not to inform
neighbours if a facility is small and does not require planning permission. Otherwise, it is
better to inform them.

It is also important to distinguish between informing and consulting. Neighbours should
not be encouraged to think they have a right to object, except for the specific reasons open
to them through planning procedures.
See Appendix 5 for sources of further information on this issue.

Another source of assistance for your project could be an external advisor. The Safe Haven was eventually successful in its application for planning permission when it paid a consultant to advise it on the best strategy to use. Again see Appendix 5 for more information.

**Group exercise 15**

*SWOT analysis*

**Purpose**
To develop a strategy for dealing with potential opposition from neighbours and the local community

**Notes for facilitator**
1. Divide people into groups of about four.
2. Give each group a piece of paper set out like this:

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Ask each group to identify the strengths, weaknesses, opportunities and threats of the project and complete the grid.
4. Ask the groups to report back and discuss their ideas. Those strengths, weaknesses, opportunities and threats identified by most of the groups can be written up on an overall grid, representing the view of the group as a whole.
5. This material can then be used to write a strategy for dealing with opposition, should it arise. It can also be used alongside Group exercise 16 to develop action plans to maximise strengths and opportunities and minimise weakness and threats.
6. This exercise can also be used to identify how best to tackle opposition from mental health workers.
**Group exercise 16**

**Developing an action plan**

**Purpose**
To create an action plan to deal with potential opposition from neighbours and the local community.

**Notes for facilitator**
2. Go through Handout 14 with the group to:
   - agree which points have already been covered by existing plans
   - take out any that are not relevant to your crisis project
   - add any that you think are needed.
3. Address each remaining item on the checklist, determining how and when it can be dealt with.
4. Write down the plans you have agreed on in point 3 through discussion. This will form your action plan.

**Opposition from mental health workers**
Several of the Crisis Programme projects experienced opposition from staff in other services. Examples of obvious hostility included:
- a consultant psychiatrist blocking referrals
- comments such as, ‘I do not see any need for your project’
- refusal to co-operate by, for example, withholding information from service users.

Other actions were less directly hostile but were still undermining. They included:
- not accepting that a crisis project could help someone who would otherwise be admitted to hospital, even though that is what it was set up to do.
- a key worker, quizzing someone who had been resident in a crisis house, as if trying to find justification for criticising it.

When you put a lot of effort into setting up a project of which you are justifiably proud, it can be a bit of a shock if it is criticised or undermined by people who you had expected to welcome this addition to local mental health services.

However, it should not be surprising. After all, you probably set up the project because of your own criticism of existing services. Perhaps you thought there were unacceptable gaps in provision, or that people from minority ethnic groups encounter racism when using
them, or that there is too much emphasis on medication and not enough on listening and understanding. The criticism behind your motivation may be more obvious to other service providers than you thought. Also, there is fierce competition for funds. If your project receives funding, people in other organisations may be jealous, and not overly keen to help your project to succeed.

To counter this criticism from within the mental health service develop a strategy early on for gaining as much support as possible and for minimising opposition. Some of the methods used by the crisis projects included:

• putting effort into meeting mental health workers to publicise and explain your project
• holding regular open days for people who are interested in what you do
• using allies in the statutory sector to speak up, positively, about your project.

If all else fails, find ways of bypassing obstructive professionals through publicising and explaining your project directly to potential service users.

Planning permission: your questions answered

What is planning permission?
It is the permission you will need from your local authority if you propose to change the use of your building.

What is a change of use?
Various categories of use have been designated under the relevant legislation, The Town and Country Planning Act 1990. These can be obtained from your local planning department, and are listed and explained in Not in My Back Yard (National Housing Federation, 1994).

What should we do if we think we may need planning permission?
Talk to staff of your local planning department. They will also be able to advise you about the local development plan, which may have an impact on planning permission.

What problems may we come up against?
The local authority may have requirements that do not seem relevant to you. For example, they may require a certain number of car parking spaces to be available. They may also be concerned about such matters as noise, if there are going to be people coming and going late at night.

What right do neighbours have to object?
They can object ‘on planning grounds’. This includes such matters as ‘destroying the character of the area’. They cannot object to the facility being used by a particular group of
people (such as people with mental health problems), although prejudice may be behind their objections.

These answers are based on legislation and guidance for England, which may be different to that in Northern Ireland, Scotland or Wales. If you are planning to establish a crisis house in these areas, please be sure to check with your local authority in case planning requirements differ to those outlined above.

**Lessons for telephone helplines**

Some important lessons were learned by the three telephone helplines that were set up as part of the Mental Health Foundation-funded Crisis Programme. The following lessons were identified by the learning sets.

**Lesson One: Generate enough calls**

It is crucial to generate enough calls to justify the time of volunteers and the effort and expense of providing the service. This can be done by:

- being available to a large enough group of people
- not restricting the purpose of the line too much
- making people aware of the line through a sustained outreach and publicity campaign.

Each of the helplines began with an idea that was untested.

- The GLOSS group offered an out-of-hours crisis line to the 180 or so people who used a day centre.
- WAND set out to provide support to around 400 people in North Devon with the most severe mental health problems.
- The Asian Mental Health Helpline was based on an existing model, the English language line, but was only relevant to three per cent of the population in the area served by the English language line.

Each learned some, sometimes painful lessons, about generating enough calls.

- The GLOSS helpline was open 18-hours-a-week for 17 months. During this time, there were around 25 calls. Some of the calls were crucially important for the users concerned. In a way, they fully justified the presence of the helpline. However volunteers, understandably, were not prepared to spend most shifts doing nothing. Attempts were made to offer the helpline to a wider group of potential callers, but volunteers were already drifting away and the line folded.
- WAND abandoned its original remit when the local health trust opened a line that offered something similar. This event may have steered it in a better direction. It was eventually launched as a support line (rather than a crisis line) and was open to anyone
in North Devon with a concern about mental health, including informal carers and people who did not have a diagnosed mental health problem. After a year, it was decided to open up the line to the whole of the county.

- The Asian language helpline was always going to have a relatively small pool of potential callers, and so extensive publicity was essential for the line to be well used. This had to be spread through the many small, organised groups of Asian people in the area. The co-ordinator had to devote as much time as possible to visiting Asian organisations and explaining the purpose of the line. This was especially important because as a non-English speaking community, the target audience was not part of the usual mental health network. Issues of confidentiality were also particularly sensitive, as ‘going outside the family’ could cause tensions. Eventually, the number of calls built up to a satisfactory level, but it would have been far easier to establish the project if there had been a longer lead in period to concentrate on promoting the line before it opened. Whereas six months was allowed before the English language line opened, a year would have been more appropriate for the Asian language line.

Lesson Two: Grow slowly

Even if you take note of the above lesson, you still need to be prepared for the use of the line to grow slowly. To some extent, this applied to all the crisis projects, but helplines are particularly slow to take off, because the task of reaching potential callers is so vast. The demand is definitely there, but it takes a while to build up awareness and trust among potential callers.

It can be alarming when you have put a lot of effort into starting up, volunteers are eagerly sitting by the phones, funders are asking for figures, and you are not receiving many calls. However a representative of an established helpline put this period of potential stress in perspective: ‘Value this period. There are so many things to sort out, at the beginning, and so much learning from experience, it is good to have time to talk things through and reflect. It will not last.’ This proved to be the case at WAND. This helpline received 120 calls in its first year and 902 in its second.

Lesson Three: Draw on experience

A lot can be learned from existing helplines, including those without a mental health focus. There is a great deal of experience and good practice around on such subjects as:

- choosing the right technology
- recruiting, training and looking after volunteers
- good practice in answering calls, including difficult calls.

A good starting point for learning from the experience of other helplines is the Telephone Helplines Association. See Appendix 5 for contact details.
Confidentiality
Telephone helplines are able to offer a high degree of confidentiality. This is one of their attractions. Usually, the caller will be completely anonymous. However some situations will very occasionally arise where it may seem that confidentiality should be broken. Helplines differ in their approaches to breaking confidentiality, and you will need to think, debate and develop your own policy.

Group exercise 17
Breaks confidentiality on a telephone helpline

Purpose
To help you think about when breaking confidentiality may be necessary

Notes for facilitator
1. Give each person a copy of Handout 15.
2. Ask them to tick any of the reasons for breaking confidentiality that they agree with. Ask them to put a question mark next to any reasons they are not sure about, and a cross where they believe confidentiality should not be broken. This part of the exercise should be done quickly, within a few minutes.
3. Write the reasons listed in Handout 15 up on flipchart paper.
4. Take the group through each reason, seeing who has given it a tick, cross or question mark. Add the results to the list on the flipchart.
5. Ask if there are any other reasons for breaking confidentiality. Vote on those suggested and add the results to your list.
6. Where there is disagreement discuss each reason as a group. Feelings tend to run where there is divided opinion so do not necessarily expect to deal with all disagreements in one go, and remind people of any ground rules you have agreed for the group.
7. As you are unlikely to reach agreement in one session, propose how to take this forward. For example, you may decide to contact other helplines to find out their policies, the thinking behind them, and how they have worked in practice. You may then meet again to discuss formulating your policy, if necessary.
8. You may also wish to facilitate discussion on:
   • what participants understand by breaking confidentiality
   • possible steps towards breaking confidentiality
   • practical implications, for example, could you find out where the person lives?
   • what may be lost in breaking confidentiality.
You could divide participants into small groups for these discussions and have them report back.
Volunteers

Volunteers can provide your project with a wealth of experience and expertise to draw on. To help you think through the involvement of volunteers, and to ensure that you work with them in a consistent way, it can be useful to develop a volunteering policy. A volunteering policy sets out your organisation’s approach and commitment to volunteers. You can help make the involvement of volunteers more effective by ensuring that everyone (including those at the highest levels of your organisation) knows why volunteers are involved, what kind of roles they play, and what they can expect from your organisation.

