Mental Health Act Monitoring Committee

Wed 07 June 2023, 13:00 - 16:00

Virtual Via Teams

Agenda

13:00 - 13:00
0 min

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Jayne Sadgrove, Chair

1.2. Apologies for Absence

Jayne Sadgrove, Chair

For Noting

1.3. Declarations of Interest

Jayne Sadgrove, Chair

For Noting

13:00 - 13:00
0 min

2. CONSENT AGENDA

2.1. Items for Approval

2.1.1. Unconfirmed Minutes of the Meeting held on 8th March 2023

2.1.1 Unconfirmed Mins 8.3.23 MHAM Cmt 7.6.23wpj.pdf (9 pages)

2.1.2. Committee Draft Annual Report 2022-23 & Revised Terms of Reference

Assistant Director of Governance & Risk

Endorse for Board Approval

2.1.2 Draft Annual Report 2022-23 MHAM Committee 7 June 2023.pdf (17 pages)

2.2. Items for Noting

There are no items for noting

13:00 - 13:00
0 min

3. MAIN AGENDA

3.1. Action Log

Jayne Sadgrove, Chair

To Discuss the Action Log

3.1 Action Log MHAM Committee 8 June 2023.pdf (3 pages)

3.1.1. Matters Arising Not Otherwise Contained on the Action Log

Jayne Sadgrove, Chair

3.2. GOVERNANCE

3.2.1. Organisational Risk Register

There are currently no risks assigned to the Committee

13:00 - 13:00
0 min

4. IMPROVING CARE

4.1. Case example to highlight the use of the MHA and Outcome

Ana Llewellyn

For Discussion/Noting

4.2. MHA Operational Group Report

Robert Goodwin, Chair Operational Group

For Discussion/Noting

4.2 MHA Operational Group Report.pdf (15 pages)

4.3. MHA Quarterly Activity Report/Breaches & Unlawful Detentions

Robert Goodwin, Chair Operational Group

For Discussion/Noting

4.3 Q4 MHA activity errors-breaches (003).pdf (24 pages)

4.4. Risks Relating to the Monitoring of the MHA

Julie Denley, Director of Primary, Community & Mental Health

For Discussion/Noting

4.4 Risks Report June 23.pdf (5 pages)

4.5. Overview of the Mental Health & Learning Disabilities Care Group - Organisational Structure - Presentation

Elaine Lorton, Service Director

For Discussion/Noting

4.7 MHLD OCP Phase 2 v10 MHAM Committee 7 June 2023.pdf (3 pages)

4.6. Strategic Update from South Wales Police - Verbal

Marc Attwell, SWP

For Discussion/Notiong

4.7. 111 Performance

Aaron Jones Clinical Service Group Manager

For Discussion/Noting

4.7.2 SUDS Scale.pdf (2 pages)
4.7.3 UK Mental Health Triage Scale.pdf (1 pages)
4.7.1 Beyond the Call national Review.pdf (140 pages)
4.7 111 Performance [Final].pdf (10 pages)

4.8. Strategic Update from LA Partners - Verbal

LA Partners

For Discussion/Noting

13:00 - 13:00
0 min

5. OTHER MATTERS

5.1. Committee Highlight Report to Board

Jayne Sadgrove, Chair

5.2. Forward Work Plan

Jayne Sadgrove, Chair

5.2 Forward Work Plan MHAMC 7 June 2023.pdf (3 pages)

5.3. Any Other Urgent Business

Jayne Sadgrove, Chair

5.4. How Did We Do Today?

Jayne Sadgrove, Chair

13:00 - 13:00
0 min

6. DATE AND TIME OF NEXT MEETING

6th September 2023 at 1.00 pm

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT MONITORING COMMITTEE HELD ON 8 MARCH 2022, AS A VIRTUAL MEETING WHICH WAS HELD VIA MICROSOFT TEAMS

PRESENT

Jayne Sadgrove	-	Independent Member/ Health Board Vice-Chair (Chair)
Mel Jehu	-	Independent Member
James Hehir	-	Independent Member
Geraint Hopkins	-	Independent Member

IN ATTENDANCE

Gethin Hughes	-	Chief Operating Officer
Robert Goodwin	-	Service Group Manager, Mental Health
Alyson Jones	-	Merthyr Tydfil County Borough Council
Ana Llewellyn	-	Head of Nursing, Primary, Community, Mental Health & Learning Disabilities Care Service Group
Marc Attwell	-	South Wales Police
Colin Hatherley	-	South Wales Police
Wendy Penrhyn-Jones	-	Head of Corporate Governance and Board Business
Kathrine Davies	-	Corporate Governance Manager (Meeting Secretariat)

PART 1. PRELIMINARY MATTERS

MHA/23/03/1 **WELCOME AND INTRODUCTIONS**

The Chair welcomed everyone to the meeting.

MHA/22/03/2 **APOLOGIES FOR ABSENCE**

Apologies for absence had been received from Julie Denley, Director of Primary, Community & Mental Health and Alexandra Beckham, Rhondda Cynon Taff County Borough Council and Angela Edavene, Merthyr Tydfil County Borough Council.

MHA/23/03/3 **DECLARATIONS OF INTERESTS**

There were no interests declared.

PART 2. CONSENT AGENDA

MHA/23/03/4 **'UNCONFIRMED' MINUTES OF THE MEETING HELD ON 7 DECEMBER 2022**

Resolution: The minutes were **APPROVED** as a true and accurate record.

MHA/23/03/5 **Committee Annual Cycle of Business for 2023-24**

Resolution: The Annual Cycle of Business was **APPROVED.**

MHA/23/03/7 **ACTION LOG**

Resolution: The Committee **NOTED** the Action Log.

PART 3 - MAIN AGENDA

IMPROVING CARE

MHA/23/03/8 **MHA OPERATIONAL GROUP REPORT**

R Goodwin presented the report, which provided Members with an update on the work of the MHA Operational Group.

J. Sadgrove thanked R. Goodwin for the detailed report.

M. Jehu commented that he was delighted that an alternative 'Place of Safety' room at Prince Charles Hospital had been allocated. Ana Llewellyn stated that this alternative room was an interim solution until a permanent facility was identified.

M. Jehu referred to the decreases in Section 136 and queried whether a policy had been put in place which was impacting on numbers. M. Attwell advised that there was not a policy in place but there had been a marked reduction in Mental Health reoccurrences in the last 12 months and that Officers of the South Wales Police (SWP) remained trained in using a Section 136.

G. Hughes referred to the Section 23 data and advised that it would be interesting to understand what that looked like as a proportion of the per 1000 population and potentially as a percentage of the caseloads. He also referred to the Section 140 policy and queried what the plans were for that, for example, if they were unable to meet the requirement was that entered on the Datix system. Finally he referred to the use of Section 136 and queried whether the use of this was consistent across the Health Board, whether those

patients were known to the service and how they linked to the crisis service.

In response, R. Goodwin advised that they could look at the per capita information with the benchmarking for a future report. He added that the issue around bed availability was a UK-wide challenge and it was difficult trying to develop and commission plans with the independent sector as they too had bed capacity issues. R Goodwin agreed to prepare a report on this issue to bring back to the Committee.

A Jones confirmed that the data they collected showed those the proportion of patients detained on a Section 123 who then went on to have a Section 2 applied. She advised that the numbers were very low and not care co-ordinated.

C. Hatherley advised that SWP captured all the data referenced by G. Hughes. He added that whilst there was a significant number of repeats within CTMUHB, there was also evidence of good discharge rates for mental health which was normally around 10-20% suggesting that they were allocating the Section 136's correctly. He undertook to share this data with the Committee.

J. Hehir commented that the Section 136 cases profiling for benchmarking would be useful and it would help to have a run-rate which would be good over time. He also asked if the Committee could see the time when the application had been made which would give a better idea on the service and the transfers to the Royal Glamorgan Hospital. With regard to fundamental breaches and errors, J Hehir asked if the learning was being used to avoid basic errors.

R. Goodwin advised that the checklist which had been created to avoid such errors was fundamental and if used as required, it would be difficult to make an error. R Goodwin undertook to share this at the next meeting. He added that once completed the form was subject to review by an Advanced Mental Health Practitioner (AMHP), a doctor and a nurse which again presented further opportunities to highlight errors.

A Jones advised that the particular circumstances in which the forms were completed which sometimes were emotionally charged had the potential to impact upon the person completing it which could then lead to errors.

J. Hehir referred to the draft Mental Health Bill and the strengthening of duties for Integrated Care Boards and Local Authorities to ensure adequate supply of community services for people with learning disabilities and autistic people to avoid long-term detention and queried whether there were financial dependencies inherent in that. He also made an observation regarding the St. John Ambulance Pilot and advised that this was a good news story that needed to be shared.

J. Sadgrove referred to the recent Healthcare Inspectorate Wales (HIW) visits and the awaited publication of the Angelton Clinic Report and advised that there were some things that she would like the Operational Group to review in order to provide the Committee with assurances. She commented that there were likely to be some themes running within the report in relation to the display of patient's rights information and that this was ubiquitous across the Health Board. J Sadgrove also referenced some other requirements which relating to record keeping.

W. Penrhyn-Jones added that all patient information should also be bi-lingual.

R. Goodwin advised that A. Llewellyn was providing strong leadership following the HIW visit and undertook to review the findings and provide a report detailing relevant actions to provide assurance to the Committee.

Resolution: The Committee **NOTED** the Report.

Action: SWP to share the Section 136 Data.

Action: Operational Group to review the actions and issues arising out of the HIW visit and submit a report to the Committee for assurance purposes.

HA/23/03/9 **MENTAL HEALTH ACT QUARTERLY ACTIVITY REPORT/ BREACHES/ANALYSIS OF UNLAWFUL DETENTIONS**

R. Goodwin presented the report that provided the Committee with an overview of MHA activity for Adult, Older Persons and Child & Adult Mental Health Services (CAMHS) for Quarter 3 October – December 2022.

A Jones referred to the Welsh Community Care Information System (WCCIS) and queried whether the Health Board had agreed for their staff to use this. A. Llewellyn advised that a report had been submitted to the Executive Leadership Group with a number of options and WCCIS was the preferred option.

J. Sadgrove referred to the key risks section on page 12 of the report and commented that there appeared to be a fragmented approach to patient records which was continuing to cause difficulties and it would be helpful to receive clarity around timescales for the deployment of actions to improve the situation.

A. Llewellyn, in response, advised that she agreed with the comments raised around clarity in terms of mitigating the risk and added that it was a key issue that had been raised in all three inspections. She advised that they had developed a Mental Health Improvement Programme and one of the actions related to medical records issues and a Clinician and Operational Lead were taking this work forward in order to put forward options for improvement. This would also due to be discussed at the Quality & Safety Committee on 16th March 2023.

J. Hehir referred to the fees confusion and queried whether there was anything more that could be done to expedite a resolution to these delays. He added that the costs might not be significant but the impact upon patients and beds could be disproportionally high.

R. Goodwin advised that he was not aware of anything causing the delays but would feed this back to the Operational Group and report back to the next meeting.

Resolution: The Committee **NOTED** the report.

Action: Operational Group to review and report on the issues relating to fee delays and the actions to address medical records issues.

MHA/23/03/10 **RISKS RELATING TO THE MONITORING OF THE MENTAL HEALTH ACT**

A Llewellyn presented the report on behalf of J. Denley that provided an overview of the current risks relating to the monitoring of the Mental Health Act for Quarter 3 October – December 2022.

The Committee **noted** the potential consequences of the discharge review and that HIW were concerned around safe discharge and increased lengths of stay and whether it would impact on capacity moving forward.

A Jones advised that data had already been captured on the availability of Section 12 Doctors, particularly within the Merthyr Tydfil area. It was noted that there were days when there was no Section 12 cover within the community between the hours of 9.00am – 5.00 pm and this had been raised. She added that staff were sometimes having to wait until after 5.00 pm for the On-call Doctor and could be working until 9.00-10.00 pm at night as a result.

A. Llewellyn advised that the Operational Group were looking at this issue and the data would be shared.

M. Jehu queried if there was no doctor available, then would they would have to stay with the patient. A Jones confirmed that this was the case and especially for a Section 136 and they needed to also use the police for support until they could obtain the Doctor's assessment. M. Attwell stated that it was challenging for officers when they had to remain try to safeguard a patient. M. Jehu referred to the pressures that police officers were already working under and said that key partners need to be mindful that such situations did not only impact upon the NHS.

A. Llewellyn commented that this had been a very useful discussion and she would welcome sight of the relevant data. She suggested that the Operational Group needed to review the instances of delays and the time waiting for access to a Section 12 Doctor.

G. Hughes advised that Accident & Emergency (A&E) was not resourced to provide an official 'place of safety' facility. The ability for staff to care for a mental health patient in that environment was challenging and they need to look at the Section 136 provision in both the short and longer term.

C. Hatherley advised that a crucial factor was that there were three crisis teams working across CTM and each of those teams operated differently so it was almost like working in three different Health Boards which was challenging for officers.

A Llewellyn referred to the inpatient improvement programme and that one of the workstreams were looking at alternatives for inpatient admission. She advised that there was also national review and the Welsh Government's Delivery Unit had looked at this and that she would ensure that the Lead Consultant Clinical Psychologist for Acute Adult Mental Health engaged with all the stakeholders on this.

J. Sadgrove commented that there needed to be a whole system approach in order to get the smoothest possible operation.

C. Hatherley suggested that he would be happy to meet up with colleagues to give them a physical tour of the crisis centres if the Superintendent was happy for them to do this.

Resolution: The report was **NOTED**

Action: To ensure that the Lead Clinical Psychologist for Acute Adult Mental Health engages with stakeholders

Action: To arrange a potential visit to the crisis centre for Members of the Committee.

MHS/23/03/13 **STRATEGIC UPDATE FROM SOUTH WALES POLICE**

M. Attwell provided a verbal update to the Committee on the following:

- **Section 136** – The Committee were pleased to note that discharges had decreased with 735 occurrences compared with 1,190 in the previous year amounting to a 40% reduction.
- **Section 135** – The Committee were advised that these were averaging month on month ranging from 10 to 20%.
- **111** – The Committee were advised on the progress being made on the Police Triage System migrating into 111.
- **Right Care Right Time** – The Committee were advised on the initiative undertaken by Humberside Police Force that was currently being considered by South Wales Police for implementation in the future. A Llewellyn advised that she had not heard of this initiative and wondered if there was any information on it. M. Attwell agreed to share information regarding this outside of the meeting.
- **Prevention of the use of illegal drugs in Mental Health Areas** – The Committee were advised of the ongoing

detection activity work to prevent the use of un-prescribed drugs in a mental health setting.

Resolution: The Committee **NOTED** the verbal update.
Action: To share the information in relation to 'Right Care Right Time' with the Committee.

MHA/23/03/14 **STRATEGIC UPDATE FROM LOCAL AUTHORITY PARTNERS**

A Jones provided a verbal update to the Committee on the following:

- Concern was raised about the lack of **Section 12 Doctors** between the hours of 9.00 am – 5.00 pm and particularly within the Merthyr areas.
- **Section 140 Policy** – The Committee discussed the requirement for this Policy to be implemented.

Resolution: The Committee **NOTED** the verbal update.

PART 4 – OTHER MATTERS

MHA/23/03/15 **TO DISCUSS AND AGREE THE COMMITTEE HIGHLIGHT REPORT TO BOARD**

Resolution: The Committee considered items to include within the report and **AGREED** that the report would be prepared by the Governance Team following the meeting.

MHA/23/03/16 **FORWARD WORK PLAN**

The Chair advised that if there were any suggested items for future meetings to relay these to the Governance Team.

Resolution: The Forward Work Programme was **NOTED.**

MHA/23/03/17 **ANY OTHER URGENT BUSINESS**

There was no urgent business to report.

MHA/23/03/18 **HOW DID WE DO TODAY**

The Chair invited members to comment and reminded them that they could also relay feedback outside of the meeting.

J. Sadgrove, commented that she felt that it had been a really honest, open discussion on the challenges that they were all facing and how they interact with each other with a view to continuing to

make improvements moving forward. She looked forward to continuing this this constructive discussion.

M. Jehu added that the Committee had gone from strength to strength particularly since partner organisations were actively contributing to it. He queried whether there were other individuals and partners who should be invited to attend to build on its strength.

M. Attwell advised that it would be helpful if colleagues from the Ambulance Service attended. It was noted that they were already in receipt of meeting invitations.

A Jones suggested a carer/ service user contribution be considered

G. Hughes advised that this had been a valuable discussion He suggested that the Operational Group reviewed the suggestions and would bring options back to the Committee in due course.

Action: Operational Group to review Membership of the Committee and bring some options back to the Committee.

MHA/23/03/19 **DATE AND TIME OF NEXT MEETING**

7th June 2023 at 1:00 pm

AGENDA ITEM
2.1.2

MENTAL HEALTH ACT MONITORING COMMITTEE

MENTAL HEALTH ACT MONITORING COMMITTEE
DRAFT ANNUAL REPORT 2022-2023

Date of meeting	7 June 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Kathrine Davies, Corporate Governance Manager
Presented by	Wendy Penrhyn-Jones, Head of Corporate Governance & Board Business
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
		Choose an item.

ACRONYMS	
MHA	Mental Health Act
CTMUHB	Cwm Taf Morgannwg University Health Board

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to highlight the activities and performance of the Mental Health Act (MHA) Monitoring committee during 2022-2023.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The Chair of the MHA Monitoring Committee is required to present an annual report outlining its business throughout the financial year to provide the Board with assurances as to scrutiny of performance in relation to meeting the requirements of the MHA 1983.

2.2 The MHA Monitoring Committee's draft Annual Report for 2022-2023 is presented at **Appendix 1** for approval.

2.3 The Terms of Reference that were previously approved by the Health Board on 26 January 2023, are presented at **Appendix 2** with further minor updates to reflect the attendance of Clinical Service Group representatives. These are presented for endorsement by the Committee prior to being submitted in due course, for Board approval.

2.4 The Committee is committed to reviewing its effectiveness by completing an annual self-assessment review. This will be undertaken during the summer of 2023 and will be considered by the committee meeting to be held in September 2023 in order that recommendations and aligned actions can once again be developed and implemented in terms of areas identified for improvement.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The publication of the annual report demonstrates compliance with the Standing Orders, which stipulates that each Committee is required to submit an annual report to the Board at the end of the reporting year. This needs to set out its activities during the year and detail the results of a review of its performance and any sub-groups established.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Mental Health Act Monitoring Committee is asked to:

5.2 **DISCUSS** and **ENDORSE** the Annual Report for submission to the Health Board at its meeting to be held on 12 October 2022.

5.3 **ENDORSE FOR BOARD APPROVAL** the revised Terms of Reference (previously approved by the Health Board at its meeting held on 26 January 2023)

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Appendix 1

DRAFT
Mental Health Act (MHA) Monitoring Committee

Annual Report 2022-2023

MENTAL HEALTH ACT (MHA) MONITORING COMMITTEE
DRAFT ANNUAL REPORT 2022-23

1. FOREWORD

I am pleased to present the Annual Report of the Mental Health Act Monitoring Committee for the period 2022-2023. The purpose of this report is to formally report on the work of the Committee for the year ending 31 March 2023 in accordance with the Committee's Terms of Reference.

I would like to express my thanks to all the Officers of the Health Board, Local Authority Partners and South Wales Police who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines.

As members of the Committee will be aware, Philip Lewis, Head of Nursing for Mental Health has recently retired and I would like to extend my thanks to him for the important contribution he had made to the Committee. We now have a new Nurse Director for Primary Care, Community and Mental Health, Ana Llewellyn who is a member of the Committee.

The Committee has continued to foster and promote a culture of working in partnership with a view to service improvement for the Cwm Taf Morgannwg population. As Chair, I have ensured that the work of the Committee progresses in line with its Terms of Reference and also ensured that crossover work is seamless with the Together for Mental Health Partnership Board which I also chair.

This will be my final Committee Annual Report submission due to my time with the Health Board drawing to a close at the end of the summer of 2023. Two more long standing colleagues who are members of the Committee, James Hehir, and Mel Jehu are also drawing to a close over the coming months. I would therefore wish to take this opportunity to extend my personal thanks to them for their important contributions and scrutiny of issues.

Jayne Sadgrove
Chair, Mental Health Act (MHA) Monitoring Committee/ Vice Chair, CTMUHB.

2. INTRODUCTION

The MHA Monitoring Committee is chaired by the Vice-Chair of the Health Board and monitors the Health Board's compliance with the statutory requirements of the MHA. The work of this Committee and its Terms of Reference, were reviewed and approved by the Board refreshed in January 2023 and are presented along with this annual report for further review to reflect changes to the membership that now includes the Service Care Groups. The Committee has continued to evolve with changes to report format and agenda content during the year.

As part of CTMUHB's commitment to openness and transparency, the meeting papers for this Board Committee are routinely published on the CTMUHB website.

The Committee meets on a quarterly basis and, following each meeting, produces a highlight report which is then submitted to the next Board meeting to highlight key issues and risks.

The purpose of the MHA Monitoring Committee is to ensure that all the requirements of the MHA 1983 (as amended) are met by the Health Board.

The Committee considers:

- how the delegated functions under the MHA are being exercised (for example using the Annual Audit) and in line with the 'Code of Practice' requirements
- the multi-agency training requirements of those exercising the functions (including discussing the training report for assurance)
- the operation of the 1983 Act within the Cwm Taf Morgannwg area
- issues arising from the operation of the hospital managers' power of discharge
- suitable mechanisms for reviewing multi agency protocols / policies relating to the 1983 Act
- trends and patterns of use of the MHA 1983
- cross-agency audit themes and sponsor appropriate cross-agency audits
- lessons learnt from difficulties in practice and the development of areas of good practice.

The Committee is also responsible for developing an annual report for presentation to the Health Board.

3. MEMBERSHIP

The membership of the MHA Monitoring Committee comprises both Independent and an Executive Director Members, enabling the Committee to

provide appropriate scrutiny and assurance to the Board independently of the management decision-making processes.

Independent membership of the Committee during 2022-23 was as follows:

- Jayne Sadgrove, Vice Chair of the Health Board (Chair of the Committee)
- James Hehir, Independent Member (Vice Chair of the Committee)
- Mel Jehu, Independent Member
- Geraint Hopkins, Independent Member

4. MEETINGS

The MHA Monitoring Committee met on four occasions during 2022/23 and its forward work programme was reviewed to ensure that issues were appropriately prioritised.

The four dates on which it met during 2022-23 were as follows:

- 8 June 2022
- 12 October 2023
- 7 December 2022
- 8 March 2023

Mental Health Act Monitoring Attendance 2021-2022		**8 June 2022**	**12 Oct 2022**	**7 Dec 2022**	**8 Mar 2023**	**Total**
Jayne Sadgrove (Chair)	Vice Chair, Independent Member	√	√	√	√	**4/4**
Mel Jehu	Independent Member	X	√	√	√	**3/4**
James Hehir	Independent Member	√	X	√	√	**3/4**
Geraint Hopkins	Independent Member	√	X	X	√	**2/4**

All of the above meetings were quorate.

The Committee's Terms of Reference were reviewed and approved by the Committee at its December 2022 meeting with minor amendments made and were approved by the Health Board in January 2023. The Terms of Reference are presented as part of this report reflecting further amendments in respect of Committee attendees following implementation of Care Group arrangements at operational management level. The Committee is being asked to endorse the amendments for onward approval by the Board. These are attached at attached at **Appendix 2.**

5. MAIN AREAS OF MHAM COMMITTEE ACTIVITY

The agenda for each meeting has followed a standard format in five main parts:

- Part 1 - Preliminary Matters
- Part 2 - Items for Approval/Discussion
- Part 3 - Governance, Performance and Assurance
- Part 4 - For Information / Other Matters.

Part 1 - Preliminary Matters

This section of the meeting provides the standard governance approach within all Board Committees within CTMUHB. This includes the action log which captures all areas for attention following the meeting.

Part 2 - Items for Approval / Discussion

This section has included receiving the:

- Committee Annual Report 2021-2022 and self-assessment questionnaire
- Results of the Committee Self-Assessment and Self-Assessment Action Plan
- Committee Annual Cycle of Business 2023-2024.

Part 3 - Governance, Performance and Assurance

This section has included reports throughout the year which included:

- Mental Health Act – Quarterly Activity Statistical Report
- Report from Mental Health Operational Group
- Strategic update from South Wales Police (Section 13,15 & 136) - including mental health staff in police control centre
- Strategic update from Local Authority Partners
- Mental Health Act Breaches Relating to the Mental Health Act
- Risks related to the Monitoring of the Mental Health Act
- Crisis Care Concordat
- Processes for Learning Lessons Including Those Related to the Application of the MHA.
- Use of the MHA for Patients with a Learning Disability.
- Update on the South Wales Police Mental Health APP.
- Healthcare Inspectorate Wales Report on Child and Adolescent Mental Health (CAMHS) – Action Plan Progress Report.

Part 4 - For Information / Other Matters

There were no items shared during the meetings held in 2022-2023 under this agenda heading.

The Committee's 'Forward Work Plan' was received at each meeting to ensure appropriate focus of its area of remit.

A Committee Highlight Report is produced following each meeting and subsequently presented to the next available Board meeting.

Links with Other Committees/Boards
Where appropriate a process is in place for any relevant matters to be referred to other Board Committees for scrutiny and or action.

6. ACTION LOG

In order to monitor progress and any necessary follow-up action, the Committee uses an Action Log that captures all agreed actions and this is reviewed at the beginning of each meeting.

7. GOVERNANCE

The Committee provides an essential element of the overall governance framework for the organisation. The Terms of Reference for the Committee provide a robust commitment to monitor the application of the MHA.

8. ASSURANCE TO THE BOARD

Like many service areas, mental health services were impacted by the pandemic and Welsh Government made provision for how the Mental Health Act could be applied and administered should the pandemic have warranted this. The committee was assured that patients' needs were met and full compliance with legislation maintained.

The Committee continued to receive updates regarding ongoing audit work and changes put into place to improve the application of the MHA and work to integrate approaches and policies in relation to the Act have again continued in year.

The MHA Monitoring Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2022-2023, there are effective measures in place to scrutinise and monitor the application of the MHA.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Appendix 2

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the University Health Board Standing Orders

MENTAL HEALTH ACT MONITORING COMMITTEE

TERMS OF REFERENCE & Operating Arrangements

Reviewed December 2022
Approved by Health Board 26.01.23

For review 7 June 2023

INTRODUCTION

The CTMUHB Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

In accordance with Standing Orders (and CTMUHB scheme of delegation), the Board shall nominate a committee to be known as the **Mental Health Act Monitoring Committee**- "the Committee**"**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

CONSTITUTION AND PURPOSE

The purpose of the Committee is to advise and assure the Board that the arrangements to monitor and review the way functions under the Act are exercised on its behalf are operating appropriately and effectively and in accordance with legislation.

SCOPE AND DUTIES

The Committee shall consider:

- how the delegated functions under the Mental Health Act are being exercised (for example using the Annual Audit) and in line with the 'Code of Practice' requirements
- the multi-agency training requirements of those exercising the functions (including discussing the training report for assurance)
- the operation of the 1983 Act within the Cwm Taf Morgannwg area
- issues arising from the operation of the hospital managers' power of discharge
- a suitable mechanism for reviewing multi agency protocols / policies relating to the 1983 Act
- trends and patterns of use of the Mental Health Act 1983
- cross-agency audit themes and sponsor appropriate cross-agency audits
- lessons learnt from difficulties in practice and the development of areas of good practice
- Develop an annual report for presentation to the Health Board.

DELEGATED POWERS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The Mental Health Act Monitoring Committee has a key role in assisting the Board to fulfil its oversight responsibilities to ensure it is operating effectively and in accordance with legislation.

Hospital Managers may arrange for their functions under the Mental Health Act to be carried out on a day to day basis by particular Officers on their behalf. (COP 11.7) The arrangements for authorising decisions has been set out in a Scheme of Delegation.

AUTHORITY

The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its terms of reference. It may seek relevant information from any:
    - employee (and all employees are directed to cooperate with any legitimate request made by the Committee), and
    - Any other committee, or group set up by the Board to assist in the delivery of its functions.

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements

- approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees

The Committee may, subject to the approval of the Health Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

Related Sub Groups

- Mental Health Act Monitoring Operational Group
- Together for Mental Health Partnership Board
- Crisis Concordat Meeting Forum.

ACCESS

The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

MEMBERSHIP

Members:
A minimum of **(4)** members, comprising

Chair	Vice Chair of the Board
Vice Chair	Independent Member of the Board
Members	Two Independent Members of the Board

The 1983 Act is operated by health and social care practitioners, in collaboration with a range of agencies including police and ambulance services, as well as third sector bodies such as advocacy providers. Membership of the Committee should reflect this, as different agencies and practitioners have differing responsibilities and duties under the Act.

The Vice Chair of the Health Board shall Chair the Committee given their specific responsibility for overseeing the Health Board performance in relation to mental health service.

Attendees

- Chief Operating Officer
- Deputy Chief Operating Officer (Director of Primary, Community & Mental Health) (in their absence nominated Care Group Lead)
- Representative from South Wales Police
- Representative from Rhondda Cynon Taf County Borough Council
- Representative from Merthyr Tydfil County Borough Council
- Representative from Bridgend County Borough Council
- Chair of Mental Health Act Monitoring Operational Group
- Head Administrator - Mental Health Act Administration Team

- Carer Representative from the Together for Mental Health Partnership Board
- Representative from Welsh Ambulance Services Trust (minimum twice per annum)
- Clinical Director for Mental Health
- Head of Nursing for Mental Health Merthyr Cynon Locality Group (minimum twice per annum)
- Mental Health Clinical Service Group Manager Bridgend Integrated Locality Group
- Mental Health Clinical Service Group Manager Rhondda & Taff Ely Integrated Locality Group
- Clinical Director, Child & Adolescent Mental Health Service (CAMHS) (minimum twice per annum)
- Head of Nursing CAMHS

By Invitation:

- Other Directors /Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

- The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Secretariat

The Director of Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

Member Appointments

The membership of the Committee shall be determined by the Chair of the Board, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

The Director of Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

- Co-ordinate the provision of a programme of training, specific support or organisational development for Committee Members as part of the overall Health Board's Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

COMMITTEE MEETINGS

Quorum
This will comprise of two Independent Members, the Director of Primary, Community and Mental Health or the Assistant Director; a representative from the partner organisations either from the South Wales Police, Local Authorities or the Welsh Ambulance Services NHS Trust and also at least one clinical representative.

Frequency of Meetings
Meetings shall be held no less than four times a year, and otherwise as the Chair of the Committee deems necessary.

The Committee will arrange meetings to fit in with key statutory requirements during the year consistent with the Health Board's annual plan of Board Business.

Withdrawal of individuals in attendance
The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

Circulation of Papers
The Director of Governance / Board Secretary will ensure that all papers are distributed at least 7 calendar days in advance of the meeting.

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year

- bring to the Board's specific attention any significant matters under consideration by the Committee

- ensure appropriate escalation arrangements are in place to alert the LHB Chair, Chief Executive or Chairs of other relevant committees of any urgent / critical matters that may affect the operation and / or reputation of the LHB.

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

The Committee, through the Committee Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and

- sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.
The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

Related Sub Groups

- Mental Health Act Monitoring Operational Group
- Together for Mental Health Partnership Board
- Crisis Concordat Meeting Forum.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in relation to the Quorum.

CHAIR'S ACTION ON URGENT MATTERS

There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

REVIEW

These Terms of Reference shall be adopted by the Committee at its first meeting and subject to review at least on an annual basis thereafter, with approval ratified by the Health Board

ACTION LOG - MENTAL HEALTH ACT MONITORING COMMITTEE					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at June 2023)
23/03/08	March 2023	**Operational Group Report** South Wales Police to share the 136 Data	SWP	April 2023	**Update to be provided at the meeting.**
23/03/08	March 2023	**Operational Group Report** Operational Group to review the actions and issues arising out of the HIW visit and submit a report to the Committee for assurance purposes.	Chair Operational Group	June 2023	**Complete** Update provided within the MHA Operational Group Report for the June 2023 meeting.
23/03/09	March 2023	**MHA Quarterly Activity & Breaches Report** Operational Group to review and report on the issues relating to fee delays and the actions to address medical records issues	Chair Operational Group	June 2023	**Complete** Update provided within the report
23/03/10	March 2023	**Risks Relating to the Monitoring of the MHA** To arrange a potential visit to the crisis centre for Members of the Committee	SWP	May 2023	**Update to be provided at the meeting.**
23/03/18	March 2023	**Any Other Business** Operational Group to review Membership of the Committee and bring	Chair Operational Group	May 2023	**Complete** Dr Tim Chan will be joining the group as a representative from Older Peoples Services.

		some options back to the Committee			
23/03/10	March 2023	**Strategic Update from SWP** To share the information in relation to 'Right Care Right Time' with the Committee	SWP	March 2023	**Complete** Circulated to members via email March 2023
MHA/22/10/10	October 2022	**Risks Related to the Monitoring of the MHA** Care Group to review back in relation to any themes and patterns in terms of breaches for six months' time.	Primary Community & Mental Health Care Group	August 2023	**In Progress** Added to Forward Work Plan for September 2023

PREVIOUSLY COMPLETED ACTIONS

MHA/22/12/8	December 2022	**Operational Group Report** To receive a further update on the place of safety room at Prince Charles Hospital at the next meeting.	Chair/Clinical Lead Operational Group	March 2023	**Complete** Update provided within Operational Group Report for March 23 meeting.
MHA/12/22/9	December 2022	**MHA Quarterly Activity Report** Further update on the Fundamental Breaches to be brought to the next meeting of the Committee.	Chair/Clinical Lead Operational Group	March 2023	**Complete** Update provided within Operational Group Report for March 23 meeting.

MHA/12/22/11	December 2022	**HIW Report on CAMHS Action Plan Progress Report** To share the Missing Patient Form as part of the improvement plan	Chair/Clinical Lead Operational Group	March 2023	**Complete** Caswell Clinic Missing Patient Form shared with CAMHS Head of Nursing. Update on auditing of Section 17 Leave improvements requested for the 12 April 2023

AGENDA ITEM
4.2

MENTAL HEALTH ACT MONITORING COMMITTEE

MENTAL HEALTH ACT OPERATIONAL GROUP REPORT

Date of meeting	07/06/23
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	(Robert Goodwin, Clinical Service Group Manager Bridgend ILG)
Presented by	(Robert Goodwin, Clinical Service Group Manager Bridgend ILG)
Approving Executive Sponsor	Executive Director of Primary, Community & Mental Health
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
	MHA – Mental Health Act
	AMHP – Approved Mental Health Practitioner
	EDT – Emergency Team
	SWP – South Wales Police
	CAMHS – Child and Adolescent Mental Health Service
	IMHA – Independent Mental Health Advocacy

1. SITUATION/BACKGROUND

1.1 The Operational Group has met on one occasion since the last meeting of the Mental Health Act Monitoring Committee which took place on 08 March 2023. The meeting on 28 April 2023 was well attended with representatives from across Adult Mental Health, CAMHs, Mental Health Act team, Social Services, South Wales Police, Ambulance Service and South Wales Advocacy.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Mental Health Act Activity Report Q4, January – March 2023

The group considered the Q4 Activity Report. Of particular note was the absence of any fundamental breaches during the period. There were 18 minor errors, the same number as in Q3. Section 4 was used on 6 occasions (2 in the Princess of Wales and 4 in the Royal Glamorgan hospitals) compared to 3 in Q3. There were 7 CAMHS detentions for CTMUHB residents, 4 in Ty Llidiard and 3 at the Royal Glamorgan Hospital Mental Health Unit. The Mental Health Act team had transferred its audit documentation process onto the Health Board's electronic AMAT system. The Operational Group would consider this at its next meeting.

2.2 Fundamental Errors & Breaches April 2019 – March 2022

The MHA Monitoring Committee has asked the Operational Group to undertake a 3 year review of Errors & Breaches to determine if any lessons could be learned. The table below shows the number of breaches over a 3 year period and the professional involved in the error:

Table 1 - Review of Fundamental Errors & Breaches April 2019 – March 2022

Professional involved	Section	Description of error	Total
Doctor	5(2)	Use of English Form	**1**
		Not signed, timed or dated	**5**
	5(2)	Patient on a CTO-unable to use holding powers	**1**
	2	Form HO4 not signed/dated	**1**
	2	Form HO3 failed medical scrutiny	**3**
		Professional conflict of interest	

	2 2	Improper use of s2- *Back- to back use of s2, without a significant change in presentation.*	**1** **1** **13**
AMHP	2 2 3 3 2 2	Form HO2 stated wrong hospital Form HO2 not signed Form HO6 not signed/dated Form HO2 used not HO6 Inappropriate use of s2- *the AMHP mistakenly believed that they could not detain under Section 3, as they had not been able to speak to the nearest relative and used a consecutive section 2* Only 1 medical recommendation used by AMHP citing emergency legislation due to corona virus. Emergency powers had not been implemented by Welsh Government.	**1** **2** **1** **1** **1** **1** **7**
Nurse	2 S5(4)	Form HO14 not signed/dated Patient on a CTO	**1** **2** **3**
TOTAL			**23**

The Operational Group noted the high number 'simple errors' which related to documents not being signed, dated or timed. The professional conflict of interest was also a theme with errors occurring on 3 occasions.

The following actions are being delivered to help improve compliance:

- Roll out of a revised Receipt & Scrutiny Checklist (please see Section 2.3 below.
- Further training provided across the Health Board to clinical teams.
- Conflict of Interest concern to be again raised within the Mental Health & Learning Disability Care Groups Senior Medical Staff Committee.
- Training delivered in doctor's induction program, to highlight the importance of accuracy when completing Form HO12.
- Training boards on all wards including information on the use of Doctor's holding powers under S5(2) Form HO12.
- MHA Manager attends AMHP team meetings with the three Local Authorities, to discuss any issues/errors/delays with the submission of MHA paperwork

2.3 Mental Health Act Scrutiny Check-list

The Operational Group and the MHA Team have worked with colleagues to develop the Mental Health Act Scrutiny Check List. This is one of the actions identified to reduce the number of Fundamental Errors & Breaches in relation to documentation. The revised checklist is shown below:

Receipt & Scrutiny Checklist for Section 2/3/4

(As per Chapters 35.9/35.10 of the Code of Practice for Wales)

Patient's Name	DOB	Section	Date of Section

Circle relevant answer

Have you completed a HO14 (Record of detention) with the correct name and address *Yes/No
(Ensure that the name matches on all section papers)

A HO14 "does not" need to be completed for a Section 5(2) or 5(4)

NB Only complete Part 2 (Back of HO14) when the patient has been detained on Section 2 following the completion of a HO4 after being previously detained on Section 4.

Check that all professionals have signed and dated all forms? *Yes/No

Check patient's full name and address are the same over all paperwork. *Yes/No

Check that the hospital address on the application is where the patient is being detained. *Yes/No

Is the full address and postcode of the hospital spelt correctly? *Yes/No

Is the full name and address of the nearest relative (if known) entered on the AMHP application *Yes/No
(There should be no telephone numbers on the papers)

Check that the AMHP has deleted have/have not (informed the NR) *Yes/No

Medical Recommendations - Check that not more than five days has elapsed between the days on which the examinations took place. *Yes/No

Check if at least one of the doctors who have completed the recommendations is approved under Section 12 of the Mental Health Act? *Yes/No

If neither doctor has previous acquaintance, has the AMHP stated why? *Yes/No

No initials or abbreviations to be used throughout paperwork
Clearly initial any amendments, for example incorrect spellings

I certify that these documents are correct and in accordance with the provisions of the Mental Health Act

Signed_____ Date_____

Print Name_____

Please ensure that you scan/email Section Papers, AMHP Report (If applicable) and scrutiny checklist to the CTT_MHAA@wales.nhs.uk as soon as you have completed the HO14
Post all originals to the Mental Health Act Office, Royal Glamorgan Hospital, Ynysmaerdy, Pontyclun, CF72 8XR
5th January 2023

2.4 Mental Health Act activity for CTMUHB residents with a Learning Disability who are in hospital placement on 31 March 2023

There are four facilities commissioned by Cwm Taf Morgannwg University Health Board to provide care and treatment for CTM patients with a Learning Disability. The following table shows the responses received from the 4 facilities for 31 March 2023. This confirms that no breaches of the Mental Health Act were recorded for the 3 patients detained in Pinetree Court Hospital at this time.

Table 2 – Mental Health Act Information for patients with a Learning Disability detained on 31 March 2023

Facility	Number of patients	Section	Breaches of the MHA	Frequency of Audit	Audit Tool	Is a MHA Activity report compiled?	Is data focused on CTM patients able to be shared
Priory Hospital, Llanarth Court	0	0	0	Annual full MHA, Monthly section & consent	Yes	Yes, as electronic patient records	Does not include specific CTMUHB data
Hafod y Wennol SBUHB	0	0	0	Annually by Mental Health Act Manager or Deputy	Yes	Yes, quarterly MHA Activity reports for Legislative Committee and Power of Discharge Committee	Does not include specific CTMUHB data
Cefn Carnau, Elysium Healthcare	0	0	0	Audits are carried out yearly by the MHA Manager	Yes	No we not currently compile an activity reports	n/a
Pinetree Court, Ludlow Street Healthcare	3	3	0	Mental Health Act Manager completes quarterly	Yes	Yes , on a quarterly basis	Does not include specific CTMUB data

2.5 Hospital Managers Power of Discharge Committee Meeting

The group considered the Minutes of the Power of Discharge Committee Meeting held 15 February 2023. The meeting was again well attended and discussed some learning points from recent Hospital Managers Hearings. This included requests for clinical reviews to have been completed no longer than 3 months before the hearing, clearer arrangements to be made for the provision of interpreter services and notice to be given where a solicitor was due to attend to help represent the patient. Members of the committee asked for the decision making template to be reviewed and had welcomed the proposal to introduce annual appraisals.

