London Ambulance Service - Improving Mental Health Services: A report of the findings of 7 focus groups.

1 Executive Summary

1.1 63 people took part in focus groups between March and September 2015. The groups generated feedback from patients, service users and carers as well as London Ambulance Service staff.

1.2 Those taking part provided a range of constructive responses and ideas with the aim of helping London Ambulance Service improve the service it provides to people with a mental health need.

1.3 The following key themes emerged for further discussion and development:

- Initial contact and response
- Education and training
- Additional and community based services
- Crisis prevention
- Receiving the right kind of help
- Being referred to or transported to the right place
- Providing feedback

2 Background Information

2.1 Seven focus groups were held in total between March and September 2015. Six of the groups were held with people who have experienced mental health services and their carers and one of the groups was held with staff.

2.2 All focus groups were independently facilitated by Patient and Public Involvement Solutions and were attended by a member of London Ambulance Service staff. Groups were held in venues across London and a total of 63 people participated.

2.3 Focus Groups with people who have experienced mental health services were supported and arranged by a range of mental health organisations and voluntary and community sector partners. We would like to thank the following organisations for their help and support in carrying out the Focus Groups: Oxleas Mental Health Trust (ResearchNet), South London and Maudsley NHS Foundation Trust, Hear Us, South West London and St. George’s NHS Trust, Healthwatch Waltham Forest and Enfield Mental Health Users Group.

2.4 London Ambulance Service wants to improve the services they provide to people with mental health needs. Focus Groups were chosen as a way of talking in depth with people to learn more about opinions on a topic and to guide future action.
To achieve this, groups needed to include people who have experience of having a mental health condition and who have used London Ambulance Services in the past or who might need to use the services in the future. Participants were asked to think about the questions from the perspective of being a mental health patient, service user or carer. Staff were asked to think about times when they have provided a service to people who have mental health needs and their carers.

2.5 Five questions were asked, with the same question being asked at each group to ensure consistency. Six questions were asked at the staff group. Additional prompt questions were used by the facilitator as appropriate to ensure participants were able to say all that they wanted to. Notes were taken at each event. People were invited to read the notes on the day to ensure their views were accurately recorded and represented. Each participant was also sent the notes from their relevant sessions after the event and invited to review them for accuracy.

2.6 The main body of the report is written through the words and phrases used by the people who took part. This has been done to ensure the language used reflects as closely as possible the intention of participants.

2.7 We would like to thank all those who took part for their time and generosity in sharing their thoughts, ideas and views.
Summary of Findings from the Focus Groups with patients, service users and carers.

Question 1 - When you think of the London Ambulance Service, what does it mean to you?

3.1 The word cloud below provides an indication of words and phrases used. The more often they were used, the bigger the word appears below.

3.2 Generally more responses to this question were positive than negative. Some comments related to a general perception of the service such as: ‘an immediate response’, ‘life-saving’, ‘first port of call’, ‘protectors in society’, ‘safety net’, ‘being taken to a place of safety’, ‘professional calmness’, ‘skilled’, ‘non-judgmental’, ‘responding to a crisis’, ‘a human touch’, ‘calling an ambulance is the last resort’, ‘hope they will look after me, give me the best care’, ‘contact ambulance because I can’t cope anymore, I’m giving over control, it’s a final straw’.

3.3 With a number of comments relating more directly to a person’s experience of using the London Ambulance Service, comments were both positive and negative in nature. Negative comments include: ‘not much choice, felt I lost control in the ambulance’, ‘did things to me, like giving me too much medication’, ‘I don’t want anyone to force anything on me’, ‘very scary for me’, ‘not telling you what’s going on is very scary’, ‘when the call taker says call back if the condition worsens – it is
difficult to assess yourself in a time of crisis’, ‘staff seemed scared of me’, ‘I was transported in a secure vehicle, a caged vehicle’, ‘made to feel time wasting by ambulance crew’, ‘999 call taker hung up on me’, ‘feel not worthy, apologizing, feel guilty’.

3.4 More positive comments generally related to the skill and attitude of staff, such as ‘never had a bad experience with ambulance staff, compassionate, calm and practical’, ‘treated with great care and consideration’, ‘reassurance, empathetic, providing safety for patients, good experience of London Ambulance Service’, ‘staff were, kind, warm and comforting’, ‘the ambulance service does try to look at you holistically, your mental health as well as anything physical’.