Take time to discuss with all those in your organisation the reasons for involving volunteers and the kind of work you want them to do. Be realistic, and remember that you will have to attract and retain volunteers, so opportunities need to be interesting and worthwhile.

There are five steps in producing a volunteering policy.

1. **Research** – look at the policies of other organisations.
2. **Consultation** – involve as many staff and volunteers as possible, including those at senior levels. Discuss why you want to involve volunteers, what they might do, and the issues arising from their involvement. Handout 16 is a useful example of a volunteering policy and could be distributed at a meeting to stimulate discussion.
3. **Write it** – use clear language and keep it as brief as possible.
4. **Distribution** – who will your policy go to?
5. **Review** – establish how your policy will be reviewed to see if it has been effective. In addition to a volunteering policy you may want to consider developing volunteering terms and conditions.

An example of such a document can be found in Handout 17 and sets out many practical guidelines including expenses and a more detailed job description.

For further information about volunteers contact the National Centre for Volunteering (see Appendix 5 for contact details). There may also be local volunteering organisations in your area that can provide assistance.

Registering as a care home

If you are offering short-stay accommodation, you may be wondering if you have to register as a residential care home. New legislation makes it very unlikely that you will have to do so. The text in this section is based on legislation and guidance for England, which may be different in Northern Ireland, Scotland and Wales. If you are planning to establish a crisis house that provides short-stay accommodation in these areas, please be sure to check with your local authority in case legal requirements differ to those outlined here.
Under the Care Standards Act (Department of Health, 2000), providing meals is not a reason for having to register and personal care appears to be defined in such a way that excludes short-term crisis accommodation. 'For an establishment to be a registerable care home … the Act makes clear that ‘the care which it provides must include assistance with bodily functions (such as feeding, bathing and toileting) where such assistance is required.’ (Taken from A Guide to the Care Standards Act 2000.)
References


Faulkner, Alison (1997) *Knowing Our Own Minds* London: Mental Health Foundation.


National Housing Federation (1994) *Not in my Back Yard (NIMBY): a guide for housing associations and local authorities on special needs housing and the planning system* National Housing Federation.


NCVO (2002) *Directory of NCVO approved consultants 02/03* London: NCVO
Handouts

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Handout 1  A definition of user

At a WAND learning set we discussed names to describe people who have experienced mental health problems. The preferred term was ‘expert by own experience of mental health problems’. This was thought to be accurate but also long and needing explanation. WAND decided to use it when there was the space and time to explain it. Otherwise, they would continue to describe themselves as a user-led organisation, because people would know what they meant.

Some people in the group were not sure if they were service users/survivors. It was important this was clarified as it affected their role in the group. The WAND constitution gives user members 1.5 votes each. So they needed to come up with a definition and they decided upon:

A person who has or has had personal mental health problems which they perceive as having a significant influence on their life and identity.

The word ‘personal’ was used to emphasise that the individual has to have had experienced mental health problems themselves, not simply been close to someone else who has.

This definition helps with a couple of dilemmas we came across in the projects. Two examples where the WAND definition does and does not apply follow.

• Staff at one crisis house were all supposed to be service users or survivors. However the manager was keen to appoint someone who did not necessarily qualify. He had experienced vivid sensations that would undoubtedly have been diagnosed as a form of psychosis, if he had been seen by a doctor, but he had been able to stay away from services. They decided to appoint him anyway. WAND’s definition does include him.

• A person who worked for one of the projects felt that, although they had briefly used services, it did not make sense to identify as a service user. It had not made a great impact on the course of their life and was not the reason why they were working in mental health. This definition does not include them.
Handout 2 Checklist for service user/survivor-led projects, and partnerships between service users/survivors and professionals

1. Is your project service user/survivor-led? Why? Why not?
2. Is your project a partnership between service users/survivors and professionals? If so, briefly describe the partnership arrangement.
3. If you have answered ‘no’ to the first two questions, how are service users/survivors involved in running the project?
4. Do you need a definition of service user/survivor? If yes, do you have one? (Refer to Group exercise 2)
5. What is your policy about appointing service users/survivors as staff?
6. What arrangements do you have for user and ex-users of your service to have input into running the project?
7. Are non-service users/survivors involved in running the project, involved in a different way from service users/survivors? If so, how?
8. What are the key papers that define who is responsible for the project, and the roles of service users/survivors and others?
9. Is there an arrangement for running the project that you are working towards? If so, what is it and how are you going to get there?

What are you doing to make sure service user/survivor involvement in your project succeeds? Is there anything else you should be doing?
Handout 3 Story of a partnership

This is about a partnership between an informal group of service users/survivors and a social services department. It highlights some of the advantages and disadvantages of this sort of partnership, and suggests some ways of bringing out the positives.

The idea for a crisis house, as an alternative to hospital admission, arose from a consultation exercise with service users/survivors carried out by the social services department.

The main funding source of joint finance (money allocated to be spent jointly by the health authority and social services) was identified. An informal group of service users/survivors and the social services department put a bid together and were successful in being allocated the funding.

The plan was that eventually, the project would be run by a charity in which service users/survivors would hold the key positions. Meanwhile, the social services department would be able to take responsibility for holding the grant, dealing with issues such as planning permission for a building and generally assisting with the development of the project.

A joint steering group of service users/survivors, social services staff and a voluntary sector representative was set up to take the project forward. The project was delayed for several years because of difficulty in finding a suitable building and obtaining planning permission, partly because of a campaign against it by local residents.

Meanwhile, the relationship between the service users/survivors and the social services department deteriorated. Some of the reasons are outlined below.

• As so little seemed to be happening, the number of service users/survivors involved fell away.
• Partly due to the above, those remaining lost confidence in their ability to run the project.
• Senior managers in the social services department who were not on the steering group took decisions that affected the project. These occurrences created a feeling of resentment among the service users/survivors. The representatives of social services on the steering group were put in a very difficult position.
Fortunately, things did not remain at this low point. Several events helped to move the situation forward.

- Inclusion in the Mental Health Foundation programme provided support for service users/survivors and contact with service users/survivors from other projects through the national learning set.
- The learning set programme allowed some of the problems to be aired and dealt with in a safe environment.
- The service users/survivors, who were chair and vice chair of the steering group, went to the chair of the social services committee, said they wanted more control of the project and got it.
- Representatives of the health authority were invited to join the steering group. They had not been caught up in past frustrations and were able to bring a fresh perspective.
- A suitable building was found (for which planning permission was not a problem) and money was released to buy it. This raised morale and gave a focus for activity.
- A co-ordinator was appointed who was able to advance the work.
- The service users/survivors started meeting together informally, which created a stronger sense of solidarity.
- A programme was established to steadily build the new service users/survivor-led organisation, and for it to eventually take over running of the project.

Difficulties continued to occur. For example, when jobs were advertised, the social services department, which was handling recruitment, insisted that they be included in a general social services recruitment advertisement. The service users/survivors wanted the advertisement to be separate and more clearly for a service user/survivor-led crisis project.

As the project progressed, some things got easier and more people became involved (staff, volunteers and users of the project). Whatever difficulties there had been, everyone could see that the partnership had succeeded in making the crisis project happen.
The lessons learned in this process indicate the following.

1. The money should have gone to the service user/survivor group from the start.
2. The value of investing in independent, external support for service users/survivors and workers should have been recognised earlier.
3. Decision-making procedures for the steering group should have been clearer.
4. The division of responsibilities between service users/survivors and social services staff needed to be discussed, agreed and written down.
5. The service users/survivors should have had their own, separate, meetings from the beginning.
6. There needed to be more open communication and mutual support between partners.
7. There needed to be more focus on strengthening the service user/survivor group – building confidence and skills – and recruiting others to join them.

An informal group of service users/survivors and a large local government department are never going to be perfect companions. However, they are able to bring different skills, resources and perspectives to a project, and that is why the, sometimes painful, process of partnership may be worth it.
Handout 4  How well are we doing?