2.6 Reform of the Mental Health Act – Welsh Government Response to the Joint Committee Report

In June 2022 the UK Government published a draft Mental Health Bill containing several proposals to amend the Mental Health Act which would be applicable in Wales. The report contains 54 recommendations and can be read in full here:

https://committees.parliament.uk/committee/605/joint-committee-on-the-draft-mental-health-bill/publications/.

The Welsh Government is reviewing the following 3 recommendations which will be considered by the Operational Group at its next meeting:

- A recommendation to introduce a statutory mental health commissioner.
- Abolition of community treatment orders for Part II patients.
- Creation of a statutory position of "responsible person" in each Health Authority with a range of duties set out in the report.

2.7 Independent Mental Health Advocacy Q4 Report, January – March 2023

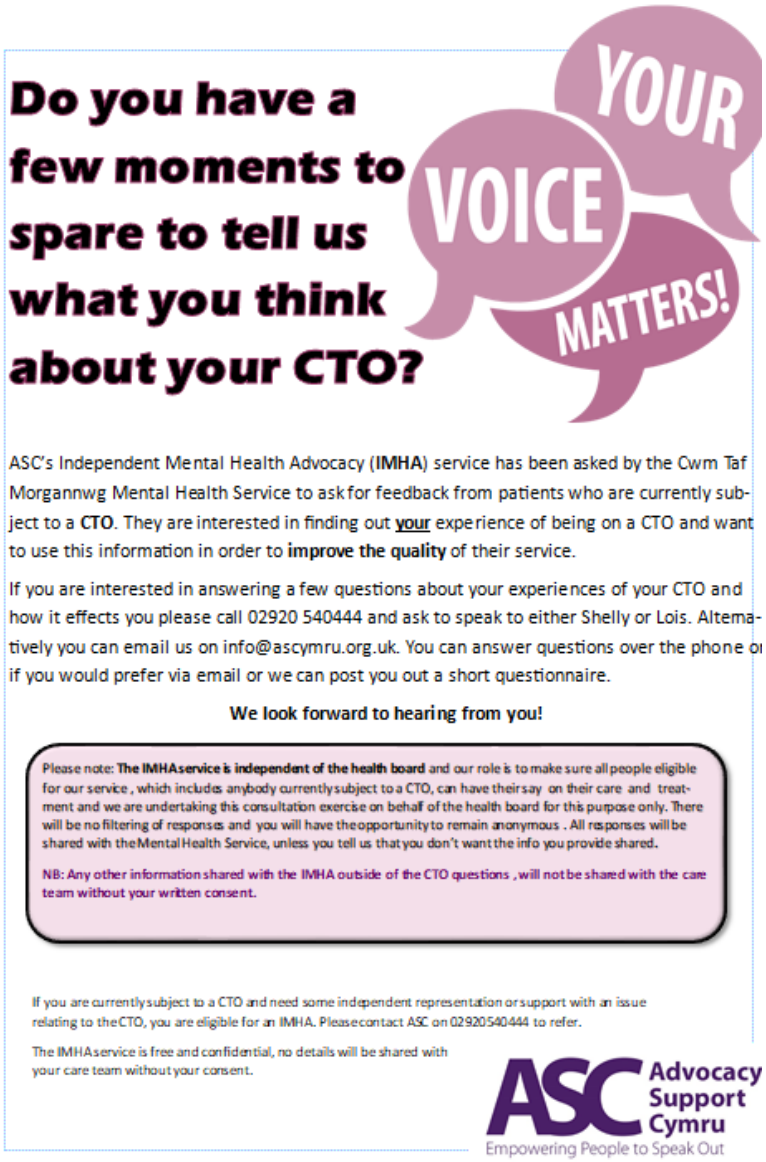
The group considered the Q4 report noting the 146 referrals, 62 of which were from detained and 84 from informal patients. Advocacy Support Cymru reported CTMUHB as making more referrals than other Welsh Health Boards for which they provided an IMHA service. The number of referrals from Bridgend and CAMHS had increased following some awareness raising sessions. There was discussion about the potential number of patients who could be offered support by the IMHA team. The group were advised of new a Key Performance Indicator which would compare number of assessments against the total number of

patients within the service. The group considered whether the Deprivation of Liberty Safeguards were being used in Older Peoples' Services when the Mental Health Act maybe more appropriate. Senior medical colleagues would be asked to consider this further.

The IMHA service had restarted their regular advocacy liaison meetings in the Royal Glamorgan Hospital and were aiming to extend these into the Princess of Wales Hospital. The IMHA team had agreed to provide some further training on the IMHA and IMCA.

2.8 Service User Community Treatment Order Questionnaire

Members of the Mental Health Act team have been working closely with Advocacy Support Cymru to design a service user questionnaire developed to gain feedback from those patients subject to a Community Treatment Order. A poster to publicise this work is shown below.



2.9 Update on Mental Health Act related actions following HIW Inspection of Mental Health Services

1) Visit to Ty Llidiard, 8 – 10 November 2021

The Health Inspectorate Wales report following their unannounced visit was published on 4 March 2022 and made the following recommendations:

Standard – Monitoring of the Mental Health Act – The Health Board must ensure that Section 17 Leave forms are completed accurately in full and address the issues identified. These included the need to describe the intended outcome or purpose of the leave or review how it went upon the patient's return. The patient's involvement in developing the leave form was also recommended.

The Clinical Director has ensured that medical staff are aware of the need to accurately complete Section 17 Leave forms and has completed an audit of Section 17 Leave for the period 01/06/2022 - 30/09/2022. The audit tool was based on the Section 17 guidance contained in the MHA Code of Practice. 13 patients were detained in Ty Llidiard during the audit period. The audit examined a random selection of 30 Section 17 Leave forms derived from all of the detained patients.

The audit identified several areas of good practice, for example: all detained patients had Section 17 leave in place, there was evidence this was regularly reviewed and conditions that would prevent leave were clearly specified on all the forms examined. However, the audit also highlighted areas with scope for improvement. In particular, it was found that the leave conditions and duration were not always clearly set out. There was also limited evidence alternative discharge options such as a CTO were actively considered for those granted Section 17 leave. There was limited evidence of Section 17 documentation being shared with carers and other professionals which may reduce the prospects of success for this intervention. There were also leave instances where the duration of Section 17 leave exceeded the period of the patient's detention. The group considered there to be evidence that further work was required on the compliance with Section 17 Leave documentation. The Clinical Director for CAMHS reassured the group about this ongoing work highlighting his regular meetings with colleagues to discuss progress. A follow up audit is due to be completed mid-June.

2) Visit to Angelton Clinic, 14 – 16 November 2022

Health Inspectorate Wales published their report on 15 March 2023 and made the following recommendations:

Standard 4.2 - Patient Information requires the Health Board to insure that a range of information for patients is displayed with the wards. This includes guidance around Mental Health Legislation and access to Advocacy Services. The Operational Group were reassured that ward notice boards now contained this information. A Carers Information Booklet is being coproduced and will be finalised shortly.

Standard 6.2 - The Health Board must ensure that copies of Detention papers are kept with patient records. This action is now complete with this being evidenced by monthly nursing note audits.

3) Visit to North Bridgend CMHT, 13 – 14 December 2022

A Joint Health Inspectorate Wales and Care Inspectorate Wales announced visit report was published on 16 March 2023. This report made the following recommendations:

Standard – Mental Health Act Monitoring – The Health Board must ensure that Community Treatment Order (CTO) documentation contains all the required detail. A letter containing all of the specific details of the CTO will be given to all patients subject to this detention. Arrangements have also been introduced to record the 'giving of rights' and information on the Appeal arrangements. The Mental Health Act team have developed an audit tool and will be transferring this onto the Health Board's AMaT (Audit Management and Tracking) process to monitor compliance. These audits should begin in July.

2.10 Review of Section 135 & 136 activity

The number of Section 136 detentions had increased from 36 in Q3 to 76 in Q4. Section 135 detentions had also increased from 4 in Q3 to 6 in Q4. This increase coincided with higher numbers of assessments discharged without follow up from 12 to 18 and those discharged with referral to community services from 11 to 35. A higher proportion of patients' detained following assessment indicated better use of these powers by the Police. It was reported that some medical staff understood there was a requirement for 2 Section 12 Approved Doctors to complete the assessment rather than the 1 specified in The Act. The group discussed a small number of instances which indicated a poor understanding of Section 135 & 136 by the Police Call Centre. The Operational Group recommended a multi-agency training event to help improve general understanding.

There was also a discussion about the accuracy of some information and it was thought that a review of the South Wales Police data set would be helpful.

The group were advised about the roll-out of a pilot scheme within the North Yorkshire Police entitled 'Right Care, Right Person'. This scheme may limit the Police response linked to mental health concerns. The scheme was being evaluated and may have some implications for the South Wales Police and their partners going forward.

'Right Care, Right Person' to be rolled-out from 31 January 2023

11:14 24/01/2023

In close collaboration with health and social care partners across North Yorkshire and the City of York, North Yorkshire Police is set to roll-out a significant new policy from 31 January 2023.

'Right Care, Right Person' is a model designed to ensure that when there are concerns for a person's welfare linked to mental health, medical or social care issues, the right person with the right skills, training and experience will respond.

In recent years, police officers have often been required to offer support to those who really require specialist medical or psychological care.

Under 'Right Care, Right Person', our officers will no longer be taking on this responsibility when it is not appropriate to do so.

2.11 Review waiting times in relation to Mental Health Assessments for Section 12 Approved Doctors and AMHPs

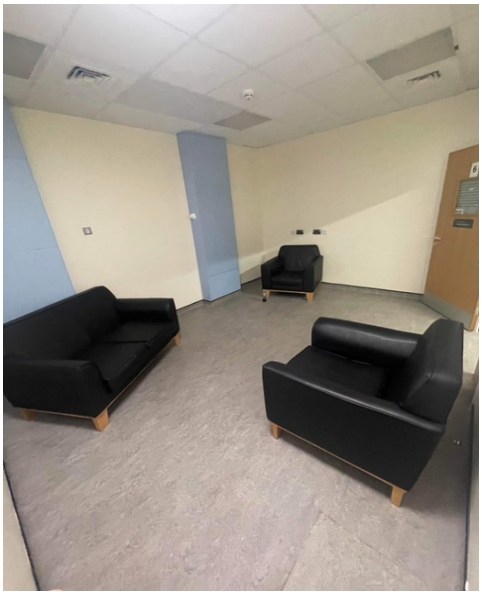
The Operational Group considered the information submitted from each of the Local Authority AMHP groups for the period January – March 2023.

Table 3 – Number of Mental Health Act Assessments completed by AMHPs in Q4

Month 2023	Bridgend AMHP No. of Assessments	Merthyr AMHP No. of Assessments	RCT AMHP No. of Assessments
January	16	8	23
February	11	4	37
March	17	12	20
Total	**44**	**24**	**80**

The Regional AMHP Group was considering the development of a standardised process for data capture around Mental Health Act assessments. The aim was for this to be completed electronically which would be able to record individual waiting times for the AMHP and Section 12 Approved Doctor at each assessment. Discussions were also beginning with the South Wales Police on the development of Section 136 activity information and in particular waiting times for Section 12 Approved Doctors. This improved date collection system could also potentially record waiting times for a bed to be identified when this was requested following assessment. This information would help with the review of 'Place of Safety' arrangements across the Health Board.

Progress had been made on upgrading the assessment facilities at Prince Charles Hospital with some photographs below evidencing this.



2.12 Operational Policy Review

The MHA team have applied the Health Board's Risk Assessment Tool to each of the policies listed in the table below. The meeting held on 28th April 2023 had approved the final two policies which had a red priority rating.

Table 4 - Schedule of Operational Policies

REF NUMBER	TITLE	LEAD PERSON	PROGRESS
MH09	Hospital Managers Operational Procedure	Alison Thomas	Agreed 09/07/2021
MH12	Section 17 leave policy	Jeremy Burgwyn	Agreed 09/07/2021
MH28	Hospital Managers Scheme of Delegation	Alison Thomas	Agreed 09/07/2021
MH04	Community Treatment Policy	Alison Thomas	Agreed 15/10/2021
MH17	Section 132&133 patient's rights procedure	Jeremy Burgwyn	Agreed 06/05/2022
New	Allocation of Responsible Clinician	Alison Thomas	Agreed 05/08/2022
MH06	Section 5 (4)	Alison Thomas	Agreed 27/01/2023
MH07	Section 5 (2)	Jeremy Burgwyn	Agreed 28/04/23
MH08	Consent to Treatment Sec 58 and Sec 58a	Alison Thomas	Agreed 28/04/23
MH03	Section 136	Jeremy Burgwyn	Awaiting Police to update national policy- 23/08/2022
MH02	Section 135(1) Section 135(2)	Jeremy Burgwyn	Awaiting Police to update national policy-23/08/2022
MH16	IMHA Procedure	Alison Thomas	For review Lapsed 18/07/2021-AT awaiting Policy update from LD
MH29	Applying to become an Approved Clinician	Alison Thomas	For review Lapsed 18/07/2021

AGREED FOR REVIEW FOR PRIORITY REVIEW

The Operational Group approved policies MH07 the Doctors' Holding Power, Section 5(2) and MH08 Consent to Treatment.

2.13 Operational Group Work Plan

The group considered a proposed work plan including the following items:-

Table 5 - Operational Group Work Plan

Activity	Progress	Timescale
Service user feedback	Advocacy Support Cymru to circulate CTO Questionnaire through the MHA Team. Report back to the Operational Group.	July 2023
Audit	MHA Team to complete audit of Statutory Documentation using the CTMUHB AMAT audit tool.	July 2023
Policy Work	All remaining policies to be ratified at the Operational Group.	October 2023
Monitoring of AMHP and Section 12 Approved Doctor waiting times for Assessments	The regional AMHP group is developing an electronic reporting tool to facilitate collection of this information.	October 2023
Nominated Adolescent Bed on Adult MH Wards	Capital funding and policy work to be concluded in order to facilitate the transfer of this service to Ward 14 POWh.	July 2023

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Mental Health Activity for CTMUHB Residents with a Learning Disability who are in hospital placement on 31st March 2023

The Operational Group will continue to monitor Mental Health Act activity for patients with a learning disability placed in hospitals outside the Health Board. For Q4 there were 3 such patients detained under the Mental Health Act with 0 fundamental breaches reported in the administration of the Act.

3.2 Independent Mental Health Advocacy Q4 Report, January – March 2023

Good progress is being made on improving access to the Independent Mental Health Advocacy into Bridgend and CAMHs. Some training events are being scheduled focusing on the relationship between the Mental Health Act and the Mental Capacity Act. IMHA liaison meetings within local inpatient settings are being reintroduced following the pandemic.

3.3 Improved Data Collection for Mental Health Assessments

The regional AMHP and Police Liaison groups are developing electronic systems to improve data collection. This could potentially be used to records delays in the provision of Section 12 Approved Doctor and AMHP services together with the availability of inpatient beds.

3.4 Fundamental Errors and Breaches of the Mental Health Act

Whilst 0 fundamental breaches were recorded in Q4 the roll out of the new scrutiny check list will help to ensure future breaches are kept to a minimum.

3.5 Review of Section 135 & 136 Activity

The number of Section 135 detentions has increased sharply in Q4. Further work is planned with South Wales Police colleagues to improve data collection and a multi-agency educational event is being planned to ensure all partners fully understand the circumstances under which these powers should be used.

3.6 Mental Health Act related actions following HIW Inspection of Mental Health Services

The Care Group is prioritising the improvement actions following a number of recent HIW visits. This includes some improvements required in relation to the Mental Health Act. For example, use of Section 17 Leave and communication with patients about their rights.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below.

withdrawn policies and services.	If no, please provide reasons why an EIA was not considered to be required in the box below.
	The MHA Operational Group meets bi-monthly to review the application of the Act across CTMUHB
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The committee is asked to note the work of the MHA Operational Group.

AGENDA ITEM
4.3

MENTAL HEALTH ACT MONITORING COMMITTEE

ACTIVITY REPORT AND BREACHES AND ERRORS FOR QUARTER 4 (JANUARY-MARCH 2023)

Date of meeting	07 June 2023
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	Mrs Alison Thomas -Mental Health Act Team Manager Jeremy Burgwyn – Mental Health Act Team Leader
Presented by	Mr Robert Goodwin- Service Group Manager, Bridgend
Approving Executive Sponsor	Executive Director of Primary, Community & Mental Health
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Mental Health Act office staff		SUPPORTED

ACRONYMS	
MHA	Mental Health Act
CTMUHB	Cwm Taf Morgannwg University Health Board
CAMHS	Child & Adolescent Mental Health Services
CTO	Community Treatment Order
RC	Responsible Clinician
AC	Approved Clinician
AMHP	Approved Mental Health Professional
CoPW	Code of Practice for Wales
PICU	Psychiatric Intensive Care Unit
POW	Princess of Wales Hospital
RCT	Rhondda Cynon Taf
CMHT	Community Mental Health Team

Summary

The reporting period witnessed an increase in detentions in all services between Q3 and Q4 of the current year.

Section 4 was applied on six occasions during the reporting period. The nurse's holding power under Section 5(4) was applied on two occasions during the quarter. All within the adult wards.

There were 0 fundamentally defective errors to report.

In Quarter 4, there were 18 minor errors on section papers, all of which were rectified within the fourteen day limit as per Section 15 of the MHA.

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to present activity data including errors and breaches regarding the application of the Act within CTMUHB. This report presents the MHA activity to the MHA Monitoring Committee in respect of Q4 (January- March 2023).

1.2 Section 15 of the Act allows for the rectification of statutory detention documentation completed by Doctors and AMHPs within 14 days of admission to hospital. While the minor errors are defined by "principal de minimus" (meaning they are immaterial and too small to be of any consequence), the fundamental errors (breaches) are more serious and require further attention and scrutiny to ensure that lessons are learned and the breach does not reoccur.

1.3 The report covers Adult, Older Persons Mental Health and CAMHS services managed by CTMUHB.

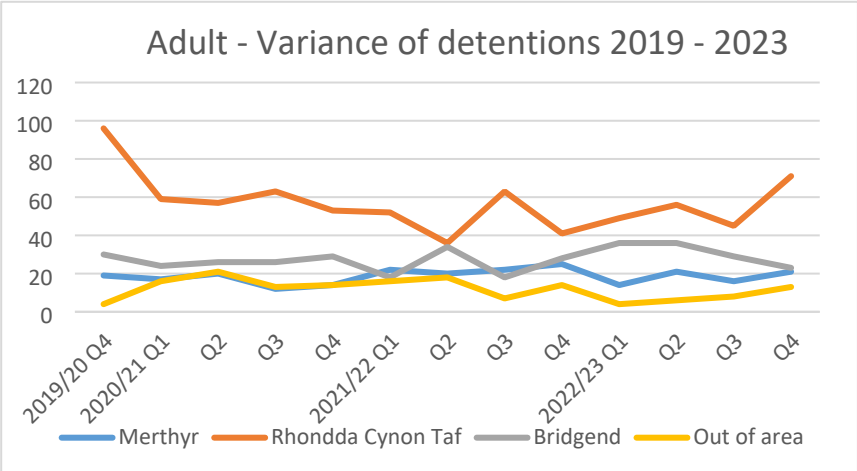
1.4 This activity is monitored in the MHA Operational Group, which is supported by the MHA Administration team. A Glossary of terms is attached for ease of reference (Appendix 2.)

2. SPECIFIC MATTERS FOR CONSIDERATION BY THE COMMITTEE (ASSESSMENT)

2.1 This quarterly MHA activity report is distributed to members of the Operational Group Meeting and is considered at individual Clinical Service Group Quality & Risk meetings. Trends are monitored to highlight and manage any risks to the organisation.

2.2 Adult Detentions - There has been an increase of 28% in the total number of detentions from 90 in Q3 to 115 in Q4. The number of detentions under S5 (2) increased from 16 to 19. Section 2 detentions increased from 48 to 66 with the number of Section 3 detentions decreasing from 21 to 20.

Graph 1



The mean figures for each area during 2019 and 2023 are shown below, along with the figures for Q4.

Table 1 – Comparison of Q4 and the Mean number of detentions (Adult)

Locality	Mean 2019/22	Q4 2022/23
Merthyr	19	21
Rhondda Cynon Taff	57	71
Bridgend	27	23
Out of area	12	13

2019/23 Mean to Q4 shifts as follows:

- In Merthyr detentions increased from baseline mean by 2 (11%) from 19 to 21
- In Rhondda Cynon Taff detentions increased from baseline mean by 14 (25%) from 57 to 71
- In Bridgend detentions decreased from baseline mean by 4 (15%) from 27 to 23.
- Out of area detentions increased from baseline mean by 1 (8%) from 12 to 13.

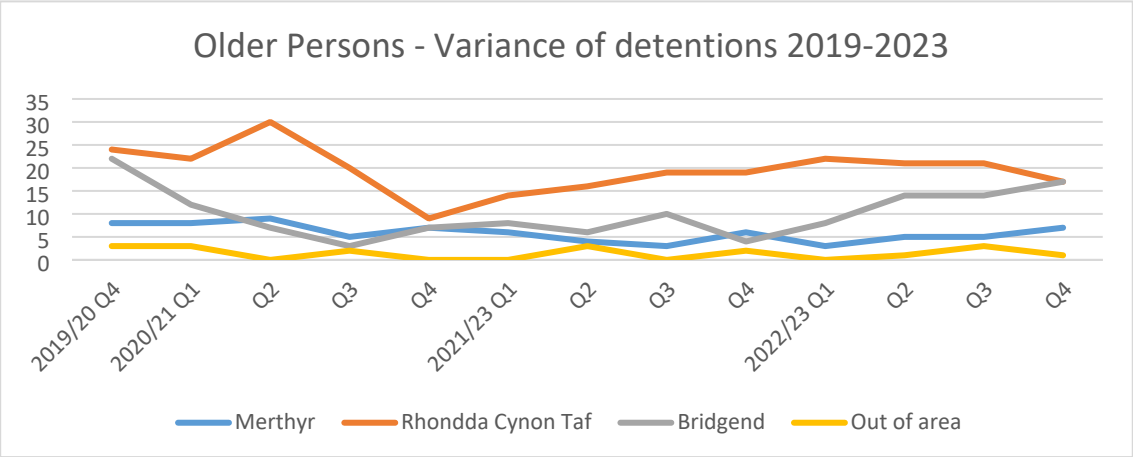
In Q4, there were 2 occasions when the nurses' holding power under Section 5(4) was utilised in the Royal Glamorgan Hospital.

In line with the guidance in the Code of Practice for Wales, both patients were assessed by a doctor within the 6-hour period and regraded to Informal status.

Section 4 was used on six occasions within the reporting period: 2 in Princess of Wales Hospital and 4 in Royal Glamorgan. Five of the section 4's were converted to section 2 within 24 hours and 1 patient was regraded to informal status.

2.3 Older Persons Detentions - The total number of detentions in Older Persons services increased by 2.5 % from 40 in Q3 to 41 in Q4, with variance across the localities as below:

Graph 2



The mean figures for each area during this time period are shown below, along with the figures for Q4.

Table 2 – Comparison of Q4 and the Mean number of detentions (Older People)

Locality	Mean 2019/22	Q4 2022/23
Merthyr	6	7
Rhondda Cynon Taf	20	17
Bridgend	10	17
Out of area	1	1

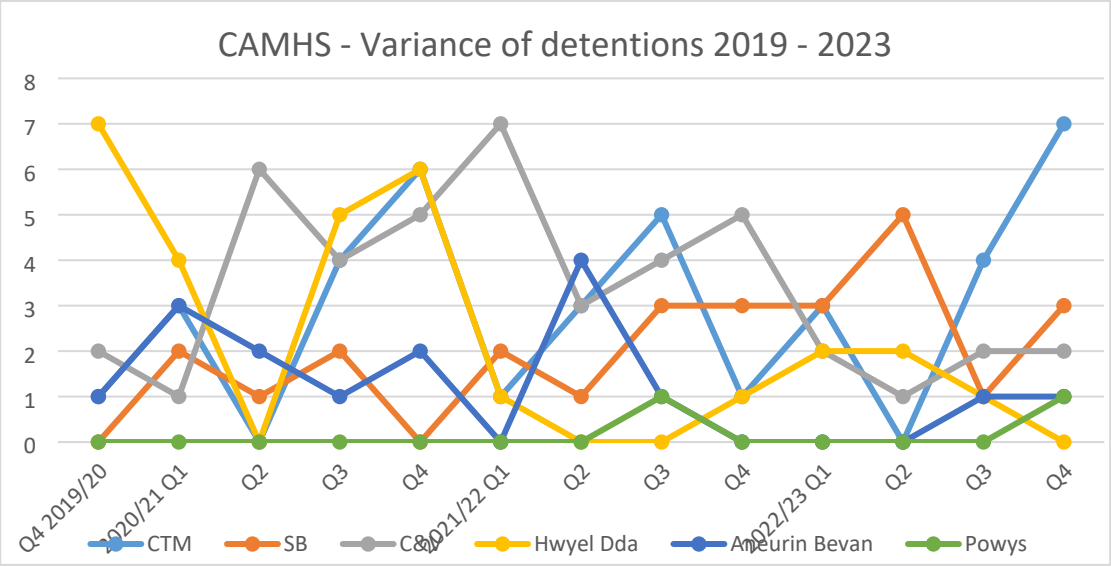
2019/23 Mean to Q4 shifts are as follows;

- In Merthyr detentions increased from baseline mean by 1 (17%) from 6 to 7.
- In Rhondda Cynon Taff detentions decreased from baseline mean by 3 (15%) from 20 to 17.
- In Bridgend detentions increased from baseline mean by 7 (70%) from 10 to 17.
- Out of area, detentions remained the same.

2.4 CAMHS Detentions

CAMHS detentions witnessed an increase. In Q4, there were 14 detentions (3 from Swansea Bay UHB, 0 from Hywel Dda UHB, 2 from Cardiff and Vale UHB, 1 Aneurin Bevan, 1 Powys and 7 from Cwm Taf Morgannwg UHB). Of the 14 detentions for Q4, 2 were on Admission Ward RGH, 1 was on PICU RGH and 11 were in Ty Llidiard.

Graph 3



The mean figures for each area during this time period are shown below, along with the figures for Q4.

Table 3 – Comparison of Q4 and the Mean number of detentions (CAMHS)

Health Board	Mean 2019/22	Q4 2022/23
Cwm Taf Morgannwg	3	7
Swansea Bay	2	3
Cardiff & Vale	3	2
Hywel Dda	2	0
Aneurin Bevan	1	1
Powys	0	1

2.5 Community Treatment Orders (CTO)

There were 8 new CTOs applied in Q4 of the current reporting period, in comparison with 10 in Q3.

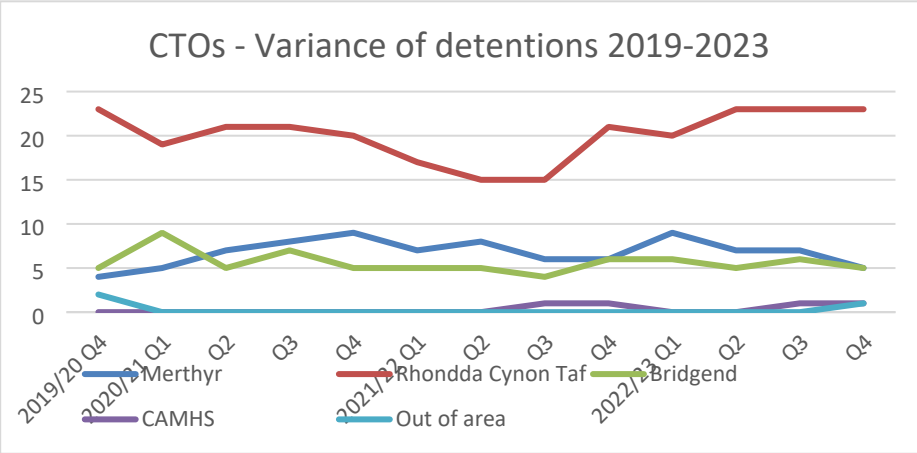
In Q4, there were 11 CTOs extended, 1 recalled, 5 recalled and revoked. 4 patients were discharged from detention under CTO in the quarter.

The mean figures for each area during this time period are show below.

Table 4 - Comparison of Q4 and the Mean number of CTO detentions

Locality	Mean 2019/22	Q4 2022/23
Merthyr	7	5
Rhondda Cynon Taf	20	23
Bridgend	6	5
CAMHS	0	1
Out of area	0	1

Graph 4



There were 35 CTOs in place as at the end of Q4.

2.6 Use of Section 135/136 Police Powers

Section 136 detentions increased from 36 in Q3 to 76 in Q4- a 111% increase, Section 135 detentions increased from 4 in Q3 to 6 in Q4 - a 50% increase.

Table 5 - Use of Section 135 and 136 by area for Q4 2022/2023

Area	Q3 2022/23	Q4 2022/2023
Merthyr	9	15
Rhondda Cynon Taf	14	41
Bridgend	15	22
Out of area	2	4
Total	**40**	**82**

The triage scheme that works alongside SWP should ensure that patients are being appropriately signposted to the correct service rather than receiving a crisis assessment.

The new electronic forms are helping police officers ask the right questions to patients, which may possibly lead to an increase in informal crisis assessments.

The use of Section 136 will continue to be monitored in the MHA Operational Group meeting. Any trends will be discussed and reported back to the Committee.

2.7 Current Challenges

The MHA team are experiencing problems with the non completion of the S135 All Wales Monitoring forms by South Wales Police.
This has potentially identified a training issue , which is currently being looked into by GM.

British Transport police do not have access to the electronic app, which means reverting back to completion of the S136 paper forms.

2.8 Errors and Breaches

It it pleasing to note that there were 0 fundamentally defective errors during Q4.

Rectifiable Errors

These are minor errors resulting from inaccurate recordings, which can be rectified under Section 15 of the Act. Examples include incomplete addresses and misspelled names.

The application or medical recommendation, if found to be incorrect or defective, may, within that period, be amended by the person by whom it was signed. Upon such amendments being made the application or recommendation shall have effect and shall be deemed to have had effect as if it had been originally made.

Fundamentally Defective

These are errors, which cannot be rectified under Section 15 and render the detention unlawful, therefore resulting in a breach of the Act.

Examples include unsigned section papers, incorrect hospital details or the wrong form being used. Medical recommendations and applications that are not signed cannot be remedied under Section 15 and therefore render the detention invalid.

Administrative and medical scrutiny of section documentation is carried out by the MHA Office and medical staff approved under Section 12 of the Act to ensure compliance and to identify any amendments needed within the target time limit. The majority of errors recorded within this report are minor, relating to demographics.
All breaches are reported via DATIX to enable monitoring and for training to be put in place as necessary.

2.9 The total number of minor errors across all services in Q4 was 18, the same figure as in Q3. All of which were rectified within the 14 day time limit. The table below provides a more detailed breakdown of the type of error.

Table 6 – MHA Forms and Minor Errors Q4

Rectifiable Errors		POW			RGH				Angelton	Ty Llidiard	
Responsible for Error	Forms	PICU	14	15	Admissions	22	PICU	St David's	2	Enfys	Total
AMHP	HO2	2		0	3	1	2	1			9
AMHP	HO6		1								1
Doctor	HO3										0
Doctor	HO4	1	1	1							3
Doctor	HO8										0
Doctor or Nurse	HO12										0
Nurse	HO14		1	1	1				1	1	5
Other UHB	TC1										0
	Total	**3**	**3**	**2**	**4**	**1**	**2**	**1**	**1**	**1**	**18**

2.10 The breakdown of errors will assist the MHA team in identifying areas of concern, which will highlight the priority areas for MHA training. The overall aim is to reduce the number of minor errors and eliminate any fundamental breaches of the Act.

2.11 There were **no fundamentally defective** errors within CTMUHB during Q4 compared to 2 in Q2. As mentioned previously, whereas the minor errors are inconsequential, the fundamentally defective errors (breaches) require investigation by the MHA team and are always reported via the Datix system.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Until the introduction and roll out of WCCIS, all data relating to MHA detentions, applications and referrals under the MHA 1983 are recorded on an Excel spreadsheet.
All further options of using different electronic systems, such as the PIMS+ to record and monitor MHA activity, which allows for the production of accurate reports, have been dismissed.

3.2 Following a visit to Maesteg CMHT in December 2022, HIW requested a CTMUHB wide audit of the documentation for patients detained under a Community Treatment Order.

The audit further highlighted the different types of patient health records and systems in use throughout the Health Board and in the local authorities.
Compliance with the filing of the CTO statutory documentation was higher in the electronic health record over paper based files, as the MHA team upload all detention paperwork to CarePartner. This eliminates the requirement for the documents to be printed out and filed, which is the current system in use in Bridgend.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.

Link to Main Strategic Objective	To provide strong governance and assurance
Link to Main WBFG Act Objective	Work collaboratively with our public service partners and a broader range of partners to join up health and other services where this potentially represents better value for our residents and care users

5. RECOMMENDATION

5.1 The MHA Monitoring Committee is asked to:

- DISCUSS and NOTE the report

Appendix 1.

Graph 1

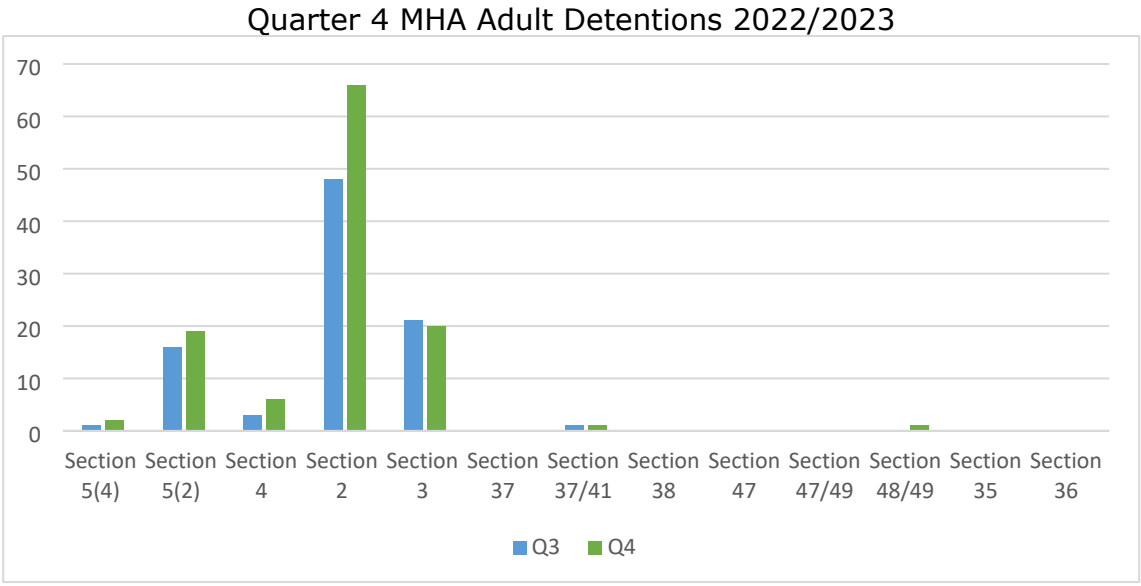


Table 1 – Quarter 4 MHA Activity 2022/2023

Section	Q3	% of total	Q4	% of total
Section 5(4)	1	1.11%	2	1.74%
Section 5(2)	16	17.78%	19	16.52%
Section 4	3	3.33%	6	5.22%
Section 2	48	53.33%	66	57.39%
Section 3	21	23.33%	20	17.39%
Section 37	0	0.00%	0	0.00%
Section 37/41	1	1.11%	1	0.87%
Section 38	0	0.00%	0	0.00%
Section 47	0	0.00%	0	0.00%
Section 47/49	0	0.00%	0	0.00%
Section 48/49	0	0.00%	1	0.87%
Section 35	0	0.00%	0	0.00%
Section 36	0	0.00%	0	0.00%
Total	**90**	**100%**	**115**	**100%**

*there were 13 out of area detentions in Q4-

Table 2 – Number of Adult MHA detentions per locality

Area	Q3 2022/23	Q4 2022/23
Merthyr	16	21
Rhondda Cynon Taf	45	71
Bridgend	29	23
Out of area	8	13

Graph 2

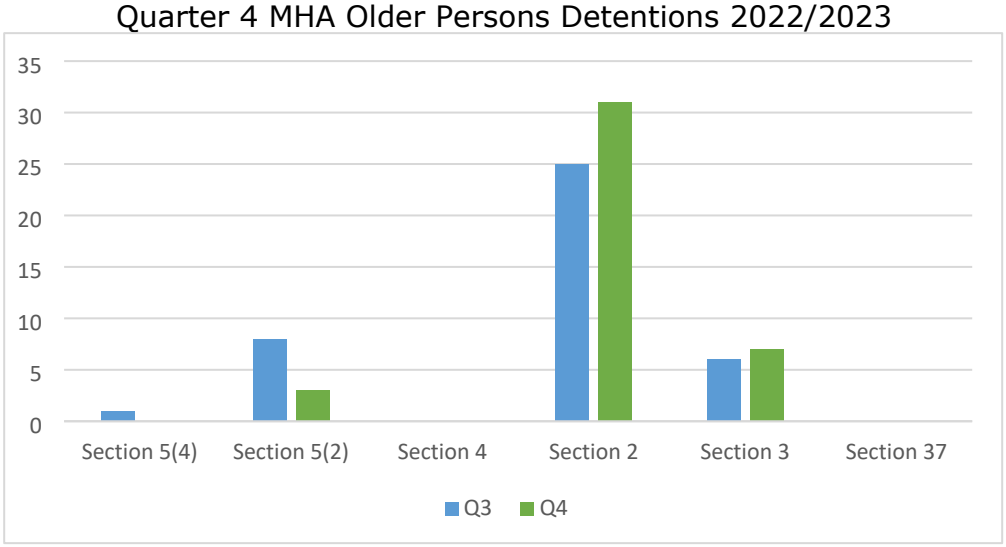


Table 3 - Quarter 4 MHA Older Persons Activity 2022/2023

Section	Q3	% of total	Q4	% of total
Section 5(4)	1	2.50%	0	0.00%
Section 5(2)	8	20.00%	3	7.32%
Section 4	0	0.00%	0	0.00%
Section 2	25	62.50%	31	75.61%
Section 3	6	15.00%	7	17.07%
Section 37	0	0.00%	0	0.00%
Section 37/41	0	0.00%	0	0.00%
Section 38	0	0.00%	0	0.00%
Section 47	0	0.00%	0	0.00%
Section 47/49	0	0.00%	0	0.00%
Section 48/49	0	0.00%	0	0.00%
Section 35	0	0.00%	0	0.00%
Section 36	0	0.00%	0	0.00%
Total	**40**	**100%**	**41**	**100%**

Table 4 – Number of Older Persons MHA detentions per locality

Area	Q3 2022/23	Q4 2022/23
Merthyr	5	7
Rhondda Cynon Taf	21	17
Bridgend	14	17
Out of area	3	1

Graph 3

Quarter 4 CAMHS Activity 2022/2023

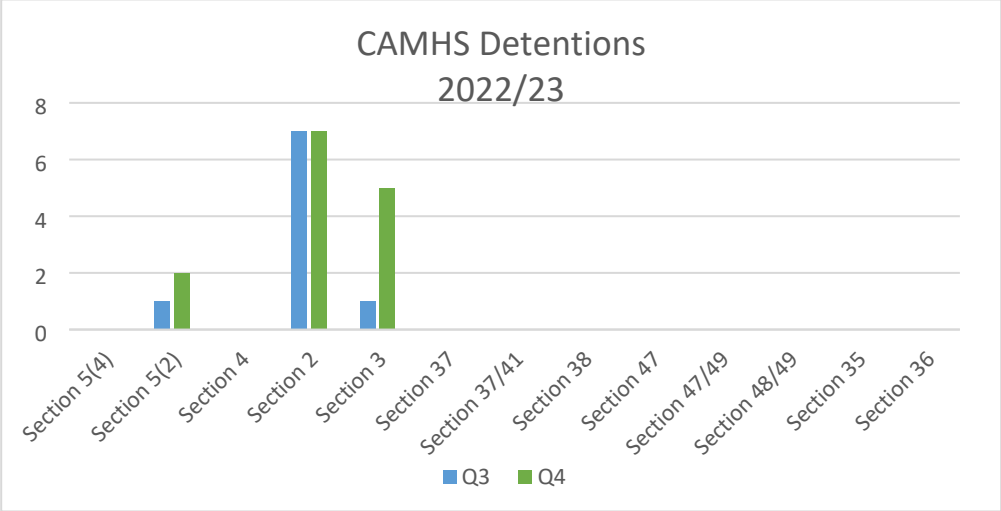


Table 5 - Quarter 4 CAMHS Activity 2022/2023

Section	Q3	% of total	Q4	% of total
Section 5(4)	0	0.00%	0	0.00%
Section 5(2)	1	11.11%	2	14.29%
Section 4	0	0.00%	0	0.00%
Section 2	7	77.78%	7	50.00%
Section 3	1	11.11%	5	35.71%
Section 37	0	0.00%	0	0.00%
Section 37/41	0	0.00%	0	0.00%
Section 38	0	0.00%	0	0.00%
Section 47	0	0.00%	0	0.00%
Section 47/49	0	0.00%	0	0.00%
Section 48/49	0	0.00%	0	0.00%
Section 35	0	0.00%	0	0.00%
Section 36	0	0.00%	0	0.00%
Total	**9**	**100%**	**14**	**100%**

Table 6 - Number of CAMHS MHA detentions per locality

	Q3	Q4

Health Board	2022/23	2022/23
Cwm Taf Morgannwg	4	7
Swansea Bay	1	3
Cardiff & Vale	2	2
Hywel Dda	1	0
Aneurin Bevan	1	1
Powys Teaching	0	1

USE OF SECTIONS AND OUTCOMES for October 2022 – March 2023

Section 5(2) of the Mental Health Act 1983

A 'holding power' can be used by doctors to detain an inpatient in hospital for up to 72hrs for assessment under the Act. This cannot be used in A&E because the patient is not an inpatient. A non-psychiatric doctor on a general medical ward can use this section.