3.5 People also made reference to their use of the ambulance service in connection with other services such as the police, their GP, A&E and mental health services. ‘During a mental health crisis I do not associate my condition with 999. I didn’t think to call the ambulance’, ‘ambulance and police comes together for mental health’, ‘mental health services are only 9 – 5’, ‘I have needed to call 999 a number of times because nothing else was available’, ‘it is often out of hours when people need their care co-ordinator and those services are not there then’, ‘it is 24/7 not like other services’, ‘I wanted to see my GP’, ‘all the local mental health in-patient units are now closed’, ‘if you are in a crisis where do you start?’, ‘imagine if the ambulance service wasn’t there, who would help us?’, ‘the Enfield Club House meetings have helped me’, the ambulance service is part of a ‘chain, a network’.

4 Question 2 – When you contact London Ambulance Service in an emergency, what do you want to happen next?

4.1 Some people responded with specific advice and ideas about what they would like to happen when they contact the ambulance service, such as: a calm response, given a time of when they will arrive, reassurance, to be listened to, ‘someone to keep talking to me on the phone’ and ‘step-by-step instruction on what to do’. Speaking to a relative or carer was identified by some as important, ‘I can’t always articulate what I want and need others to help’. Education and training for call handlers was suggested to ensure ‘quicker recognition from the call handler that there is a mental health issue’ and to ensure the right approach is used with people who have mental health issues, ‘you want ambulance people to be caring and trusting, especially if paranoid or hearing voices, a friend, someone to look after them’.

4.2 When contacting the ambulance service with a mental health need, some people spoke of specific issues. ‘I expect the call taker to be tolerant of my situation and understand I may be confused and rude’, ‘it is difficult to make the ambulance staff aware of the situation when in a crisis, it is difficult to explain how I feel’. A number of people spoke of a fear of being judged and treated differently for having mental illness, ‘after initial triage of a non-life threatening situation, I feel like I am being side-lined’.
4.3 A number of responses related specifically to concerns about the difference between physical illness and mental illness. Some people were concerned that a physical illness may be missed because of their mental health record: ‘I want to be taken seriously’. Others felt that mental illness was treated as less serious than physical illness: ‘it is similar to being in extreme pain and difficult to express yourself’. People also spoke of the stress of physical emergencies bringing on their mental health issues: ‘a double whammy when it is a physical and mental health problem’.

4.4 Some people talked about how it can be difficult to know themselves whether the issue is physical or mental: ‘when I felt physically unwell, I panicked and then I realised it was my mind that was packing up, not my body’.

4.5 A concern raised in a number of the groups was a fear of being taken to a mental health in-patient unit when there were other options available. The following comments were made: ‘to understand the person calling and what they want as an individual, e.g., go to hospital or stay at home’; ‘the last place I want to go is hospital’; ‘..would rather have safe house/crisis haven with a calm person to spend some time with me’; ‘once you go in you have no control’.

4.6 Some people commented that a crisis could be de-escalated with the right help and support: ‘They are too quick to take mental health people to hospital, when it is possible to treat in your own home’; ‘reassuring supportive and practical advice given on the phone made me feel safe’; ‘a friend has kept me away from hospital, she comes straight away, and knows me’. People spoke about the potential for a process that would enable people to communicate and/or receive the best help and support for them in a crisis. A more tailored approach that aimed to de-escalate rather than lead to a hospital admission. A number of ideas were provided: ‘Hospitals are not always a place of safety – develop an organisation, outreach, trouble shooters, the person can then get better in their own environment – more cost effective too’; ‘A specific care plan or person to call’; ‘a crisis card’; ‘can you have a patient specific protocol for mental health patients?’ to include specific requests, phone numbers, things to say and do that help the person in a crisis.

5 Question 3 – If there is a delay before an ambulance can get to you, what is important to you about the way this is managed?

5.1 Most groups spoke about clear information and communication about how long the wait is likely to be with a request to be given as much information as possible: ‘make people aware its not a delay because of them’. Some specific knowledge of mental health was seen as important, so that particular questions could be asked, and people treated in an appropriate way. Keeping on the line is seen as important if possible, with regular call-backs if staying on the line is not possible. If the person is alone people recommended suggesting a friend, neighbour or relative that could stay with them. Being aware of how time is perceived for
people in a crisis was mentioned: ‘10 minutes is a long wait for some, especially if going through a crisis’, ‘I was told a 30 minute wait, the ambulance arrived 2 hours later – keep your promises’. Honesty was a word repeated: ‘someone saying sorry that you had to wait’; ‘I called at 9pm and an ambulance came at 2am’; ‘they just didn’t come, it was really distressing’. The use of text and email alerts to update on progress was also suggested.