Please give your opinion on following statements by circling the appropriate number:

1  Definitely not  2  Probably not  3  Don’t know  4  Probably    5  Yes, definitely

Are there enough people on the management committee?  1  2  3  4  5

Are there enough active people on the management committee?  1  2  3  4  5

Are there enough service users/survivors on the management committee?  1  2  3  4  5

Do we have all the officers we need?  1  2  3  4  5

Do management committee members understand their roles and responsibilities?  1  2  3  4  5

Do management committee members work effectively together  1  2  3  4  5

Are meetings conducted well?  1  2  3  4  5

Are the different roles of elected members and advisors well understood?  1  2  3  4  5

Are service users/survivors really taking the lead on the management committee?  1  2  3  4  5

Are there members of the management committee who feel that too much is expected of them?  1  2  3  4  5

Are there members of the management committee who would like to be more involved?  1  2  3  4  5
Handout 5  The forty jobs

1. Notify committee members about meetings
2. Summarise discussions at meetings
3. Set the agenda
4. Compile the accounts
5. Agree the budget
6. Check to see that income and expenditure are in line with budget predictions
7. Oversee the accounts
8. Prepare the audit
9. Submit the accounts to the Charity Commission and/or Companies House
10. Check that the organisation is keeping to the law
11. Supervise the senior member of staff
12. Represent the organisation at meetings and functions
13. Sign cheques on behalf of the organisation
14. Raise money
15. Make decisions between management committee meetings
16. Make sure that meetings are conducted properly, as set out in the constitution
17. Send out notification of the annual general meeting
18. Call an extraordinary general meeting
19. See that the committee is up to strength
20. Make sure that all members are able to contribute to discussion
21. Recruit new members
22. Decide the order of items on the agenda
23. Interview prospective staff members
24. Regularly visit the organisation to keep an eye on work
25. Chair disciplinary or grievance meetings
26. Put items on the agenda
27. Send out the agenda, minutes and committee papers
28. Sign the minutes as a correct record
29. Welcome new members
30. Clarify the purpose of each item on the agenda
31. Take the minutes
32. Resolve conflict at meetings
33. Keep the meeting on time.
34. Make sure the finances are healthy
35. Ensure that the assets are used only for the promotion of the objectives of the management committee and in the interests of the beneficiaries (i.e. the people who will be using the service/project)
36. See that the management committee is able to carry out its role of financial management
37. Make sure that committee members know the dates of meetings
38. Rule on disputes about the constitution
39. Have a second or casting vote in the event of a tied vote at a meeting
40. Ensure all members behave in ways that help the committee to do its work

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Handout 6  The forty jobs explanatory notes

In the following notes, each number refers to the relevant task in the list in Handout 5.

1. Notify committee members about meetings  
The secretary of the committee normally does this. In most organisations that employ staff, the senior staff member takes on the role of the secretary. Where there is no paid member of staff, the secretary of the committee has an important and time-consuming role.

2. Summarise discussions at meetings  
The chair should do this. However, there is no reason why other committee members should not also summarise discussions from time to time, as this can improve the quality of meetings.

3. Set the agenda  
Typically, the chair and the senior staff member would be involved in setting the agenda for meetings. The chair should have final say in what is on the agenda and its order.

4. Compile the accounts  
It is generally not the job of the committee members to compile the accounts. A member of staff usually does this or someone employed to keep the books and make up the accounts. If the organisation is very small and has no staff, then the treasurer may compile the accounts. The treasurer makes sure the accounts are compiled satisfactorily.

5. Agree the budget  
All of the committee should be involved in agreeing the budget. The treasurer may contribute expertise to the discussion on the budget but it is not up to the treasurer, alone, to decide the budget.

6. Check to see that income and expenditure are in line with budget predictions  
All the committee should be involved in this item. The treasurer must make sure that the committee receives adequate financial information.

7. Oversee the accounts  
This is the job of the treasurer.

8. Prepare the audit  
If the organisation’s accounts have to be audited, you must employ a professional.
9. **Submit the accounts to the Charity Commission and/or Companies House**
   The paid members of staff generally submit the accounts. If there are no paid members of staff, the secretary would be responsible for submitting accounts to the Charity Commission. If the organisation is a company limited by guarantee, then the company secretary has to see that accounts and annual returns are submitted on time to Companies House. The constitution may require that the company secretary is not a member of the management committee.

10. **Check that the organisation is keeping to the law**
    It is the job of all the trustees (i.e. members of the management committee, except for non-voting advisors) to make sure that the organisation abides by the law. The secretary may have a particular duty to make sure that this is done.

11. **Supervise the senior member of staff**
    The management committee as a whole must ensure that the senior member of staff (and all the other staff) is adequately supervised in his or her work. Often, the chair of the committee supervises the director through a regular meeting, perhaps weekly or monthly.

12. **Represent the organisation at meetings and functions**
    All members of the management committee may be called upon to represent the organisation at meetings and functions. For this reason, it is essential that all members have a clear and agreed view about what the organisation is for and the progress it is making. The chair may play the most active role as a representative and spokesperson.

13. **Sign cheques on behalf of the organisation**
    Any members of the management committee, usually at least two, may be asked to become signatories of the organisation's chequebook. The signatories normally include the treasurer and often the chair.

14. **Raise money**
    All management committee members may be asked to assist the organisation in raising money, as volunteers. The management committee, as a whole, must see that the organisation has proper plans to raise sufficient money to maintain its workload and to develop its activities in the future.
15. Make decisions between management committee meetings
Very often, an organisation allows the chair, in consultation with the other officers, to take decisions on urgent matters between management committee meetings. The management committee should receive a report on such decisions. It would not usually expect the chair and officers to make decisions on matters of policy or strategy. The only occasions when such decisions might be necessary would be in extreme crisis. It would be wise, in such circumstances, to call an emergency meeting of the management committee.

16. Make sure that meetings are conducted properly, as set out in the constitution
The chair and the secretary have a particular duty to make sure that meetings are conducted in accordance with the rules of the organisation. However, this duty extends to all the management committee members.

17. Send out notification of the annual general meeting
The secretary (or staff member acting as secretary) does this. In the case of a company limited by guarantee, the company secretary may carry out this task. The constitution sets out the precise way in which members must be notified of the annual general meeting.

18. Call an extraordinary general meeting
Any member of the organisation, not just members of the management committee, can take action to call an extraordinary general meeting. The procedure for doing this is set out in the constitution. In most cases, it requires a request in writing and usually requires more than one member to sign such a request.

19. See that the committee is up to strength
The chair and secretary play a major role in making sure that the committee is up to strength.

20. Make sure that all members are able to contribute to discussion
This is the role of the chair.

21. Recruit new members
The committee should have a recruitment process. This should spring into action as soon as the committee is short of members. The secretary has responsibility for this process. It is usually set out in the constitution. If it is not, it should be written down elsewhere.
22. Decide the order of items on the agenda
   The chair has a responsibility for ordering the agenda. This is usually done
   in conjunction with the secretary (this may be the senior member of staff).

23. Interview prospective staff members
   The management committee is responsible for selecting the senior
   member of staff and sometimes for other members of staff. All
   management committee members may be asked to take part in the
   selection process.

24. Regularly visit the organisation to keep an eye on work
   Some management committee members may be able to do this.
   However, it is not a requirement. It is possible to be an effective
   management committee member without actually visiting the
   organisation on a regular basis.

25. Chair disciplinary or grievance meetings
   If the whole committee is dealing with the disciplinary or grievance
   matters, then the chair of the committee should chair the meetings. In
   larger organisations, it would be more usual for a sub-committee dealing
   with employment matters to deal with disciplinary and grievance matters.
   This sub-committee would usually elect its own chair.

26. Put items on the agenda
   Any member of the management committee, member of the
   organisation, or member of staff, should be able to put items on the
   agenda. There should be a procedure for doing so, such as submitting
   items in writing to the secretary by a certain date before each meeting.

27. Send out the agenda, minutes and committee papers
   This is the responsibility of the secretary. The secretary may, in fact, be the
   senior member of staff of the organisation, who may delegate the task to
   his or her administrative staff.

28. Sign the minutes as a correct record
   The minutes are a legally binding record of decisions made at the
   management committee meetings. The chair should sign them.

29. Welcome new members
   The chair should formally welcome new members to committee
   meetings, but all existing members should try to make sure that new
   members feel welcome.
30. Clarify the purpose of each item on the agenda
   The chair should do this.

31. Take the minutes
   The secretary should make sure that minutes are taken. However, the
   secretary need not take them himself or herself. The task can be
delegated to a minutes secretary. This could be a member of staff, or any
member of the management committee.

32. Resolve conflict at meetings
   It is up to the chair to make sure that meetings function effectively.
   However, this can only be done with the consent and co-operation of all
the management committee members.

33. Keep the meeting on time.
   The chair should make sure the meeting keeps to time. Again, this
   requires the co-operation of all the management committee members.
The rule for all management committee members should be ‘keep
contributions brief and to the point’.

34. Make sure the finances are healthy
   This is the responsibility of all the management committee members. It is
   up to the treasurer to make sure all members have sufficient information
to make these judgements.

35. Ensure that the assets are used only for the promotion of the objectives
   of the management committee and in the interests of the beneficiaries
   This is the responsibility of all the management committee members.

36. See that the management committee is able to carry out its role of
   financial management
   This is the job of the treasurer. It is up to her or him to provide
information in a suitable form so that the committee understands it.

37. Make sure that committee members know the dates of meetings
   The chair should make sure that all members are clear on the dates and
locations of meetings. The secretary should circulate this information to
members and a record kept at the organisation.

38. Rule on disputes about the constitution
   The chair is often given authority in the constitution to act on disputes
about the constitution in the course of meetings.
39. Have a second or casting vote in the event of a tied vote at a meeting
   Most constitutions give the chair of the committee a second or casting vote.

40. Ensure all members behave in ways that help the committee to do its work
   While the chair has a role in keeping order and making meetings as effective as possible, every management committee member has a responsibility to behave properly. The chair is not responsible for each person’s behaviour at meetings.
Handout 7 The management committee and staff working together

When an organisation is established it tends to follow a pattern of development which is outlined in four stages below.

Stage One: The management committee is the organisation
Before any staff are appointed, the management committee is responsible for everything and does everything.
Comment: This stage is nice and simple. However, it is important to recognise and act on the changes that are needed once there are paid staff.