Table 7 – Section 5(2) Outcomes

S5(2) OUTCOMES	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Section 2	10	3	4	1	2	5
Section 3	2	0	0	0	1	0
Informal	3	1	4	4	8	5
Lapsed	0	0	0	0	0	0
Invalid	0	0	0	0	0	0

Section 2 of the Mental Health Act 1983

The power to detain someone believed to be suffering mental disorder for assessment (and treatment). The order lasts for up to 28 days and cannot be extended or renewed. The patient has a right of appeal against detention to a Mental Health Review Tribunal.

Table 8 – Section 2 Outcomes

S2 OUTCOMES	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Section 3	8	5	3	8	11	9
Informal	13	12	12	15	19	12
Discharged	5	5	9	6	6	11
Lapsed	0	0	1	0	0	0
Invalid	0	0	1	0	0	0

Transfer	2	2	0	3	1	1

Section 3 of the Mental Health Act 1983

The power to detain someone for treatment of mental disorder. This section lasts for up to 6 months and can be renewed for another six months and then annually. Patient has the right of appeal against detention to a Mental Health Review Tribunal.

Table 9 – Section 3 Outcomes

S 3 OUTCOMES	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Section 3 renewed	3	5	3	2	1	0
Informal	5	5	3	2	6	3
Discharged	5	6	2	4	8	5
Lapsed	0	0	0	0	0	0
Invalid	0	0	0	0	0	0
Transfer	2	2	1	2	0	0
CTO	2	1	3	1	1	1

Table 10 – Number of compulsory admissions under the Mental Health Act 1983 (Sections 2, 3, 4 and 37 only)

	Q3 2022/23	Q4 2022/23
Adult Detentions	72	92
Older Persons detentions	31	38
CAMHS detentions	8	12
TOTAL	**111**	**142**

SECTION LAPSING

Detentions under the Mental Health Act can lapse for the following reasons:

- A section expires without the Responsible Clinician exercising their power to discharge under Section 23 MHA or the patient is not further detained under Section 3 of the MHA.
- The AMHP and Responsible Clinician have a difference of opinion on the appropriateness of further detention under Section 3 of the MHA.
- No further assessment by an AMHP and/or Responsible Clinician has taken place in respect of the next steps in relation to the patient's detention status.
- Although it is permitted to allow the section to lapse near the end of the section when no further detention is required, it is good practice for the Clinician to complete a discharge form.

- It is particularly poor practice to allow the section to lapse when the Responsible Clinician has not seen the patient. In this instance, the issue is reported to the Clinical Director and monitored to avoid re-occurrence.

Table 11 – Q3 & Q4 Comparison of Section lapses

Section lapses	Section	Q3 2022/23	Q4 2022/23
Adult	2	1	0
	3	0	0
	4	0	0
	CTO	0	0
	136	0	1
Older Persons	2	0	0
	3	0	0
	4	0	0
CAMHS	2	0	0
	3	0	0
	4	0	0

TRANSFER BETWEEN HOSPITALS

Section 19 of The Mental Health Act allows for the transfer of Part 2 (Section 2, 3 and CTO Patients) and some Part 3 (Section 37,37/41, 47, 47/49 and 48/49) detained patients from a hospital under one set of managers to a hospital under a different set of managers. For restricted patients transfers are subject to the prior agreement of the Secretary of State.

Table 12 – Q3 & Q4 Comparison of Patient Transfers

SECTION	Q3 2022/23	Q4 2022/23
Part 2 Patients to CTUHB	9	10
Part 3 patients to CTUHB	1	1
Part 2 patients from CTUHB	10	11
Part 3 patients from CTUHB	1	0
TOTAL	**21**	**22**

COMMUNITY TREATMENT ORDER, Section 17A (CTO)

Table 13 – Q 3 & Q4 Comparison of CTO Activity 2022/2023

SECTION	Power	Q3 2022/23	Q4 2022/23
17A	Community Treatment Order made	10	8
	Community Treatment order extended	10	11

	Recalled to hospital and not revoked	2	1
	Recalled to hospital and revoked	2	5
	Discharged from CTO	2	4
	Transferred	1	0
	Other (Deceased)	0	0

Table 14 – Q3 & Q4 Comparison of Current CTO by area

Area	Q3 2022/23	Q4 2022/23
Merthyr	7	5
Rhondda Cynon Taf	23	23
Bridgend	6	5
CAMHS	1	1
Out of area	0	1
Total	**37**	**35**

USE OF SECTION 135 AND SECTION 136

Police powers under the MHA to authorise removal to a Place of Safety.

Section 135

Warrants under the Act for (1) assessments on private premises and (2) recovering patients who are absent without leave. Lasts for up to 36hrs.

Table 15 – Q3 & Q4 Comparison of Section 135 outcomes

Section 135 of the Mental Health Act	Q3 2022/23	Q4 2022/23
Assessed and admitted informally	0	0
Assessed and Discharged	0	0
Assessed and detained under Section 2	3	5
Assessed and detained under Section 4	0	0
Assessed and detained under Section 3	0	1
Recalled from Community Treatment Order	1	0
TOTAL	**4**	**6**

Section 136

Power to detain someone in immediate need of care or control and remove him or her to a place of safety. Power to detain lasts for up to 24hrs.

Table 16 – Q3 & Q4 Comparison of Section 136 outcomes

Section 136 of the Mental Health Act	Q3 2022/23	Q4 2022/2023
Assessed and admitted informally	7	8
Assessed and detained under Section 2	6	11
Assessed and detained under Section 4	0	2
Assessed and detained under Section 3	0	1
Discharged with no follow up required	12	18
Discharged referred to community services	11	35
Section 136 lapsed	0	1
Other /(Recall from CTO)/ or transfer	0	0
TOTAL	**36**	**76**

HOSPITAL MANAGERS HEARINGS

Under the provisions of the Mental Health Act 1983, detained patients have a right to have their detention reviewed by the Hospital Managers. The Hospital Managers responsibilities are as follows:

- Undertake a review of detention at any time
- Must review a patient's detention when Responsible Clinician (RC) submit a report under Section 20/20A renewing detention and extending CTOs
- Must consider holding a review when a patient requests it
- Must consider holding a review when the RC makes a report under Section 25 (1) barring a nearest relative application for the patient's discharge.

Table 17 – Q3 & Q4 Outcome of Managers' Hearings

Hospital Managers Hearings	Q3 2022/23	Q4 2022/23
Number of Hearings held	22	16
Number of Referrals by Hospital Managers	14	24
Number of Appeals to Hospital Managers	2	0
Number of Detentions upheld by Hospital Managers	20	16
Number of detentions discharged by Hospital Managers	0	0
Number of patients discharged by RC prior to Hearing	0	4

Q4:

1 Adjourned
3 Postponed
1 Discharged by MHRT prior to hearing

TRIBUNAL HEARINGS

The Mental Health Review Tribunal for Wales (MHRT) is a statutory body that works independently of the Health Board to review appeals made by detained patients for discharge from their detention and community orders under the Mental Health Act 1983. Patients are also automatically referred by the Hospital Managers in certain circumstances.

Table 18 – Q3 & Q4 Comparison of MRHT Hearing outcomes

MHRT Hearings	Q3 2022/23	Q4 2022/23
Number of Hearings held	30	23
Number of Referrals by Hospital Managers	10	18
Number of referrals by Ministry of Justice	1	2
Number of referrals by Welsh Ministers	0	0
Number of Appeals to MHRT	36	49
Number of Detentions upheld by MHRT	24	19
Number of detentions discharged by MHRT	2	4
Number of Hearings adjourned/postponed	8	11
Number of Hearings cancelled by patient	11	9
Number of patients transferred to another Health Board prior to Hearing	2	1
Number of patients discharged by RC prior to Hearing	2	20

OTHER ACTIVITY

Death of a Detained Patient

The Hospital Managers have a duty to report to Healthcare Inspectorate Wales (HIW) any patients deceased who are subject to the Mental Health Act within 72 hours of death. This applies to in-patients as well as community treatment order and guardianship patients. The Coroner must also be informed.

Q4: There were no deaths of patients detained under the MHA 1983 during the quarter.

EXAMPLES OF GOOD PRACTICE

CTO service user involvement

The MHA are working closely with South Wales Advocacy service by sending out questionnaires to service users, who are subject to a Community Treatment Order.
The overall aim is to ensure that we listen to patients and make improvements where possible.

The MHA propose to sent out the CTO flyer to service users in both English and Welsh in the coming weeks.

Use of Care Partner in Cefn Yr Avon

It has been agreed that Cefn Yr Avon will soon be switching over to the electronic system called FACE for their patient recording.

Use of AMAT audit tool

The MHA team will be conducting their audits of statutory documentation electronically using the Health Board's AMAT system. The CTO audit will be completed on an annual basis and quarterly for detained inpatients.

Mental Health Review Tribunal Hearings

Since the 1st March 2023, patients who apply or are referred to the Mental Health Review Tribunals for Wales have been given a choice of a face-to-face hearing or Microsoft teams. To date, the Health Board has not encountered any difficulties in obtaining a suitable venue as per the minimum requirements set by the Tribunal office.

TRAINING

Medication awareness training was delivered to the Associate Hospital Managers on 9th March 2023.

Appendix 2

MENTAL HEALTH ACT (1983)

GLOSSARY OF TERMS

SUMMARY OF COMMON SECTIONS OF THE MENTAL HEALTH ACT 1983

Section 5(4) Nurse holding power.	This means that if a Nurse feels that a patient suffers from a mental disorder and should not leave hospital s/he can complete this form allowing detention for 6 hours pending being seen by doctor or Approved Clinician (*1 holding power form required*)
Section 5(2) Doctor's or Approved Clinician's Holding power	This means that an inpatient is being detained for up to 72 hours by a doctor or Approved Clinician if appears to suffer from mental disorder and patient wishes to leave hospital. (*1 holding power form required*)
Section 4 Admission for assessment in cases of emergency	Individual is detained for up to 72 hours if Doctor believes person is suffering from mental disorder and seeking another Doctor will delay admission in an emergency. *(1 Medical Recommendation and AMHP assessment required)*
Section 2 Admission for assessment	Individual is detained in hospital for up to 28 days for assessment of mental health. **Criteria:** Suffering from mental disorder of a nature or degree that warrants the detention of the patient in hospital for assessment for at least a limited period. And it is necessary that patient ought to be detained in the interests of own health, own safety, protection of other persons *(2 Medical recommendations (or 1 joint recommendation) and AMHP assessment required)*
Section 3 Admission for Treatment	Individual is detained in hospital for up to 6 months for treatment of mental disorder. **Criteria:** Suffering from mental disorder of a nature or degree which makes it appropriate for patient to receive medical treatment in hospital Moreover, it is necessary for the patient's own health, safety, protection of other persons that patient receive treatment in hospital. In addition, such treatment cannot be provided unless the patient is detained under Section 3 of the Mental Health Act. *(2 Medical recommendations (or 1 joint recommendation) and AMHP assessment required)*

Section 7 Guardianship	Individual who suffers from mental disorder can be given a guardian to help them in the community. Guardianship runs for six months and can be renewable. **<u>Criteria:</u>** Live in a particular place Attend for medical treatment, occupational; education or training at set places and at set times. Allow a doctor, an approved mental health professional or other named person to see patient *(2 Medical recommendations (or one joint recommendation) and AMHP assessment required)*
Section 37 Guardianship by Court Order	Court can make an order (6 months) that patient be given a guardian if needed because of mental disorder. The guardian is someone from social services. **<u>Criteria:</u>** Live in particular place Attend for medical treatment, occupational education or training at set places and times Allow a doctor or an approved mental health professional or other named person to see you *(Court Order required)*
Section 37/41 Admission to hospital by a Court Order with restrictions	Individual admitted to hospital on the order of the Court. This means that the Court on the advice of two doctors thinks that patient has mental disorder and need to be in hospital for treatment. The Court makes restrictions and as such, patient cannot leave hospital or be transferred without the Secretary of state for Justice agreement. *(Court Order with restrictions required)*
Section 135 Admission of patients removed by Police under a Court Warrant	Individual brought to hospital by a Police Officer on a warrant from Justice Of Peace, which means that an AMHP feels that individual is suffering from mental disorder for which s/he must be in hospital. Warrant last for 24 hours (but can be extended up to 36 hours). *(Section 135 (1){**non-detained patient**} warrant required or Section 135 (2){ **sections and CTO patients**} required)*
Section 136 Admission of mentally disordered persons found in a public place	Individual brought to hospital by Police Officer if found in public place and appears to suffer from mental disorder. Assessment by Section 12 Approved Doctor and Approved Mental Health Professional. Section 136 last for 24 hours (but can be extended up to 36 hours). *(Police Service Section 136 monitoring form required)*
Section 17 A Community Treatment Order (CTO)	CTO allows patients to be treated in the community rather than detention in hospital. Order last 6 months and is renewable. There are conditions attached which are: Be available to be examined by Responsible Clinician for review of CTO and whether should be extended.

	Be available to meet with Second Opinion Doctor or Responsible Clinician for the purpose of certificate authorising treatment to be issued. The Responsible Clinician may also set other conditions if relevant to individuals, carers and/or family. (*CP1 Form to be completed by Responsible Clinician and AMHP)*
Section 17 leave	Allows Responsible Clinician (RC) to grant day and/or overnight leave of absence from hospital to patient liable to be detained under the Mental Health Act 1983.Leave can have set of conditions attached for the patient's protection as well as protection of others. Leave can be limited to specific occasions or longer-term. There is a requirement for RC to consider CTO if overnight leave will be over 7 days. Patients can be recalled to hospital if they do not comply with the requirement of their leave. *(Section 17 leave non-statutory form required)*
Section 117 aftercare	This section applies to persons who are detained under Section 3, 37, 45 A, transferred direction under section 47 or 48 and who cease to be detained after leaving hospital. It is the duty of the Health Board and Local Authorities to provide aftercare under Section 117 free of charge to patients subject to the above sections. Patients can be discharged from Section 117 aftercare if they no longer receiving services.
MHAM Hearings (Mental Health Act Managers)	Patients detained under sections of the Mental Health Act are entitled to appeal against their detention to the Hospital Managers several times during their period of detention. Patients are also referred to the Hospital Managers by the Mental Health Act Administrators when the Responsible Clinician (RC) submits a report renewing the section.
MHRT Hearings (Mental Health Review Tribunal)	Patients detained under Sections of the Mental Health Act are entitled to appeal against their detention to the Mental Health Review Tribunal for Wales once in each period of detention. If a patient decides to withdraw their appeal, they can appeal again at a later date and do not lose the right of appeal. Patients are also automatically referred to the Mental Health Review Tribunal by the Mental Health Act Administrators if they have not exercised their right of appeal after a set period. Mental Health Act Administrators also automatically refer patient subject to a CTO, which has been revoked by the Responsible Clinician, to MHRT.

AGENDA ITEM
4.4

MENTAL HEALTH ACT MONITORING COMMITTEE

RISKS RELATED TO THE MONITORING OF THE MENTAL HEALTH ACT

Date of meeting	07/06/2023
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	Julie Denley Director Primary Care & Mental Health
Presented by	Julie Denley Director Primary Care & Mental Health
Approving Executive Sponsor	Chief Operating Officer (COO, DPCMH)
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Mental Health Act Team	(DD/MM/YYYY)	SUPPORTED

ACRONYMS	
MHA	Mental Health Act
UHB	University Health Board
RC	Responsible Clinician

ILG	Integrated Locality Group
AMHP	Approved Mental Health Practitioner

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to present risks related to the monitoring of the Mental Health Act (MHA) evident in quarter 4 2022/23 and for discussion and scrutiny related to actions and key milestones related to mitigating these risks.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The number of minor errors on section reduced to 18 in quarter, the same as Q3 when typically 25 in previous quarters. It is good to see the operational group focusing in on the rectifiable errors and the two highest areas involve AMHPs and Nurses which should bring greater opportunity as typically less turnover than with medical staff.

2.2 It was pleasing to see 0 fundamentally defective errors during Q4. The look back audit over three years is helpful to ensure well targeted and sustainable learning and the actions set out in the operational group are welcomed.

2.3 The significant increase in the use of the MHA in quarter against the mean is noted and if the same is evident next quarter a further review of the changes should be undertaken by the operational group. The increase in use of Section 136 is particularly noteworthy.

2.4 The MHA team are experiencing problems with the non-completion of the S135 All Wales Monitoring forms by South Wales Police, a potential training issue. It is noted that British Transport police do not have access to the electronic app, which means reverting back to completion of the S136 paper forms.

2.5 Although this paper focuses on risks for balance, a few key positive highlights in other papers are noted below:

- It was pleasing to see 111#2, a telephone-based advice and support line that will provide guidance for persons of all ages who are experiencing a mental health need. Particularly good to see is there were 151 police support calls in just over a month as this was as area of change to service provision and as such a potential risk area.

It will be important to track impact for the people contacting the service but also for wider service demand and for the purpose of this Committee any potential change in patterns of use of Section 136 that may be attributable.

- The Review the use of the MHA in learning disability settings is positive in that no breaches in the use of the ACT were evident.

- It was reassuring to see the CTM region are making more referrals to the Independent Mental Health Advocacy service than any other Health Board area.

- Progress on policies review is very evident.

- Progress on the environment in Prince Charles Hospital.

- A clear forward work plan for the operational group that clearly links to issues arising and discussed.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 It is good to see the issue of conflict of interest concerns related to fundamental errors in MHA processes being raised within the Mental Health & Learning Disability Care Groups Senior Medical Staff Committee.

3.2 The consideration of the minutes of the power of discharge committee was helpful to see by the operational group. One issue raised was the timing of clinical reviews pre a hospital managers hearing, and a standard agreed that these should be no longer than 3 months pre a hearing. An audit of these will be added to this Committee's forward plan.

3.3 The lack of a bespoke system to record and monitor MHA activity, which allows for the production of accurate reports and the wards across CTMUHB using different types of health records remains a concern and patient safety concern.

3.4 The much stronger oversight of Health Inspectorate Wales inspection actions related to the use of the MHA is clearly evident in the operational group report with ongoing work related to the use of Section 17 leave clearly evident. The Committee are asked to ensure system wide learning in relation to this area.

3.5 The level of demand and the modeling the service is based on is noted and is clearly being monitored operationally to revisit capacity as needed.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The issue of a lack of a single clinical record system stems from patient safety concerns and learning from events.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Mental Health Act Monitoring Committee is asked to:

DISCUSS and NOTE the report and the areas for reporting through to Board.

4.5	7th June 2023	Mental Health Act Monitoring Committee	Overview of the Mental Health & Learning Disabilities Care Group – Organisational Structure

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	N/A
Prepared By:	Elaine Lorton – Service Director, MH&LD
Presented By:	Elaine Lorton – Service Director, MH&LD
Approving Executive Sponsor:	Julie Denley – Deputy COO – Primary, Community & Mental Health
Report Purpose	For Noting
Engagement undertaken to date:	Internal Care Group Discussions Phase 2 Steering Group

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	The correct Care Group structure is key in the safe delivery of services, effective oversight and assurance.
Related Health and Care Standard	Governance, Leadership & Accountability
Has an EQIA been undertaken?	No – pending final structure
Are there any Legal Implications /Impact.	Yes – Employment Law
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Yes – savings sought as part of the operational element of the proposed structure.
Link to Strategic Goals	All Strategic Goals relevant

Comments

- Only 2 posts have been classed as “out of scope” within the operational structure – these are 2 temporarily funded / fixed term posts which already work pan-CTM
- No further changes have been made to the clinical structures but 10% saving has been found in the operational structure – there are moderate risks in the Older Adult and CAMHS+ clinical service groups.
- Savings based on costs at middle point of the band – risks to be exposed through the OCP where top of band staff are slotted in
- SIF funding has supported this restructure including the Care Group Service Director and the service / quality improvement and transformation posts. Those which are recurrently appointed have been included within scope for Phase 2. Further work on this part of the structure will be completed separately.

Recommendation:	**The Board or Committee are asked to:** NOTE the current development of the Phase 2 structure for the Mental Health & Learning Disability Care Group

Subjective Units of Disturbance Scale (SUDS)

A **SUDS** or a **Subjective Units of Disturbance Scale** (or a **Subjective Units of Distress Scale**) is a scale of “0" to “10" for measuring the subjective intensity of disturbance or distress currently experienced by an individual. The individual self-assesses where they are on the scale. The SUDS may be used as a benchmark for a professional or observer to evaluate the progress of treatment.

The SUD-level was developed by Joseph Wolpe in 1969. It has been used in EMDR, Trauma-Focused Therapy (TFT), EFT, CBT, Anxiety Disorders and for research purposes.

Basis

There is no hard and fast rule by which a patient/client can self assign a SUDS rating to his or her disturbance or distress, hence the name subjective.

Some guidelines are:

- The intensity recorded must be as it is experienced now.
- Constriction or congestion or tensing of body parts indicates a higher SUDS than that reported. *(Continued)*

DR. DIANNE RUTH **PhD in Psychology • Anxiety Care Coach & Alternative Counselor**

Email: DrRuth@AnxietyCareCoach.com • **Website:** AnxietyCareCoach.com • DynamicResources.net
Call/Text (619) 961-7500 • Sessions in Person or by Phone ... that really work!

The Scale

Here is one version of the scale:

10 = **Feels unbearably bad,** beside yourself, out of control as in a nervous breakdown, overwhelmed, at the end of your rope. You may feel so upset that you don't want to talk because you can't imagine how anyone could possibly understand your agitation.

9 = **Feeling desperate.** What most people call a 10 is actually a 9. Feeling extremely freaked out to the point that it almost feels unbearable and you are getting scared of what you might do. Feeling very, very bad, losing control of your emotions.

8 = **Freaking out.** The beginning of alienation.

7 = **Starting to freak out,** on the edge of some definitely bad feelings. You can maintain control with difficulty.

6 = **Feeling bad** to the point that you begin to think something ought to be done about the way you feel.

5 = **Moderately upset,** uncomfortable. Unpleasant feelings are still manageable with some effort.

4 = **Somewhat upset** to the point that you cannot easily ignore an unpleasant thought. You can handle it OK but don't feel good.

3 = **Mildly upset.** Worried, bothered to the point that you notice it.

2 = **A little bit upset,** but not noticeable unless you took care to pay attention to your feelings and then realize, "yes" there is something bothering me.

1 = **No acute distress** and feeling basically good. If you took special effort you might feel something unpleasant but not much.

0 = **Peace, serenity, total relief.** No more anxiety of any kind about any particular issue.

From Wikipedia, the free encyclopedia

UK Mental Health Triage Scale				
Triage Code /description	**Response type/ time to face-to-face contact**	**Typical presentations**	**Mental health service action/response**	**Additional actions to be considered**
A Emergency	**IMMEDIATE REFERRAL Emergency service response**	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	**Triage clinician to notify ambulance, police and/or fire service**	Keeping caller on line until emergency services arrive / inform others Telephone Support.
B Very high risk of imminent harm to self or to others	**WITHIN 4 HOURS Very urgent mental health response**	Acute suicidal ideation or risk of harm to others with clear plan or means Ongoing history of self harm or aggression with intent Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Urgent assessment under Mental Health Act Initial service response to A & E and 'front of hospital' ward areas	**Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&E department** (where the person requires medical assessment/ treatment)	Recruit additional support and collate relevant information Telephone Support. Point of contact if situation changes
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	**WITHIN 24 HOURS Urgent mental health response**	Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent Rapidly increasing symptoms of psychosis and / or severe mood disorder High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Overt / unprovoked aggression in care home or hospital ward setting Wandering at night (community) Vulnerable isolation or abuse	**Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment**	Contact same day with a view to following day review in some cases Obtain and collate additional relevant information Point of contact if situation changes Telephone support and advice to manage wait period
D Moderate risk of harm and/or significant distress	**WITHIN 72 HOURS Semi-urgent mental health response**	Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight /early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	**Liaison/CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
E Low risk of harm in short term or moderate risk with good support/ stabilising factors	**WITHIN 4 WEEKS Non-urgent mental health response**	Requires specialist mental health assessment but is stable and at low risk of harm during waiting period Other services able to manage the person until mental health service assessment (+/- telephone advice) Known service user requiring non-urgent review adjustment of treatment or follow-up Referral for diagnosis (see below) Requests for capacity assessment, service access for dementia or service review / carer support	**Out-patient clinic or CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
F Referral not requiring face-to-face response from mental health	**Referral or advice to contact alternative provider**	Other services (outside mental health) more appropriate to current situation or need	**Triage clinician to provide advice, support Advice to contact other provider and/or phone referral to alternative service provider** (with or without formal written referral)	Assist and/or facilitate transfer to alternative service provider Telephone support and advice
G Advice, consultation, information	**Advice or information only OR More information needed**	Patient or carer requiring advice or information Service provider providing information (collateral) Initial notification pending further information or detail	**Triage clinician to provide advice, support, and/or collect further information**	Consider courtesy follow up telephone contact Telephone support and advice

Sands, N. Elsom, E, Colgate, R & Haylor, H. (2016) Development and inter-rater reliability of the UK Mental Health Triage Scale (In Press). *International Journal of Mental Health Nursing.*

GIG CYMRU NHS WALES

Uned Gomisiynu Cydweithredol Cenedlaethol
National Collaborative Commissioning Unit

BEYOND THE CALL

NATIONAL REVIEW OF ACCESS TO EMERGENCY SERVICES FOR THOSE EXPERIENCING MENTAL HEALTH AND/OR WELFARE CONCERNS

OCTOBER 2020

AUTHORS: S . MILLS , R . BAGSHAW & A . WATT

BEYOND THE CALL

Authors of this National Review

This National Review was written by Mr. Shane Mills, MSc, RMN, Director of Quality & Mental Health/Learning Disabilities at the National Collaborative Commissioning Unit with research, analysis and contributions by Dr Andrew Watt, BSc, PhD SFHEA, and Dr Ruth Bagshaw BSc, DclinPsych senior academics and lecturers from Cardiff Metropolitan University.

Acknowledgments

The author would like to thank the following for their support during this National Review:

- Police and ambulance call handlers, control room staff and mental health support teams for answering the calls and collecting the information used in this National Review. ICAN volunteers and staff for collecting information used in this National Review.
- Welsh Alliance for Mental Health, Welsh Ambulance Service Trust, Dyfed–Powys Police, Gwent Police, North Wales Police, South Wales Police, Mid and West Wales Fire Service, North Wales Fire Service, South Wales Fire Service, NHS Wales Heath Boards and the Local Authorities in Wales for their cooperation during this National Review.
- Members of the Expert Reference Group who provided invaluable advice and support.
- Staff of the National Collaborative Commissioning Unit for coordinating and supporting the National Review.

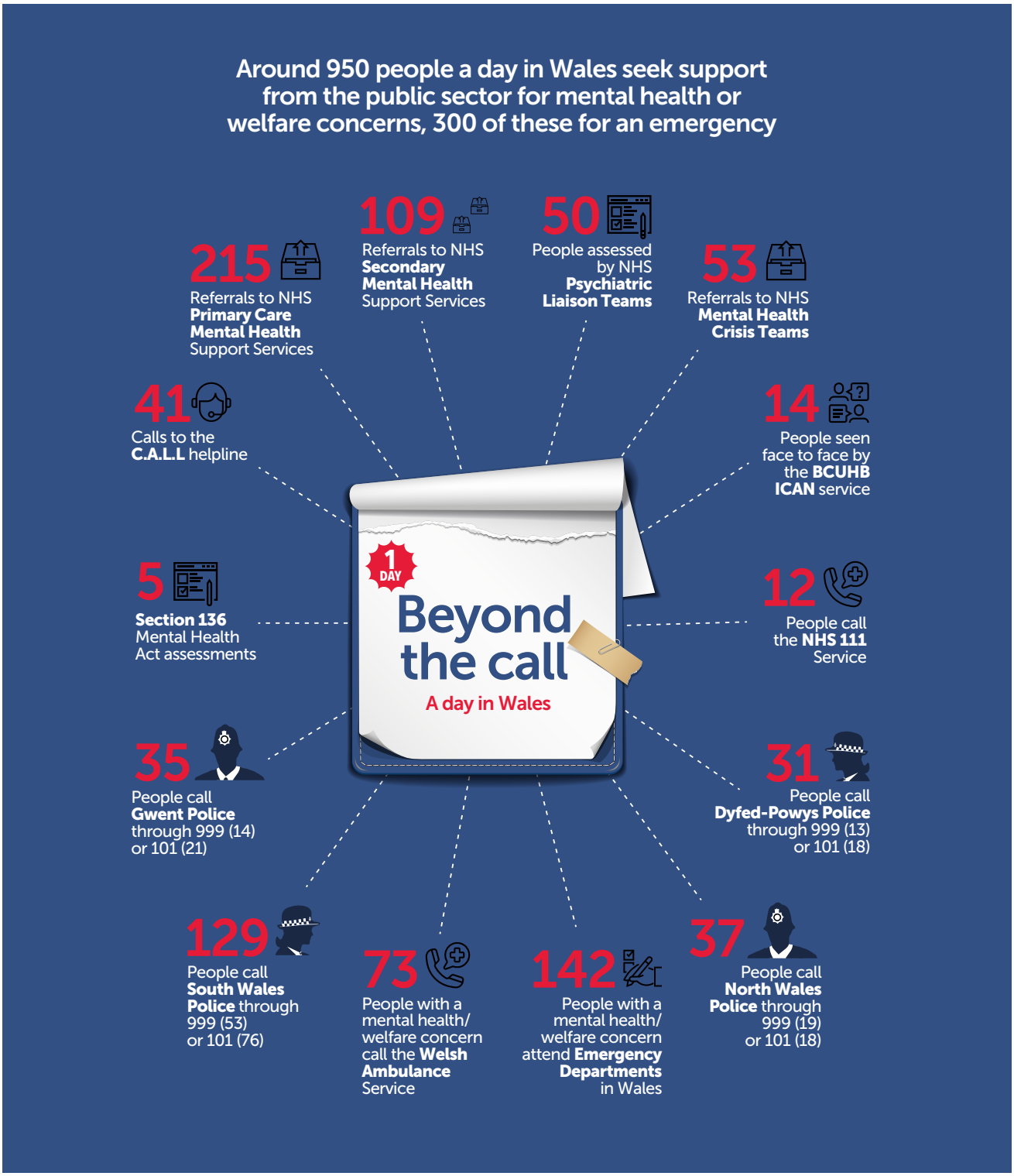
Notes

- Some of the trigger words in the bespoke data collection can be viewed as plainspoken and no offence is intended by the use of colloquial terminology
- The data and information used in this National Review was collected before the Coronavirus pandemic which may affect future demand and service response.

About this National Review

This National Review has been commissioned by Welsh Government as part of the Together for Mental Health Delivery Plan through the National Crisis Care Concordat Assurance Group. This National Review was commissioned to achieve greater understanding of the issues leading the public to access emergency services when experiencing mental health and/or welfare concerns.

This National Review initially covered the method and instances of conveyance by emergency or dedicated transport services for person experiencing mental health issues post-assessment but, due to the disruption in the production of this National Review caused by the Coronavirus Pandemic, this aspect will be addressed through a supplementary report. It was planned to undertake a 'lived experience' survey in collaboration with the Mind mental health charity and the Wales Alliance for Mental Health. This survey was to better understand the personal experiences involved in contacting emergency public services for a mental health or welfare concern. Due to the disruption caused by the Coronavirus pandemic this survey will be undertaken at a later date and published through a supplementary report.



Graphic is for illustrative purposes only. Numbers are averages. Exact figures are **946** overall, **319** classed as emergency ('999' calls to police and ambulance, Sec 136 and attendance at emergency department). Police data is from MH snapshot day November 2019. Emergency department is **4%** of attendances. Other data is from bespoke data requests or published data. Data does not include social care, third sector or telephone helpline support. Police figures do not include persons in custody with mental health flags or missing person calls. Some overlap may occur as calls to police could result in ambulance call, emergency department attendance or NHS mental health services referral, similarly calls to ambulance or NHS 111 could result in police calls, emergency department attendance or referral to NHS mental health service. Some emergency department figures could include subsequent referral to psychiatric liaison or ICAN services. Many calls or referrals could result in an assessment with no determination of a mental illness. Numbers could refer to single calls from single person, multiple calls from a single person or multiple calls about a single person. Further explanations can be found in this National Review.

Foreword

I am pleased to present this National Review on access to emergency services by people in crisis who have mental health and/or welfare concerns. The Review has found that each service responds to the needs of people in crisis in a way that is informed by their own organisation's understanding of what 'crisis care services' mean. We need to ensure that the planning and delivery of crisis care services is better joined up and coordinated across a range of public sector services, and that the use of resources and expertise is better targeted to meet people's needs.

The Review has highlighted where there are gaps in data and evidence, and stresses the need to focus on a whole system approach to planning and delivering crisis care services. The Review has also found that issues classified as 'a mental health issue' are not always indicative of mental illness, and that some people present in crisis as a consequence of social or welfare issues.

The Review highlights the complexity of planning and delivering crisis care services across multi agencies, and how presentations do not just relate to health matters but also to matters such as confusion, intoxication, loneliness, debt and homelessness amongst many others.

Although there will always be people who require specialist mental health services, there are many others who need access to a range of other help, advice and support services, including people who need support out-of-hours. We must ensure we have the appropriate response in Wales to deal with this range of health and welfare issues through a preventative agenda. The current pandemic and its resultant impact on wellbeing reinforces this need.

I would like to take this opportunity to thank Shane Mills and all the other contributors for their work on producing this report. I appreciate the challenges in completing the Review and producing the report during a worldwide pandemic.

This Review will help to set the direction for ensuring that high quality crisis care services are planned and delivered across Wales over the next decade.

Emrys

EMRYS ELIAS- CHAIR,
NATIONAL CRISIS CARE CONCORDANT GROUP AND
VICE CHAIR, ANEURIN BEVAN UNIVERSITY HEALTH BOARD

PART A

BACKGROUND & METHODOLGY

Contents

> **'[A CORE PRINCIPLE IS] SECURING BETTER QUALITY AND MORE MEANINGFUL DATA'**
>
> **STATEMENT FROM: WELSH GOVERNMENT AND PARTNERS MENTAL HEALTH CRISIS CARE CONCORDAT (2015)**

1. Background

In May 2019 the Welsh Government, through the National Crisis Care Concordat Group, commissioned the Director Of Quality & Mental Health/Learning Disabilities at the NHS Wales National Collaborative Commissioning Unit to undertake a National Review to achieve greater understanding of the issues leading the public to access emergency services when experiencing mental health and/or welfare concerns, henceforth referred to as 'the Review'.

The Review supports the Together for Mental Health Delivery Plan 2019-2022 aim that 'outcomes are improved for people in crisis'[1]. The Review was originally proposed to be published in May 2020 but was delayed due to the Coronavirus pandemic.

2. Scope

Services within the scope of the Review were those with direct access from the public in an emergency, such as police, fire, ambulance services and emergency departments. Services which require a referral from another professional such as NHS mental health crisis services, criminal justice liaison services, community mental health services, frequent attender networks and psychiatric liaison services were excluded. Support services provided by charities, support groups and helplines, although acknowledging their critical role in supporting people in crisis, were excluded as not being statutory public services.

3. Methodology

In order to ensure the Review was evidenced based, data informed, cognisant of lived experience and took account of expertise and knowledge the following were proposed:

- An Expert Reference Group,
- Partnership with Cardiff Metropolitan University for research and data analysis purposes,
- Commission to Picker Europe to undertake a representative population perception and comprehension survey,
- Collaboration with Mind, the mental health charity, to understand the views of people with lived experience who have accessed mental health services.

Unfortunately the disruption to the Review due to the Coronavirus pandemic caused a delay in conclusion and publication of the population and lived experience surveys.

3.1 Expert Reference Group

The Expert Reference Group was established to:

- Inform the approach for the National Review,
- Provide expert advice on the key issues,
- Highlight relevant practice.

Key stakeholders were invited to be part of the Expert Reference Group from areas such as charitable groups, crisis care concordat members, social services, NHS mental health services, NHS Delivery Unit, NHS National Collaborative Commissioning Unit, NHS 111 service, fire and rescue services, coastguard, police force and ambulance services. Membership of the Expert Reference Group is detailed in Appendix 1.

3.2. Data Collection

Data presented in the Review is from a range of sources and is the latest available, although in a limited number of cases it may be a few years old and not reflective of any rise or change in demand. All data collected as part of the Review related to non-person identifiable information only. Some aspects of access to emergency services such as ethnicity, deprivation, geography and epidemiology cannot be explored in the Review due to the scope and nature of data available or collected.

Data shown for public services in the Review relates to 'mental health' as defined by that specific service and may not be indicative of the prevalence of clinical diagnosis of mental illness. Due to the complexity of the issues involved and the limitations of information gathered, the data presented in the Review may not identify all, or may over-represent, mental health related incidents or calls. Numbers classed as 'calls' in the Review could refer to single calls from single person, multiple calls from a single person or multiple calls concerning a single person. Data used in the Review and referenced is in the public domain, unreferenced data has been requested as part of the Review and must be accepted as unverified. Some percentages have been rounded so the total may not equate to 100%.

Different emergency services employ different methodologies to quantify and assess mental health or welfare calls. To understand and scope demand across different services a bespoke data collection was developed to provide an identical method of assessing calls across services. Data collection took place across three months from 1 December 2019 to 29 February 2020.

Due to the nature of how contact is made and recorded by some emergency public services and the ability to integrate the data collection process into the operation of the service, the bespoke data collection was undertaken by the four police forces of Wales, Welsh Ambulance Services Trust and the North Wales NHS 'ICAN' services. Each of these services will be discussed in the Review.

A bespoke data collection form and explanatory sheet were developed for the Review, this data collection form was specifically designed as a single sided A5 sized sheet in order that it could be completed quickly by call handlers and not delay any requirement to dispatch an emergency vehicle or divert the call to an appropriate service as soon as possible. Both the development of the data collection form and the drafting of the explanatory sheet was guided by the Expert Reference Group, a reproduction of both of these documents can be found in Appendix 2.

Some police forces transposed the data collection sheet into internal police systems although the data gathered was identical. The ICAN services see people face-to-face but for reasons of simplification, they have been classified as 'calls'. Although data collection was standardised and an explanatory sheet produced, individual interpretation by call handlers cannot be completely eliminated.

4. Defining Mental Health & Welfare Concerns

'Mental health' and 'welfare' are broad terms. Mental health can often refer to a positive state of being and the World Health Organisation defines it as a 'state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community'[2]. The term 'mental health', as used by some public services, may not relate to well-being, or a diagnosis of mental illness, but any issue related to the mental and emotional state of a person. The broadness of this meaning can cause misunderstandings and occasionally discord between emergency services and NHS mental health services, as the latter may require a diagnosis or the meeting of certain eligibility criteria to access care.

For the purpose of the Review 'mental health' is the term used to classify any incident, reported by callers, to be primarily associated with a mental disorder or condition. In order to reflect the types of language often used by callers, mental health has been further sub divided into 'low mood/depression', 'anxiety, 'dementia and 'other mental illnesses', which may include conditions such as schizophrenia, bipolar disorder or personality disorder.

'Welfare concerns' is the term used within the Review to describe any incident, reported by callers, to be primarily associated with emotional, environmental, social, drug or alcohol related distress that is impacting on a person's overall wellbeing. It should be noted that there is considerable co-occurrence between mental health and welfare concerns.