5.2 There was a perception amongst some of the groups that specific mental health patients are known and so receive a different level of response. ‘You might not want to commit suicide and when they ask questions about you its like a slap in the face’; ‘in my experience it depends on who answers the phone, as soon as I mention mental health I feel like I’m not a priority’. Some people went on to talk about escalating their own crisis in order to speed up or justify a higher priority: ‘the longer you wait the more of a burden you feel and I have upped the ante to get a quicker response’, ‘I might consider taking more of an overdose to get a quicker response’. However people also talked about not seeking help when they need it because they feel like a burden: ‘if the ambulance is taking too long the patient may walk away and not get any help’.

5.3 Some people spoke about being in a crisis and how this affects their ability to manage simple requests and process information: ‘if thinking rationally we wouldn’t be doing what we are doing, don’t always remember our own phone number’, ‘when you’re paranoid its not going to change what you’re thinking or feeling so it won’t always make a difference what they say on the phone if the ambulance isn’t turning up’.

5.4 People across the groups talked about a lack of support within the community: ‘mental health teams have gone from three to two, not dealing with the crisis’, ‘I feel that the ambulance service are being used to mop up the lack of services in the community’, ‘I would prefer not to call 999 but in desperation I do’. People saw a direct link between a lack of community-based services and their likelihood of having a crisis and needing to call an ambulance. Some people were keen to avoid this situation and felt that an admission to hospital was not a good outcome: ‘I had collapsed at home and got taken to hospital. I didn’t want to go to hospital and feel it made me worse’. A number of the groups discussed the potential for a community-based non-clinical support service that could attend the situation before an ambulance could arrive. Those that had heard of the Community Responders scheme, gave this as an example, others spoke of the mental health first aid course. Street Triage was discussed in detail at one of the Focus Groups as an area where this has been trialed: ‘street triage is a perfect course of action, better for the patient’. A number of people talked about the Samaritans and whether with permission they could be asked to contact the caller whilst they wait for the ambulance.
6  Question 4 - What would make you want to write a thank you letter?

6.1 A number of people across all groups expressed that it’s the humanitarian aspect that is so important, simple things like good communication, how people are spoken to, how they are touched, being reassured and feeling like a unique person with unique needs: ‘being treated with dignity and respect’, ‘being cherished, feeling cherished’, ‘for making me feel like a person’, ‘treat me as a human being not as a fruit and nut case’, ‘hope’.

6.2 An understanding of what it is like to have a mental health crisis and ensuring staff are specifically trained was seen as something that would be extra helpful: ‘if the call handler could ask if there is a crisis plan’, ‘to be trained to assess Capacity’, ‘to listen to me as a carer and learn what I know about mental health’, ‘if they were comfortable talking about mental health in a relaxed way’, ‘not being fobbed off’.

6.3 People generally had very positive things to say: ‘I don’t have a negative thing to say about the ambulance service (the way they dress, their manner, how they hold themselves)’, ‘I can’t praise ambulance staff enough’, ‘London Ambulance Service listen to carers as human beings’, ‘staff do not condescend’, ‘ambulance service never judge me’.

6.4 People across the groups also talked about how difficult it is in practice to say thank you to ambulance staff. ‘I would like to know, what happened after the event, who treated me, what medications were given to me’, ‘can you send me the name of the ambulance staff who treated me?’ ‘People don’t always know how to contact the ambulance service’, ‘I saw a thank you letter in yesterdays Metro’, ‘I wouldn’t know where to send it’.

7  Question 5 – What advice would you give London Ambulance Service staff about helping people with mental health needs?

7.1 People in each group valued being asked this question and were very willing to provide constructive advice.

7.2 The following word cloud is created by using the words and phrases people used in response to this question, the larger the words appear the more often they were used across all groups.
7.3 There were lots of messages about general attitude and communication:

‘Stay calm’
‘Be patient’
‘Listen and respect me’
‘Take me seriously’
‘Be non-judgemental’
‘Don’t use fancy words’
‘Put yourself in the persons shoes’
‘Don’t be frightened of me’
‘Be aware of my fear’
‘I want to say thumbs up to London Ambulance Service’