Stage Two: Staff take over some responsibilities
Staff take on specific responsibilities, working under the direction of the management committee. The management committee continues to be actively involved in the day-to-day running of the organisation. Some members may be volunteers as well.
Comment: This is appropriate if staff are appointed to run a particular project or if, for example, there is only one member of staff, perhaps a development worker.

Stage Three: Clearer distinction between staff and management committee roles
The management committee withdraws from day-to-day operation of the project and staff take more control. The main purpose of the management committee is now to meet and make decisions that are beyond the remit of staff. Some management committee members may continue to be volunteers but everyone needs to be clear about which role they are in at any one time.
Comment: Ideally, this allows the staff to get on with their jobs without having to take on additional responsibilities. The management committee is clearly in charge of the organisation. There needs to be good communication and understanding between the staff and management committee for this to work well.
Stage Four: The management committee takes a background role

The staff become the focus of the organisation. The management committee is in the background and tends to act on recommendations from the staff. Its main roles are:

• for the chair to support and supervise the most senior member of staff
• to act when there is a particular difficulty, for example, a complaint against the organisation or insufficient funding
• to make major, strategic decisions, such as deciding to start up a new project.

Comment: Once there is a staff team responsible for the main work of the organisation, this tends to become the way the organisation operates in practice. It is more satisfactory if this happens with everyone’s agreement, and senior staff are properly given the responsibility and time they need. Management committee members may not want to hand over this much responsibility to the staff but they need to be realistic about what they can do themselves. They are still, ultimately, in control.

Difficulties arise in an organisation in the following circumstances.

A. The stage being followed is inappropriate for the size and nature of the organisation.
B. There are different perceptions about which stage is being followed.
C. The organisation fluctuates between the different stages.
Handout 8 Someone to get me through the night: User-led research into the need for out-of-hours crisis support
Bev Sedley

Why we did the research
I’m an ex-user of mental health services and co-ordinator of a user-run service. In 1997, while doing a Diploma in Mental Health Innovations at Anglia Polytechnic University, I decided to do a project on whether users, carers and professionals thought out-of-hours support in a crisis was adequate in our area. I would also ask them what else, if anything, was needed.

The reason for this was that our members of the user-run service had been saying for a long time that more help was needed. In 1996 our health authority gave money to the local trust to set up an out-of-hours service, which operated Friday evenings and weekend daytimes, but this closed after a year because of under-use and cuts in mental health services. People who had said all along that services were already adequate felt justified, and those of us who were sure more was needed were very disappointed.

Aims and methods
As well as finding out people’s views, the aim of the research was to look at good practice elsewhere in the country and investigate as far as possible what happens to people in crisis locally. The final aim was to bring together all stakeholders to hear the findings and follow this up with a working group to produce proposals. Altogether this was quite an ambitious project and I was lucky to get a lot of support from other people locally. We formed a project group of eight users, a carer, a professional and a graduate research assistant. Nobody got paid except for two of the user interviewers and the research costs of £750 were eventually shared between the health authority, the city council and the trust. We managed to interview 54 users, 17 carers and 50 professionals, and also sent questionnaires to 176 GPs (43% responded).
Results
The results showed that only 19% of users, 29% of carers, 25% of GPs and 7% of the non-community mental health team (CMHT) professionals thought current services were adequate in a crisis. All carers and non-CMHT professionals, almost all users, 83% of GPs and 72% of CMHT members thought there was need for further out-of-hours crisis services. The preferred options were home visits from professionals, a crisis house and a telephone helpline. But only a third of CMHT members (most of these belonging to one team) thought CMHTs should extend their hours.

People felt that the weekend service had failed not because it was not needed, but because its referral procedure was too strict and complicated and because the service was not publicised enough. Users could only be referred by a professional during the week before the weekend crisis was supposed to happen. Booking your crisis in advance seems a little bizarre!

Users being turned away in crisis
I had expected users and carers to say more was needed and I was encouraged by the fact that so many professionals and GPs did too. What I had not expected and was really shocked by was the high number of users (all seeing two or three professionals regularly) saying that they had been turned away when they needed help: 39% had tried and failed to get help from statutory services in a crisis. This appeared in the data; it was not asked as a question. Many did get help later on. Eight users had harmed themselves after failing to get help.

Many users and carers said that they did not know the right place to contact in a crisis and they were told off for going to the ‘wrong’ place. For example a recently discharged patient who approached the ward in his confusion was sent away with the words ‘You cannot just walk in here.’ Another notable lesson from the research was the importance of relationships for users. What they wanted most was someone to talk to.
The case for more community support
According to local health authority/Trust figures, between 1994 and 1996 there were 162 people (excluding those in the rehabilitation service) who spent 90 or more days on an acute ward in the local psychiatric unit, usually with more than one admission. This would indicate the need for more community support. This is backed up by the fact that there were consistently more Mental Health Act assessments on Fridays. I was told by an approved social worker that this was because they felt they could not leave people in the community over the weekend. Over a six-month period there were also 525 attendances at accident and emergency which involved some kind of psychiatric problem, including overdoses and 225 of these were out of hours. All in all there were a lot of indications that more support was needed.

Presenting the results
We presented the results at a day workshop hosted jointly with the trust and attended by 85 people, including users, carers, professionals, voluntary organisations and health authority and social services purchasers. People were enthusiastic about the findings and about taking things further and 25 people signed up to join a steering group.

Positive responses to our research
Over the following year there were some positive developments. The trust issued instructions to ward staff to respond positively to ex-patients asking for help and our organisation joined forces with the Samaritans to apply successfully to the National Lottery to set up an evening phone helpline. (Social services will pick up the cost after three years.) The helpline started in May 1999 and operates 7-11pm, 365 days a year, averaging 4-6 calls a night. One of the four CMHTs wants to run an extended hours service, but so far nothing has happened about this. Hopefully more will happen soon, as our local health improvement programme group has put 24-hour access to services and extended hours working top of its list of priorities, in line with the National Service Framework.

So that’s where we stand at the moment. I think the research was worth it as we put the topic back on the agenda and certainly achieved some practical results, but there’s still a great deal more to do before local users get the out-of-hours services they want.

Reprinted from Sedley, Bev (2000) Someone to get me through the night: User-led research into the need for out-of-hours crisis support Crisis Point Vol. 1, No 11. A fuller account of this project can be found in Ramon, Shulamit (ed.) (2000) A Stakeholders Approach to Innovation in Mental Health Services Brighton: Pavilion Publishing.
Handout 9 Making some basic decisions

So, you have an idea for a crisis project. Now is the time to make some basic decisions about it. These might include:

1. What is the purpose of your crisis project?
2. Who is it for?
3. Why is it needed?
4. What is your vision of the project?
5. How do you want service users/survivors to be involved in managing the project?
6. What organisation is going to be responsible for it?
7. Are you going to employ staff?
8. Are you going to use volunteers?
9. What are your ideal opening hours? What opening hours would you like to start with and what are the minimum opening hours you would consider?
10. What sort of accommodation/building is needed?
11. What will it be called?
12. Anything else?

Some of the answers may be obvious, others will require more thought and some may be controversial among the people making the decisions.
Handout 9b  Making some basic decisions – comments
These comments, on each of the questions in Handout 9, may help with your discussions:

1. What is the purpose of your crisis project?
   It may be obvious to you but you have got to convince others. Here are some possibilities:
   • to provide an alternative to hospital admission
   • to provide support when other services are closed
   • to provide support for people who are under stress but do not want to be diagnosed as ‘mentally ill’.

2. Who is it for?
   You may already have in mind a specific group, such as women, or people of African heritage. What about the area you cover? If you are providing a crisis house, you need to think about how far people will travel to use it; if it is a telephone line, the number of people it should be available to, to generate enough calls.

3. Why is it needed?
   If you have carried out local research, it will help you answer this question. Alternatively, you could refer to national research, such as Knowing Our Own Minds, available from the Mental Health Foundation.
4. What is your vision of the project?
This can be difficult to explain, but it is important your group agree on this. There will be so many pressures to fit your project within existing frameworks that you will need an agreed vision to hold on to.

The management committee and staff of the Dial House crisis service in Leeds brainstormed words and phrases that reflected their vision. From this, they were able to construct a leaflet about themselves with these words:

What we believe:
• People in crisis should have an alternative to hospital admission.
• People in crisis should be helped to identify their needs and find their own solutions.
• We believe in a non-medical approach that takes people's whole lives into account.
• Just because you are having a crisis does not mean there is something wrong with you.
• We recognise the need to respect the wide variety of beliefs, lifestyles and needs of the diverse community we are here to support.

What we do:
• We try to offer the support you would want from family or friends.
• We offer a place to come to that is safe and welcoming.
• We aim to be there for you and offer a listening ear.

5. How do you want service users/survivors to be involved in managing the project?
Some of the ways of doing this are discussed in Chapter 1 of this workbook. Your answers to this question will also link in with question 6.
6. What organisation is going to be responsible for it?
Outlined here are some of the typical choices that you may have, with some of the advantages and disadvantages of each.

**Service user/survivor-led organisation with no other funded projects**
Advantages
- Will ensure that the project is service user/survivor-led.
- Will not be bound by existing ways of doing things that are not appropriate to your service.
Disadvantages
- Will have to work out everything from scratch.
- May make heavy demands on the time of a few people.

**Well-established mental health voluntary organisation**
Advantages
- Will already have paid staff who can develop the project.
- Will be able to use existing policies and procedures, for example for employing staff.
Disadvantages
- Service users/survivors may be sidelined in the management of the project.
- Its policies may not be appropriate for the service you want to provide.