5. Overview of 'Crisis'

For the purpose of the Review, a mental health and/or welfare crisis describes any situation in which an incident related to public safety or individual welfare prompts a call to emergency

services and is linked to a person's mental health or wellbeing. The person may be at immediate risk of harming themselves or others, or an immediate risk of being unable to adequately care for themselves or be cared for within existing support structures or function safely in the community, and where there is an identified trigger or vulnerability associated with their diagnosed mental health condition, or other social, emotional or clinical situation.

Identifying mental health crises and/or welfare crises can be a challenge for call handlers due to the diversity of situations that might prompt a call to emergency services. The presence of a mental health or welfare crisis may be immediately apparent, for example a report of a person with dementia missing from home or, alternatively callers may report a wide array of environmental or social problems where an underlying mental health or welfare concern is not immediately apparent.

People vary enormously in their reactions to personal distress and challenging life events. People may turn to family or friends for emotional support, whilst others may find themselves using strategies that in the longer term might be harmful, such as alcohol or substance misuse, suicidal or self-harm acts, aggression or social withdrawal. Recognising tangible social problems, distinguishing them from the emotional and psychological impact they have on a person and how they interact with any other underlying mental illness is complex. Reflecting this complexity, the array of services to support people experiencing crises are broad and multifaceted. People's access to and pathways through mental health, well-being and welfare support services is highly individual and can change over time.

It is widely reported that various groups or communities experience barriers to accessing mental health care. For example children[3], young adults[4], black and minority ethnic communities[5], individuals identifying as lesbian, gay, bisexual or transgender[6], asylum seekers and refugees[7], women with perinatal problems[8], less affluent and middle aged men[9], armed forces veterans[10], people with intellectual disabilities[11] and older adults[12].

Barriers stated across the studies cited above include the inability to recognise and accept mental health problems, impact of social networks, reluctance to discuss psychological distress and seek help, cultural identity, negative perception of, and social stigma against, mental illness, financial factors, language barriers, poor communication between service users and services and lack of knowledge about service availability.

Many mental health or well-being services are available only through referral; others encourage self-referral. Some services operate 9am-5pm Monday to Friday, others operate outside of these 'normal office hours'. Some services require an appointment, others operate 'drop-in' facilities, some offer helplines, others online support. Knowing who to contact about mental health or welfare concerns, what services are available, how, when and where to contact them can be challenging to discover for someone in a crisis or whose welfare is at risk.

Emergency services such as the police and ambulance are familiar to everyone, operate twenty four hours a day, respond quickly and have memorable contact numbers, making them an obvious first point of contact for many people in crisis, or for someone concerned about another person's welfare. However, whilst these emergency services traditionally have a broad remit in responding to crises, they are not specifically designed to be mental health urgent care or triage services which may result in a mismatch between caller expectations, service provision and staff knowledge and skills.

4.6. Crisis Care Concordat

The Mental Health Crisis Care Concordat was published by the Welsh Government and partners in 2015[13]. The Concordat set out the ways in which twenty-three partner agencies should work together to deliver a high-quality service response to people in crisis. These partners, including Welsh Government, Police, NHS, justice, social services, third sector, Royal Colleges of Psychiatrists and Nursing and Healthcare Inspectorate Wales set out a vision to improve mental health crisis services and established 'four core principles' which were:

- People have effective access to support before the crisis point,
- People have urgent and emergency access to crisis care when they need it,
- People receive improved quality of treatment and gain therapeutic benefits of care when in crisis,
- Recovery and staying well and receiving support after crisis.

Two further core principles were later added with the launch of the Concordats 'National Action Plan'[14]. These principles were:

- Securing better quality and more meaningful data, with effective analysis to better understand whether people's needs are being met in a timely and effective manner
- Maintaining and improving communications and partnerships between all agencies/ organisations, encouraging ownership, and ensuring people receive seamless and coordinated care, support and treatment

The Concordat and National Action Plan is a shared commitment to ensure services are focused around the safety and the needs of the person. It was part of the commitment of the Concordat to continually improve understanding of crisis and its impact on the individual and on services that the Review was commissioned.


EMERGENCY

PART B

PUBLIC SERVICES

Contents

> **'PEOPLE IN MENTAL DISTRESS SHOULD BE KEPT SAFE AND FIND THE SUPPORT THEY NEED FROM WHATEVER SOURCE'**
>
> **STATEMENT FROM: WELSH GOVERNMENT AND PARTNERS MENTAL HEALTH CRISIS CARE CONCORDAT (2015)**

7. Public Services

In the United Kingdom the term 'public services' covers a broad range of government or local authority provided, or commissioned, operations such as police, fire and rescue, administrative agencies, policy departments, healthcare, education, social care and refuse collection. The term 'emergency services' normally refers to the police, fire and rescue, emergency medical, mountain rescue and coastguard services.

The emergency number '999' was launched in 1937, on the recommendation of a government committee, after a fatal fire at a doctor's surgery in London. The '999' number is to contact police, fire and rescue, coastguard or ambulance services when the caller believes it to be an emergency. There are other methods to contact the police, such as the '101' number, when the caller does not think they require an emergency police response. For urgent, but non-emergency, medical concerns the NHS '111' number is being introduced across Wales.

Across the UK there were circa 33 million '999' calls received by services in 2019, 49% of these calls requested police support, 47% ambulance, 4% fire and 1% from the coastguard. In a survey of adults in Wales, 65% said they did not know to call the police '101' number for a 'non-emergency' issue and 48% of women and 72% of men did not know to call NHS 111 for a 'medical non-emergency'[15].

Every day people with mental health or welfare concerns contact emergency services to ask for urgent advice or aid. These services report increasing numbers of persons with 'mental health' issues accessing their services, although these self-same services often report a 'lack of understanding', or a deficit of data, as to the extent and nature of their 'mental health demand'[16,17]. Studies suggests that a proportion of mental health related calls to emergency services are a result of a lack of suitable alternative services, particularly outside typical office hours[18]. NHS mental health services are aware of these pressures, although they recognise that the drivers of demand are complex and multifaceted. In a 2019 survey NHS mental health leaders viewed socio-economic factors, such as changes to the welfare system, cuts to local social care provision, loneliness and housing issues to be a significant factor in driving an increase in people seeking support from services[19].

8. Third Sector

The 'third sector' is a term used to describe a range of organisations that are neither public sector nor private sector. It includes voluntary and not-for-profit organisations such as charities, associations, self-help groups, social enterprises and co-operatives[20].

In Wales, many of these third sector organisations are members of the Wales Alliance for Mental Health, which is has been the 'collective voice' in the 'field of mental health' for over twenty five years[21]. Many members of the Alliance work directly with people in crisis, or with people seeking support or advice, as well as providing care services, undertaking research and surveys, working with families and carers and advocating for people with 'lived experience'.

A 2019 study found that in some areas of Wales eligibility for some third sector services is dependent upon eligibility for NHS provided mental health services and this is 'not consistent with the preventative or early intervention agenda'[22].

A recent study exploring the value of third sector agencies in supporting people in a crisis identified a 'wide range of activities' that provided an immediate response and contributed to 'prevention and recovery'. The study highlighted that these activities were 'attractive and acceptable' to individuals in a crisis and that they could potentially address the complex interactions between 'mental health, inequality and socioeconomic conditions'. The study concluded that 'understanding and awareness' of the third sector contribution to crisis care has not been 'fully realised'[23].

Some third sector organisations in Wales, working jointly with Health Boards, have established 'crisis houses' to provide 24 hour staffed, short term accommodation as an alternative to hospital admission and to provide a 'holistic approach to promoting recovery[24]. Crisis houses have been shown to reduce admissions[25] and that, although 'functioning' was not 'significantly increased', self-esteem, social networking and satisfaction all improved for those cared for in a crisis house[26]. Crisis houses have been shown to have reduced benefit in areas where NHS home treatment services are 'fully functional'[27].

In other areas of Wales the third sector have been partners, with the NHS and police, in establishing 'sanctuaries' or 'crisis cafés'[28], offering support to people at risk of 'deteriorating mental health' when other 'services are closed'[29]. These 'sanctuaries' also assist people with 'stress, anxiety, low mood and financial worries'[30]. A study of one crisis café found that the service was 'preventing crises' and avoiding the need for people to present to public services[31]. In parts of the UK, the NHS has recently announced funding and support for crisis cafés, sanctuaries and crisis houses as part of a long term plan for improving crisis care[32].

A study has recommended that having a range of options such as crisis houses, sanctuaries, host families and peer support services can facilitate service user choice, meet a diversity of needs, and help NHS mental health crisis teams work 'more effectively'[33].

There are dozens of telephone support lines available to the citizens of Wales. Some of these support lines offer advice for a broad range of mental health or welfare issues such as those provided by Mind Cymru or Hafal. Some support lines deliver advice to those with more specific problems such as Wales Drug and Alcohol Helpline, Alzheimer's Society, Anxiety UK or BEAT (eating disorders). Some of these support lines can have very high use, one such example is operated by the Samaritans, often used by people with thoughts of self-harm or suicide which in one year answered 3.6 million calls from across the UK[34]. Many third sector organisations also offer support through telephone text or host online support services.

Also available in Wales is the 'Community Advice & Listening Line', often abbreviated to C.A.L.L, this support service has expanded to be an national service, since starting in 1995 in North Wales, and since 2001, is directly funded by the Welsh Government. The service provides telephone advice, signposting and online support and in 2019, received 14,733 calls, 3771 text messages and 1778 emails.

9. Health Services - Overview

Although the following sections of the Review focus on those aspects of the NHS that support people with mental health and welfare concerns these issues are not always separate from physical health. Studies have shown that having a long-term physical illness 'doubles' a person's chances of having a 'mental health difficulty' and that co-occurring mental health problems in turn worsen physical illness[35]. Providing a positive outcome for persons with both mental health and physical illness is better achieved with professionals from both areas working seamlessly together.

9.1 Primary Care

A study has stated that '90%' of adults with mental health problems are supported in primary care. This study also stated that some General Practitioners (GPs) felt that access to mental health services was an 'issue' and that 'eligibility thresholds' for these services leave many individuals, including those with 'complex and high-risk needs', to be managed in primary care[36]. People who attend their GP more often have been shown to have higher rates of mental health conditions, including depression, anxiety and somatic disorders[37].

One of the biggest gaps in provision reported by GPs is the increasing number of people who do not fit a clear referral pathway because of the complexity of their needs. Increasing complexity is one of the major factors responsible for the 'rising workload' in general practice[38] and part of this relates to growing levels of 'multimorbidity', of which mental health is a key component[39]. There is also a wide variety of social factors – such as poverty, social isolation and trauma – that can add to the complexity of a person seeking support from primary care services[40].

In Wales, GPs are supported by a 'Primary Care Mental Health Service' provided by each Health Board. These services undertake assessments, provide short-term psychological interventions and, if necessary, can refer people to different parts of the NHS mental health system. These services also provide information and advice to individuals and carers as well as 'signposting' them to other sources of support, including third sector organisations. In 2019 there were 78,345 referrals to these services across Wales[41]. In support of primary care the Welsh

Government are investing in third sector services[42] and online provision[43] and many Health Boards operate additional services such as counselling[44] or commission extra activity from third sector partners.

9.2 Community Services

All areas of Wales are covered by 'Community Mental Health Teams', who care for individuals who are experiencing enduring mental ill health that cannot be managed by primary care services or for those requiring specialist interventions. In December 2019, there were 22,690 people in Wales[45] receiving secondary care mental health support and during the same period as the bespoke data collection, 1 December 2019 to 29 February 2020, adult mental health services received 9,791 referrals[46].

A recent review of Community Mental Health Teams in Wales found many areas of good practice in Wales but also 'variability' in access to crisis care. This Review found that 51% of people receiving care from these services did not know who to contact when in crisis 'out of hours' and 57% were 'not satisfied' with the 'help' offered 'out of hours'. The Review recommended that community services strengthen 'links' with other services such as crisis teams and 'alcohol and drug misuse teams'[47].

In Wales, 'NHS Crisis and Home Treatment Services' are available in all Health Board areas. These services will respond to people in crisis and provide assessment and if necessary short duration interventions. Many of these services are referral pathways for police and ambulance services although the strength of these pathways is variable. NHS crisis services were planned to be available 24 hours per day either through a 'core service or 'on-call' response, and to provide interventions that cover 'social, financial, housing as well as treatment needs' and provide 'support and education to carers/family where appropriate'[48]. In 2018, there were 19,269 referrals to NHS crisis and home treatment services in Wales[49]. A review is currently underway by the NHS Wales Delivery Unit on the effectiveness of NHS crisis and psychiatric liaison services.

Children and Adolescent Mental Health Services in Wales are much smaller than adult mental health services and often do not have the equivalent crisis services, especially bed based assessment services or alternatives to admission. The routes into these services are often through pediatric health services, schools, social services and emergency departments.

9.3 Ambulance Services

The Welsh Ambulance Services NHS Trust is the organisation commissioned in Wales to provide a response for persons contacting 999, as well as NHS 111 and NHS Direct, which will be dealt with in the following paragraph. The service provides an emergency or urgent response for individuals with a range of medical issues from minor injuries to life-threatening illnesses. Responses include supporting or signposting people over the telephone or dispatching emergency air and land ambulances to treat people at scene or convey them to hospital.

The call classification systems used by ambulance services in the UK are designed to prioritise calls safely and speedily, in order to identify life threatening issues and ensure the caller gets the most appropriate response. This system is

not designed to allow in-depth assessments and identifying mental health or welfare concerns can be challenging over a brief call.

Studies have indicated that mental health is a significant contributor to the number of calls to ambulance services[50]. Studies have proposed as a 'reasonable estimate' that one in call in every ten to ambulance services relate to mental healths, although there has been acknowledgement that more work is needed to better identify those with mental health concerns[51,52]. The Welsh Ambulance Service answered nearly 112,965, '999' calls in the first three months of 2020[53] and internal reports show 'mental health demand' to be between 7% and 10% of calls, with about third of calls resulting in conveyance to a hospital or emergency department. A proportion of this demand will be appropriate for ambulances services to triage, treat or convey, such as overdoses or those with physical injuries, but some calls will be appropriate for referral to mental health crisis, primary or community services or other support or advice agencies.

In a 2018 survey Welsh Ambulance Services staff felt they had 'a lack of training' to be able to deal with calls from persons experiencing mental distress[54]. The Trust has employed an experienced mental health lead who is working to inform the ambulance workforce in mental ill health recognition and support. An evaluation of a trial of mental health nurses based in an ambulance control room found that confidence of other staff was improved and there was a 'positive impact' on service delivery from a patient and service perspective[55], a similar trial is being evaluated in the Welsh Ambulance Service.

9.4 NHS 111 Service & NHS Direct

In Wales 'NHS Direct', which provides telephone and online support is being superseded by the 'NHS 111 service', which is currently available in five health board areas and will be deployed across the whole country in the near future. The NHS '111' number was developed for when callers want support for issues which they believe are urgent but not emergencies. People may also call NHS 111 when they are unsure who to contact for medical help or if they require health advice. When people call the NHS 111 service, they will speak to a trained advisor, supported by healthcare professionals, who after an assessment, will direct the caller to the most appropriate service or support or, if necessary, transfer the call to emergency services.

In Wales the NHS 111 service is not currently designed to provide specialised mental health support but, during the in the first three months of 2020, circa 1% of the 170,875 calls received, in the areas where the NHS '111' service is available, were classed as mental health calls.

Parts of the UK are planning to ensure that the NHS 111 service becomes the 'single universal point of access for urgent mental health care by 2024'[56] and several projects are underway to understand the impact of mental health professionals in NHS 111 control centres. These projects are designed to ensure parity between mental and physical health, provide specialist mental health support and to signpost callers to NHS, social care or other agencies or groups, which can best meet their needs[57]. Some of these projects have been undertaken in partnership with police, as they provide opportunities for police officers to seek advice from mental health

professionals. One Police and Crime Commissioner, in reference to a local NHS 111 initiative, said improving access to mental health support from NHS 111 would reduce mental health police deployments and 'provide those most vulnerable with the appropriate professional support they need'[58]. Evaluation of pilot projects have found that having mental health professionals as part of the NHS 111 service resulted in '25% fewer' people needing to attend an emergency department for mental health concerns[59]. Another pilot evaluation found that, of the people triaged by mental health professionals through a NHS 111 service, 3% needed a police or ambulance response, 17% needed a 'face to face' crisis assessment and the other 80% were signposted to third sector partners, crisis sanctuaries or were referred to primary or community services[60].

9.5 Emergency Departments

Studies have shown that people with a mental illness use more unplanned hospital care for physical health needs than the general population[61]. Other studies have shown only one in five episodes of hospital care for individuals with a mental illness was 'directly for mental health needs' with four in five episodes for 'other health concerns'[62]. Although people attending emergency departments for mental health issues still only account for a small proportion of total attendances, it has been reported that the number of people attending increased by '50%' between 2012 and 2017[63]. It is difficult to understand the true demand of presenting mental health cases at emergency departments as data validity is variable, categorisation is broad and data may only include cases where a mental health problem was the primary diagnosis and could omit underlying issues. As part of the Review, for the same period as the bespoke data collection, 1 December 2019 to 29 February 2020, data from ten emergency departments in Wales was analysed. All presentations recorded as 'alcohol', 'illicit drug', poisoning/overdose' and 'psychological/ psychiatric' were considered as 'mental health' demand, although other issues can be covered by these categories. The data indicated that 'mental health' demand accounted for circa 4459 attendances or around 4% of total attendances, which is in line with other studies[64], although this proportion should be caveated with the challenges of understanding demand discussed previously in the Review.

Of these 4459 attendances, 48% received 'no follow up', 21% were admitted, 20% were referred to primary care, 3% received another appointment, possibly by mental health services, 2% self-discharged from the emergency department and 6% were unknown. The numbers discharged without follow up may indicate an opportunity to provide signposting and advice. Some people attend the emergency department on a repeat basis and have been termed by some agencies as 'frequent attenders' and by others as 'high intensity' individuals. These people have a broad range of issues but one study reports that '65% had mental health symptoms' and '15% had significant alcohol problems'[65]. There is a recognition that these individuals need to be treated with understanding and compassion and supported by multi agency cooperative working. In Wales a 'Welsh Emergency Department Frequent Attenders Network' is in place to work across agencies and, in just one hospital, between 2017 and 2019, this service received 758 referrals[66].

All General Hospitals in Wales are supported by a 'psychiatric liaison service', these services are intended for people presenting at emergency departments with urgent mental health care needs or for patients being treated on medical wards for co-occurring physical illness and mental ill health[67]. The mental health professionals in these services work with individuals attending emergency departments to ensure assessment, treatment and onward referral or, if necessary, to arrange hospital admission. In Wales each of these teams deals with circa 50 referrals per week.

An innovative practice in Wales is the 'ICAN' service supporting emergency departments across Betsi Cadwaladr University Health Board. ICAN is a collaborative approach to working with volunteers, people with lived experience and the third sector to shift the focus of care to prevention and early intervention. The ICAN project has a number of strands, one of which is basing trained volunteers in the three emergency departments in North Wales between 7pm and 2am to offer support and signposting for individuals attending with mental health or wellbeing issues who do not require medical treatment, admission or acute mental health care[68].

A Welsh Government Minister who visited one service stated that it was 'clear' the service 'had a positive impact'[69]. The ICAN service is currently being evaluated but during the same period as the bespoke data collection, 1 December 2019 to 29 February 2020 the service supported 431 people 'face-to-face' and undertook 771 supportive calls. During this period, of the people seen face-to-face, only 15% required diverting to NHS services with 85% provided with advice, or signposted to other agencies or support.

9.6 Social Care

Social Services are the division of local authorities that protect the well-being of children and vulnerable adults. Across Wales, every local authority provides an out of hours 'emergency duty' social work service, although in these services there can be minimal staff covering considerable geographical areas and high activity. Their work includes attending to adults experiencing mental health crises that could lead to them being admitted to hospital under the Mental Health Act, responding to calls about vulnerable adults, children at risk of harm and carers in need. A study has found that when social care professionals come into contact with older people it is often in an emergency situation when 'office hours services are not available'[70].

There appears to be few, if any, studies into the numbers, nature or outcomes of calls to emergency duty teams across Wales, nor to what extent calls to emergency services are diverted to duty teams to address welfare concerns and vice versa. It is inevitable that calls to police related to mental health crises that might result in application of the Mental Health Act will involve social services. There is data available related to Section 136* and other Mental Health Act related activity involving multiagency collaboration between police, health and social services across Wales. There were 431 Section 136 Mental Health Act assessments in the first three months of 2020[71]. However, the links

*Section 136 of the Mental Health Act gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety, usually a NHS mental health hospital, for an assessment. Specialist social workers and psychiatrists support these assessments.

between emergency calls, diversion and emergency duty team response is not well understood.

10. Police

The Police undertake a wide range of activities, from preventing, detecting, and responding to crime, to public safety and community cohesion. Police officers are often the first to be called to any incident of a person in need or experiencing distress[71]. Police forces deal with a 'significant number of calls' related to situations and events related to welfare concerns, mental health, social difficulties and distress[72].

These can lead to a variety of interventions such as:

- Emergency response to calls regarding welfare concerns, mental ill health or concerning someone putting themselves or others in danger,
- 'Welfare check' requests, where health or social care staff may ask police to check on someone when they can't contact them or the person has failed to turn up for an appointment,
- Supporting victims of crime, as people with vulnerabilities may require extra support through the investigative process,
- Missing persons calls from schools, mental health hospitals, care homes or supported accommodation when staff are concerned when people have had unplanned leave or have not returned from leave as planned,
- Neighbourhood patrols where police officers may check whether vulnerable persons are looking after themselves[73].

The broad range of needs reflected in mental health or welfare calls, demonstrated later in this Review, is a challenge for police forces who, typically, are not trained to the extent that might be considered necessary to effectively triage and respond to such calls. Views vary about the police role in responding to crises linked to mental health and welfare concerns with studies indicating that a significant amount of police time is now taken up by 'non-traditional' demand[74]. The notion of 'failure demand' has been coined to describe non-urgent, non-traditional calls to police[75], a proportion of which are likely to relate to mental health or welfare concerns. 'Failure demand' reflects the proposition that such calls indicate a lack of availability of suitable alternative services and that calls 'peak' during hours when mental health agencies and social welfare services are not readily accessible[76,77,78].

Police forces in Wales apply, what are termed, 'flags' for mental health calls. These 'flags' can be defined as the presence of a virtual marker on police computer systems, which, through previous interactions or current information, alerts call handlers that the call may involve a person with a mental health issue. Although there can be problems with the 'flag' system[79], and it may erroneously categorise mental health as a possible cause of an issue, it is not intended as a substitute for clinical, social or well-being assessments but to support police forces to better divert and support people with vulnerabilities, mental illness or welfare concerns.

As well as 'mental health', for some police forces these 'flags', which can be on file for up to 5 years or, in some cases 'life' can also cover self-harm or suicide[80]. These 'flags' can be applied to people who have come into contact with police through being a victim or perpetrator of crime or as a vulnerable or missing person or someone with a welfare concern. It is the presence of one or more of these flags which is often used to measure mental health demand by the police. In 2017, on average, 3% of police incidents had a mental health flag[81], but this proportion may currently be higher. It may be expected to see some rise in demand due to 'flags' remaining on the system for a long time and therefore more of the population will be covered by a 'flag'.

A significant number of calls a day to police forces related to missing persons, and an 'internal snapshot' of demand on one day in November 2019 saw 29 such cases across three Police forces in Wales, many of these calls come from schools, facilities caring for older or vulnerable persons or from hospitals. Searching for missing persons can take a significant amount of resources and police forces will always be eager to work with local services to ensure that everything is done to appropriately and safely minimise the number of these calls. Many police forces are also working with mental health professionals within their call centres, these staff, whether from a health or social care background, can provide expert advice to police officers and call handlers and assist with triage and diverting callers to appropriate alternative services.

One such service in the Gwent Police control room receives hundreds of requests for support each month[82]. Another service, in addition to working in control rooms supporting officers, also coordinates mental health assessments in custody suites and magistrates courts. This service, the North Wales' Criminal Justice Liaison Service, has been involved in circa 200 calls a month since it launched full time at the start of 2020. A recent study has stated that as 'almost every' police force now has its own mental health triage services and demand 'has not reduced', then there needs to be greater emphasis on 'early intervention' to prevent the need for a crisis response. This same study stated that police are often the 'primary responders' to calls related to mental health or welfare concerns as these often occur 'out of hours' when other services are not available, although the study noted there was a 'general lack of understanding' by polices forces of the 'extent and nature of their mental health demand'[83].
The College of Policing estimated that between 15% and 20% of police incidents were linked to 'mental health'[84], and the Sainsbury Centre for Mental Health estimated 15%[85]. This demand can be through '999'calls, '101' calls, missing persons, patrol incidents or related to persons in police custody and can be explored using a single day's data from an internal 'snapshot' in November 2019. This 'snapshot' saw the following defined as mental health demand:

- Dyfed-Powys Police respond to 13 '999' calls (3.7% of daily demand), 18 non-emergency calls (5.1% of daily demand) and 4 missing persons appeals,
- Gwent Police respond to 14 '999' calls (3.4% of daily demand), 21 non-emergency calls (5.1% of daily demand) and 14 missing persons appeals,
- North Wales Police respond to 19 '999' calls (4.4% of daily demand), 18 non-emergency calls (4.2% of daily demand). The number of missing persons appeals was undisclosed.
- South Wales Police respond to 53 '999' calls (4.2% of daily demand), 76 non-emergency calls (6% of daily demand) and 11 missing persons appeals.

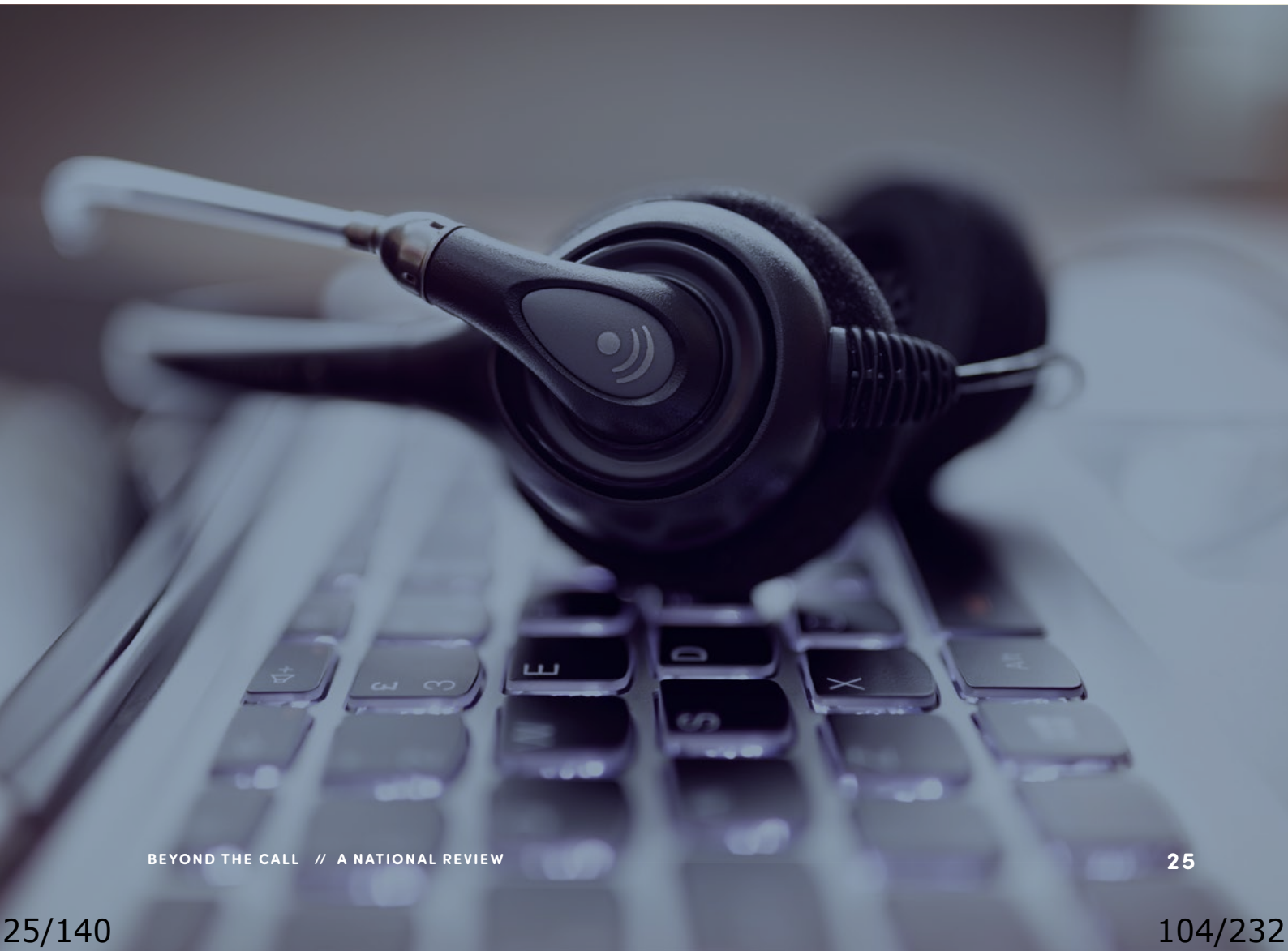
This 'snapshot' data evidenced that demand from '999' and non-emergency calls was 9.4% of total calls across all four Welsh police forces. The proportion reported by the Police may be higher

due to other events such as arrests, custody, missing persons and police patrol incidents also being associated with mental health demand. For circa 80% of these calls a police officer was dispatched or attended. Each call or missing person's appeal may have been responded to by more than one officer and taken a considerable amount of time. A proportion of these incidents, such as those related to public order, will be appropriate for a police response but some calls will be more appropriate for referral to mental health services or other support or advice agencies. The resources linked to responding to mental health demand and the importance police forces have now placed on mental health, supports the fact that police perform an essential role in preventing harm to vulnerable people and enabling access to other agencies.

11. Fire and Rescue

The Welsh Fire and Rescue services, as well as fighting and preventing fires and floods and responding to accidents and incidents also undertake 'safe and well' visits, which include a brief health assessment, advice and support to reduce fire risks for vulnerable persons[86].

South Wales Fire and Rescue Services works in partnership with 'over forty' third sector, charitable and voluntary organisations to undertake these safe and well visits for 'high risk or vulnerable' people. Some Fire and Rescue services in Wales have projects working with vulnerable young people such as the 'Phoenix Project' run by the Mid and West Wales service[88].



PART C

BESPOKE DATA COLLECTION

Contents

> **'THE COMPLEXITY OF THE CRISIS IS LIKELY TO BE MULTI-LAYERED'**
>
> **STATEMENT FROM: WELSH GOVERNMENT AND PARTNERS MENTAL HEALTH CRISIS CARE CONCORDAT (2015)**

12. Overview of Data

As explored in the 'methodology' section, a bespoke data collection was developed for the Review. The term 'index problem' has been used to describe the nature of the concern/difficulty/experience discussed on the call.

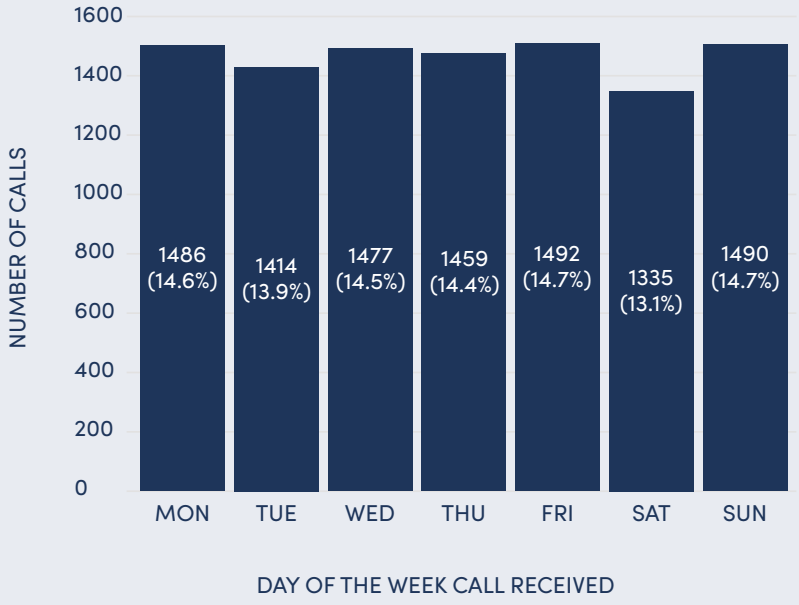
In total, **10,175** calls were recorded during the data collection period although, given the different internal processes, data collection was inconsistent between emergency services. A full breakdown of the bespoke data collection is summarised in Appendix 3.

This information is a static picture of calls that is restricted to the collection period and does not take into account any seasonal or longitudinal differentials in demand.

13. Day of the Week That Calls Were Received

For 99.8% (10,153) of calls, the day of the week the call was received was recorded. There was less than a 2% difference between the lowest and highest proportion of calls received per day. The day of the week with the lowest proportion of calls received was Saturday and the highest was Friday. **Figure 1** shows the day of the week that calls were received.

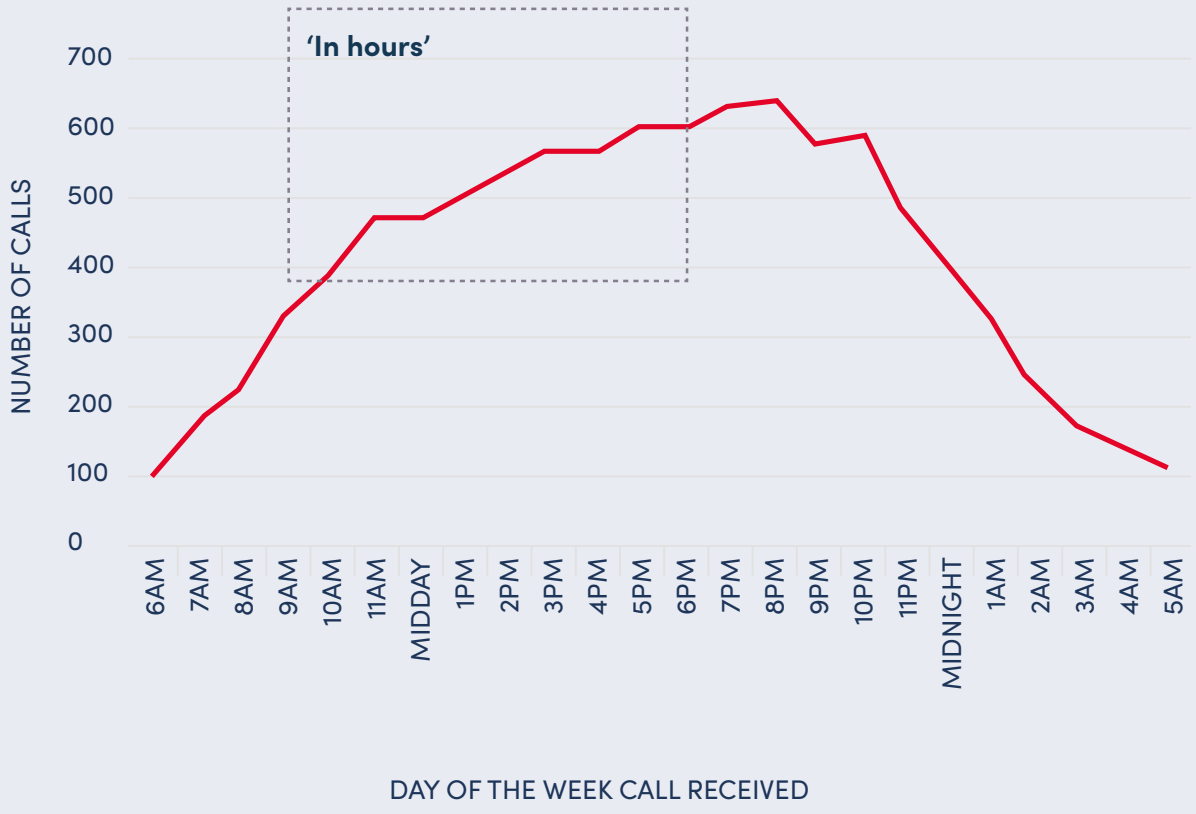
Figure 1:
Number and Proportion of Calls Received Per Day of the Week



14. Time of Day of Call

For 99.5% (10,126) of calls, the time the call was answered had been recorded. These calls were grouped into hourly intervals. The lowest proportion of calls (1.1%) were received between 6am and 7am and the highest proportion (6.4%) were received between 8pm and 9pm. The majority of calls (61%) occurred 'out of hours' from 5pm to 9am. **Figure 2** shows the time of day that calls were received in hourly intervals.

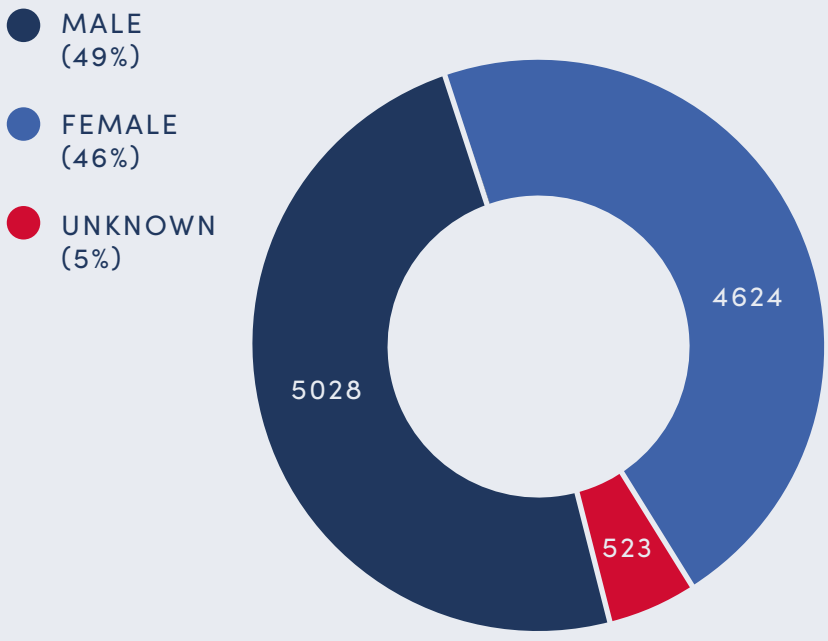
Figure 2:
Number of Calls Received by Time of Day



15. Gender of Person with Index Problem

For 94.8% (9652) of calls the gender of the person with the index problem was able to be established. These calls were sorted into either male, female or unknown/undisclosed. Official statistics state that, according to the last census, 51% of the population was female and 49% male[89]. There were slightly more calls from or about males than females as shown in **Figure 3.**

Figure 3:
Proportion of Calls by Gender of Person with Index Problem

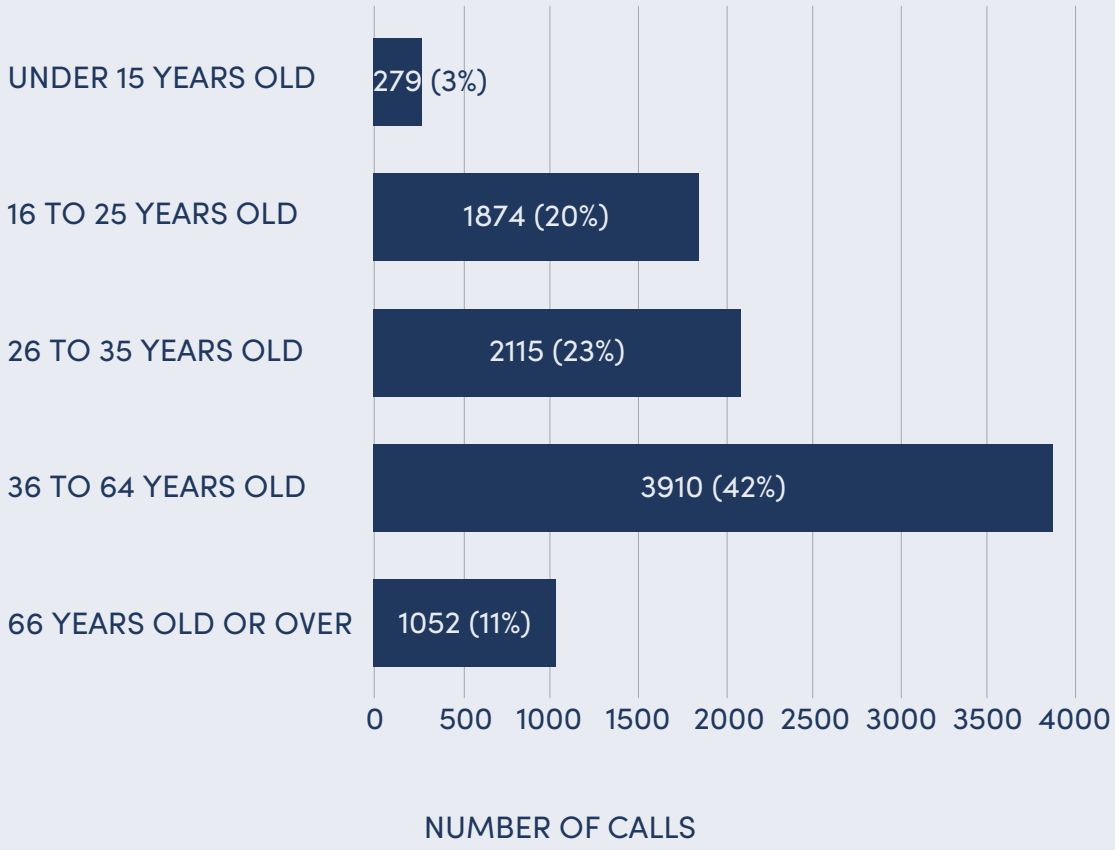


16. Age of Person with Index Problem

For 90.7% (9,230) of calls the age of the person with the index problem was able to be established. The youngest age recorded was 9 years old and the oldest was 100 years old. These ages were sorted into groups, some of which have a much broader age range than others. Official statistics state that in 2019, 18% of the population of Wales were under 15 years old, 11% were between 16 and 24 years old, 50% were between 25 and 64 years old and 21% were over 65 years old[90].