7.4 There were also a number that were specifically about mental health:

‘Stay with me, don’t leave me alone’
‘Sit and talk’
‘Don’t be discouraged’
‘Mental health is a legitimate issue’
‘Anyone can have mental health problems’
‘Have knowledge of mental health’
‘Don’t assume – I have balance problems and people assume I’ve been drinking’
‘We can forget things’
‘Mental health patients have a mixture of problems’
‘Remember it is just a broken mind, like a broken arm’
‘It is important to remember we have rights, even though people don’t always look after themselves and might not wash etc..’
‘Retain calmness, compassion, equilibrium and this will be mirrored back’
‘Talk to me not those around me’

7.5 Some very practical suggestions were made too:

‘More training, more understanding, more knowledge, listen to us and learn more’
‘Have a toolkit – a packet of cigarettes, a bottle of water, some mints – it might just do the job’
‘LAS should be involved with Clinical Commissioning Groups regarding mental health – they need to have a voice’ and ‘be part of the overall plan’
‘Give out information to the public about the Service’
‘Get on board with street triage have mental health nurses to respond to calls, tap into the information that is already there, incorporate Community First Responders.’
8 One focus group with staff took place. 6 questions were asked, the questions broadly mirrored those asked of patients, service users and carers. A summary of the findings is set out below.

**Question 1 – When you think of the term ‘mental health service user’, what does it mean to you?**

8.1 A range of different responses were provided to this question, some saw ‘mental health service users’ as specific and made reference to ‘people who regularly see a support worker, mental health worker or psychiatrist’. Whilst others saw it as ‘anyone in a crisis’, rather than someone with a history of mental health problems, including a carer or a parent.

8.2 A general theme was how London Ambulance Service is perceived by people who have a mental health need: ‘LAS is easy to access’, ‘999 gives them a guaranteed response and free of charge’.

8.3 A lack of other services was also mentioned by a number of people within the group: ‘crisis teams are difficult to access’, ‘not enough alternatives available’, ‘LAS struggles to refer to appropriate units’, ‘crews are compassionate but have a lack of appropriate pathways’. The idea of a mental health crisis centre was raised: ‘we have cardiac catheter labs and stroke centres why not mental health crisis units?’

8.4 A number of comments related to how people with mental health needs can be perceived by the ambulance service: ‘these patients take a long time to deal with’, ‘very time consuming when the patient does not wish to go to A&E’, ‘Grief, not appropriate to go to A&E, get stuck with the patient’.

**Question 2 – When someone contacts the London Ambulance Service in a mental health crisis – what do you think should happen next?**

**Question 2a – What information would be helpful for you to receive about the patient before arriving on the scene?**

9.1 A number of comments were about whether an ambulance was the right service for people who are having a mental health crisis: ‘patient should speak to a mental health professional’, ‘doesn’t need to be a paramedic to attend’. A number of people also spoke about the appropriateness of patients and service users being taken to hospital: ‘I feel they should be transferred directly to a mental health professional’, ‘9 out of 10 of my attempts at referring someone who is a known mental health service user with no conflicting factors i.e. no intoxication, have lasted in excess of 1 hour 30 minutes and have been pointless efforts’, ‘by the time the patient has been seen in the emergency department the crisis is normally over’.

9.2 Getting the right response for people in a mental health crisis was discussed at some length: ‘if purely a mental health crisis then we should be sending specialist
LAS staff to these patients’, ‘a mental health nurse to speak to people on the phone’. There was some discussion about having a specific mental health crisis number such as 888, however others felt this could pose a risk of missing a physical condition.

9.3 Managing the transfer of a patient to the right place was discussed at some length. Some people felt that patients and service users were sometimes reluctant to go to hospital: ‘it is difficult on the scene to persuade patients to go to hospital’. The use of patient specific protocols was raised and this was seen as useful. Street triage was also seen as part of the solution: ‘have an alternative vehicle with a mental health professional and a clinician’, ‘worried that if we don’t get patients to hospital and something happens we will be held responsible, therefore we take them to the Emergency Department and they don’t get the right treatment’.

9.4 Comments were also made about understanding the full picture before arriving on the scene: ‘who is the patient, if they are aggressive, history of assaulting staff or public, history of self harm, what has been done before to help them that has been successful, their history with mental health services’. Again the use of a patient specific protocol was seen as useful.