**Well-established voluntary organisation offering services to a particular group**
This could be an option if you are intending to offer your service to a particular group of people, such as an ethnic minority, gay, lesbian and bisexual people.
Advantages
- The organisation will be known and trusted by potential users of your service.
- It will not be identified with other mental health services that may not share your aims and values.
Disadvantages
- People already involved in the organisation may not have positive attitudes towards people with mental health problems.
- There may not be the skills within the organisation to manage a mental health project.
7. Are you going to employ staff?

It is going to be a challenge to achieve much without employing staff but organisations have understandable doubts about taking on paid staff. The GLOSS Group Crisis Line was set up and run without employing staff, although there was input from staff employed by social services. However when the learning set looked at what GLOSS Group members wanted it to be doing in five years time, it seemed that it would be difficult to achieve with volunteers alone. So the learning set looked at the advantages, disadvantages, challenges and safeguards in employing staff.

Advantages
• Staff can work to attain accommodation.
• Staff can represent the group to other organisations.
• Staff can be available to answer the phone.
• Staff can do administrative tasks and handle day-to-day financial matters.
• Staff can fundraise.
• Staff can co-ordinate activities.
• Staff can set up new projects.

Disadvantages
• Difficulty for service user members of the management committee in letting go and handing over the project to other people.
• Service user members may lose control. There is a risk of ending up with a staff team that has become the organisation.
• The workers may have more status than the service user members.
• It may stop being user-led.
• Potential conflicts between service user members/volunteers and staff.
• The need to continually fundraise to keep staff.
• The role of the management committee changes completely.
• There is a risk of instability if funding is lost.

Challenges
• Keeping it user-led.
• Staying in charge of the staff.
Safeguards
• Management committee doing its job well.
• Employing people with the right attitude towards service users.
• Having a co-ordinator rather than a manager.
• Having a probationary period for new staff.

8. Are you going to use volunteers?
If you have not already made a decision, you could brainstorm the advantages and disadvantages, and then think of the challenges and safeguards of involving volunteers. See page 46 for good practice in using volunteers.

9. What are your ideal opening hours? What opening hours would you like to start with and what are the minimum opening hours you would consider?
Your ideal opening hours may not be those you want to start with. It could make sense to start relatively small and build up the service over time. Also, you may not get all the money you need to start how you wish, so you may need to think about what would be an acceptable level of service to begin with.

10. What sort of accommodation/building is needed?
You also need to think about a location for your crisis service. In deciding on a location consider points such as the following:
• How good are public transport links?
• What car parking space is available nearby?
• Will people feel safe entering and leaving the building after dark?
• You will also need to think about physical access to and within the building.

11. What will it be called?
You are probably calling it something already. Where did that name come from and does everyone like it? When the learning set looked at naming the Leeds project, the name was ‘Leeds User-based Crisis Service’. We realised it had originally been ‘Leeds User Led Crisis Service; someone in social services had changed it to ‘user-based’, which was meaningless. It was decided to change it back. Later, the name was changed again to the Leeds Survivor Led Crisis Service.

It is worth brainstorming names, picking out the more popular and debating their merits.
Here are some rough figures to illustrate the costs incurred by a crisis project.

**Capital expenditure**
Cost of buying and refurbishing the house: £200,000.
It is more common to rent or lease premises. In this instance, the money came from the a health authority and social services joint budget, and there is an agreement that if the project folds, the health authority will take possession of the building.

**Revenue expenditure**
£70,000 per year for the service to open three evenings a week (6-10.30pm). This includes the cost of employing a full-time co-ordinator and four part-time crisis support workers.

Another £55,000 per year is paying for a telephone helpline (the Connect Helpline) to open seven evenings a week (6-10pm). Volunteers take the calls so the expenses of this aspect of the project are the full-time co-ordinator, a part-time administrator, and volunteers’ expenses.

Another grant, of £144,000 a year, makes it possible for the crisis service to open from 6pm on Friday until 10am on Monday, enabling visitors to stay overnight. Staff salaries have been put up because the project was not able to attract staff on the previous salary levels. There are new posts of full-time deputy co-ordinator, part-time senior crisis support worker and three more part-time crisis support workers. This grant is also paying for a part-time assistant to the management committee and a finance worker eight hours a week. These staffing arrangements allow for a minimum of two staff on duty at any time, including sleepovers.

Finally, a grant of £145,000 over two-and-a-half years is paying for a Millennium Volunteers Scheme. This project provides volunteers for Dial House, the Connect helpline, and various other mental health projects. It pays for a full-time co-ordinator, and running costs, including volunteers’ expenses.
Handout 11  Possible reason for excluding someone from using your service

A person may be excluded from using your crisis service for the following reasons, if he or she:

- has the wrong diagnosis
- has a background of violence
- is threatening suicide
- is damaging property
- refuses to take medication
- refuses to stop taking medication
- is the wrong age
- is homeless
- is living in the wrong area
- is smelly
- is known to abuse drugs or alcohol
- is being racist or sexist
- is not mentally ill
- is not making good use of service offered
- has learning difficulties
- does not speak English
- needs to be in hospital
- is deaf
- is a carer, not a service user/survivor
- is not in crisis
- is a member of the management committee
- takes up too much time
- is transsexual and the service is for women
- is currently drunk or high on drugs.

Are there any other issues to warrant a person’s exclusion from your service?
Handout 12 The Safe Haven exclusion policy

Someone may be excluded from the Safe Haven in the following circumstances, if they:

- threaten to commit an act of violence or serious harassment on others
- are thought to be under the influence of alcohol or illicit drugs, and are causing distress to others
- are attempting to consume alcohol or use illicit drugs on the premises and, after having been asked to stop, refuse to do so
- behave in a way that is consistently causing distress to others.

The decision to exclude an individual will be made by the person ‘in charge’, in the presence (whenever possible) of another worker. The reason for exclusion will be clearly explained to the individual in question, with reference to their right of appeal or to complain. Whenever possible the user will be offered a complaints leaflet.

Every reasonable effort will be made to signpost the individual to an alternative source of support. If the individual refuses to leave the premises, assistance from the police will be called.

Initial exclusion will be time limited, usually for that night. The individual may be offered a follow-up daytime appointment to discuss the reason for exclusion and further access. An individual has the right to use the service again once the reason for exclusion is no longer present (for example, if the individual is no longer under the influence of alcohol or behaving in a violent manner).

The manager in consultation with the Safe Haven Committee may make exclusion for an extended time period. Exclusion will be reviewed at Safe Haven committee meetings.
An abusive call is any call that would cause unnecessary offence to any of our volunteers (not just the volunteer receiving the call).

You may choose to advise a caller that their behaviour is not acceptable and offer them a chance to, for example, stop swearing or shouting or stop using racist, sexist or homophobic terms. It may help both you and the caller to point out that this service is offered by a whole range of people and that the level of acceptable behaviour is not your personal decision.

If the call involves personal abuse, sexually explicit or suggestive content, or threats of any kind please remember: abusive phone calls will not be accepted by the Mental Health Helpline.

To reduce their frequency and the distress caused to volunteers, in the case of an abusive call you should state the following:

- The Mental Health Helpline does not take calls of this nature.
- I am ending the call.

If you have reached this point you should not enter into a discussion with the caller, simply hang up the phone.
Handout 14 Checklist for project development and community liaison

- Identify the nature and purpose of project.
- Consult with users of the project (if identifiable) about the location.
- Identify a location for the project.
- Investigate your local authority guidelines on care in the community development and consultation.
- Establish whether planning permission is needed.
- If it is, establish a relationship with planning officers and determine who is taking responsibility for informing local residents.
- Decide how much information will be given at this stage, in what form and by whom.
- Prepare briefing notes for key people.
- Investigate whether there has been a history of special needs development in the area and any opposition.
- Identify local community groups, tenants associations, community organisations, etc.
- Identify community leaders (councillors, MPs, leaders of religious and cultural organisations, school governors).
- Liaise with statutory and voluntary organisations in the area.
- Liaise with local police community liaison officer.
- Prepare a press release and liaise with local press and media. Draft model responses for likely questions.
- Investigate the possibility of establishing a neighbourhood steering group.
- Decide whether a public meeting will be fruitful or to be avoided.
- Clarify who is the lead person or team for neighbourhood liaison. Establish one main contact point.
- Maintain detailed records of all interactions.
- Agree the extent and nature of personal contact with neighbours prior to work commencing on site.
- Agree with on-site contractors the nature of the information being given to casual inquirers.
- Clarify a neighbourhood liaison policy with the project team, once appointed.
- Decide whether to hold an open day at the project.

Taken from Good Neighbours: Meeting Opposition in the Back Yard published by Mental Health Media.
Handout 15  Possible reasons for breaking confidentiality on a telephone helpline

• The caller tells you they have taken an overdose  □
• The caller is threatening to harm someone else □
• You think the caller needs to be sectioned □
• The caller thinks they are going to self-harm □
• The caller confesses to a serious crime □
• The caller give you details of a bomb they say is going to go off □
• Are there any other reasons for breaking confidentiality? □
Handout 16  Sample volunteering policy

Introduction
AnyOrg exists to ... (insert your organisation’s mission statement here)
In line with this mission, AnyOrg seeks to involve volunteers to:
• ensure that our services meet the needs of our clients
• provide new skills and perspectives
• increase our contact with the local community we serve.