Figure 4 shows the number of calls by age group of the person with the index problem as a proportion of calls where age was recorded. Although ages are grouped differently, comparing the proportions in Figure 4 with the official population statistics shows lower proportions of callers at the two ends of the spectrum (under 15 years old or older than 65 years old) and higher proportions in the young adult group (16–25 years old) and combined adult groups (26–64 years old).

Figure 4:
Number and % of Persons with Index Problem by Age Groups



17. The Relationship of Caller to Person with Index Problem

For 58.9% (6,002) of calls the relationship between the caller and the person with the index problem was able to be established. As a proportion of calls where relationship was recorded:

- **38%** (2310) of calls were from the **person with the index problem themselves**,
- **20%** (1202) of calls were from a **professional, such a nurse, social worker or GP**,
- **17%** (1031) of calls were from a **relative or parent** of the person with the index problem,
- **12%** (723) of calls were from a **member of the public or a person with no relationship with the person** with the index problem,
- **11%** (663) of calls were from a **friend or neighbour** of the person with the index problem,
- **1%** (73) of calls were from a **child** of the person with the index problem.

Due to different data collection methodologies, only three services were able to record the relationship. There was divergences between these services as shown in **Figure 5**, with nearly half of callers to the Welsh Ambulance Service being the person themselves and the public far more likely to call the police than ambulance services.

Figure 5:

Relationship of Caller by % Across Three Services

	Dyfed Powys Police	South Wales Police	Welsh Ambulance Service
Self	28%	35%	46%
Professional	21%	25%	16%
Parent/Relative	16%	17%	22%
Public/Stranger	22%	12%	3%
Friend/Neighbour	12%	9%	13%
Child	1%	2%	1%
Total	100%	100%	100%

The age of the person with the index problem was able to be identified in 95.3% (5,723) of the 6,002 calls where the relationship was also able to be established. **Figure 6** shows the age of the person with the index problem by relationship to caller. The figure shows that self-callers tended to be the biggest proportion for all age groups except parents/relatives calling about someone who was 15 years old or younger, professionals tended to call about children and the public were twice as likely to call about a person over 65 years old than a child.

Figure 6:
Relationship of Caller by % Across Age Groups

	Under 15 yrs. Old	16 to 25 yrs. Old	26 to 35 yrs. Old	36 to 64 yrs. Old	Over 65 yrs. Old
Self	10%	34%	37%	44%	44%
Friend/Neighbour	6%	13%	11%	10%	10%
Parent/Relative	40%	16%	18%	14%	14%
Child	2%	1%	1%	2%	2%
Professional	34%	25%	20%	19%	17%
Public/Stranger	7%	10%	13%	12%	14%
Total	100%	100%	100%	100%	100%

18. Postcode of Caller

For 77.2% (7,854) of calls the postcode of the caller was able to be established. The proportions may be affected by recording methods and/or influenced by population density and therefore not indicative of demand. As there were total of 174 different postcodes recorded they have been grouped into postcode or geographical areas as shown in the list below as a proportion of total calls:

- **20%** (2059) of calls were made **within postcode SA** which covers areas of South West Wales including Swansea, Neath, Port Talbot, Carmarthen and Pembroke,
- **14%** (1442) of calls were made **within postcode CF** which covers areas of South Wales including Cardiff, Bridgend and Merthyr Tydfil,
- **10%** (970) of calls were made **within postcode LL** which covers areas of North Wales including Llandudno, Conway, Rhyl, St Davids and Wrexham,
- **9%** (868) of calls were made **within Newport** or the surrounding area,
- **7%** (681) of calls were made **within Caerphilly** or the surrounding area,
- **4%** (444) of calls were made **within Torfaen** or the surrounding area,
- **3%** (356) of calls were made **within postcode SY** which covers areas of Central Wales including Newtown and Welshpool,
- **3%** (343) of calls were made **within Monmouth** or the surrounding area,
- **3%** (326) of calls were made **within Blaenau** or the surrounding area,
- **2%** (195) of calls were made **within postcode CH** which covers areas of North West Wales including Mold and Flint,
- **1%** (125) of calls were made **within postcode LD** which covers areas of Central Wales including Llandrindod Wells, Brecon and Knighton.

Additional information on postcodes can be found in Appendix 4.

19. Specific Index Problems

The broad spectrum of index problems was sub-divided into seventeen different categories. These index problems were not clinical, scientific or academic classifications but rather pragmatic groupings so that emergency call handlers with no clinical background or specialist training could identify and record the problem quickly. Categories were generated by consensus within the Expert Reference Group and generated to provide a comprehensive range of likely presenting needs.

20. Overview

The index problems were defined by 'trigger words' in order for call handlers to identify them promptly through lay terms, many of which are interchangeable or interrelated such as 'self-harm' and 'overdose'.

Call handlers were asked to identify all the index problems that were discussed, disclosed or identified during the call and overall, for the 10,175 calls recorded as part of the bespoke data collection, there were **21,023** individual index problems identified.

The seventeen index problems are listed om the right in descending order by proportion of the total index problems identified, call numbers in parenthesis. Index problems may have been recorded as singular or in conjunction with other problems. Trigger words used by the call handlers are emphasised in bold.

- **15.6%** (3288) of calls identified **low mood** or **possible depression** as an index problem,
- **14.4%** (3032) of calls identified a **past or current mental illness** as an index problem,
- **14.1%** (2966) of calls identified **suicidal behaviour** as an index problem,
- **14%** (2939) of calls identified **confusion or strange behaviour** as an index problem,
- **9.9%** (2081) of calls identified **self-harm or deliberate overdose** as an index problem,
- **6.5%** (1367) of calls identified **drunkenness or intoxication** as an index problem,
- **5.9%** (1250) of calls identified **stress, anxiety or panic** as an index problem,
- **4.9%** (1026) of calls identified **relationships** as an index problem,
- **3.7%** (772) of calls identified **substance misuse** as an index problem,
- **2.9%** (601) of calls identified **loneliness or isolation** as an index problem,
- **2.6%** (548) of calls identified **domestic abuse** as an index problem,
- **1.6%** (334) of calls identified behaviour related to **possible dementia** as an index problem,
- **1.2%** (250) of calls identified **debt or money, or state benefits** as an index problem,
- **1.1%** (228) of calls identified **homelessness or concerns over housing** as an index problem,
- **1%** (220) of calls identified **harassment or bullying** as an index problem,
- **0.5%** (100) of calls identified **issues at work or school** as an index problem,
- **0.1%** (21) of calls identified **gender identity** as an index problem.

Each of these areas will be explored later in the Review. Caution must be taken with gender identity figures due to the very low numbers.

21. Index Problems and Age

For 95% (19,981) of the index problems the age of the person was able to be established. The figures in this section are Odds Ratios, with the confidence intervals removed, comparing the likelihood of a problem being reported in one age group with the other four age groups. These figures detail which index problems occur with abnormal frequency or infrequency for each of the age groups. If the Odds Ratio is above 1 then there is an increased chance of that index problem being present for that age group, below 1 a decreased chance and at 1 an equivalent chance.

Figure 7 shows the Odds Ratio of each category where the person with the index problem was 15 years old or younger.

The figure shows that the ratios are higher in the relationships, harassment/bullying and work/school categories relative to the other age groups and lower in the homelessness/housing and gender identity categories.

Figure 7:

Odds Ratios by Index Problem for 15 Year Old or Younger Age Group

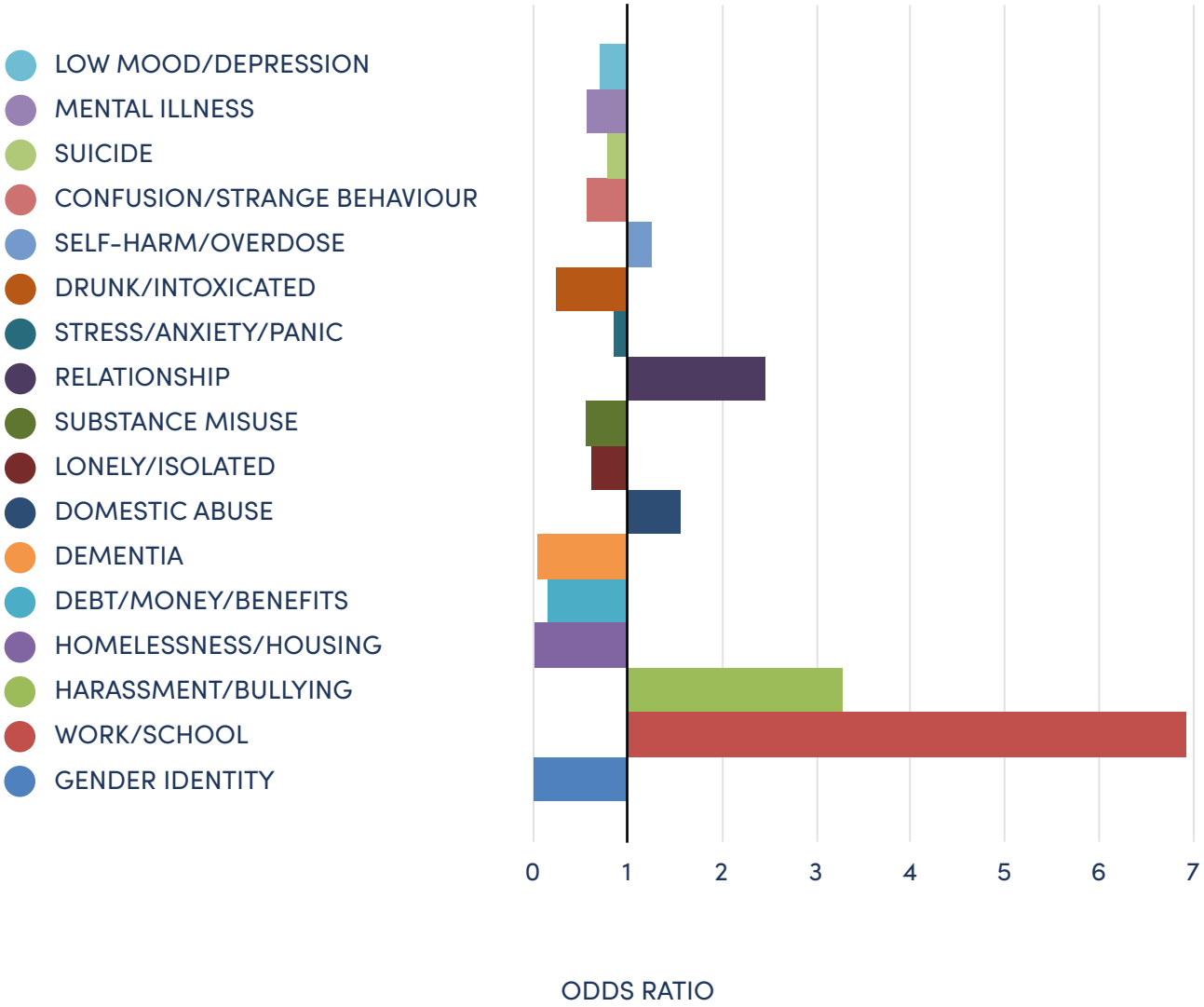


Figure 8 shows the Odds Ratio of each category where the person with the index problem was between 16 and 25 years old. The figure shows that the ratios are higher in the suicide and self-harm/overdose categories relative to the other age groups and lower in the dementia category.

Figure 8:

Odds Ratios by index Problem for 16-25 Year Old Age Group

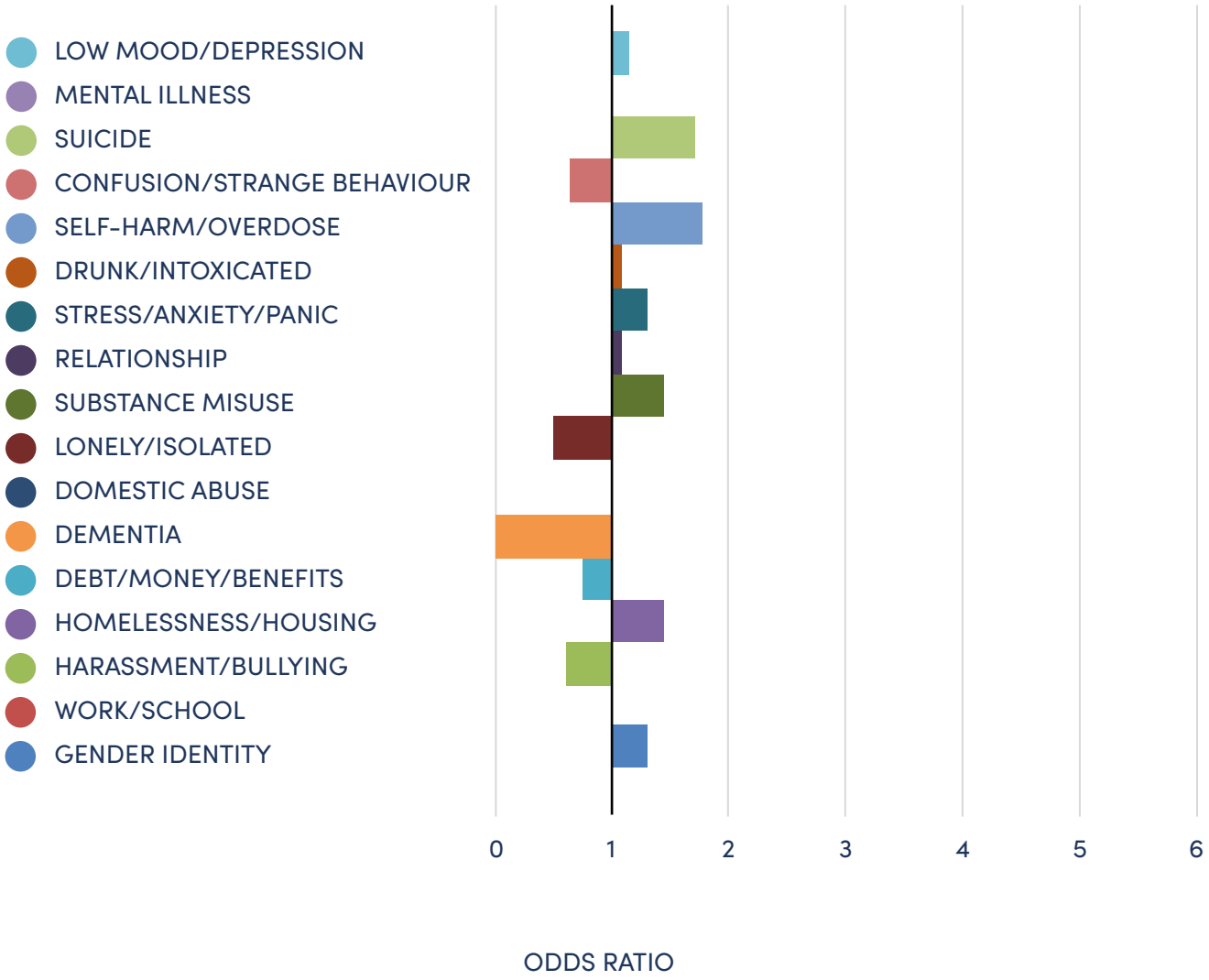


Figure 9 shows the Odds Ratio of each category where the person with the index problem was between 26 and 35 years old. The figure shows that the ratios are higher in the substance misuse and gender identity categories relative to the other age groups and lower in the dementia category.

Figure 9:
Odds Ratios by index Problem for 26-35 Year Old Age Group

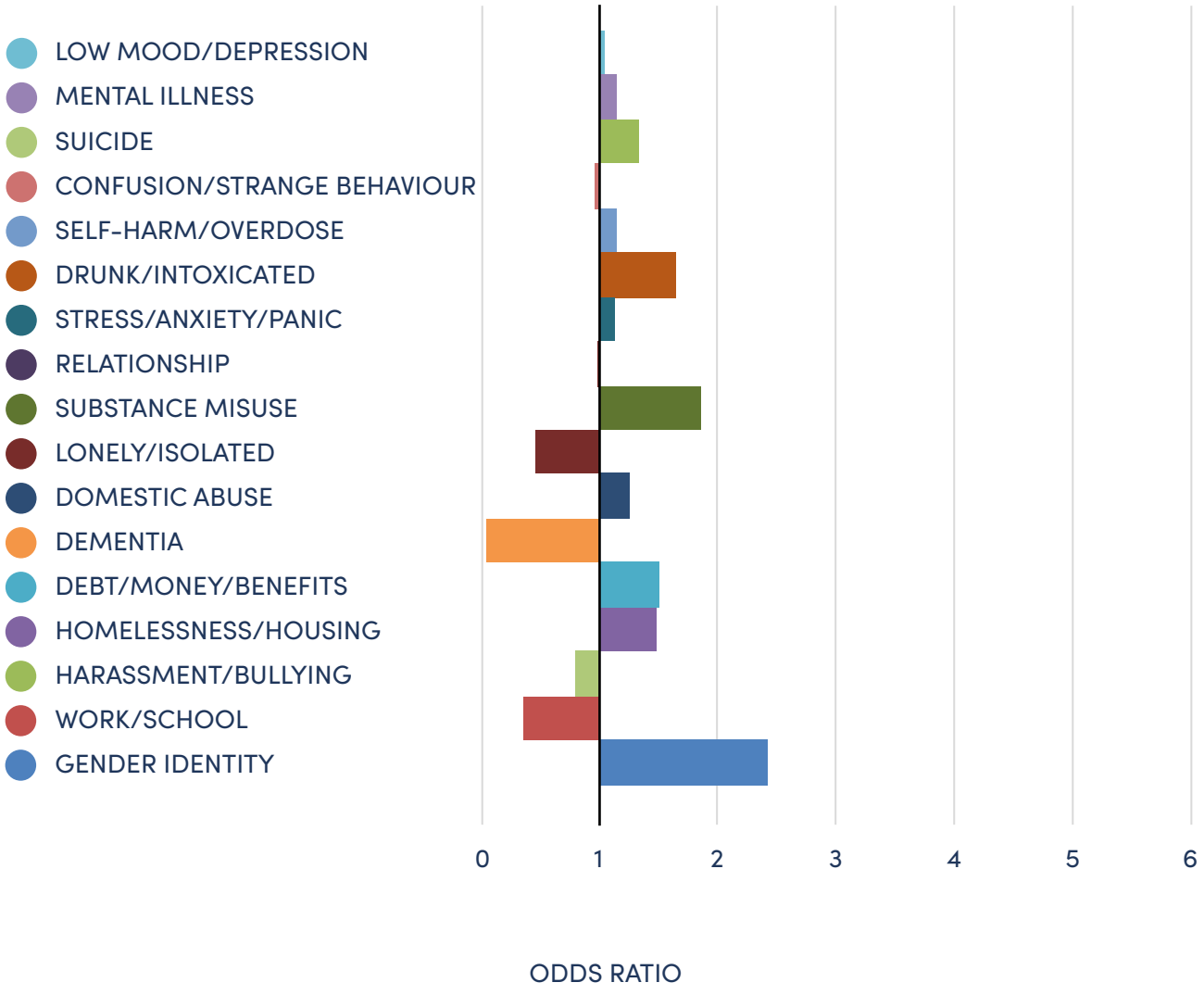


Figure 10 shows the Odds Ratio of each category where the person with the index problem was between 36 and 64 years old. The figure shows that the ratios are higher in the drunk/intoxicated and debt/money/benefits categories relative to the other age groups and lower in the dementia and work/school categories.

Figure 10:

Odds Ratios by index Problem for 36-64 Year Old Age Group

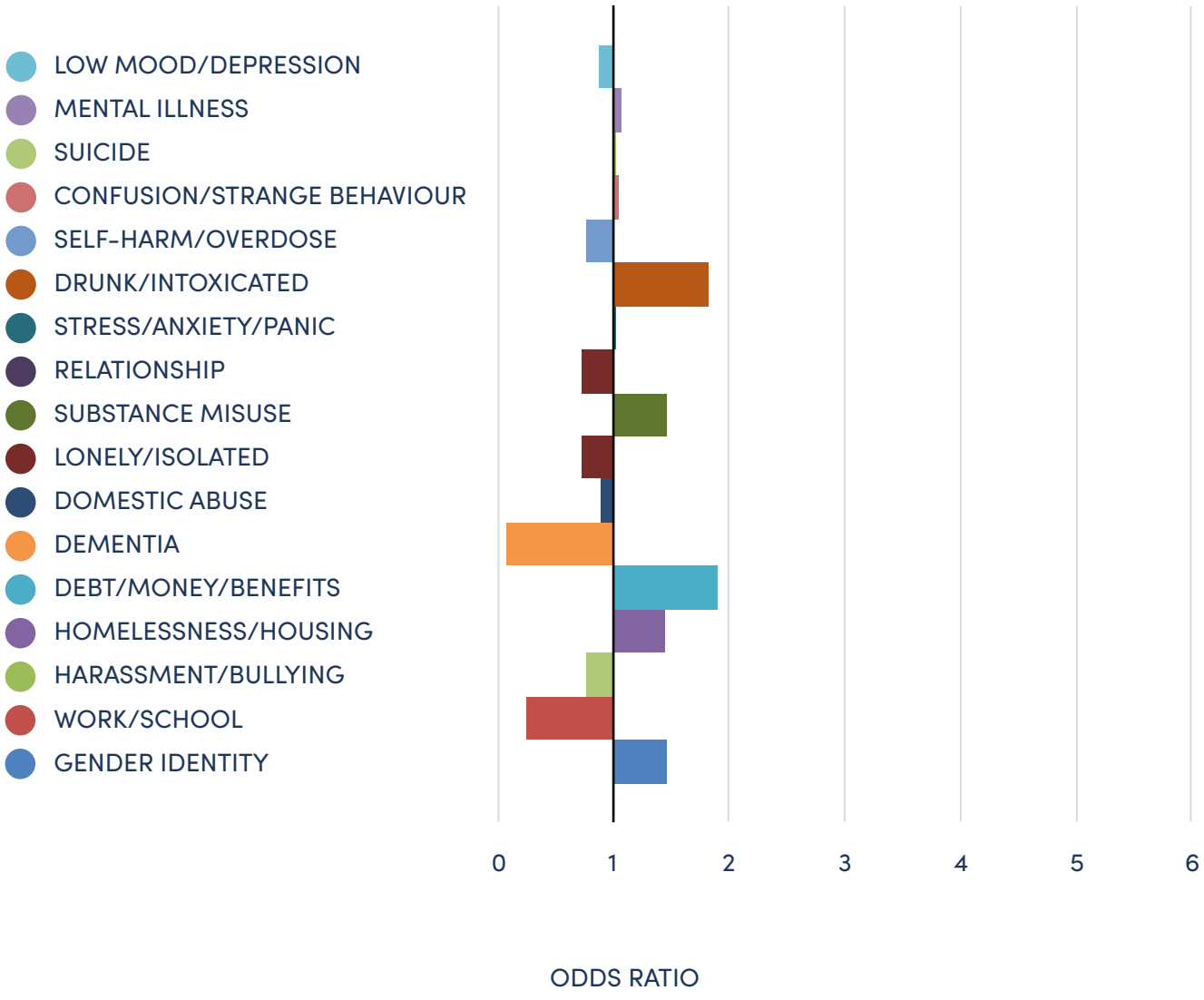
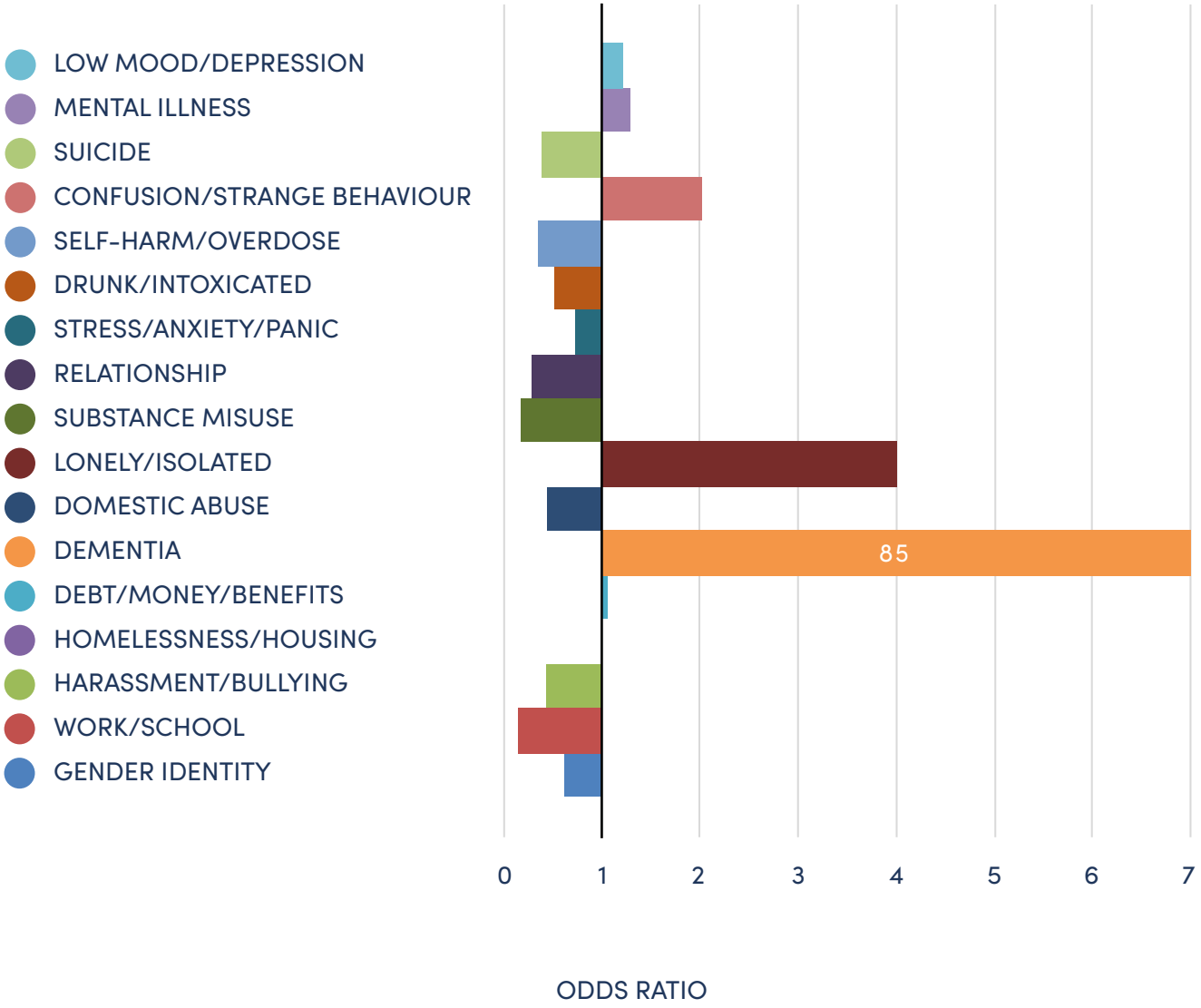


Figure 11 shows the Odds Ratio of each category where the person with the index problem was over 65 years old. The figure shows that the ratios are higher in the confusion/strange behaviour and lonely/isolated categories relative to the other age groups and lower in the substance misuse and work/school categories. The dementia category exceeded the chart parameters being 85 times more frequent.

Figure 11:

Odds Ratios by index Problem for Over 65 Year Old Age Group



22. Index Problems and Gender

For 98% (20,543) of the index problems the gender of the person was able to be established. The figures in this section are Odds Ratios with the confidence intervals removed, comparing the likelihood of a problem being reported for one gender with the other gender. These figures detail which index problems occur with abnormal frequency or infrequency for each gender. If the Odds Ratio is above 1 then there is an increased chance of that index problem being present for that gender, below 1 a decreased chance and at 1 an equivalent chance.

Figure 12 shows the Odds Ratio of each category where the person with the index problem was male. The figure shows that the ratios are higher in the substance misuse, debt/money/benefits and homelessness/housing categories relative to females and lower in the domestic abuse and dementia categories.

Figure 12:
Odds Ratios for Males with Index Problems

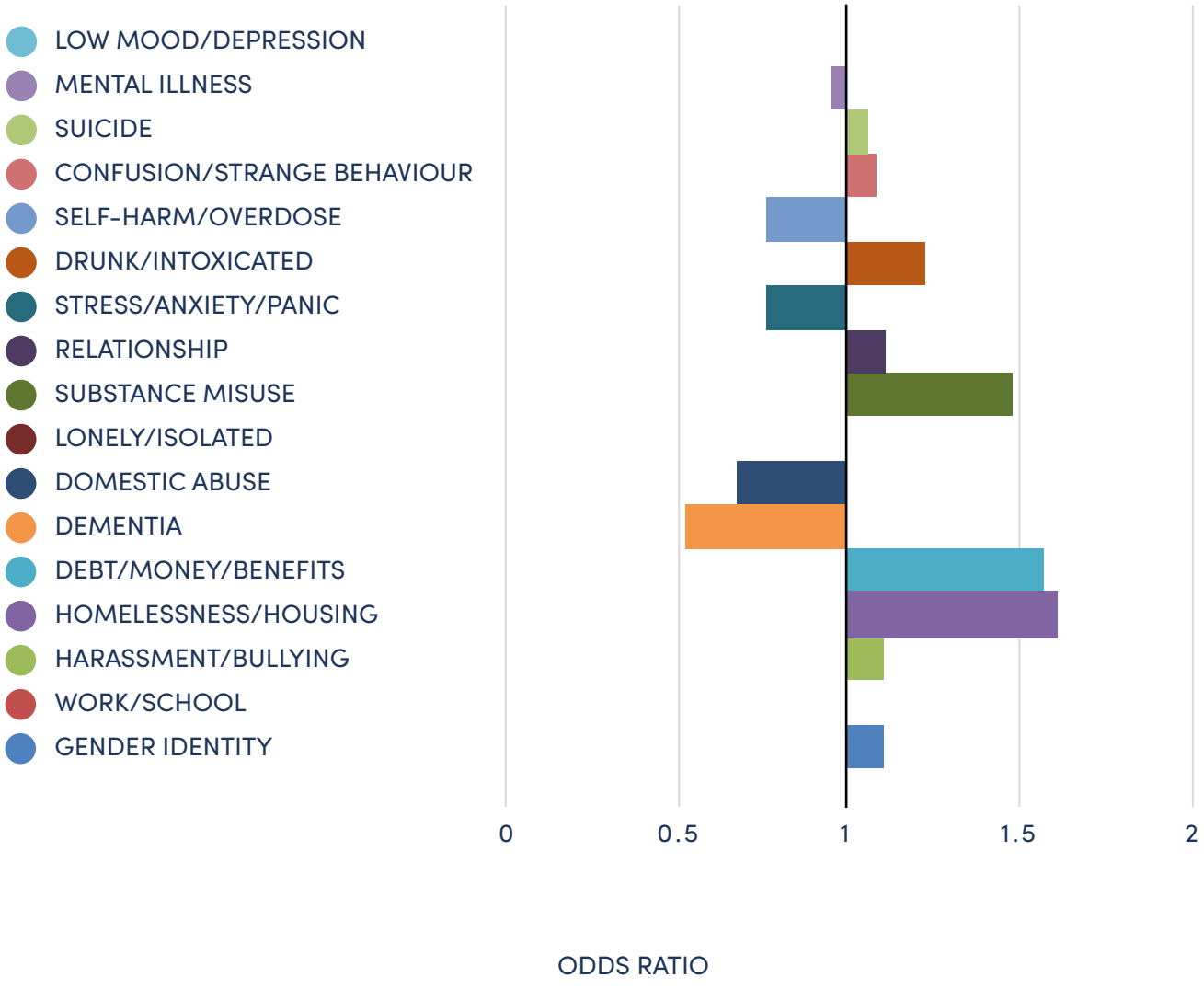
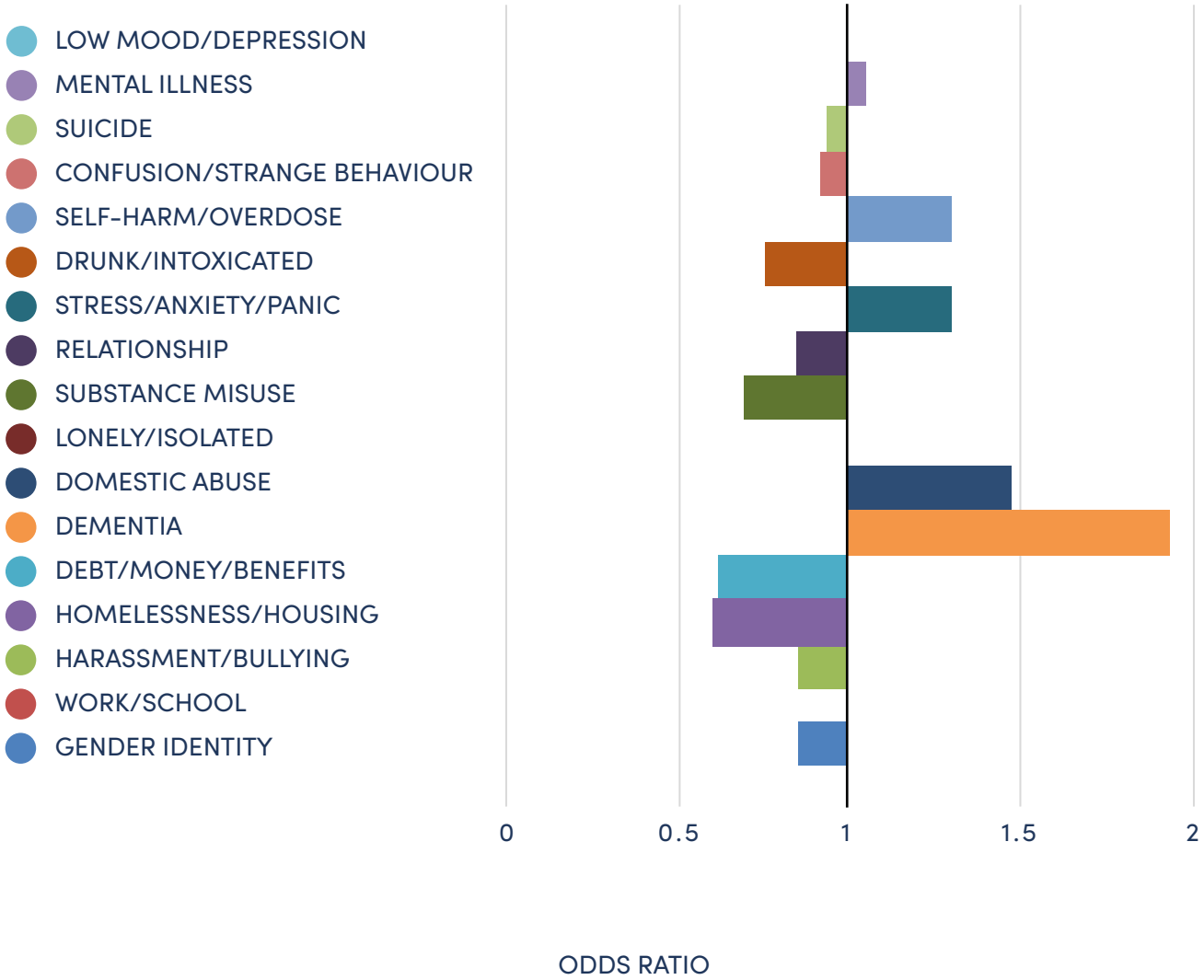


Figure 13 shows the Odds Ratio of each category where the person with the index problem was female. The figure shows that the ratios are higher in the dementia and domestic abuse categories relative to males and lower in the substance misuse, debt/money/ benefits and homelessness/ housing categories.

Figure 13:
Odds Ratios for Females with Index Problems



23. Relationship of Caller to Person with Index Problem

For 72% (15,205) of the 21,023 index problems the relationship between the caller and the person with the index problem was able to be established. The figures in this section are Odds Ratios, with the confidence intervals removed, comparing the likelihood of a problem being reported in one type of relationship with the other relationship types.

These figures detail which index problems occur with abnormal frequency or infrequency for each of the relationship types. If the Odds Ratio is above 1 then there is an increased chance of that index problem being present for that type of relationship, below 1 a decreased chance and at 1 an equivalent chance.

Figure 14 shows the Odds Ratio of each category where the person with the index problem were themselves calling. The figure shows that the ratios are higher in the stress/anxiety/panic, lonely/isolated and gender identity categories relative to the other types of relationships and lower in the dementia and work/school categories.

Figure 14:
Odds Ratios by Index Problem for Type of Caller - Self–Callers

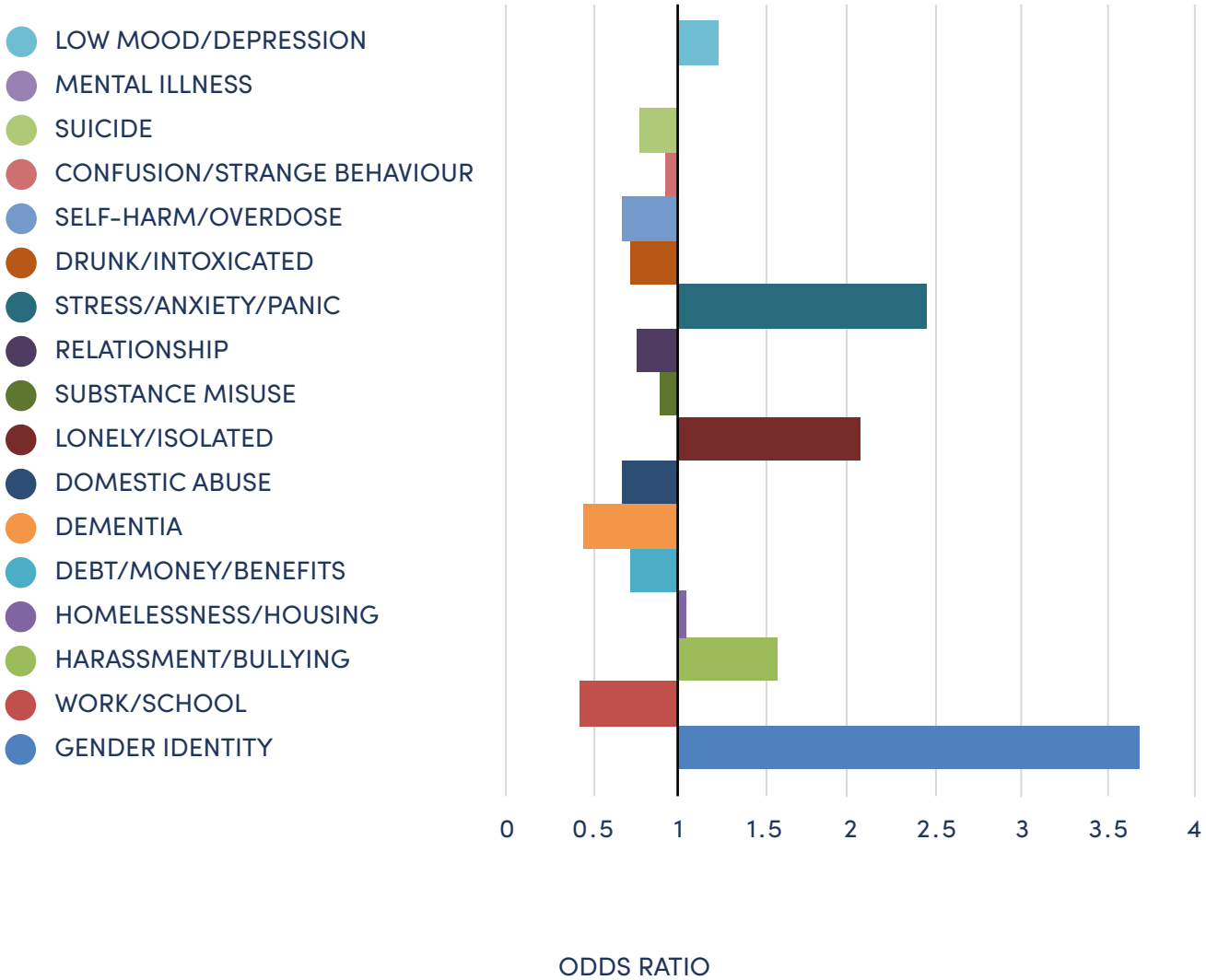


Figure 15 shows the Odds Ratio of each category where the caller was a friend or neighbour. The figure shows that the ratios are higher in the self-harm/overdose, drunk/intoxicated and work/school categories relative to the other type of relationships and lower in the domestic abuse and homelessness/housing categories.