10 Question 3 – What are your thoughts about the mental health nurses working in the Clinical Hub (CHUB)?

10.1 Generally speaking staff spoke very positively about the role of the mental health nurses working in the CHUB: ‘a brilliant idea’. There were some questions and comments about how to recruit more nurses and about how to keep the support provided consistent across the whole service: ‘we are finding it hard to recruit’, ‘if they are consistent staff can trust them’, ‘is the news that mental health nurses are in the CHUB being disseminated to all staff?’ There were some cautious comments about ensuring successful pathways for mental health were available to support the mental health nurses and to ensure that the role was fully funded across the whole service.

11 Question 4 – On the mental health Clinical Performance Indicators (CPI) checks, the lowest areas of compliance documented are: consideration of safeguarding referral, capacity form if in doubt and description of appearance – why do you think that might be?

11.1 A number of comments related to a lack of clarity about definitions, specifically related to safeguarding and the complexity of the system of referring: ‘I think people (including myself) struggle with defining what is a safeguarding matter and what is a welfare matter’, ‘safeguarding referrals are too complicated’. People talked about more training, specifically for mental health: ‘crews not being shown how to document it’, ‘don’t understand what’s being asked of them’.
11.2 People also talked of crews not having the check list sheets and suggested that too much is being asked of them at the scene. There was a feeling that LAS is good at safeguarding, but not good at documenting on to the Patient Report Forms (PRF). A suggestion was made to make the reporting simpler: ‘why not have a question on the PRF of “safeguarded – Y or N” rather than a free text box’.

11.3 Learning from the Metropolitan Police with regards to their ABC 136 assessments was suggested, with a suggesting that more 136 suites and specialist training would help.

12 Question 5 – What do you think would be the gold standard of service the LAS could provide for mental health service users?

12.1 The group generally spoke from a point of frustration on behalf of mental health patients, service users and carers and described a number of ways they would like to see the service provided so that it would come closer to a ‘gold standard’.

12.2 Comments described the need for LAS to work with others to improve the pathways for people who have a mental health need: ‘appropriate places to take mental health patients keep closing and need to re-open’; ‘A&E is not the right place for mental health patients’. Two people made the following comments: ‘I believe that many people with a known on-going mental health diagnosis could be assessed and referred over the phone if there is definitely no medical emergency’, ‘have LAS staff who are willing to stay on the phone to mental health callers’.

12.3 People also spoke about a specific service for people in a mental health crisis: ‘mental health nurse could be on call to attend in a car with the paramedic’, using ‘unmarked vehicles’. The following description was provided: ‘patient calls 999, gets a mental health nurse and specialist vehicle and are taken to a suite, 4 days later they are followed up on, the crews are updated and a plan is then put in place = gold standard’.

13 Question 6 – What can the LAS do for you to help you provide a better service to mental health service users.

13.1 The following word cloud is created by using the words and phrases people used in response to this question, the larger the words appear the more often they were used in the group discussion.
13.2 A number of the comments related to training specifically in relation to dealing with people who have mental health needs. A pan London approach was mentioned a number of times and the need to be consistent and sustained in the way the service is provided and improved. An effective pathway for mental health patients and service users was seen as important, requiring work with other organisations and agencies to achieve it: ‘treat mental health the same as cardiac care then it will work’. People also spoke about the need for appropriate funding to support a sustained improvement for people who have mental health needs and for work to be joined up and led from the top of relevant organisations.

14 Conclusions

14.1 Overall the service provided is appreciated by the user groups, if not always deemed as adequate.

14.2 The following are themes that can be drawn from the feedback and are proposed as areas for further discussion, development and action.

15 Initial Contact and Response

15.1 The initial contact and response is important and sets the scene. Honesty is important in relation to expectations.
15.2 Where possible call handlers should give an accurate description of what time help will arrive. Introducing the use of regular text or call updates to let people know when help will arrive would provide reassurance.

15.3 Call handlers should have training to ensure an understanding of the unique needs of people with a mental health need or facing a mental health crisis. To listen to individuals needs, be reassuring and where possible stay on the phone with the caller until an ambulance arrives.

15.4 The quality of the service provided would be improved if all call handlers could receive training in basic mental health as part of their induction and orientation into the role.

16 Education and Training

16.1 Additional education and training in mental health is important across the board. This would generate greater awareness of the specific needs of people experiencing mental health issues and enable a more tailored response, allowing the individual to feel different yet included in a plan of action at every stage. If this is achieved, it could empower the user to a level where their need for ‘point of crisis’ intervention is decreased and could be accommodated at a far earlier stage.