Principles
This volunteering policy is underpinned by the following principles:
• AnyOrg will ensure that volunteers are properly integrated into the organisation
• AnyOrg does not aim to introduce volunteers to replace paid staff
• AnyOrg expects that staff at all levels will work positively with volunteers.

Practical guidelines
The following guidelines deal with practical aspects of the involvement of volunteers. More detailed information, including copies of the various documents referred to, is provided in the Volunteer’s Handbook. See Handout 17 – Volunteering Terms and Conditions.

Recruitment
All prospective volunteers will be interviewed to find out what they would like to do, their skills, suitability and how best their potential might be realised.

Volunteer agreements and voluntary work outlines
Each volunteer will be asked to sign a Volunteer Agreement establishing what AnyOrg undertakes to provide them. In addition they will agree a written outline of the specific work they will be undertaking.

Expenses
All volunteers will have their travel and other expenses reimbursed. This could mean that volunteers working a minimum of five hours per day will be able to claim expenses for lunch (for details see the Volunteer’s Handbook).
**Induction and training**
All volunteers will receive an induction into AnyOrg and their own area of work. Training will be provided as appropriate.

**Support**
All volunteers will have a named person as their main contact. They will be provided with regular supervision to feed back on progress, discuss future development and air any problems.

**The volunteer’s voice**
Volunteers are encouraged to express their views about matters concerning the organisation.

**Insurance**
All volunteers are covered by AnyOrg’s insurance policy while they are on the premises or engaged in any work on AnyOrg’s behalf.

**Health and safety**
Volunteers are covered by AnyOrg’s Health and Safety Policy, a copy of which is in the Volunteer’s Handbook.

**Equal opportunities**
AnyOrg operates an equal opportunities policy applicable to both paid staff and volunteers. A copy of this policy is in the Volunteer’s Handbook.

**Problem solving**
AnyOrg aims to identify and solve problems at the earliest possible stage. A procedure has been drawn up for dealing with complaints either by or about volunteers. A copy of the procedure is included in the Volunteer’s Handbook.

**Confidentiality**
Volunteers will be bound by the same requirements for confidentiality as paid staff.

Taken from *Good Practice Guide* published by the National Centre for Volunteering.
Handout 17  Volunteer terms and conditions

Volunteers at XXX are valued members of the staff team and provide an essential input to our work. XXX hopes that, in return, its volunteers will enjoy the experience of working in an office environment and that those seeking paid work will increase their employment opportunities through the acquisition of new skills and relevant experience.

The following terms and conditions are designed to clarify XXX’s responsibilities to the volunteer and, also, the volunteer’s rights and responsibilities whilst at XXX. It also outlines how problems will be addressed, if and when they arise on either side.

1  Induction
All new volunteers will be given a volunteer handbook on their first day at XXX. They will also be asked to complete a volunteer record form and hand it in to administration.

The member of staff supervising the volunteer will be responsible for familiarising the volunteer with the workspace and its procedures, including health and safety, in the volunteer’s first week. They will also introduce the volunteer to the finance team, from whom they can claim their expenses.

The supervising member of staff will also be responsible for introducing the volunteer to other members of staff.

2  Confidentiality
All volunteers should be aware that any matters of a confidential nature, particularly matters relating to XXX’s activities, individual staff and financial information, must not, under any circumstances, be divulged or passed on to any unauthorised person or persons. This duty remains, not only throughout the period during which the volunteer is working for XXX, but also after the volunteer has ceased to work for XXX.
3 Expenses
Volunteers will be reimbursed for reasonable travel expenses and for lunch up to £ per day – receipts must accompany the expense claim whenever possible.

To be eligible for the lunch expense volunteers are required to work a minimum of five hours per day.

Expenses for childcare may be claimed but must be discussed in advance.

Expenses are to be claimed from XXX’s finance department on a weekly basis using a XXX ‘Expenses claim form’.

4 Job description
All volunteers will be issued with a job description, to clarify their role, after they have been at XXX for a few weeks and have a clearer idea as to what they can most suitably do. The job description will be drafted by the supervisor, after negotiation with the volunteer.

Volunteers will not be expected to undertake any task outside this job description without their prior agreement.

5 Support and supervision
The member of staff supervising the volunteer will be expected to arrange regular meetings to provide their volunteer with support and supervision. These review meetings will provide the opportunity for both supervisor and volunteer to feed-back on progress and any problems.

6 Training
XXX is committed to making training available to volunteers where possible.

Volunteers are ordinarily welcome to attend any in-house training arranged at XXX or working lunches where outside practitioners are invited to talk about their work.
7  Reliability
Volunteers will be encouraged to state on which days and over what period of hours they will be working and will be expected to keep to these wherever possible.

If a volunteer has agreed to come into XXX’s office and then find they are unable to do so, they are expected to notify their supervisor as soon as possible.

8  Attendance at staff meetings
Volunteers can attend staff meetings at the supervisor’s discretion, in an observer capacity, and contribute to the meeting where appropriate. It needs to be borne in mind, however, that there may be some rare occasions on which only contractually bound members of staff will be able to attend.

9  Equal opportunities

9.1  Policy
As an employer the Mental Health Foundation is obliged to make sure that its policies (and in particular its employment policies) ensure equality of opportunity and guarantee no discrimination on the basis of sex, race, colour, nationality or ethnic origins, i.e. to comply with the Race Relations Act 1976, the Sex Discrimination Act 1975 and the Disability Discrimination Act 1995.

XXX has an equal opportunities policy which is available as a separate document.

9.2  Sexual harassment
All volunteers have the right to be treated with dignity in the workplace and elsewhere. Sexual harassment by and/or of volunteers at work will not be permitted or condoned. Anyone, who believes they have been subjected to such treatment, has the right to complain and, in such a case, the matter will be investigated by management and may result in disciplinary action being taken.

10  Health and safety
All volunteers are expected to adhere to the XXX’s health and safety procedures, which are detailed in the volunteer handbook.
11 Job applications
Where a volunteer is seeking paid employment, their supervisor can be approached to supply a reference and, if requested, will endeavour to assist and advise the volunteer in applying for posts.

12 Review of volunteering arrangements
If a volunteer feels that they are not getting enough experience from working at XXX, they should discuss it at their review meeting with the supervisor. Every effort will be made to improve the situation by providing support and/or training, however, if the volunteer still feels dissatisfied, they may choose to end their contract with XXX.

If a volunteer is unable to meet the standard of work as required by the supervisor, then the supervisor will have the right to terminate the volunteer’s contract.

13 Departure of volunteers
The volunteer will be expected to inform their supervisor if they intend to leave XXX. An exit interview will be offered by the supervisor.

Please sign and date this agreement in the space provided below to show that you have read, understood and accept the terms and conditions set out above. Before signing, please feel free to discuss with your supervisor anything in this agreement about which you are unclear.

Volunteer’s signature  Supervisor’s signature (on behalf of XXX)

Print name  Print name

Date  Date
### Appendix 1:
The services of the Crisis Programme as at February 2002