Figure 15:

Odds Ratios by Index Problem for Type of Caller - Friends/Neighbour

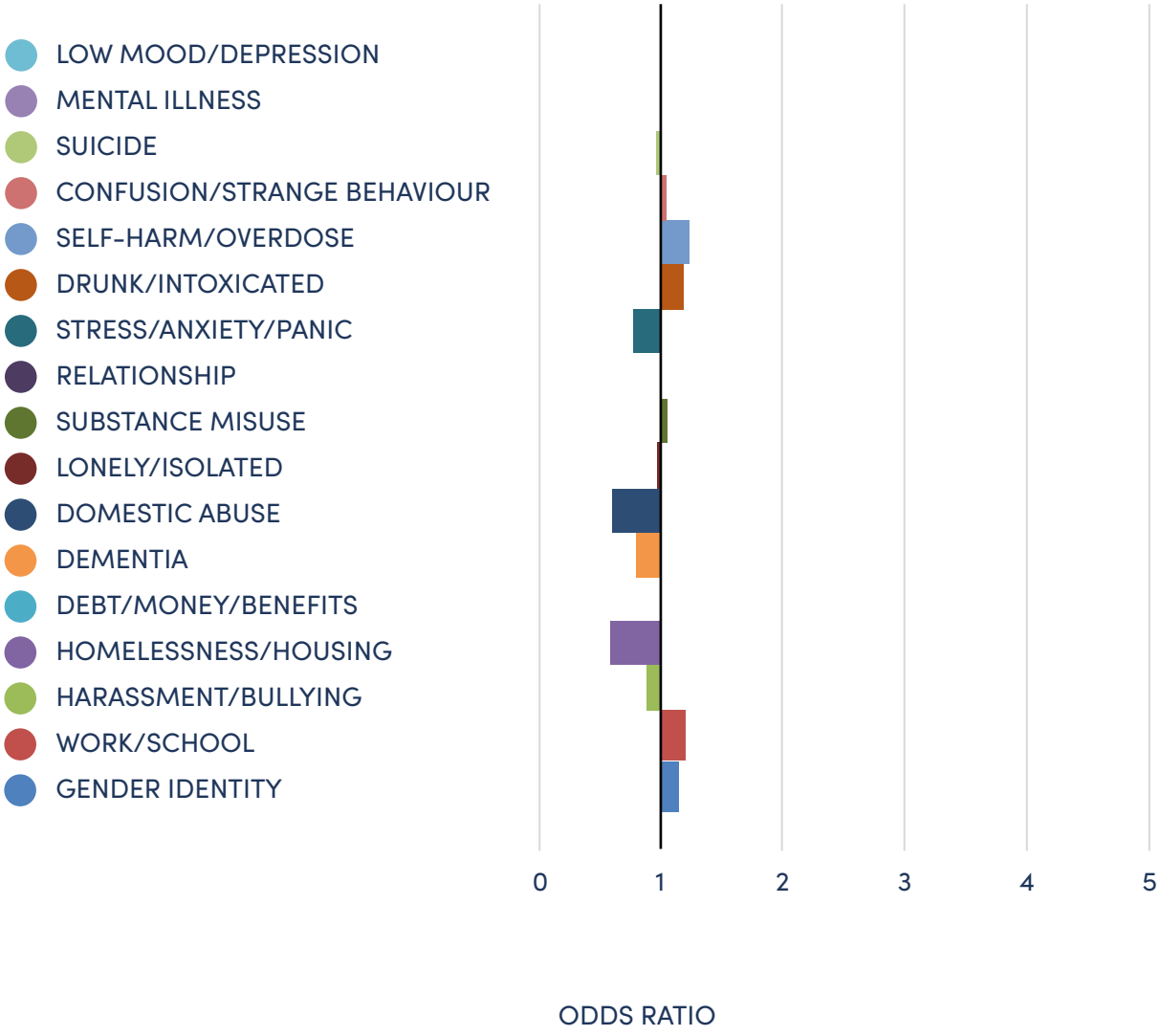


Figure 16 shows the Odds Ratio of each category where the caller was a parent or relative. The figure shows that the ratios are higher in the relationship and work/school categories relative to the other type of relationships and lower in the homelessness/housing categories.

Figure 16:

Odds Ratios by Index Problem for Type of Caller - Parent/Relative

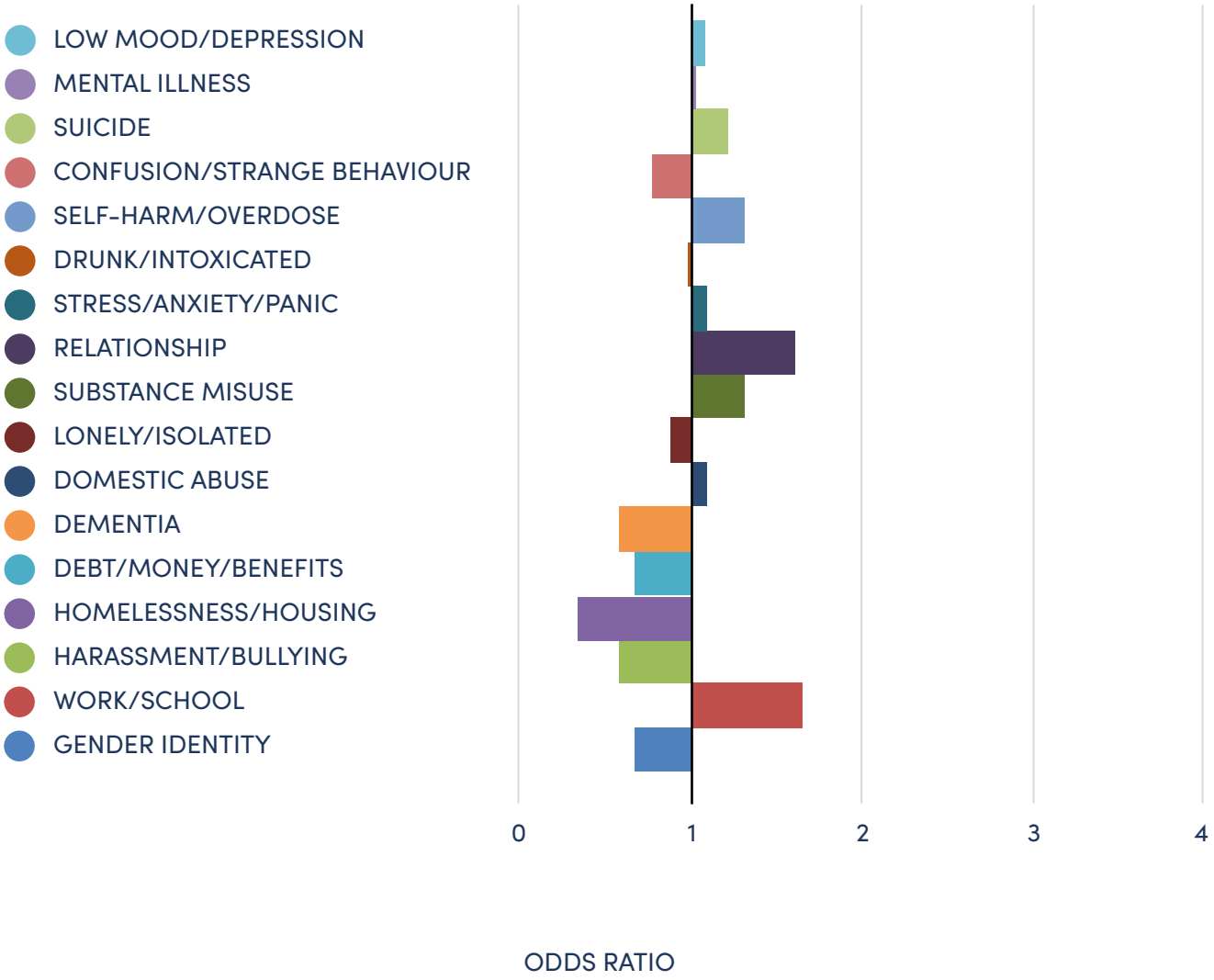


Figure 17 shows the Odds Ratio of each category where the caller was a child of the person with the index problem. The figure shows that the ratios are higher in the relationship, domestic abuse, dementia and harassment/bullying categories relative to the other type of relationships and lower in the gender identity categories.

Figure 17:

Odds Ratios by Index Problem for Type of Caller - Child

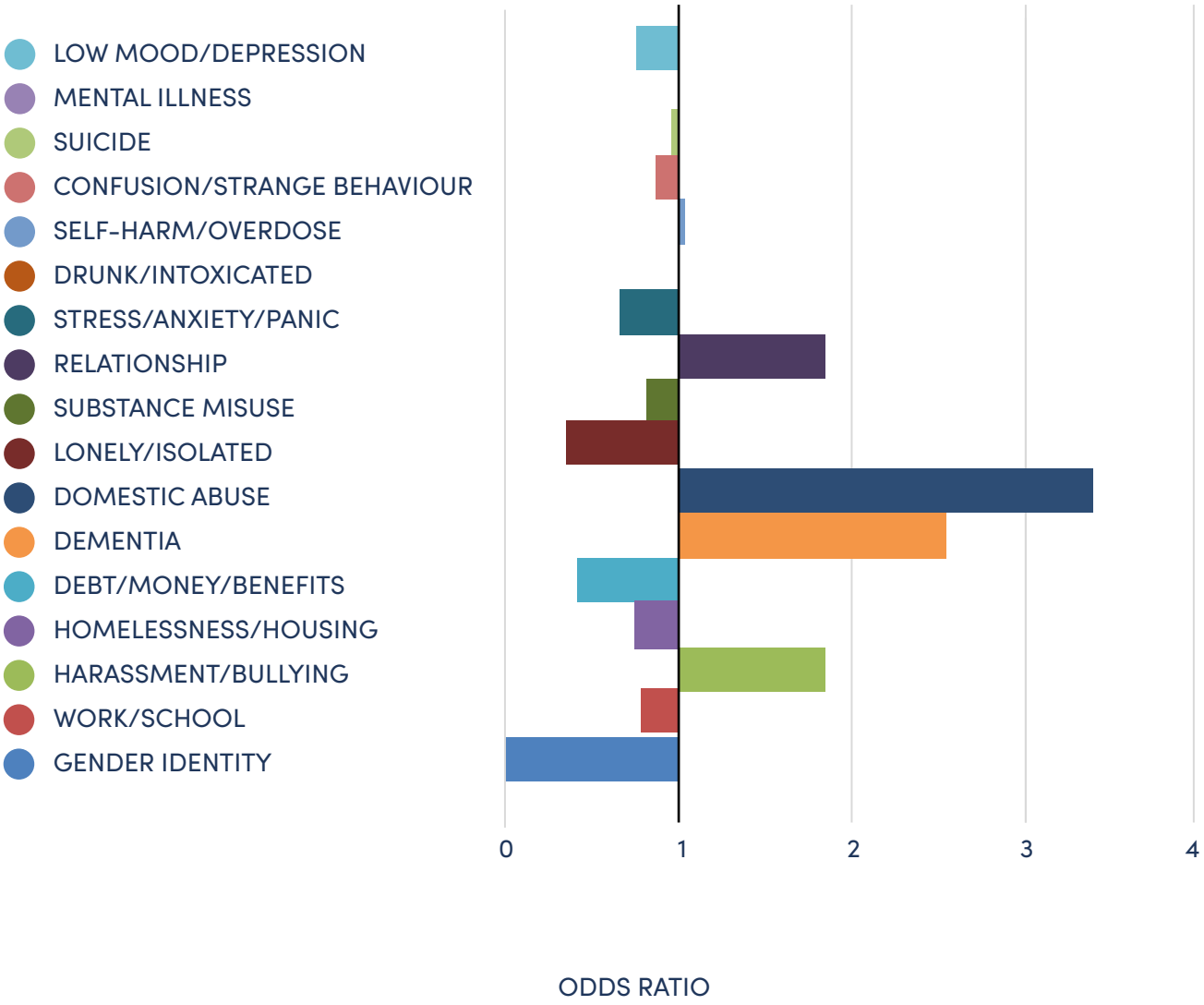


Figure 18 shows the Odds Ratio of each category where the caller was a professional. The figure shows that the ratios are higher in the suicide and self-harm/overdose categories relative to the other type of relationships and lower in the relationship, domestic abuse and gender identity categories.

Figure 18:

Odds Ratios by Index Problem for Type of Caller - Professional

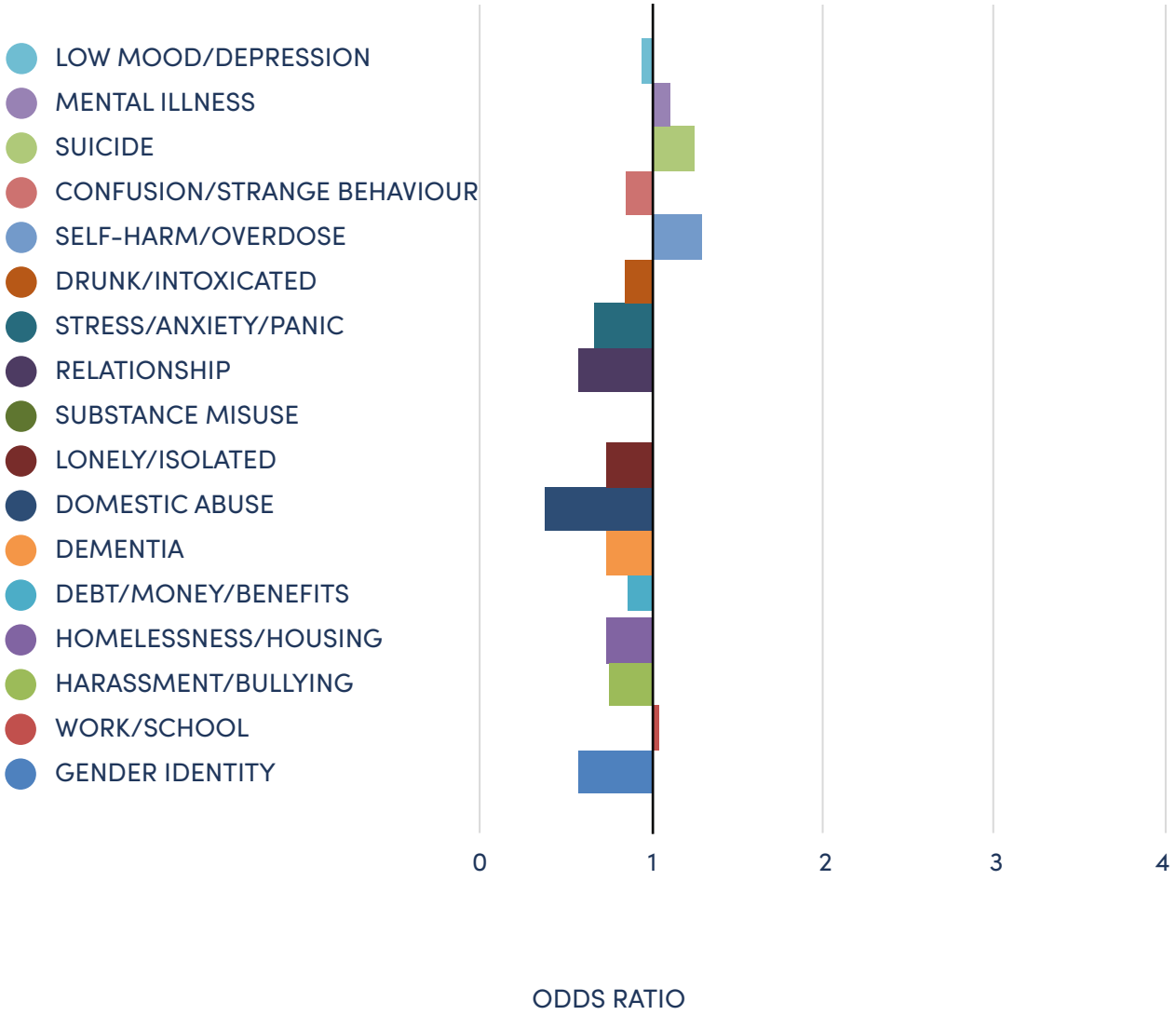
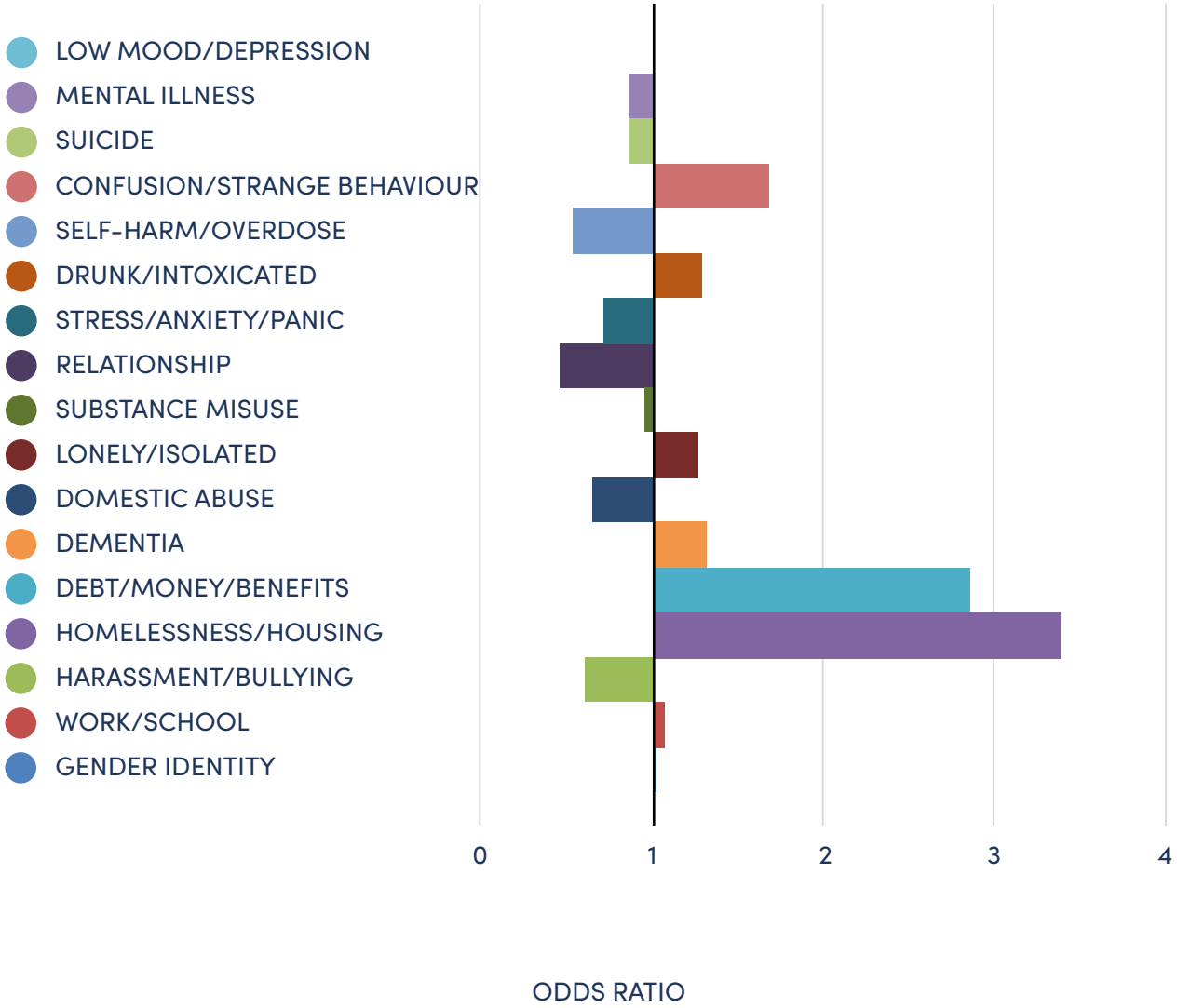


Figure 19 shows the Odds Ratio of each category where the caller was a member of the public or stranger. The figure shows that the ratios are higher in the confusion/strange behaviour, debt/money/benefits and homelessness/housing categories relative to the other type of relationships and lower in the self-harm/overdose, relationship and harassment/bullying categories.

Figure 19:

Odds Ratios by Index Problem for Type of Caller - Public or Stranger

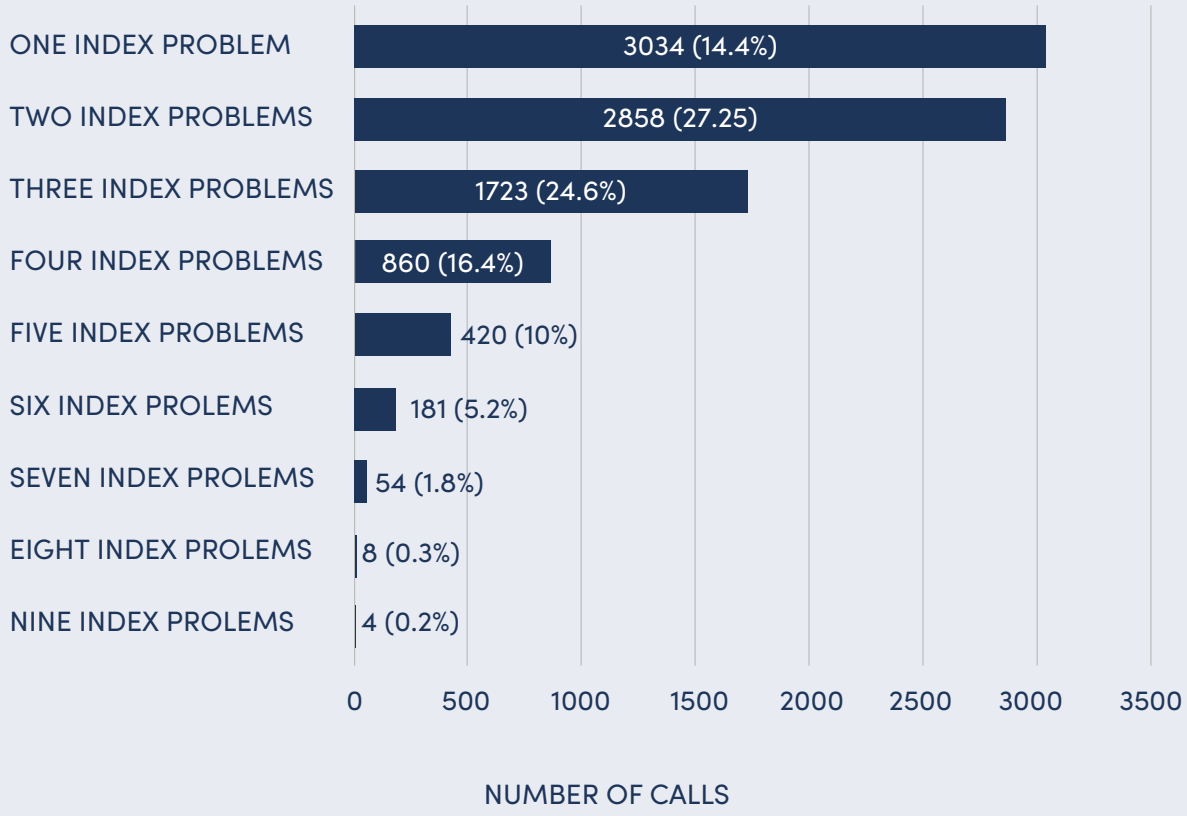


24. Associations Between Index Problems

The bespoke data collection found that for the 21,023 index problems there were on average **2** index problems per call. The number of index problems ranged from one to nine. **Figure 20** shows the number and proportion of calls by how many index problems were recorded.

Figure 20:

Number of Index Problems Per Call by Number and %

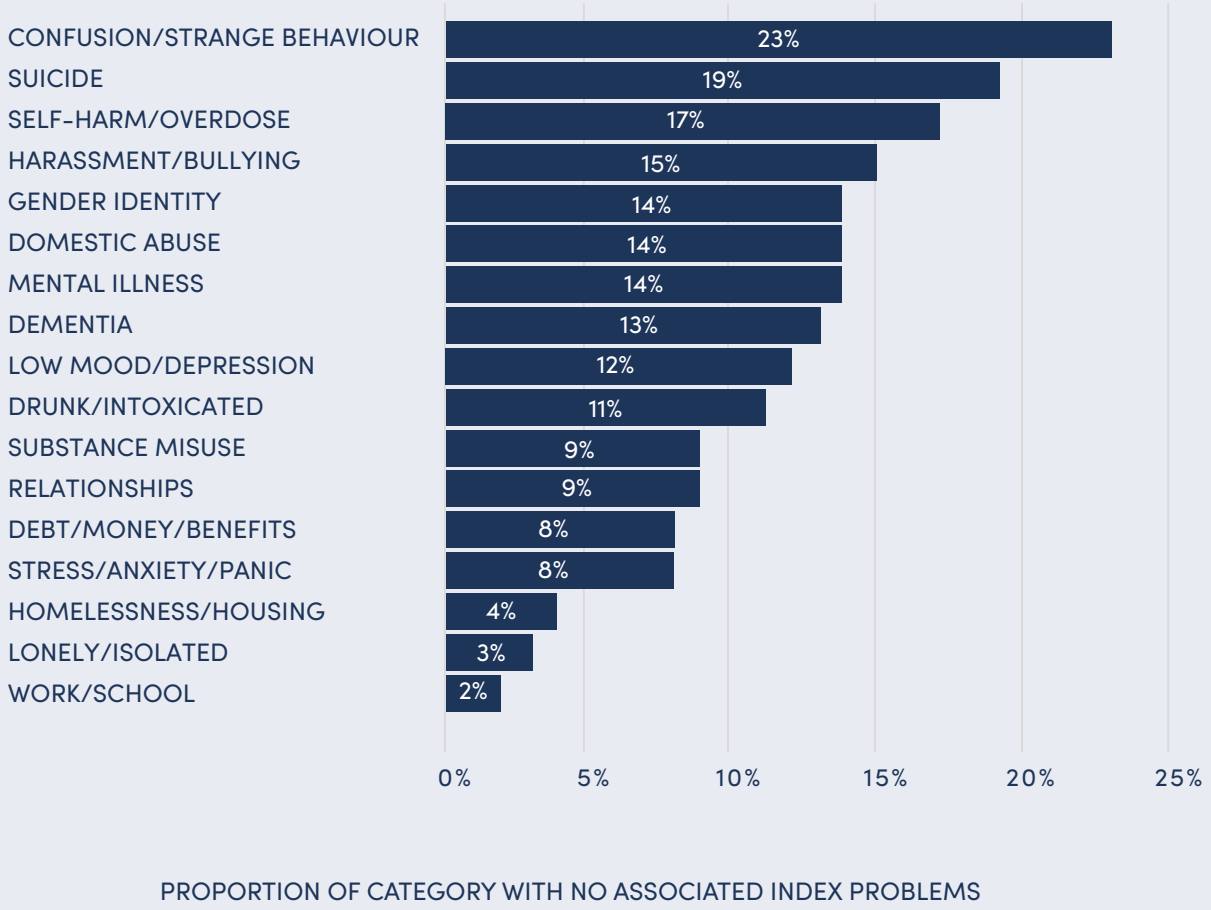


Across the seventeen categories the number of calls where only one index problem was recorded averaged 14% and ranged from 2% for work/school to 23% for confusion/strange behaviour. **Figure 21** shows, for each of the seventeen categories, the proportion of calls where no other index problem was recorded from highest to lowest.

Across the seventeen categories the number of calls where only one index problem was recorded averaged 14% and ranged from 2% for work/school to 23% for confusion/strange behaviour. **Figure 21** shows, for each of the seventeen categories, the proportion of calls where no other index problem was recorded from highest to lowest.

Figure 21:

% of Each Category with no Associated Index Problems



For 85.6% (17,989) of calls more than one index problem was recorded. Each of these associations will be discussed alongside the specific Index problems later in the Review. A summary of the associations can be found in Appendix 5.

25. Call Duration

Call durations were able to be calculated for a total of 71.6% (7,290) of the 10,175 calls included in the Review. Normally one of the 'success' criteria for emergency calls is the speed of response, although ensuring the response is the right one to meet the callers need is just as important[91].

Measuring the duration of a call normally entails determining the time between when the call is answered to when the call is resolved, however for some services 'resolution' can mean the total period of involvement in the 'incident', which may include call duration, dispatch, face-to-face contact, conveyance and closure.

As can be seen in **Figure 22** there is a marked difference between Dyfed Powys Police and Welsh Ambulance Service, for which average call duration is recorded in minutes, and the ICAN Service, North Wales Police and South Wales Police, for which average incident duration is recorded in hours. (data was absent for Gwent Police).

Figure 22:
Average Call/Incident Duration by Service

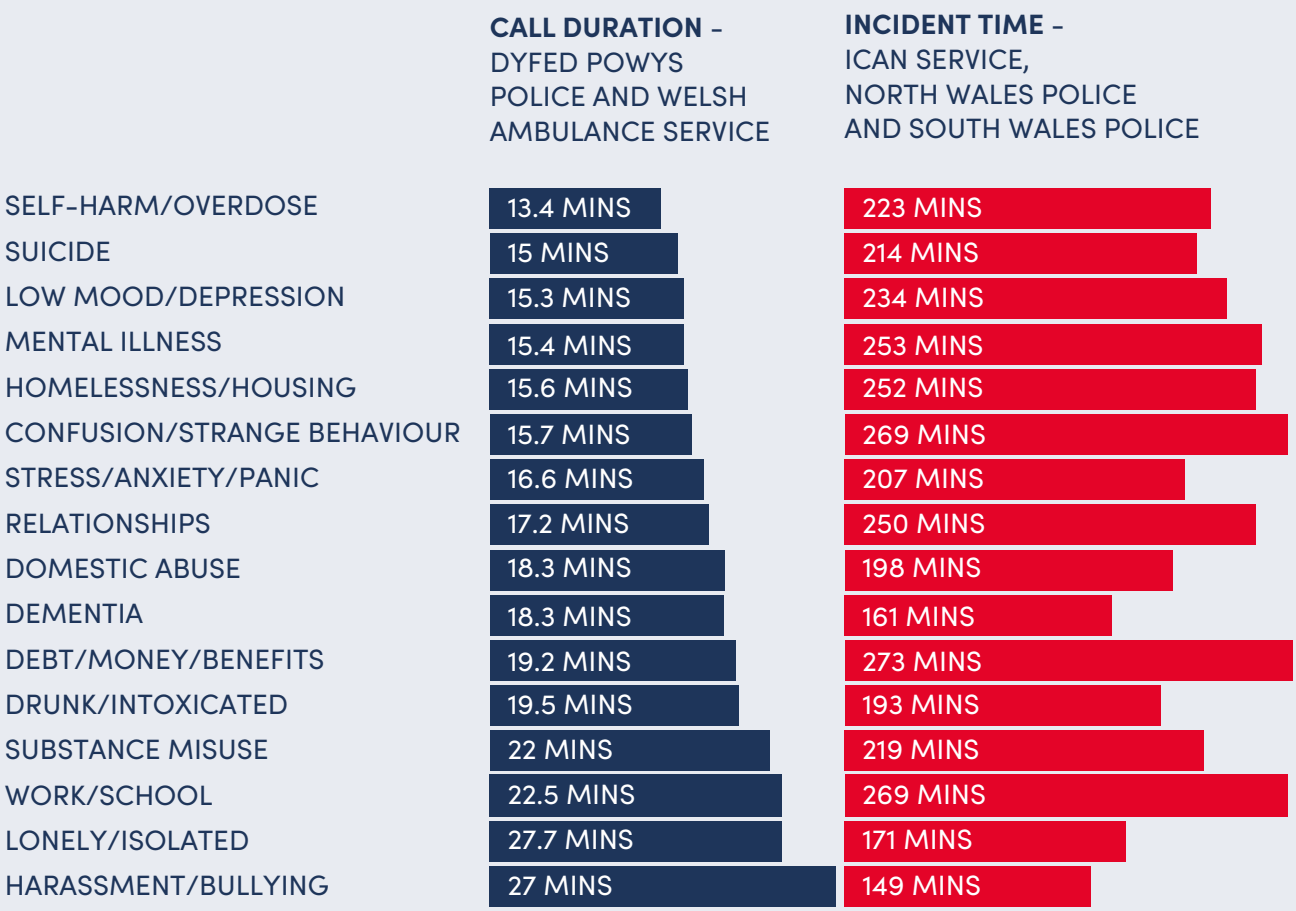
	Dyfed Powys Police	Welsh Ambulance Service	North Wales Police	South Wales Police	ICAN Service
Average call duration/ incident time in minutes	14mins	18 mins	121 mins	190 mins	228 mins

Figure 23 splits calls between two groups due to the difference in recording and excludes gender identity due to the small numbers.

These two groups, and therefore measures of time, are informative because they give different indices of service involvement. Firstly, regarding the immediate emergency service call duration time and secondly a broader and more inclusive estimate of the amount of time that emergency services remain involved in dealing with each index problem.

Figure 23:

Average Duration of Call/Incident for all Index Problems Split Between Two Groups Due to Different Recording Processes – in Ascending Order of Call Duration



26. Risk and Triage

Triage is the process of assessment that occurs at the point of entry to a service in order to prioritise responses. Since first being developed by the Surgeon-in-Chief of Napoleon's army in 1792 to manage battle causalities, 'triage' schemes are now in place for a range of services.

The assessment of risk for a person with mental health or welfare concerns is an important part of ensuring safe and effective triage and signposting. Triage in mental health is a clinical function in which a brief mental health screening assessment is undertaken to determine whether the person has a mental health related problem, the urgency of the problem, and the most appropriate service response. Triage does not formally diagnose mental health conditions but gathers information about mental health related symptoms and risks that inform decisions about the appropriate service response, if any, for each call[92]. One such triage system, in use in the UK, is shown in Appendix 6.

One of the aims of the Review was to explore the differences in demand placed on services arising from different aspects of crisis, necessary because mental health and welfare needs often fall under the remit of distinct services which may be commissioned, planned, provided and resourced separately. For the purposes of the Review the seventeen index problems were split into four bespoke domains that may require a different service response, shown in **Figure 24.**

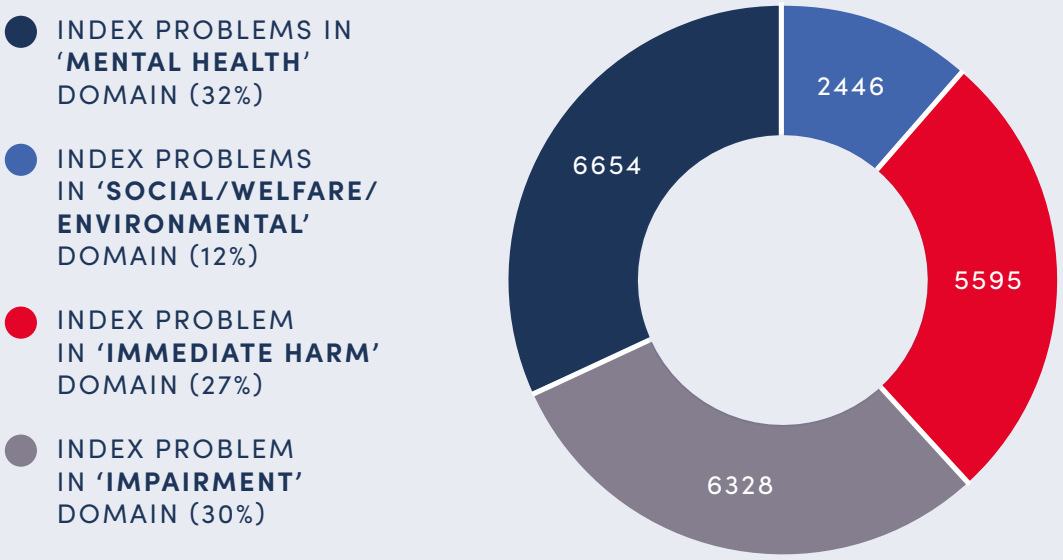
Figure 24:
Index Problems Across Four Domains

Index problems in 'Immediate harm' domain	Index problems in 'Impairment' domain	Index problems in 'Mental health' domain	Index problems in 'Social/welfare/ environmental' domain
• Suicidal • Self-harm/ Overdose • Domestic abuse	• Drunk/Intoxicated • Confusion/Strange behaviour • Stress/Anxiety/Panic • Substance Misuse	• Low mood/ Depression • Mental illness • Dementia	• Debt money • Harassment/ Bully • Lonely/Isolation • Relationship issue • Work/School • Gender identity • Homeless

These domains are not validated or indicative of clinical risk and there will be likely overlap between domains. These domains were an attempt to distinguish those calls that might possibly require an emergency service response ('immediate harm' domain), a shared physical care, mental health or substance misuse service response ('impairment' domain), a mental health services response ('mental health' domain), or a response from a range of other public or third sector welfare or well-being agencies ('social/welfare/environmental' domain).

The proportion and number of calls in each domain can be seen in **Figure 25**. The figure shows relatively equitable proportions except for a smaller proportion being in the social/welfare/environmental domain.

Figure 25:
% and Number of Index Problems in Each Domain



In order to determine potential associations across the four domains the prevalence of each specific index problem was compared to each of the other domains that did not include it. This analysis is shown in **Figure 26** and highlights some interesting associations such as:

- Relationship issues, problems at work/ school or homelessness/housing were more likely associated with index problems in the immediate harm domain.
- Loneliness/isolation, low mood/depression and problems at work/school were more likely associated with index problems in the impairment domain.
- Work/school, loneliness/isolation and stress/ anxiety/panic were more likely associated with index problems in the mental health domain
- Domestic abuse, stress/anxiety/panic and low mood/depression were more likely associated with other index problems in the social/ welfare/ environmental domain.

Figure 26:

% of Each Index Problem in Each Domain

	Immediate harm domain	Impairment domain	Mental health domain	Social/ welfare/ environmental domain
Index problems in 'Immediate harm' domain				
Suicidal		41%	49%	23%
Self-harm/ Overdose		45%	51%	20%
Domestic abuse		38%	44%	33%
Index problems in 'Impairment' domain				
Confusion/ strange behaviour	24%		54%	15%
Drunk/ intoxicated	49%		47%	21%
Stress/anxiety/ panic	40%		77%	31%
Substance Misuse	43%		46%	21%
Index problems in 'Mental health' domain				
Low mood/ Depression	46%	61%		30%
Mental illness	39%	54%		20%
Dementia	5%	33%		19%

Figure 26:

% of Each Index Problem in Each Domain (Continued from Overleaf)

Index problems in 'Social/welfare/environmental' domain				
Debt/money/ Benefits	45%	54%	65%	
Harassment/ bullying	35%	42%	53%	
Loneliness/ isolation	40%	62%	84%	
Relationship issue	58%	45%	52%	
Homelessness/ housing	50%	52%	51%	
Work/school	58%	60%	86%	
Gender identity	33%	33%	38%	

One of the main objectives of an emergency services call handler is to determine what action to take on the basis of an array of presenting features of the callers' situation. The call handler selects a response based on knowledge of appropriate or available responses. A call handler in emergency services may be more familiar, and be able to identify the appropriate response more quickly, in certain situations such as those manifesting in the 'immediate harm' and 'mental health' domains as these match most closely to the normal function of emergency services, which is to save lives or treat urgent illness.