16.2 To enhance existing training in mental health it would be beneficial if all patient facing staff could receive yearly face to face updates or ongoing mental health training in addition to their core mental health training. Additional personal development opportunities for those with a particular interest in mental health would also help to build an internal cohort of people with extra knowledge and skills within the organisation. In this way, those with a further level of training can act as ‘champions’ within the organisation to share and disseminate good practice within teams.

17 Additional and Community Based Services

17.1 Community based support services were raised across all groups including staff. A lack of support at this level appears to be creating an impact on mental health patients and service users in a number of different ways.

17.2 Crisis prevention:

17.3 LAS staff need to know what local community based services are available to people including times and availability. This could include community and voluntary schemes.

17.4 Collaborative work should be undertaken with Clinical Commissioning Groups
and other partners with a view to the whole pathway and the impact of crisis on the health of the person and the ability of the service to respond appropriately. Mental health support at a lower community level would reduce pressure on emergency services and unwanted admissions.

17.5 Receiving the right kind of help

17.6 For many people, calling an ambulance is a last option. However from those we spoke to, the call can sometimes be made before a crisis because the person with the mental health condition or their carer understands the personal pattern of behaviour and knows what is coming. With the right kind of help, there appears to be a window of opportunity where the crisis may be avoided meaning the person can remain at home. This type of intervention can take time and at present is putting pressure on the service. A cost effective option may be to enable the appropriate kind of help to be provided at a lower level. In turn reducing the time crews spend at the scene and admissions to hospital.

17.7 A collaborative scoping study with Mental Health Trusts into the development of an intervention such as a community responder service with a mental health specialism or exploring options for arrangements with local voluntary sector organisations and existing ‘appropriate adults’ would be beneficial.

17.8 The availability of mental health nurses at the call centre was generally seen as positive. Ideally this would be rolled out in a sustained way. Recruitment to these roles is recognised as an issue and whether a full roll out is achievable should be considered, avoiding a postcode lottery.

17.9 It would be good for the mental health nurse role to be extended further to provide dedicated mental health nurses that could attend with Ambulance Crews and possibly stay with patients until the crisis lessens.

17.10 Two further options for ensuring the right kind of help is provided, is the development of Patient Specific Protocols for mental health and also consistent use of the Crisis Cards developed by Mental Health Trusts. Both of these would enable a more tailored approach and allow for personal preference to be considered.

17.11 Being referred to or transported to the right place

17.12 Hospital is not always the best option for patients and service users. A range of options in addition to A&E and mental health hospitals would be ideal to enable people to be referred to the appropriate level of help and support.

17.13 The Street Triage system seems to be widely accepted as a good way forward with access to a range of professionals and a holding suit, to provide a safe space for people to receive appropriate help and support to see them through a crisis situation.
17.14 Continuing existing work with relevant partners to explore the roll out of Street Triage Schemes across London would be beneficial.

18 Providing Feedback

18.1 Staff, service users and carers alike valued the opportunity to give feedback through the focus groups. People would like to give more feedback. Patients, carers and service users would like to say thank you and get more involved in providing constructive feedback to make improvements.

18.2 A copy of this report should be sent to all service users who participated in the focus groups.

18.3 A communications campaign that explains how people can provide feedback including how to provide positive feedback and where feedback can be sent would be a useful exercise.

18.4 Staff would like more opportunities to provide their feedback and experience on services and how they can be improved.

18.5 A copy of this report should be sent to all staff that participated in the focus group.

18.6 Establishing a Mental Health Improvement Group with membership drawn from those who have participated and other interested service users to work with LAS staff and others on any recommendations and actions made as a response to this report would be worthwhile.

19 Acknowledgements

19.1 We would like to extend our thanks to all those who took part in the focus groups, for giving up their time to support this work. We would also like to thank all the organisations who helped to host and organise the focus groups and the London Ambulance Staff who ensured that all things ran to plan.
Appendix

Demographics of mental health focus group attendees

We held 7 focus groups, 6 for service users and 1 for staff. These focus groups were held at various locations around London and were attended by a wide variety of people. Below, breaks down the demographics of the attendees.

Gender of attendees:
Male 16  Female 37

Year born:

The answers given were:

Do you have a disability or long-term health condition? (e.g. diabetes, asthma, epilepsy, mental health condition):

Yes 33  No 1  Prefer not to say 1
### Ethnicity of the attendees:

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<th>Amount</th>
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