<table>
<thead>
<tr>
<th>Name of service</th>
<th>Anam Cara</th>
<th>The Nile Centre</th>
<th>Leeds Survivor Led Crisis Service</th>
<th>Corby Safe House</th>
<th>GLOSS Group crisis line</th>
<th>WAND Telephone support line</th>
<th>Asian Mental Health Helpline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time established</td>
<td>Four years</td>
<td>Four years</td>
<td>Two years</td>
<td>One year</td>
<td>Disbanded after 17 months</td>
<td>Two years</td>
<td>Three years</td>
</tr>
<tr>
<td>Type of service</td>
<td>Four bed crisis house, drop-in day support (for 50 people/week), runs crisis sponsor homes</td>
<td>Nine beds (one dedicated for respite) and home-based support for African Caribbean adults in the London Borough of Hackney</td>
<td>Friday, Saturday and Sunday 6–10.30pm safe-house and a telephone helpline opened in 2001</td>
<td>Non-residential crisis house, 6pm–2am, Tues–Sun inclusive</td>
<td>Out-of-hours telephone support (3pm–midnight, Sat and Sun) for local service users in Glossop, Derbyshire</td>
<td>8pm–midnight telephone support for people across Devon</td>
<td>Mon–Thur pm telephone support in English or Asian for people of Kent, Sussex, Brighton and London Borough of Bexley</td>
</tr>
<tr>
<td>Referral routes</td>
<td>HTTs or self-referral for second or subsequent admission</td>
<td>Hospital wards, CMHTs, GPs etc and self-referral</td>
<td>Any – emphasis on self-referral</td>
<td>Any</td>
<td>Any</td>
<td>Any</td>
<td>Any</td>
</tr>
<tr>
<td>Staffing</td>
<td>Crisis support workers called ‘recovery guides’ who have all had experience of their own crisis or used services</td>
<td>All staff are African Caribbean, who can work with people in crisis. They include mental health nurses, social workers and psychologists</td>
<td>Criteria for employment are that staff have experience of working with people in crisis, personal experience of crisis and/or of using mental health services. Some have counselling, social work or nursing qualifications</td>
<td>All ‘support workers’ have had personal experience of or cared for someone in crisis, and some have used services. Awareness of discrimination is seen as paramount, and formal professional mental health qualifications are not seen as desirable, as the service aims to be truly alternative to the medical model</td>
<td>Entirely staffed by service user volunteers</td>
<td>Two part-time co-ordinators and a team of volunteer operators, many of whom are service users</td>
<td>Asian co-ordinator and trained helpline volunteers, now including ex-service users</td>
</tr>
<tr>
<td>Name of service</td>
<td>Anam Cara</td>
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<tr>
<td>Service aims/approach/activities offered</td>
<td>Recovery-oriented, residential care. Wide range of complementary therapies offered, and gardening, music, art etc. groups. Emphasis on the value of contact with other people, with nature and the development of personal spiritual belief systems.</td>
<td>African Caribbean centred alternative crisis care with focus on learning relapse patterns and developing coping strategies. Counselling, family therapy, complementary therapy, stress management and outreach offered.</td>
<td>Out-of-hours, safe and welcoming alternative to hospital admission, run by and for service users.</td>
<td>Out-of-hours support for those in crisis.</td>
<td>Out-of-hours telephone support</td>
<td>Out-of-hours telephone support for people across Devon who have a mental health issue – from service users who may have severe and enduring mental health problems, to carers, friends and professionals. Not counselling or advice but volunteers recruited and trained to provide support, empathy, respect, warmth, autonomy to the caller and practical information, through active listening.</td>
<td>Out-of-hours telephone support in Asian languages, providing empathy, understanding and active encouragement to express feelings in order to ease distress for people with severe and enduring mental health problems and gain their approval for referral if this is felt necessary.</td>
</tr>
<tr>
<td>Name of service</td>
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<tr>
<td><strong>User involvement</strong></td>
<td>User-run project, 50% of trustees have 'lived experience' of recover from mental distress</td>
<td>A Better Way Ahead (a user-led personal development training programme designed for African Caribbean people, which promotes empowerment and self-esteem) offers personal development for centre users, provided by users</td>
<td>User-led management committee and some staff have personal experience of crisis and/or have used mental health services</td>
<td>Entirely user-run and staffed</td>
<td>Completely user-run and staffed, with high interaction with and practical support from social services</td>
<td>User-led organisation. The majority of the management committee are users, and many helpline operators are past or present users</td>
<td>Now actively recruiting ex-users of the service itself and other mental health services as helpline volunteers</td>
</tr>
<tr>
<td><strong>Funding (apart from MHF grants)</strong></td>
<td>Northern Birmingham Mental Health NHS Trust</td>
<td>East London and the City Mental Health NHS Trust, The Tudor Trust</td>
<td>Social services, health authority, mental health modernisation fund (for a helpline) and Department for Education and Employment</td>
<td>Joint social services and health authority</td>
<td>None</td>
<td>J Paul Getty Charitable Trust, local healthcare trust, social services and health authority</td>
<td>Bexley Council</td>
</tr>
<tr>
<td>Name of service</td>
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<td>The Nile Centre</td>
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<tr>
<td>Service management</td>
<td>CHANGE (a charity providing alternative care for people with mental health problems). CHANGE manager is house manager</td>
<td>Kush Housing Association. Overall responsibility is held by a management committee which includes user representatives and people from health, housing, community development and social care backgrounds</td>
<td>User-led management committee in partnership with social services (expected to become fully independent in 2002)</td>
<td>Safe house committee entirely made up of users/survivors. Others (without voting rights) periodically join committee, including those from social services, CMHTs etc.</td>
<td>GLOSS user group</td>
<td>User-led committee, with majority user representation</td>
<td>Fellowship and diverse advisory committee comprised of social service, lay people etc. from diverse cultural groups</td>
</tr>
</tbody>
</table>
Appendix 2:
Contact details Crisis Programme Services

Anam Cara
8 Oval Road
Gravelly Hill
Birmingham B24 8Pl
Tel: 0121 384 1344
Website: www.mentalhealthrecovery.org.uk

Asian Mental Healthline
Rethink Sahayak
4-5 High Street
Gravesend
Kent DA11 OBQ
Tel: 01474 364 837
Email: sahayak@rethink.org

Dial House
12 Chapel Street
Halton
Leeds LS15 7RW
Tel: 0113 260 9328
Email: userledcrisis@virgin.net

The Nile Centre
105-109 Foulden Road
Stoke Newington
London N16 7UH.
Tel: 020 7241 3003

The Safe Haven
82 Dorking Walk
Corby
Northants NN18 9NH
Tel: 01536 461 414
Email:
safehouse@dorkingwalk.freeserve.co.uk

WAND Telephone Support Line
WAND
The Castle Centre
25 Castle Street
Barnstaple
North Devon EX31 1DR
Tel: 01271 372 830
Email: enquires@wand.org.uk
Website: www.wand.org.uk
Appendix 3: Running a successful meeting

Facilitation
For your meetings to be productive and achieve their aims and you will need a facilitator – someone to be in charge of each meeting. The facilitator will need to be able to do the following.

• Keep discussion relevant to the topic.
• Understand and explain group exercises, and make sure they are completed in the time allocated to them.
• Aim for balance of contributions to group activity, with no one too dominant and no one getting left out.
• Allow conflict to be expressed without it becoming destructive.
• Create a balance between structure and spontaneity.
• Assist people to feel connected with each other.
• Assist the group to have a good time.

There are some additional tasks for a facilitator if these meetings are also used to make decisions.

Meetings that are facilitated well are more enjoyable and productive than those that are not. It is worth putting some effort into finding the best person, rather than assuming it should be the chair or asking for a volunteer.

There are many advantages of using an independent facilitator. It can be easier to be a good facilitator if he or she is not a member of the group. It means he or she is not involved in its struggles, and is not trying to participate as well as facilitate. An independent facilitator pays attention to the process rather than the problem and may have more skill and experience than members of the group. You may have to pay for their time, but it is possible to fundraise for this or pay for it out of a training budget. If you do have to pay, to minimise this cost the independent facilitator could be used to complete the exercises in this workbook. For your regular, decision-making meetings, you could use the most skilled person within your group or choose someone to get training in facilitation skills.

Ground rules
Ground rules are another aid to successful meetings. They are agreements about how members of the group will work together. The purpose of ground rules is to make the meeting as safe and comfortable as possible for everyone to contribute to the group activity. There are especially useful for tackling imbalances in a group, such as some people being confident and dominating, and others being shy and quiet.
The basic process for agreeing and using ground rules is for the facilitator to:

• propose some ground rules, write them up on flipchart paper, and explain them
• ask for other proposals to add to the list
• seek agreement for each rule. If there is any disagreement, it can be resolved through discussion, amending the ground rule or dropping it
• ask everyone to keep to the ground rules and to say if they think others are not keeping to them.

If the group meets regularly, the ground rules can be reviewed from time to time. Sessions in which ground rules are agreed can be good occasions to acknowledge any difficulties members of the group have in working together, and to come up with constructive solutions.

As an example, the following ground rules were adopted for the GLOSS learning sets.

Do:
1. Your best to be here and let someone know if you can’t be
2. Remember that we all have something to contribute, and something to learn from every other person in the group
3. Feel free to express how you feel
4. Say if you are not happy with what is going on
5. Be aware of your contribution. Hold back if you are talking too much and push yourself forward if you aren’t joining in
6. Keep personal comments, feelings and references confidential to the group.

Don’t:
1. Interrupt people. Leave it to the facilitator to intervene if someone is taking up too much time
2. Worry about saying the wrong thing
3. Have a go at anyone else in the group
4. Feel you have to speak, if asked.
Appendix 4: The policy context in brief as at February 2002

England
In 1998 the government published Modernising Mental Health Services (Department of Health, 1998). This document set the agenda for mental health care for the coming decade or more, and set out a vision for ‘safe, sound and supportive’ services with a focus on tackling social exclusion, encouraging integration of services and improving community support.

The National Service Framework for Mental Health (NSF) followed in 1999 (Department of Health, 1999) setting detailed targets for mental health services. NSF Standard 4 states that all mental health service users on the Care Programme Approach (CPA) should receive care which optimises engagement, prevents or anticipates crisis and reduces risk. NSF Standard 5 states that ‘each service user who is assessed as requiring a period of care away from their home should have timely access to an appropriate hospital bed or alternative bed or place, which is in the least restrictive environment consistent with the need to protect them and the public, and as close to home as possible’.

The NHS Plan which followed announced new revenue for mental health services, with the most substantial investments in intensive community care. This plans to provide 50 new early intervention teams to help young people who may be developing severe mental health problems and 335 crisis resolution teams (CRTs) by 2003. These teams will ‘respond quickly to people in crisis, providing assessment and treatment wherever they are’ and ‘treat around 100,000 people a year who would otherwise have to be admitted to hospital, including Black and South Asian service users for whom this type of service has been shown to be particularly beneficial. Pressure on acute inpatient units will be reduced by 30% and there will generally be no out of area admissions which are not clinically indicated’. CRTs will thus provide accessible care, 24-hours-a-day seven-days-a-week to everyone in contact with specialist services, as stated in the NSF Standard 5 (Department of Health, 1999).

In addition to the focus of CRTs on reducing pressure on hospital beds, 220 assertive outreach teams will provide support for the most disabled people living in the community. In relation to the projects described and the proposals made in this report, it is clear that the above plans, especially the emergence of CRTs, will impact upon crisis services, which must in turn be prepared to evolve in rapidly changing environments.