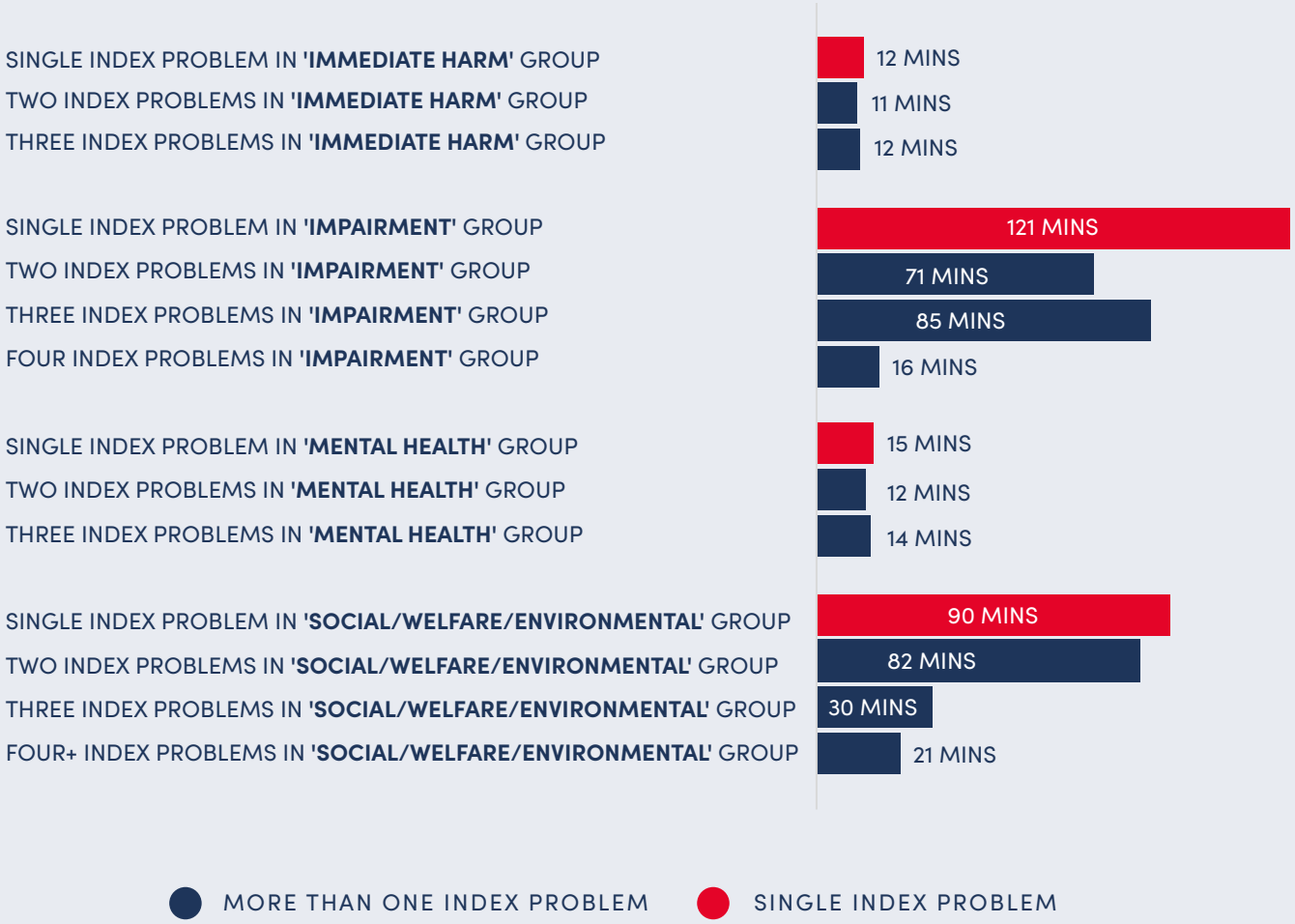
The call handler may be less familiar, and be unable to identify an appropriate response as quickly, in the 'impairment and 'social/welfare/ environmental' domains. This discrepancy between domains can be seen in the red highlighted bars in **Figure 27** overleaf, which shows the average duration of a call in minutes for those with a single index problem from each domain.

It is reasonable to assume that calls with multiple index problems would be the longest to resolve, however Figure 27 shows that the number of index problems in the domains, 'Immediate harm' or 'mental health' did not substantially increase or decrease call duration. In contrast, an increase in the number of index problems in the 'impairment and 'social/welfare/environmental' resulted in the call duration, on average, getting shorter.

This pattern of association suggests that additional index problems from the 'Immediate harm' or 'mental health' domains did not act additively to impede the call handler's ability to deal with calls quickly. However, in the domains 'Impairment, or 'social/welfare/environmental', additional index problems actually facilitated a quicker call resolution. This pattern is counterintuitive unless the level of risk and need is able to be determined more quickly as a result of the presence of additional problems.

Figure 27:

Average Duration of Calls in Minutes by Number of Index Problems in Each Domain



27. Specific Index Problem – Low Mood or Depression

27.1 The Index Problem

Feeling sad, miserable, despondent or dejected can be a natural reaction to life events or situations, but depression is different as it tends to be longer lasting and more encompassing. Depression is one of the most common mental health problems in the UK[93]. People with depression typically have lots of negative thoughts and feelings of guilt and worthlessness; they often criticise themselves and lack confidence[94].

The main symptoms of depression are feeling 'low' and losing pleasure in things that were once enjoyable. These symptoms are often combined with others, such as feeling tearful, being irritable, appetite changes, sleep problems, poor concentration and poor memory. Depression can be an acute response to an immediate crisis which remits without any specific treatment or intervention but it can also be severe and long lasting. Severe depression can result in significant alterations to a person's ability to cope with their everyday life, their capacity for problem solving and their insight and self-awareness, leading to behaviours that cause concern for others.

People with depression are be at increased risk of suicide[95], self-harm[96] or aggression[97], although these behaviours are rare compared to the overall numbers of people who suffer depression. Understanding the relationship between depression, increased risk of adverse outcomes and contact with emergency services is important in appropriately triaging and diverting such callers.

27.2 Data Overview

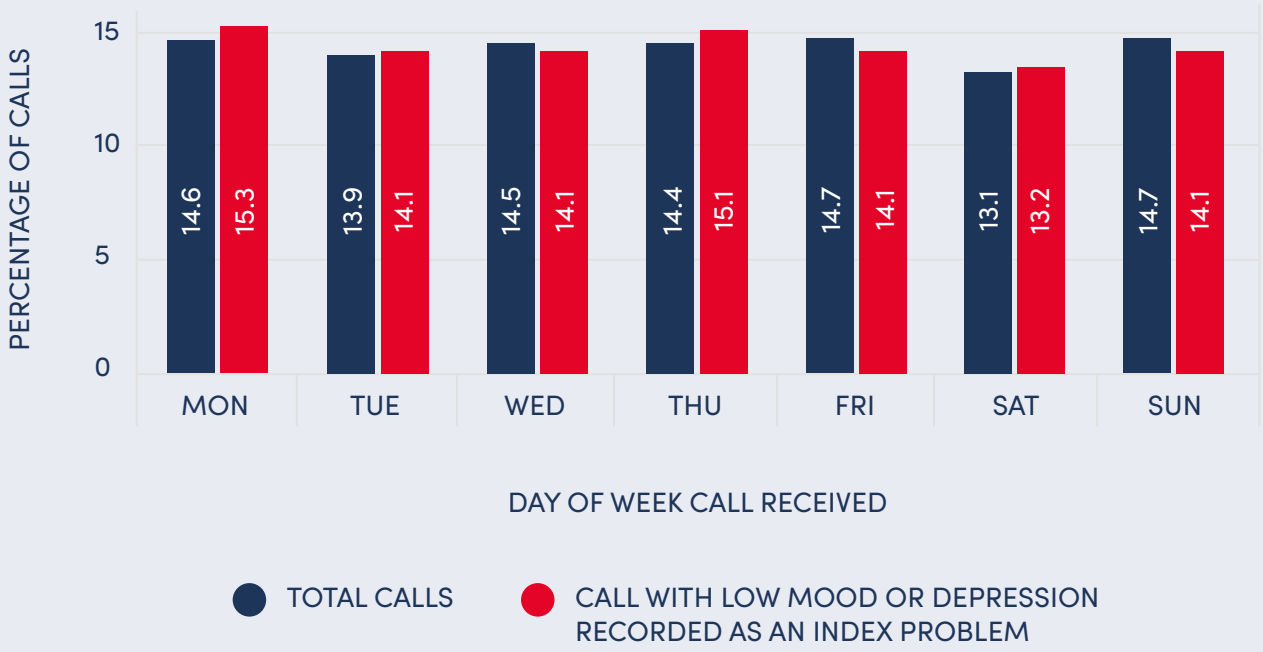
The term 'low mood' or 'depression' were the trigger words for call handlers as they are often used by people to describe feelings of despair, sadness or low self-esteem although no formal diagnosis of depressive illness may be present. The bespoke data collection documented where a caller had stated that they, or the person the call was in relation to, had low mood or was depressed. A total of **3,288** calls recorded low mood or depression as an index problem.

27.3 Day of the Week of Calls

A total of 99.8% (3,027) of calls were able to record the day of the week the call was received, out of 3,032 calls which identified low mood or depression as an index problem.

Figure 28 shows the proportion of calls received per day of the week and shows a slight peak on Monday and Thursday. The figure shows 73% of calls were received on a weekday compared to 72% of total calls and 27% of calls were received on a weekend compared to 28% of total calls.

Figure 28:
% of Calls by Day of the Week - Low Mood or Depression Versus Total Calls



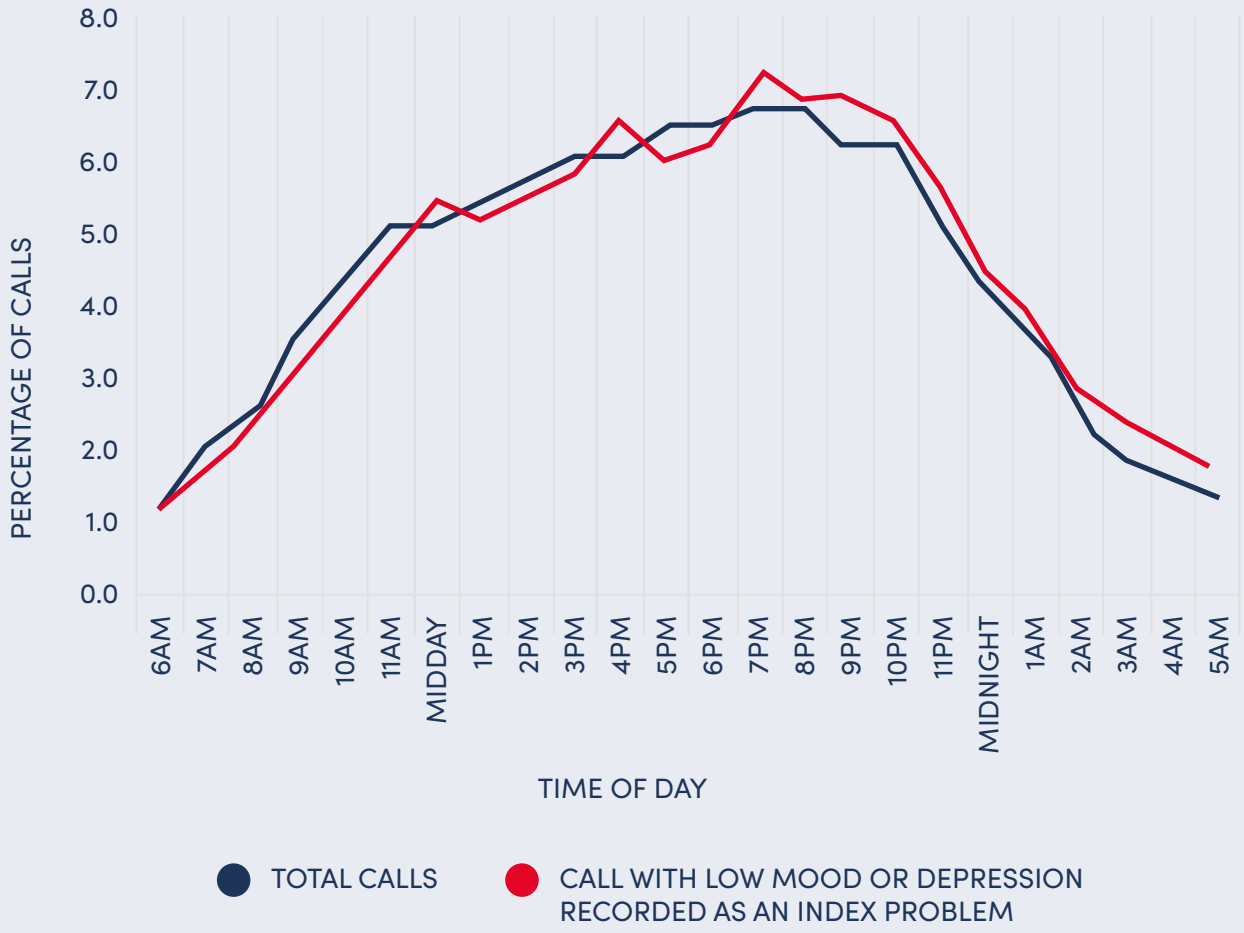
27.4 Time of Day of Calls

A total of 100% (3,027) of calls were able to record the time of day the call was received out of 3,032 calls which identified low mood or depression as an index problem. **Figure 29** shows the time of day of calls where low mood or depression had been recorded as index problems versus total calls, shown from 6am to better display overnight calls.

The figure highlights a variation between low mood or depression calls and total calls in that low mood or depression calls are lower in the morning and after a 7pm peak decline more slowly than other calls. A higher proportion of calls (57%) occurred 'out of hours', from 5pm to 9am, but this was less than the proportion of the total number of calls (61%) received 'out of hours'.

Figure 29:

% of Calls by Time of Day - Low Mood or Depression Versus Total Calls



27.5 Association with Other Index Problems

For 11.8% (388) of the 3,288 calls, where low mood or depression was recorded as an index problem, there were no other index problems recorded. For 88.2% (2,900) of calls, where low mood or depression was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **66%** of calls where **work or school** is an index problem also had low mood or depression as an index problem,
2) **62.6%** of calls where **dementia** is an index problem also had low mood or depression as an index problem
3) **56.9%** of calls where **loneliness and/or isolation** is an index problem also had low mood or depression as an index problem,
4) **56.1%** of calls where **homelessness or concerns over housing** is an index problem also had low mood or depression as an index problem,
5) **48%** of calls where **debt, money or concerns about benefits** is an index problem also had low mood or depression as an index problem,
6) **47.7%** of calls where **mental illness** is an index problem also had low mood or depression as an index problem
7) **42.3%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had low mood or depression as an index problem
8) **38.8%** of calls where **suicidal behaviour** is an index problem also had low mood or depression as an index problem
9) **38.1%** of calls where **gender identity** is an index problem also had low mood or depression as an index problem
10) **36.8%** of calls where **confusion or strange behaviour** is an index problem also had low mood or depression as an index problem
11) **36.1%** of calls where **stress, anxiety or panic** is an index problem also had low mood or depression as an index problem
12) **35.6%** of calls where **drunkenness or intoxication** is an index problem also had low mood or depression as an index problem
13) **28.5%** of calls where **relationships** are an index problem also had low mood or depression as an index problem
14) **27.7%** of calls where **harassment or bullying** is an index problem also had low mood or depression as an index problem
15) **26.5%** of calls where **domestic abuse** is an index problem also had low mood or depression as an index problem
16) **21.2%** of calls where **substance misuse** is an index problem also had low mood or depression as an index problem.

28. Specific Index Problem – Mental Illness

28.1 The Index Problem

The concept of mental illness embraces a wide range of alterations to thinking, feeling and behaviour that cause distress to the individual and sometimes to others around them. Mental illnesses can include short-term crisis resulting from changed life circumstances that may be minimal to severe in impact. Mental illness can also present as recurring difficulties that produce intermittent crises for a person who otherwise is able to manage their life with relative independence. Mental illness includes longer-term conditions such as schizophrenia, bipolar disorder and personality disorders that can have an extensive impact on a person's quality of life and independence and can result in significant social isolation, exclusion and loneliness.

Mental ill health can affect anyone at any point in their lives. There are demographic differences however, in terms of vulnerability to mental illness, how mental health is expressed, what services are sought, what services are available and offered and the impact on others. Gender, age, ethnicity, socio-economic status, disability, social and health inequalities, deprivation, loneliness and isolation, are all factors that influence mental health and related behaviour, including help seeking.

A Welsh study on averse events in childhood or adolescence, such as the child experiencing domestic violence or parental separation, or living with family mental illness or substance misuse has been shown to have 'strong associations' between the child then developing substance use, violence, mental illness and physical health problems[98]. For many, mental illness retains a stigma and there are particular groups who are less likely to access mental health services in a crisis. Middle aged men, in particular and individuals from some ethnic groups are less likely to disclose or discuss their mental health or to seek help[99].

In such circumstances, a person who might be experiencing overwhelming distress may feel they have nowhere to turn to and no one to call except emergency services.

28.2 Data Overview

The term 'mental illness' was the trigger word for call handlers as it is often used by people to describe health conditions that affect mood, thinking or behaviour, although no formal diagnosis may be present.

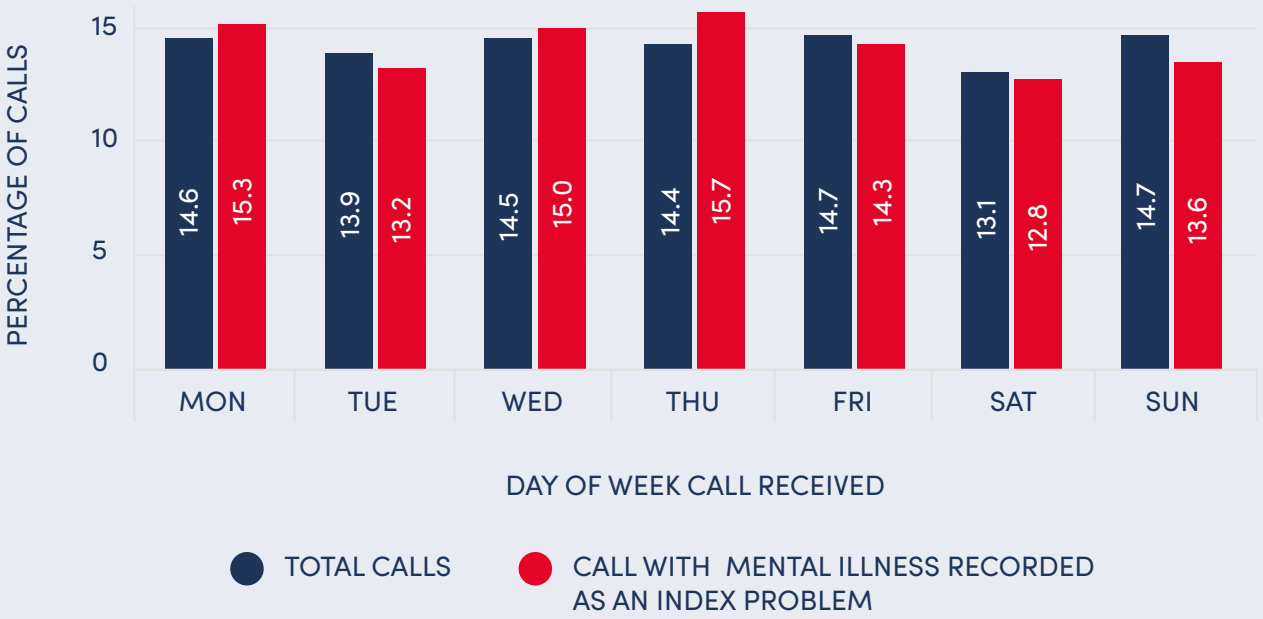
The bespoke data collection documented where a caller had stated that they, or the person the call was in relation to, had a potential, current or past diagnosis of mental illness. These statements are unverified and this data should not be taken as indicative of population prevalence of mental illness. A total of **3,032** calls recorded mental illness as an index problem.

28.3 Day of the Week of Calls

A total of 99.8% (3,027) of calls were able to record the day of the week the call was received, out of 3,032 calls which identified mental illness as an index problem.

Figure 30 shows the proportion of calls received per day of the week. The figure shows 74% of calls were received on a weekday compared to 72% of total calls and 26% of calls were received on a weekend compared to 28% of total calls.

Figure 30:
% of Calls by Day of the Week - Mental Illness Versus Total Calls



28.4 Time of Day of Calls

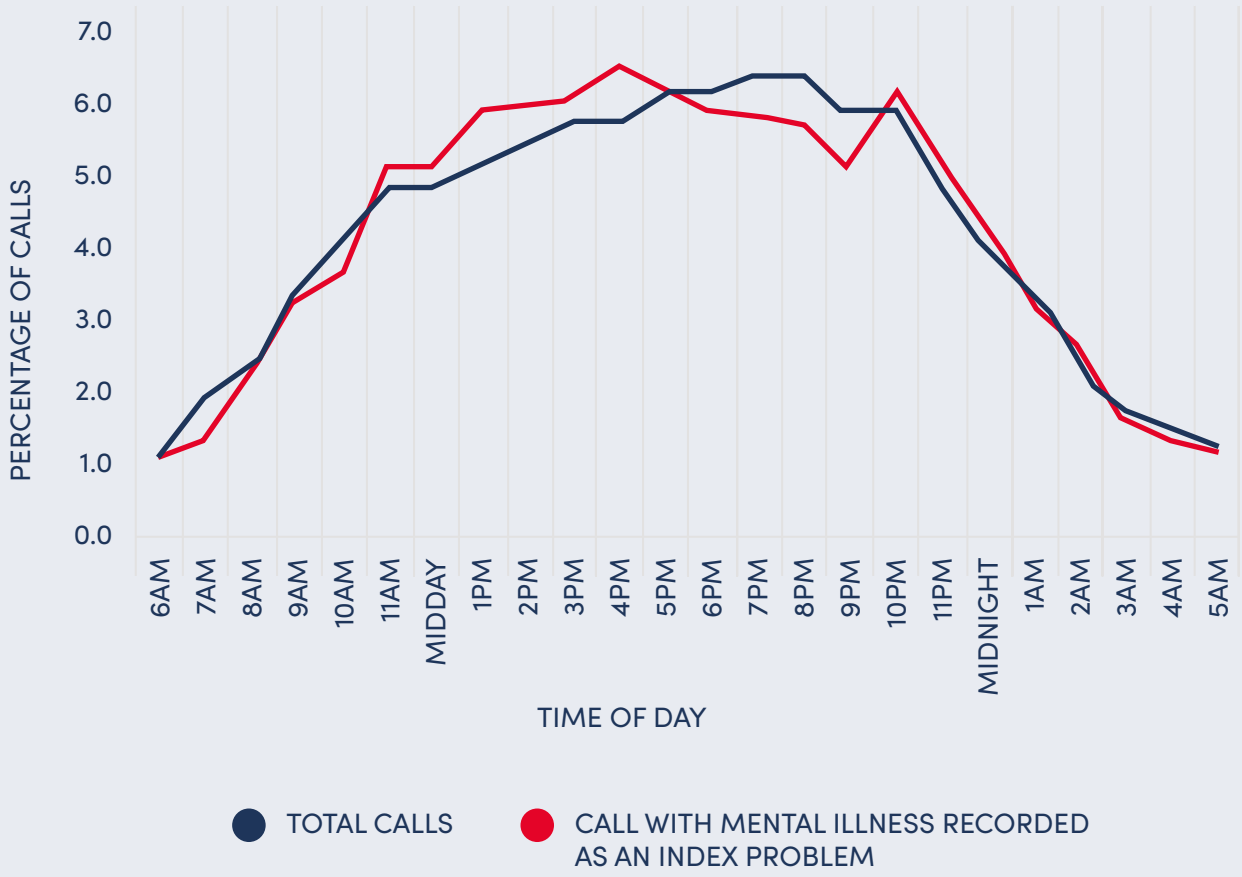
A total of 99.7% (3,024) of calls were able to record the time of day the call was received out of 3,032 calls which identified mental illness as an index problem. **Figure 31** shows the time of day of calls where mental illness had been recorded as an index problem versus total calls, shown from 6am to better display overnight calls.

The figure highlights a variation between mental illness calls and total calls in that mental illness calls are higher from 11am to 4pm then decline steeply, until rising at 9pm to match other calls.

A higher proportion of calls (59%) occurred 'out of hours', from 5pm to 9am, but this was less than the proportion of the total number of calls (61%) received 'out of hours'.

Figure 31:

% of Calls by Time of Day - Mental Illness Versus Total Calls



28.5 Association with Other Index Problems

For 13.8% (418) of the 3,032 calls, where mental illness was recorded as an index problem, there were no other index problems recorded. For 86.2% (2,390) of calls, where mental illness was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **43.9%** of calls where **low mood or possible depression** is an index problem also had mental illness as an index problem,
2) **40.4%** of calls where **dementia** is an index problem also had mental illness as an index problem,
3) **40.1%** of calls where **loneliness and/or isolation** is an index problem also had mental illness as an index problem,
4) **39%** of calls where **work or school** is an index problem also had mental illness as an index problem,
5) **38.1%** of calls where **gender identity** is an index problem also had mental illness as an index problem,
6) **37.2%** of calls where **debt, money or concerns about benefits** is an index problem also had mental illness as an index problem,
7) **34,2%** of calls where **confusion or strange behaviour** is an index problem also mental illness as an index problem,
8) **31.8%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had mental illness as an index problem,
9) **31.5%** of calls where **drunkenness or intoxication** is an index problem also had mental illness as an index problem,
10) **30.9%** of calls where **stress, anxiety or panic** is an index problem also had mental illness as an index problem,
11) **30.6%** of calls where **substance misuse** is an index problem also had mental illness as an index problem,
12) **30%** of calls where **harassment or bullying** is an index problem also had mental illness as an index problem,
13) **29.8%** of calls where **relationships** are an index problem also had mental illness as an index problem,
14) **28.5%** of calls where **domestic abuse** is an index problem also had mental illness as an index problem,
15) **27.8%** of calls where **suicidal behaviour** is an index problem also had mental illness as an index problem,
16) **27.6%** of calls where **homelessness or concerns over housing** is an index problem also had mental illness as an index problem.

29. Specific Index Problem- Suicidal Behaviour

29.1 The Index Problem

In 2019, 330 people died by suicide in Wales[100]. In previous years studies have shown that, of the people who died by suicide, 21% had been in contact with mental health services within the previous 12 months[101]. In a review of suicides in one UK city, two in ten individuals had contact with the Police in the three months prior to their death[102] with similar findings reported in other areas[103]. There are factors associated with a higher risk of suicide, such as men aged between 45 and 49 and male divorcees[104]. The Police, in collaboration with other health and social care agencies, have an important role to play in suicide prevention strategies as acknowledged by the College of Policing[105]. Police may be able to identify and signpost people presenting with suicidal thoughts and behaviours who are not known to mental health services[106].

29.2 Data Overview

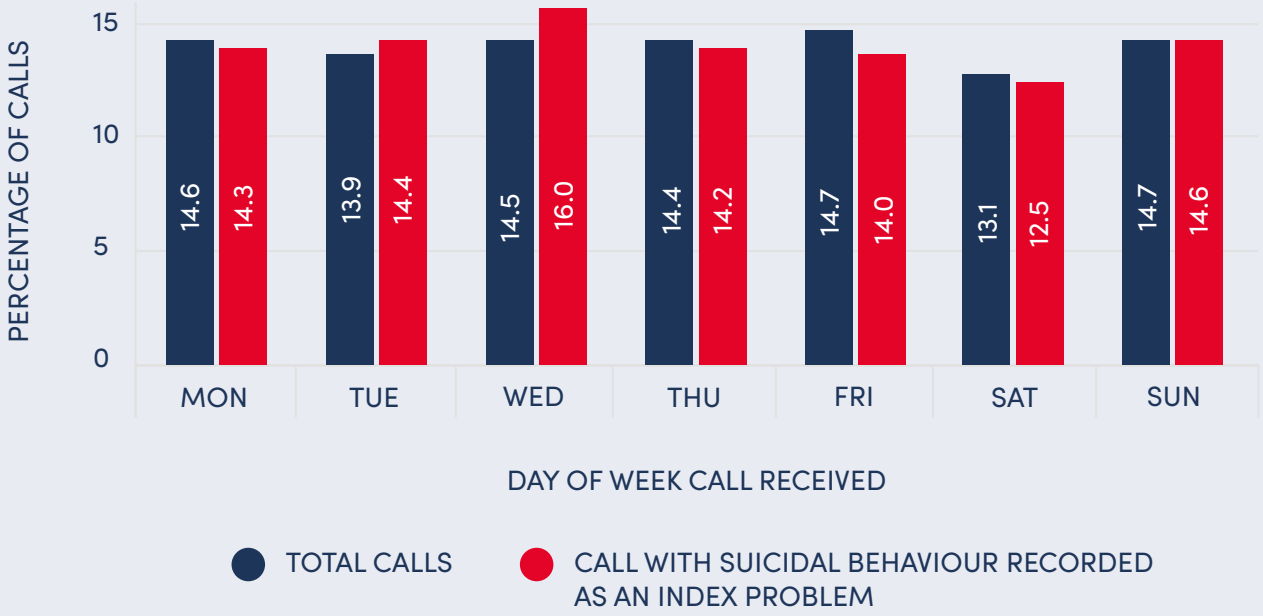
The term 'suicidal behaviour' was the trigger word for call handlers as it is often used by people to describe those contemplating or attempting to end their own life, although intent can be difficult to determine, so there is overlap with self-harm. The bespoke data collection documented where a caller had stated they, or the person the call was in relation to, had suicidal thoughts or was displaying suicidal behaviour. A total of **2,966** calls recorded suicidal behaviour as an index problem.

29.3 Day of the Week of Calls

A total of 99.7% (2,958) of calls were able to record the day of the week the call was received out of 2,966 calls which identified suicidal behaviour as an index problem.

Figure 32 shows the proportion of calls received per day of the week and shows a slight peak on Wednesday. The figure shows 73% of calls were received on a weekday compared to 72% of total calls and 27% of calls were received on a weekend compared to 28% of total calls.

Figure 32:
% of Calls by Time of Day - Mental Illness Versus Total Calls



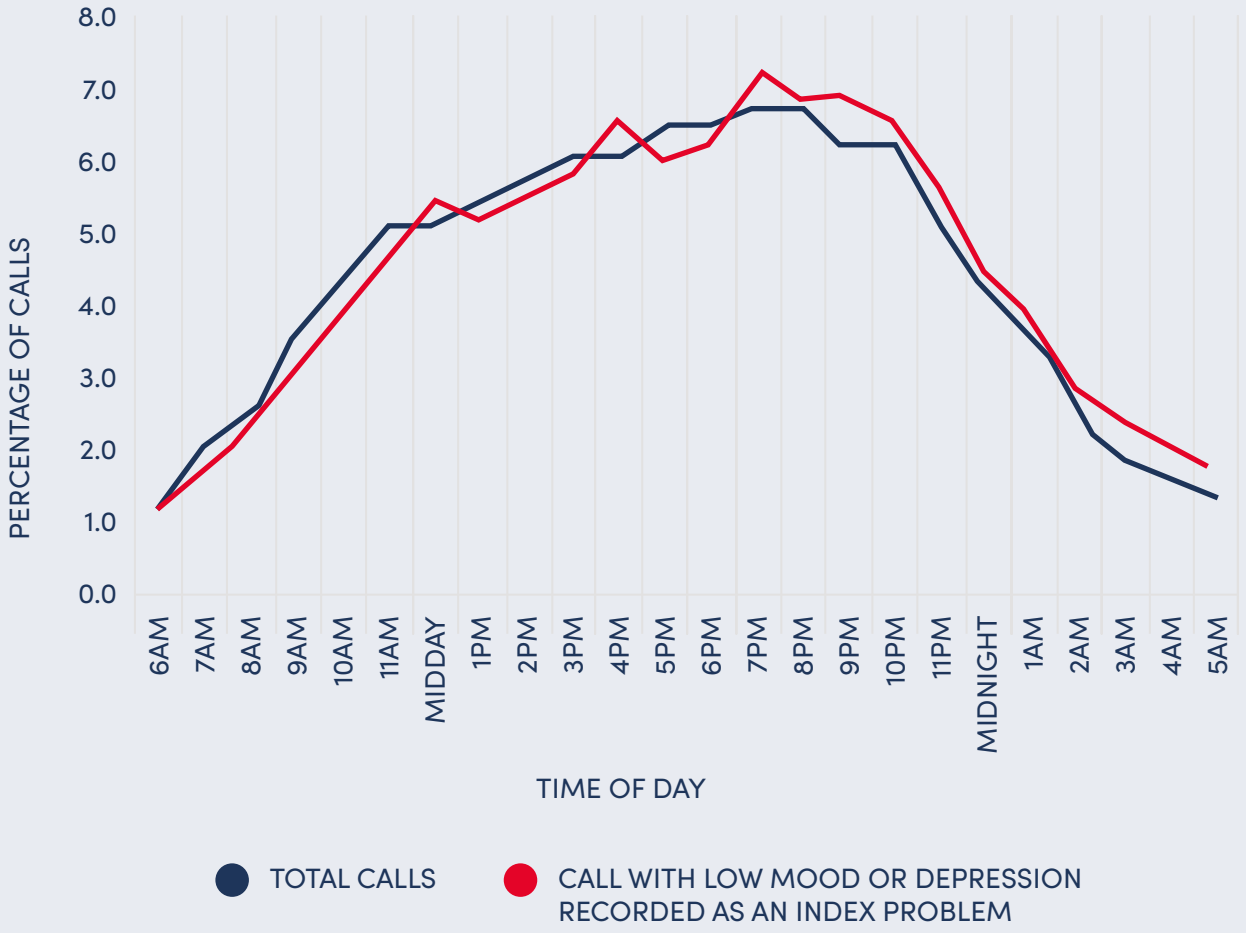
29.4 Time of Day of Calls

A total of 99.4% (2,949) of calls were able to record the time of day the call was received out of 2,966 calls which identified suicidal behaviour as an index problem. **Figure 33** shows the time of day of calls where suicidal behaviour had been recorded as an index problem versus total calls, shown from 6am to better display overnight calls.

The figure highlights variation between suicidal behaviour and total calls in that suicidal behaviour calls peak between 7pm and 8pm and remain slightly higher overnight. A higher proportion of calls (63%) occurred 'out of hours', from 5pm to 9am, and this was more than the proportion of the total number of calls (61%) received 'out of hours'.

Figure 33:

% of Calls by Time of Day - Suicidal Behaviour Versus Total Calls



29.5 Association with Other Index Problems

For 19.4% (576) of the 2,966 calls, where suicidal behaviour was recorded as an index problem, there were no other index problems recorded. For 80.6% (2,390) of calls, where suicidal behaviour was recorded as an index problem, other index problems were recorded as shown below:

1) **47.7%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had suicidal behaviour as an index problem,
2) **41%** of calls where **work or school** is an index problem also had suicidal behaviour as an index problem,
3) **34.6%** of calls where **low mood or possible depression** is an index problem also had suicidal behaviour as an index problem,
4) **33.3%** of calls where **gender identity** is an index problem also had suicidal behaviour as an index problem,
5) **31.9%** of calls where **relationships** are an index problem also had suicidal behaviour as an index problem,
6) **31.2%** of calls where **debt, money or concerns about benefits** is an index problem also had suicidal behaviour as an index problem,
7) **30.4%** of calls where **loneliness and/or isolation** is an index problem also had suicidal behaviour as an index problem,
8) **30.3%** of calls where **homelessness or concerns over housing** is an index problem also had suicidal behaviour as an index problem
9) **29.3%** of calls where **dementia** is an index problem also had suicidal behaviour as an index problem
10) **28.3%** of calls where **drunkenness or intoxication** is an index problem also had suicidal behaviour as an index problem,
11) **27.7%** of calls where **substance misuse** is an index problem also had suicidal behaviour as an index problem,
12) **27.2%** of calls where **mental illness** is an index problem also had suicidal behaviour as an index problem,
13) **27%** of calls where **domestic abuse** is an index problem also had suicidal behaviour as an index problem,
14) **23.8%** of calls where **stress, anxiety or panic** is an index problem also had suicidal behaviour as an index problem,
15) **23.2%** of calls where **harassment or bullying** is an index problem also had suicidal behaviour as an index problem,
16) **16.4%** of calls where **confusion or strange behaviour** is an index problem also had suicidal behaviour as an index problem,

30. Specific Index Problem – Confusion and Strange Behaviour

30.1 The Index Problem

Confusion affects how a person thinks, sees the world around them, and remembers things. Confusion can be a symptom of physical illnesses such as dementia, infection, head injury, diabetes or stroke. Confusion can be a consequence of alcohol or drug consumption and it can also be a symptom of a mental illness such as anxiety, mania or depression.

The main signs of confusion are sudden changes in awareness, as a person with confusion might suddenly get very sleepy and disorientated or act very upset and nervous. People observing confusion or atypical behaviour can become frightened at this 'strange' behaviour or concerned for the persons wellbeing, especially if there is no observable cause.

30.2 Data Overview

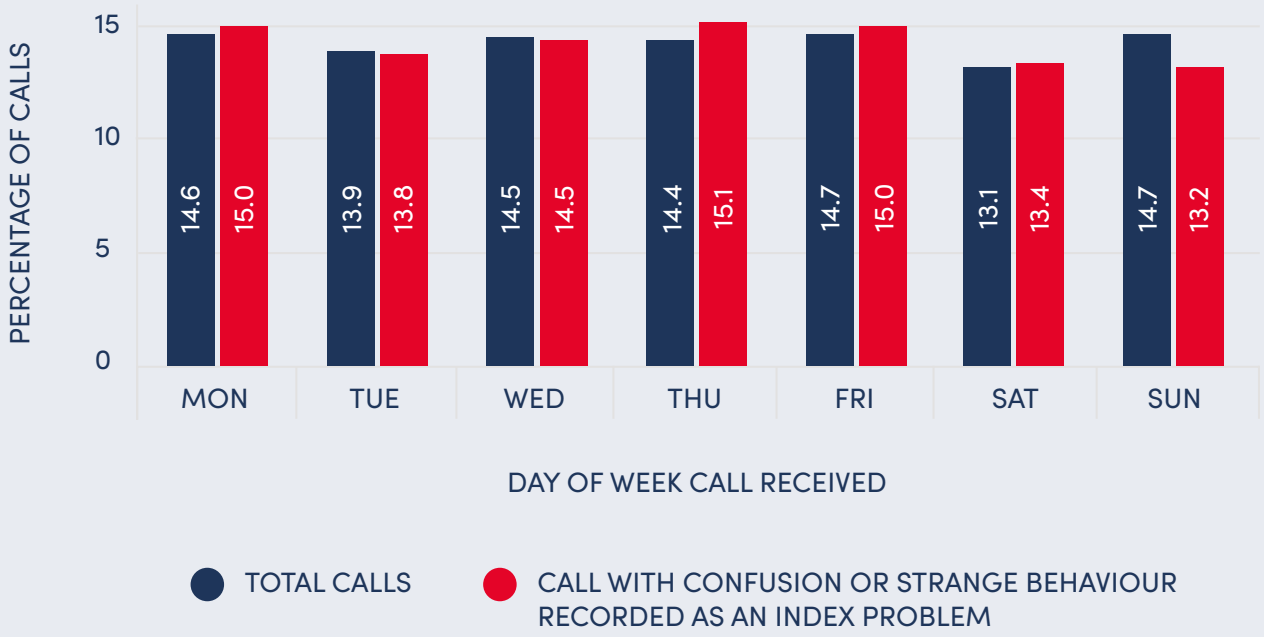
The term 'confusion' and 'strange behaviour' were the trigger words for call handlers as they are often used by people to describe unfamiliar or atypical conduct. The bespoke data collection documented where a caller had stated that they, or the person the call was in relation to, was confused or was displaying strange behaviour. A total of **2,939** calls recorded suicidal behaviour as an index problem.

30.3 Day of the Week of Calls

A total of 99.9% (2,937) of calls were able to record the day of the week the call was received out of 2,939 calls which identified confusion or strange behaviour as an index problem.

Figure 34 shows the proportion of calls received per day of the week and shows a lower proportion on Sunday and a slight peak on Thursday. The figure shows 73% of calls were received on a weekday compared 72% of total calls and 27% of calls were received on a weekend compared to 28% of total calls.

Figure 34:
% of Calls by Day of the Week - Confusion or Strange Behaviour Versus Total Calls



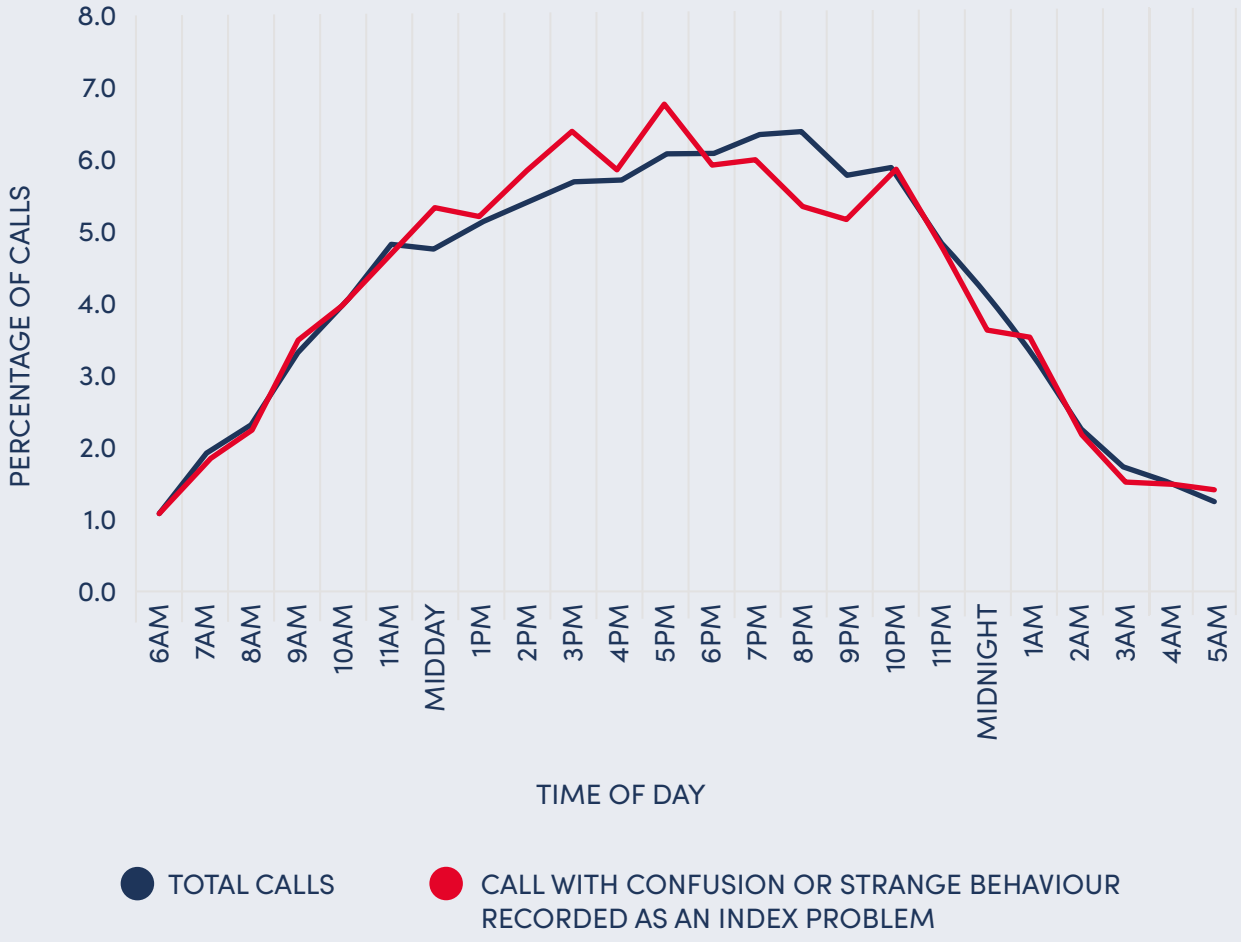
30.4 Time of Day of Calls

A total of 100% (2,939) of calls were able to recordthe time of day the call was received which identified confusion or strange behaviour as an index problem. **Figure 35** shows the time of day of calls where confusion or strange behaviour had been recorded as an index problem versus total calls, shown from 6am to better display overnight calls.