Scotland
In Scotland the National Service Framework for Mental Health recognises the need to improve crisis support, including 24-hour cover as appropriate. The service guidance for ‘emergency response’ emphasises the need for early identification of a mental health crisis and an immediate, proactive response, which might include community and home-based support as well as, or instead of, in-patient care.
The Scottish Executive (2000) has also increased investment in mental health generally, including hospital and community services and has accelerated implementation of the mental health services framework. It also recognises that people want a more ‘flexible approach to needs’, which suggests that complementary and alternative approaches to crisis support may secure support.

Wales
The Welsh Strategy for Adult Mental Health (National Assembly for Wales, 2001a) has a strong focus on prevention and makes reference to emergency assessments, an all-Wales helpline and the need to consider 24-hour support.

A mental health services framework for Wales will be launched in 2002. This will cover provision for crisis support, and will include public education about what to do in a mental health crisis. These mental health service developments are also supported by the Welsh NHS Plan (National Assembly for Wales, 2001b)

Northern Ireland
The new Assembly for Northern Ireland has not yet published a current mental health policy or services framework. However, its Programme for Government (National Assembly for Northern Ireland, 2000) sets out its general commitment to health under the section ‘Working for Healthier People’. This demonstrates that its general policy commitment remains one of ‘care in the community’ for all people requiring ongoing support and care, including people with mental health problems. It emphasises that people experiencing such difficulties need to be supported to live independently, preferably in their own homes.

Mental Health Legislation
Mental health legislation across the UK has been going through a process of review and change since the late 1990s.

• In 2000, a review of the Mental Health Act (1983) which applied to England and Wales, was completed and a draft Bill issued for consultation in 2002. There was considerable opposition to many aspects of this draft Bill for England and Wales from mental health service users/survivors and many mental health voluntary organisations, including the Mental Health Foundation. The draft Bill has not yet progressed through the Westminster Parliament.

• In 2000, a review of the Mental Health (Scotland) Act (1984) was also completed. The Scottish Executive issued a draft bill for consultation in 2002 and the Bill was approved by the Scottish Parliament in March 2003. Whilst many users/survivors and mental health organisations in Scotland feel the new Mental Health (Treatment and Care) Act (Scotland 2003) represents an improvement on the 1984 legislation, there is considerable opposition to some elements of the Act, including Community Treatment Orders.

• A review of the 1986 Mental Health Order for Northern Ireland was scheduled to commence in 2002.
Policy references


National Assembly for Wales (2001a) *Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness and Efficiency: Strategy Document*.

National Assembly for Wales (2001b) *Improving Health in Wales: A Plan for the NHS with its Partners*.


Appendix 4

*The Crisis Project Workbook*
Appendix 5: Sources of support, advice and information

Organisations

**ACAS (Advisory, Conciliation and Arbitration Service)**
Head Office
Brandon House
180 Borough High Street
London SE1 1LW
Tel: 08457 47 47 47 (national helpline), 08456 06 16 00 (textphone users) or 08702 42 90 90 (ordering ACAS publications).
Website: www.acas.org.uk

**Croner**
CCH Croner House
145 London Road
Kingston
Surrey KT2 6SR
Tel: 020 8547 3333
Fax: 020 8547 2638
Email: info@croner.cch.co.uk
Website: www.croner.cch.co.uk

**Directory of Social Change**
24 Stephenson Way
London NW1 2DP
Tel: 020 7391 4800
Fax: 020 7391 4808
Email: info@dsc.org.uk
Website: www.dsc.org.uk

**London Voluntary Service Council**
356 Holloway Road
London N7 6PA
Tel: 020 7700 8107
Fax: 020 7700 8108
Minicom: 020 7700 8163
Email: lvsc@lvsc.org.uk
Website: www.lvsc.org.uk

**Mental Health Foundation (UK office)**
83 Victoria Street
London SW1H 0HW
Tel: 020 7802 0300
Fax: 020 7802 0301
Email: mhf@mhf.org.uk
Website: www.mentalhealth.org.uk

**Mental Health Foundation (Scotland Office)**
30 George Square
Glasgow G2 1EG
Tel: 0141 572 0125
Fax: 0141 572 0246
Email: scotland@mhf.org.uk
Website: www.mentalhealth.org.uk

**Mental Health Media**
356 Holloway Road
London N7 6PA
Tel: 020 7700 8171
Fax: 020 7686 0959
Email: info@mhmedia.com
Website: www.mhmedia.com
Appendix 5

The Crisis Project Workbook

Mind (England)
15-19 Broadway
London E15 4BQ
Tel: 020 8519 2122 or 020 8221 9666 (publications)
Fax: 020 8522 1725
Email: publications@mind.org.uk or contact@mind.org.uk
Website: www.mind.org.uk

Mind Cymru
3rd Floor Quebec House
Castlebridge
5-19 Cowbridge Road East
Cardiff CF11 9AB
Tel: 029 2039 5123
Fax: 029 2040 2041

National Association of Councils for Voluntary Service (England)
177 Arundel Street
Sheffield S1 2NU
Tel: 0114 278 6636
Fax: 0114 278 7004
Email: nacvs@nacvs.org.uk
Website: www.nacvs.org.uk

National Centre for Volunteering (England)
Regents Wharf
8 All Saints Street
London N1 9RL
Tel: 020 7520 8900
Fax: 020 7520 8910
Email: volunteering@thecentre.org.uk
Website: www.volunteering.org.uk

National Council for Voluntary Organisations (England)
Regent’s Wharf
8 All Saints Road
London N1 9RL
Tel: 020 7713 6161
Fax: 020 7713 6300
Helpdesk: 0800 279 8798
Minicom: 0800 0188111
Email: ncvo@ncvo-vol.org.uk
Website: www.ncvo-vol.org.uk

National Housing Federation (England)
175 Gray’s Inn Road
London WC1X 8UP
Tel: 020 7278 6571
Fax: 020 7833 8323
Email: publications@housing.org.uk or info@housing.org.uk
Website: www.housing.org.uk

Northern Ireland Association for Mental Health
Beacon House
80 University Street
Belfast BT7 1HE
Tel: 028 9032 8474
Fax: 028 9023 4940
Email: niamh@dnet.co.uk

Northern Ireland Council for Voluntary Action (NICVA)
61 Duncairn Gardens
Belfast BT15 2GB
Tel: 028 9087 7777
Fax: 028 9087 7799
Email: nicva.org
Website: grant-tracker.org
Pavilion Publishing
The Ironworks
Cheapside
Brighton
East Sussex BN1 4GD
Tel: 01273 623 222
Fax: 01273 625 526
Email: info@pavpub.com
Website: www.pavpub.com

Scottish Council for Voluntary Organisations (SCVO)
The Mansfield
Traquair Centre
15 Mansfield Place
Edinburgh EH3 6BB
Tel: 0131 556 3882
Fax: 0131 556 0279
Textphone: 0131 557 6483
Email: enquiries@scvo.org.uk
Website: www.scvo.org.uk

Telephone Helplines Association
London Office
3rd - 4th Floor 9 Marshalsea Road
London SE1 1EP
Tel: 020 7089 6321
Fax: 020 7089 6320

Glasgow Office
Suite 418 Pentagon Centre
Washington Street
Glasgow G3 8AZ
Tel: 0141 221 1514
Fax: 0141 204 3845

Belfast Office
61 Duncairn Gardens Belfast BT15 2GB
Tel: 028 90 357850
Fax: 028 90 357851
Email: info@helplines.org.uk
Website: www.helplines.org.uk

The Scottish Association for Mental Health
Cumbrae House
15 Carlton Court
Glasgow G5 9JP
Tel: 0141 568 7000
Fax: 0141 568 7001
Email: enquire@samh.org.uk
Website: www.samh.org.uk

United Kingdom Advocacy Network (UKAN)
Volserve House
14-18 West Bar Green
Sheffield S1 2DA
Tel: 0114 272 8171
Email: ukan@can-online.org.uk

Welsh Council for Voluntary Action (WCVA)
Baltic House
Mount Stuart Square
Cardiff Bay
Cardiff CF10 5FH
Tel: 029 20431700
Fax: 029 20431701
Minicom: 029 20431702
Email: enquiries@wcva.org.uk
Website: www.wcva.org.uk
Recommended publications and videos

Croner (quarterly updates) Management of Voluntary Organisations


Mental Health Foundation (2002) Being There is a Crisis London: Mental Health Foundation.


National Housing Federation (1994) Not in my Back Yard (NIMBY): a guide for housing associations and local authorities on special needs housing and the planning system National Housing Federation.


Wallcraft, Jan and Read, Jim (1995) *Guidelines on Equal Opportunities and Mental Health*
Mind/Unison.

*Good Neighbours: Meeting Opposition in the Back Yard* is a video, and training and resource pack. Using it will help you to clarify what approach you want to use in dealing with potential opposition to your project.

*Not in my Back Yard* is a guide for housing associations and local authorities on planning permission for special needs housing. It includes advice and information about dealing with opposition to planning permission from neighbours.

The National Council for Voluntary Organisations (NCVO) in England, publishes a *Directory of approved consultants*, which is regularly updated. Please check with other national voluntary sector councils in Northern Ireland, Scotland and Wales, to see if they provide similar information.

The Mental Health Foundation is the UK’s leading charity working to promote mental well-being and the rights and needs of people with mental health problems and people with learning disabilities. We aim to improve people’s lives, reduce stigma and discrimination and to encourage better understanding. We undertake and support research and encourage improvements to local services. We provide information to the public and people working in relevant fields. We aim to maximise knowledge, skill and resources by working with service users, government and service providers.

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