The figure highlights a variation between confusion or strange behaviour and total calls in that confusion or strange behaviour calls are higher from midday until 5pm then lower between 5pm and 9pm. A higher proportion of calls (59%) occurred 'out of hours', from 5pm to 9am, but this was less than the proportion of the total number of calls (61%) received 'out of hours'.

Figure 35:

% of Calls by Time of Day - Confusion or Strange Behaviour Versus Total Calls



30.5 Association with Other Index Problems

For 23.2% (682) of the 2,939 calls, where confusion or strange behaviour was recorded as an index problem, there were no other index problems recorded. For 76.8.2% (2,257) of calls, where confusion or strange behaviour was recorded as an index problem, other index problems were recorded as shown below

1) **40.9%** of calls where **loneliness and/or isolation** is an index problem also had confusion or strange behaviour as an index problem,
2) **40.1%** of calls where **dementia** is an index problem also had confusion or strange behaviour as an index problem,
3) **33.9%** of calls where **domestic abuse** is an index problem also had confusion or strange behaviour as an index problem,
4) **33.6%** of calls where **harassment or bullying** is an index problem also had confusion or strange behaviour as an index problem,
5) **33.1%** of calls where **mental illness** is an index problem also had confusion or strange behaviour as an index problem,
6) **32.9%** of calls where **low mood or possible depression** is an index problem also had confusion or strange behaviour as an index problem,
7) **32.3%** of calls where **stress, anxiety or panic** is an index problem also had confusion or strange behaviour as an index problem,
8) **32%** of calls where **work or school** is an index problem also had confusion or strange behaviour as an index problem,
9) **31.2%** of calls where **debt, money or concerns about benefits** is an index problem also had confusion or strange behaviour as an index problem,
10) **29.4%** of calls where **substance misuse** is an index problem also had confusion or strange behaviour as an index problem,
11) **29.1%** of calls where **drunkenness or intoxication** is an index problem also had confusion or strange behaviour as an index problem,
12) **27.9%** of calls where **relationships** are an index problem also had confusion or strange behaviour as an index problem,
13) **21.9%** of calls where **homelessness or concerns over housing** is an index problem also had confusion or strange behaviour as an index problem,
14) **20.4%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had confusion or strange behaviour as an index problem,
15) **19%** of calls where **gender identity** is an index problem also had confusion or strange behaviour as an index problem,
16) **16.3%** of calls where **suicidal behaviour** is an index problem also had confusion or strange behaviour as an index problem.

31. Specific Index Problem – Self–Harm or Overdose

31.1 The Index Problem

Self-harm is associated with suicide, but often self-harm is not intended to end life. Self-harm is often linked to low self-esteem and past trauma and can be a coping strategy in the face of overwhelming distress. Self-harm can be a way to escape or avoid emotional pain as it can cause the release of hormones that produce a soothing or calming feeling or induce an altered state in which a person can feel numbed from psychological as well as physical pain. For some it can legitimise their help seeking if they believe their emotional concerns alone are not valid or worthy. Self-harm may not always carry a suicidal intent, but the method of self-harm can be potentially lethal, leading to inadvertent suicide.

Self-harm is one of the most confusing presentations for health and emergency service workers as it can be dismissed as 'attention seeking' but individuals who self-harm need to be responded to with compassion, empathy and kindness.[107]

31.2 Data Overview

The term 'self-harm' and 'deliberate overdose' were the trigger words for call handlers as they are often used by people to describe those who have caused, or are complementing, deliberate injuries or harm to themselves.

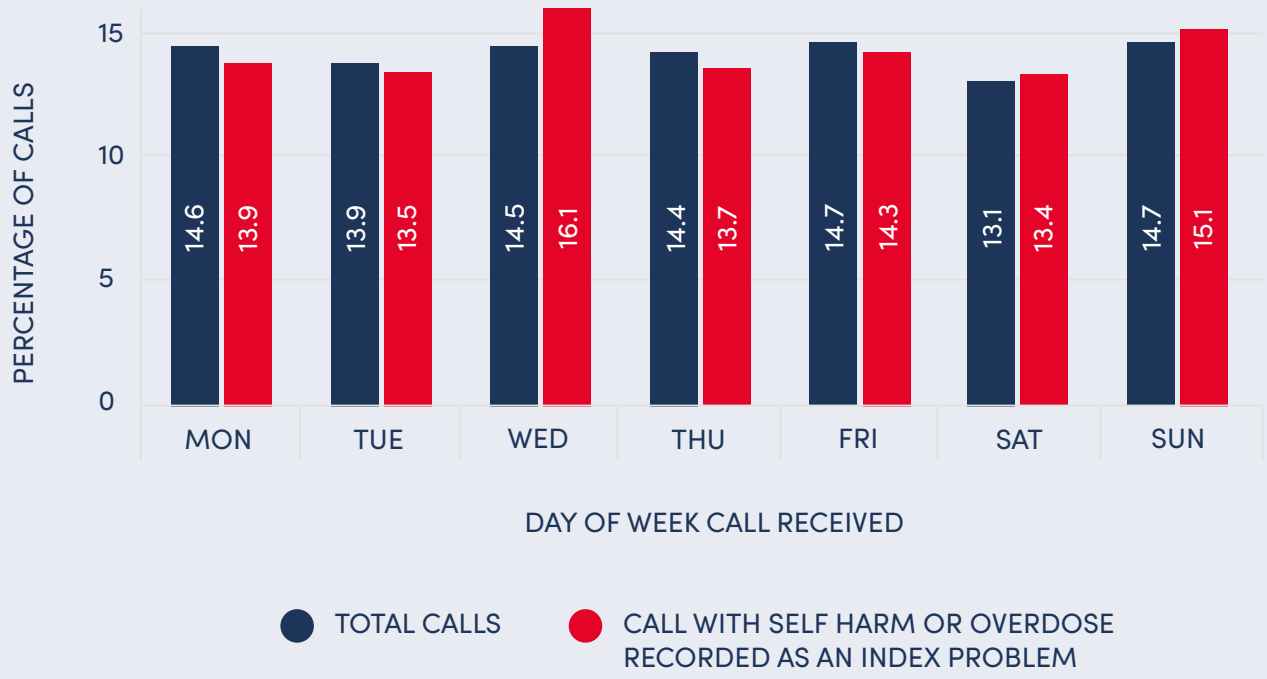
The bespoke data collection documented where a caller had stated they had self-harmed or deliberately overdosed, or that the person they were calling about had stated intent or were exhibiting signs or behaviour, which could indicate self-harm or deliberate overdose. A total of **2,081** calls recorded self-harm or deliberate overdose as an index problem.

31.3 Day of the Week of Calls

A total of 96.3% (2,003) of calls were able to record the day of the week the call was received out of 2,081 calls which identified self-harm or deliberate overdose as an index problem.

Figure 36 shows the proportion of calls received per day of the week and shows a peak on Wednesday. The figure shows 72% of calls were received on a weekday and 28% of calls were received on a weekend, the same proportion as total calls.

Figure 36:
% of Calls by Day of the Week - Self Harm or Overdose Versus Total Calls



31.4 Time of Day of Calls

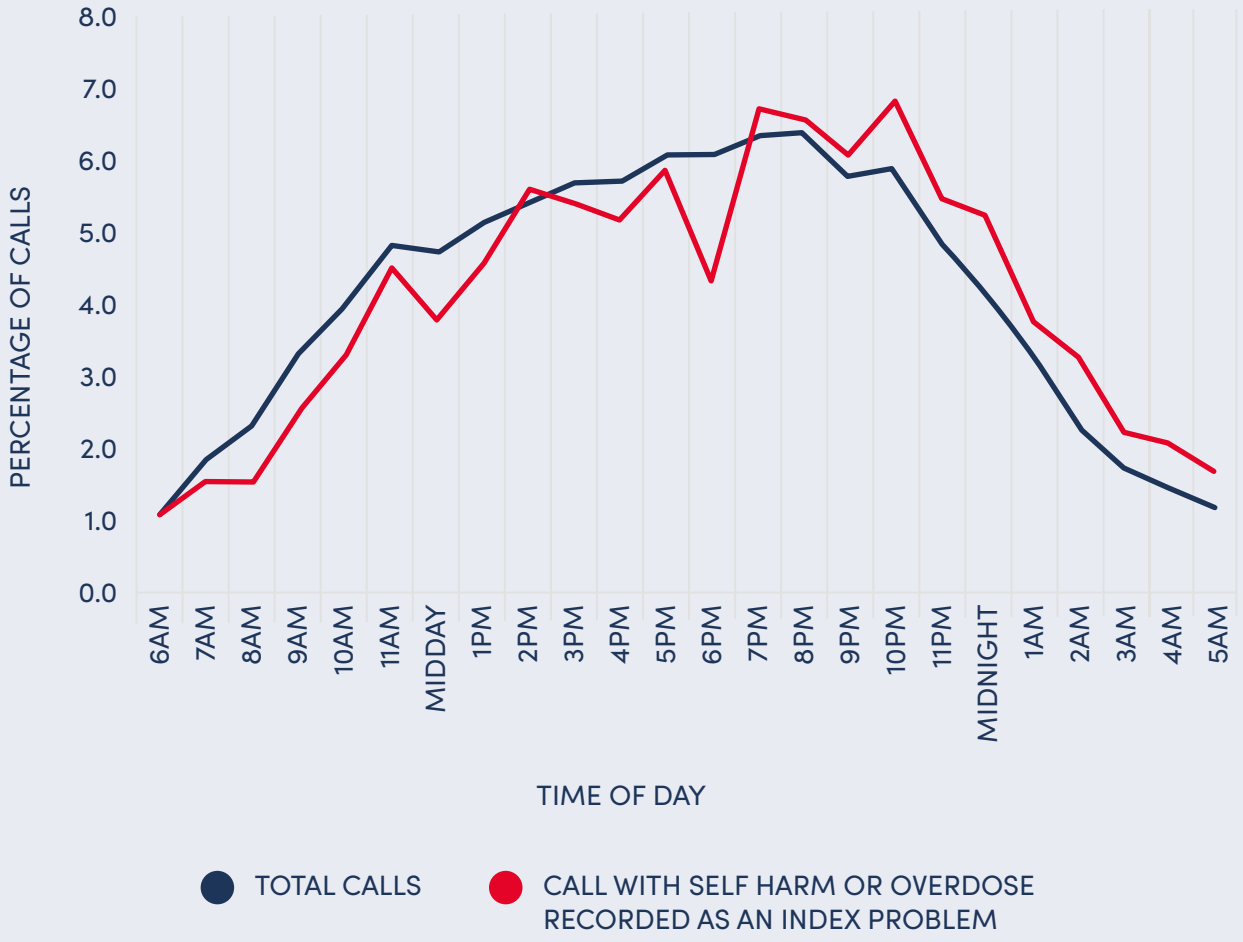
A total of 96% (1,998) of calls were able to record the day of the time of day was received out of 2,081 calls which identified self-harm or deliberate overdose as an index problem. **Figure 37** shows the time of day of calls where self-harm or deliberate overdose had been recorded as an index problem versus total calls, shown from 6am to better display overnight calls.

The figure highlights a variation between self-harm or deliberate overdose and total calls in that self-harm or deliberate overdose calls are lower during the day, then peak between 10pm and 11pm and have higher overnight calls.

A higher proportion of calls (65%) occurred 'out of hours', from 5pm to 9am, and this was more than the proportion of the total number of calls (61%) received 'out of hours'.

Figure 37:

% of Calls by Time of Day - Self-Harm or Overdose Versus Total Calls



31.5 Association with Other Index Problems

For 16.8% (349) of the 2,081 calls, where self-harm or deliberate overdose was recorded as an index problem, there were no other index problems recorded. For 83.2% (1,732) of calls, where self-harm or overdose was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **35%** of calls where **work or school** is an index problem also had self-harm or deliberate overdose as an index problem,
2) **33.5%** of calls where **suicidal behaviour** is an index problem also had self-harm or deliberate overdose as an index problem,
3) **28.6%** of calls where **gender identity** is an index problem also had self-harm or deliberate overdose as an index problem,
4) **27.1%** of calls where **loneliness and/or isolation** is an index problem also had self-harm or deliberate overdose as an index problem,
5) **26.8%** of calls where **low mood or possible depression** is an index problem also had self-harm or deliberate overdose as an index problem,
6) **25.6%** of calls where **stress, anxiety or panic** is an index problem also had self-harm or deliberate overdose as an index problem,
7) **23.7%** of calls where **homelessness or concerns over housing** is an index problem also had self-harm or deliberate overdose as an index problem'
8) **23.4%** of calls where **dementia** is an index problem also had self-harm or deliberate overdose as an index problem'
9) **22.4%** of calls where **debt, money or concerns about benefits** is an index problem also had self-harm or deliberate overdose as an index problem,
10) **21.8%** of calls where **mental illness** is an index problem also had self-harm or deliberate overdose as an index problem,
11) **20.7%** of calls where **relationships** are an index problem also had self-harm or deliberate overdose as an index problem,
12) **20.3%** of calls where **drunkenness or intoxication** is an index problem also had self-harm or deliberate overdose as an index problem,
13) **19.7%** of calls where **substance misuse** is an index problem also had self-harm or deliberate overdose as an index problem,
14) **19.1%** of calls where **harassment or bullying** is an index problem also had self-harm or deliberate overdose as an index problem,
15) **16.8%** of calls where **domestic abuse** is an index problem also had self-harm or deliberate overdose as an index problem,
16) **13.4%** of calls where **confusion** or **strange behaviour** is an index problem also self-harm or deliberate overdose as an index problem.

32. Specific Index Problem – Drunk or Intoxicated

32.1 The Index Problem

The Institute of Alcohol Studies[108] has described alcohol as placing a 'significant and unnecessary strain' on emergency services. An Institute survey concluded that in 2015, 80% of weekend arrests were alcohol related, just over half of violence offences were committed under the influence of alcohol and 53% of police time was spent dealing with alcohol related incidents. They reported that approximately 35% of ambulance journeys and 37% of ambulance time was spent dealing with alcohol related incidents in England and Wales.

Alcohol consumed in large quantities can produce changes in thinking, emotion, behaviour, and physical coordination. There are strong links between alcohol and violence due to alcohol causing loss of normal control over impulses, urges, and emotions and reduced capacity for judgement and problem solving. This loss of normal control can also lead to distress, agitation, aggression and suicidal behaviours. Severe alcohol intoxication can be life threatening, and is as much a physical health emergency as a mental health emergency.

In Wales, in 2019, 2% of adults were classed as 'harmful drinkers' and a further 16% as 'hazardous drinkers'[109]. A range of strategies have been established by the Police, NHS and partners such as 'street pastors'[110] and 'alcohol treatment centres'[111] that allow police and emergency services to safety provide support to intoxicated individuals without recourse to arrest or use of emergency departments.

32.2 Data Overview

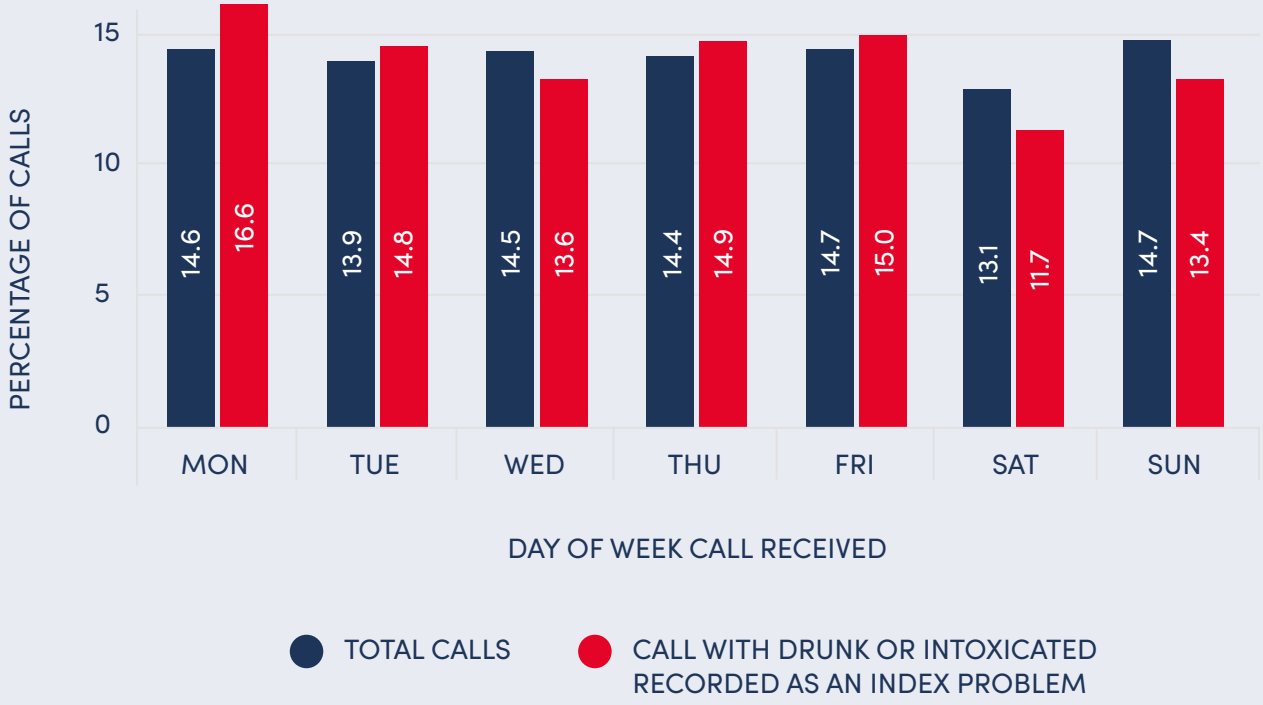
The term 'drunk' and 'intoxicated' were the trigger words for call handlers as they are often used by people to describe persons with severe cognitive and/or physical impairment due to alcohol consumption although there is overlap with substance misuse, confusion and strange behaviour. The bespoke data collection documented where a caller had stated they were drunk or intoxicated, or that the person they were calling about may be. A total of **1,367** calls recorded drunk or intoxicated as an index problem.

32.3 Day of the Week of Calls

A total of 99.9% (1,365) of calls were able to record the day of the week the call was received out of 1,367 calls which identified drunk or intoxicated was recorded as an index problem.

Figure 38 shows the proportion of calls received per day of the week and shows a lower proportion on Monday and a peak on Saturday. The figure shows 70% of calls were received on a weekday compared 72% of total calls and 30% of calls were received on a weekend compared to 28% of total calls, the biggest weekend proportion of any index problem.

Figure 38:
% of Calls by Day of the Week - Drunk or Intoxicated Versus Total Calls



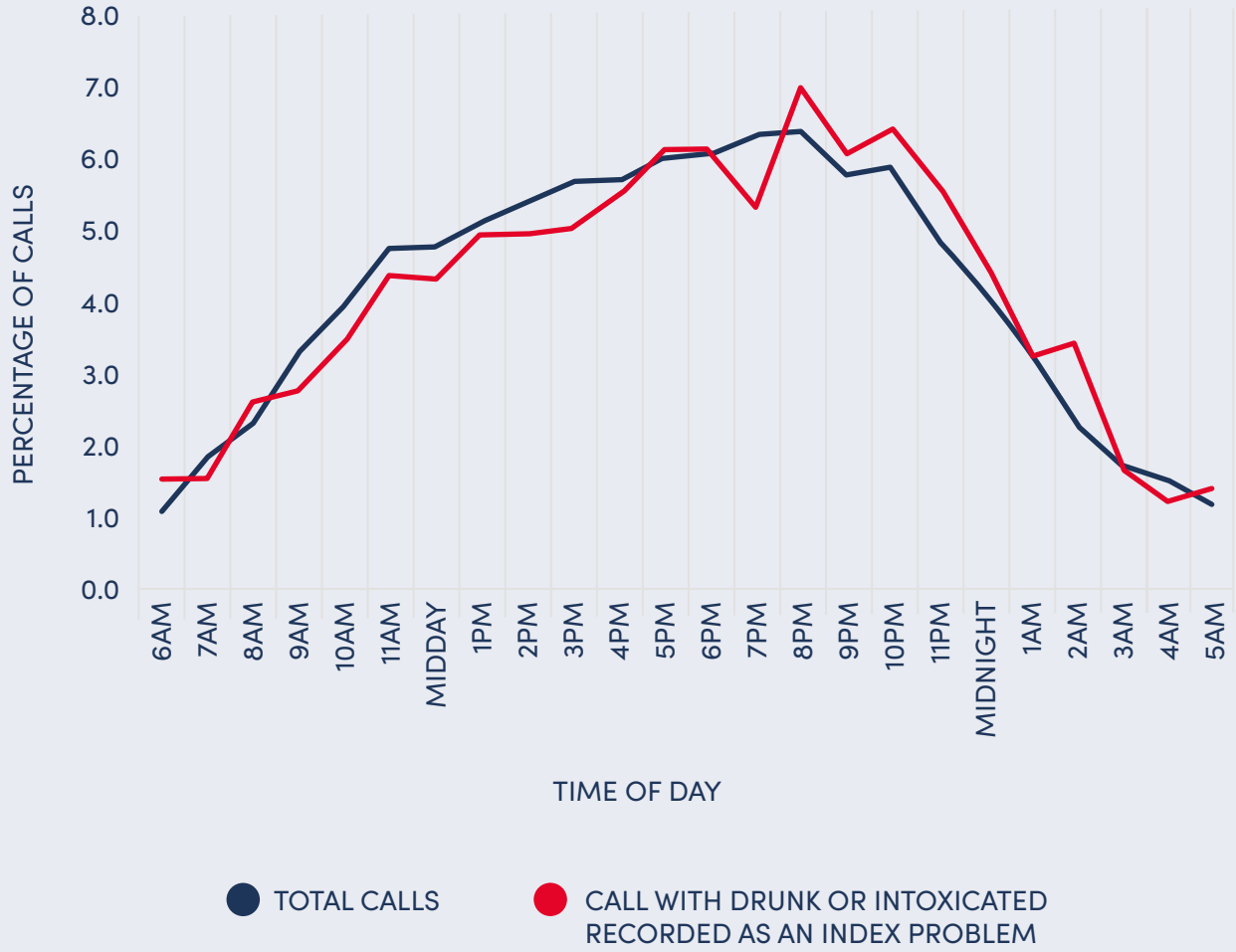
32.4 Time of Day of Calls

A total of 99.6% (1,361) of calls were able to record the time of day the call was received out of 1,367 calls which identified drunk or intoxicated was recorded as an index problem. **Figure 39** shows the time of day of calls where drunk or intoxicated had been recorded as index problems versus total calls, shown from 6am to better display overnight calls.

The figure highlights a variation between drunk or intoxicated and total calls in that drunk or intoxicated calls are lower during the day then peak between 7pm and 9pm and have higher overnight calls. A higher proportion of calls (64%) occurred 'out of hours', from 5pm to 9am and this was more than the proportion of the total number of calls (61%) received 'out of hours'.

Figure 39:

% of Calls by Time of Day - Drunk or Intoxicated Versus Total Calls



32.5 Association with Other Index Problems

For 11.2% (153) of the 1,367 calls, where drunk or intoxicated was recorded as an index problem, there were no other index problems recorded. For 88.8% (1,214) of calls, where drunk or intoxicated was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **27.8%** of calls where **substance misuse** is an index problem also had drunk or intoxicated as an index problem,
2) **17.1%** of calls where **homelessness or concerns over housing** is an index problem also had drunk or intoxicated as an index problem,
3) **15.6%** of calls where **relationships** are an index problem also had drunk or intoxicated as an index problem,
4) **14.8%** of calls where **low mood or possible depression** is an index problem also had drunk or intoxicated as an index problem,
5) **14.5%** of calls where **loneliness or isolation** is an index problem also had drunk or intoxicated as an index problem,
6) **14.2%** of calls where **mental illness** is an index problem also had drunk or intoxicated as an index problem,
7) **13.9%** of calls where **domestic abuse** is an index problem also had drunk or intoxicated as an index problem,
8) **13.5%** of calls where **confusion or strange behaviour** is an index problem also drunk or intoxicated as an index problem,
9) **13.4%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had drunk or intoxicated as an index problem,
10) **13%** of calls where **suicidal behaviour** is an index problem also had drunk or intoxicated as an index problem,
11) **11.2%** of calls where **debt, money or concerns about benefits** is an index problem also had drunk or intoxicated as an index problem,
12) **9.7%** of calls where **stress, anxiety or panic** is an index problem also had drunk or intoxicated as an index problem,
13) **9%** of calls where **work or school** is an index problem also had drunk or intoxicated as an index problem,
14) **7.3%** of calls where **harassment or bullying** is an index problem also had drunk or intoxicated as an index problem,
15) **4.8%** of calls where **gender identity** is an index problem also had drunk or intoxicated as an index problem,
16) **2.1%** of calls where **dementia** is an index problem also had drunk or intoxicated as an index problem.

33. Specific Index Problem – Stress, Anxiety or Panic

33.1 The Index Problem

Anxiety is one of the most common mental health problems in the UK[112]. Anxiety includes having one, or a number of different worries that are excessive and out of proportion to a particular situation, and having difficulty in controlling one's worries. A person with an anxiety disorder may also feel irritable and have physical symptoms such as restlessness, tiredness, trouble concentrating or sleeping. There are several mental health conditions that include anxiety as one of the prominent symptoms such as obsessive compulsive disorder, panic disorder, post-traumatic stress disorder and personality disorder.

People with anxiety disorders can sometimes experience overwhelming thoughts and sudden onset physical symptoms such as rapid heartbeat, breathlessness, sweating and palpitations which may be misinterpreted as another illness. People with anxiety may be at increased risk of suicide or self-harm. Although these behaviours are rare compared to the numbers of people who suffer anxiety, it may be that people in more extreme states are more likely to call emergency services or cause concern to other people who call emergency services on their behalf.

33.2 Data Overview

The term 'stress', 'anxiety' or 'panic' were the trigger words for call handlers as they are often used by people to describe these types of impairments which can have both physical and psychological symptoms and effects although these terms can be generalisations and there can be overlap between all three. The bespoke data collection documented where a caller had stated they were stressed, anxious or were having a panic attack or that the person they were calling about may be. A total of **1,250** calls recorded stress, anxiety or panic as an index problem.

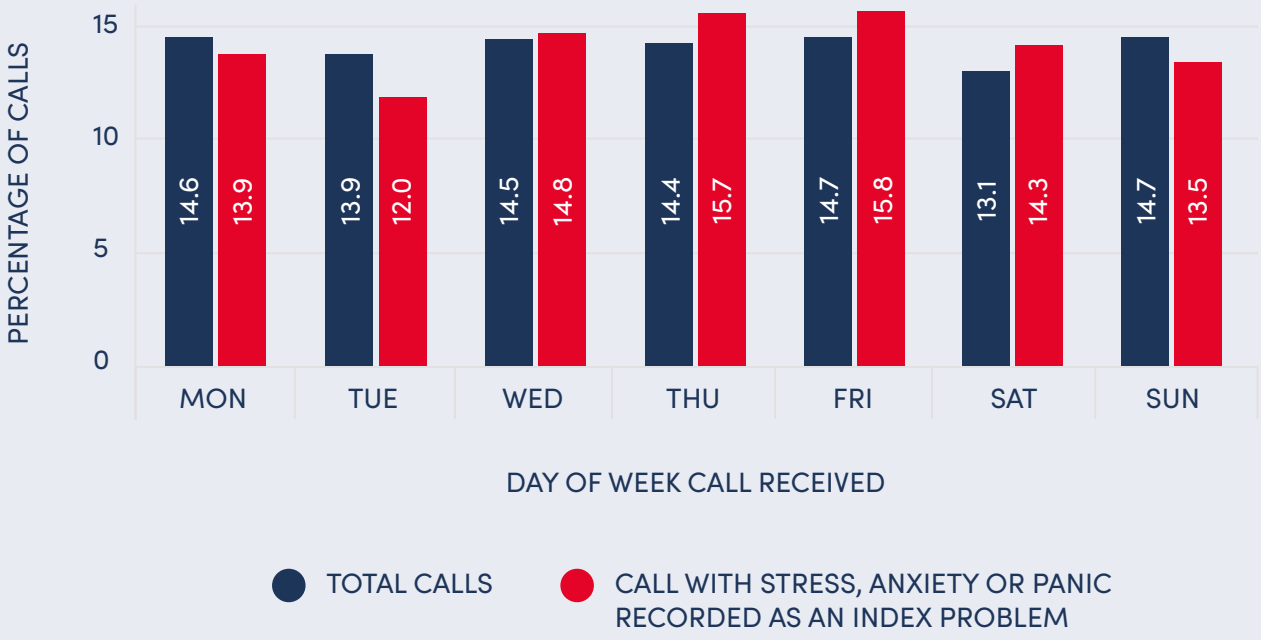
33.3 Day of the Week of Calls

A total of 99.5% (1,244) of calls were able to record the day of the week the call was received out of 1,250 calls which identified stress, anxiety or panic as an index problem.

Figure 40 shows the proportion of calls received per day of the week and shows a lower proportion at the start of the week with a higher proportion on Thursday, Friday and Saturday. The figure shows 72% of calls were received on a weekday and 28% of calls were received on a weekend the same proportion as total calls.

Figure 40:

% of Calls by Day of the Week - Stress, Anxiety or Panic Versus Total Calls



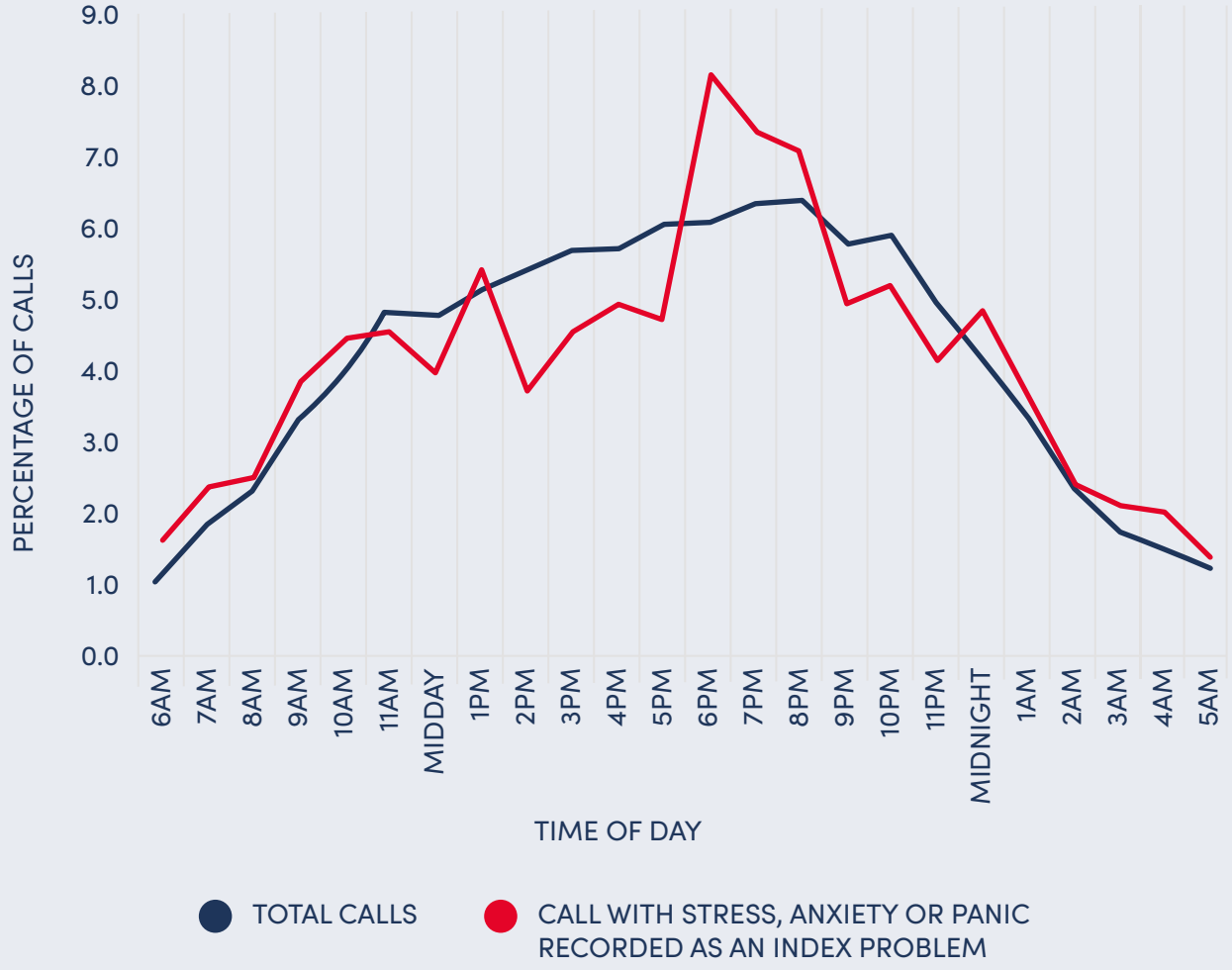
33.4 Time of Day of Calls

A total of 98.6% (1,233) of calls were able to record the time of day the call was received out of 1,250 calls which identified stress, anxiety or panicas an index problem. **Figure 41** shows the time of day of calls where stress, anxiety or panic had been recorded as index problems versus total calls, shown from 6am to better display overnight calls.

The figure highlights a variation between stress, anxiety or panic and total calls in that stress, anxiety or panic calls are lower during the afternoon then abruptly peak between 6pm and 7pm before declining before 9pm. A higher proportion of calls (65%) occurred 'out of hours', and this was more than the proportion of the total number of calls (61%) received 'out of hours'.

Figure 41:

% of Calls by Time of Day - Stress, Anxiety or Panic Versus Total Calls



33.5 Association with Other Index Problems

For 7.5% (94) of the 1,250 calls, where stress, anxiety or panic was recorded as an index problem, there were no other index problems recorded. For 92.5% (1,156) of calls, where stress, anxiety or panic was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **32.1%** of calls where **low mood or possible depression** is an index problem also had stress, anxiety or panic as an index problem,
2) **30%** of calls where **loneliness and/or isolation** is an index problem also had stress, anxiety or panic as an index problem,
3) **23.8%** of calls where **gender identity** is an index problem also had stress, anxiety or panic as an index problem,
4) **23%** of calls where **work or school** is an index problem also had stress, anxiety or panic as an index problem,
5) **22.7%** of calls where **harassment or bullying** is an index problem also had stress, anxiety or panic s as an index problem,
6) **20%** of calls where **debt, money or concerns about benefits** is an index problem also had stress, anxiety or panic as an index problem,
7) **19.3%** of calls where **homelessness or concerns over housing** is an index problem also had stress, anxiety or panic as an index problem**,**
8) **16.3%** of calls where **mental illness** is an index problem also had stress, anxiety or panic as an index problem,
9) **16.2%** of calls where **relationships** are an index problem also had stress, anxiety or panic as an index problem,
10) **12.9%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had stress, anxiety or panic as an index problem,
11) **12.2%** of calls where **suicidal behaviour** is an index problem also had stress, anxiety or panic as an index problem,
12) **10.8%** of calls where **substance misuse** is an index problem also had stress, anxiety or panic as an index problem,
13) **10.2%** of calls where **domestic abuse** is an index problem also had stress, anxiety or panic as an index problem,
14) **9.2%** of calls where **confusion or strange behaviour** is an index problem also had stress, anxiety or panic as an index problem,
15) **8.9%** of calls where **drunkenness or intoxication** is an index problem also had had stress, anxiety or panic as an index problem,
16) **3.3%** of calls where **dementia** is an index problem also had stress, anxiety or panic as an index problem.

34.1 Specific Index Problem– Relationships

34.2 The Index Problem

Relationships issues can cover abusive family dynamics, exploitation, separation or dissolution. People experiencing or witnessing relationship issues can be afraid or concerned about their own or others safety. Relationships can impact on a person's mental health and some mental health problems such as depression and anxiety can influence whether someone feels able to interact and connect to others. This means that developing relationships and socialising in traditional ways can be challenging for some people[113].

Relationship issues can affect all ages, a survey found that the single biggest presenting problem for children attending mental health services were family relationship problems[114]. Studies have found that negative social interactions and relationships, especially with partners/spouses, increase the risk of depression, anxiety and suicidal ideation[115,116].

34.3 Data Overview

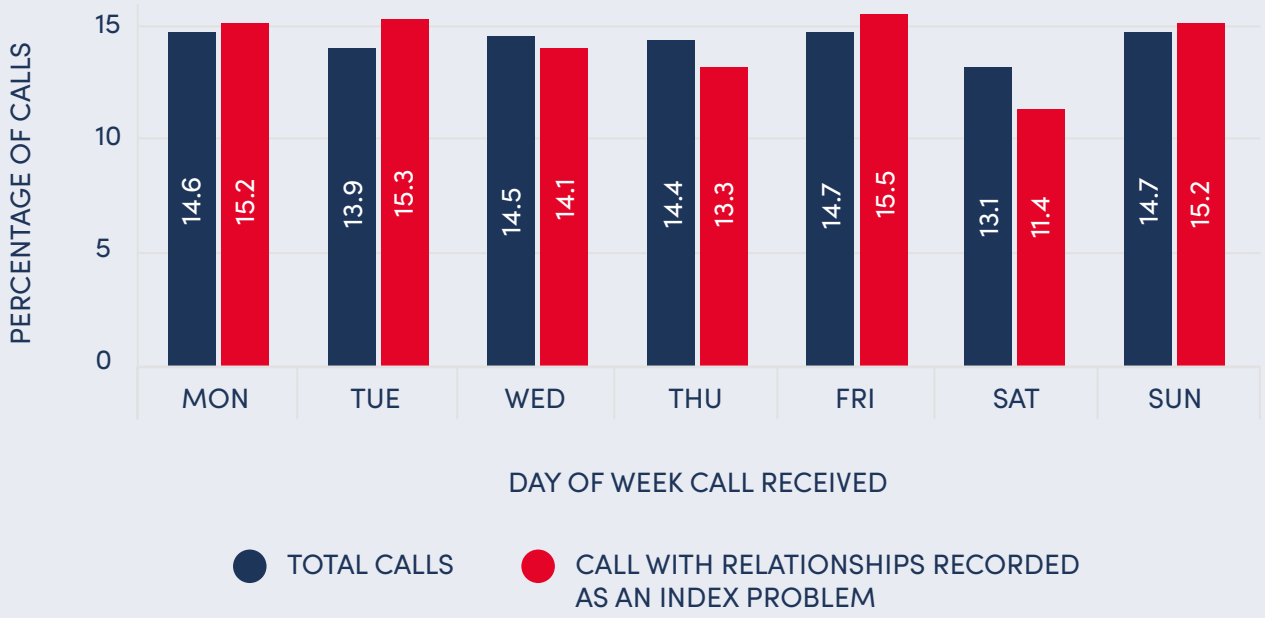
The term 'relationship' was the trigger word for call handlers as it is often used by people to describe interpersonal concerns, difficulties, fears, threats or pressures. The bespoke data collection documented where a caller had stated that they, or the person they were calling about, had a issue with a relationship. A total of **1,026** calls recorded relationships as an index problem.

A total of 100% (1,026) of calls were able to record the day of the week the call was received which identified relationships as an index problem.

Figure 42 shows the proportion of calls received per day of the week and shows a lower proportion on Thursday and Saturday with a higher proportion on Tuesday and Friday. The figure shows 73% of calls were received on a weekday compared to 72% of total calls and 27% of calls were received on a weekend compared to 28% of total calls.

Figure 42:

% of Calls by Day of the Week - Relationships Versus Total Calls

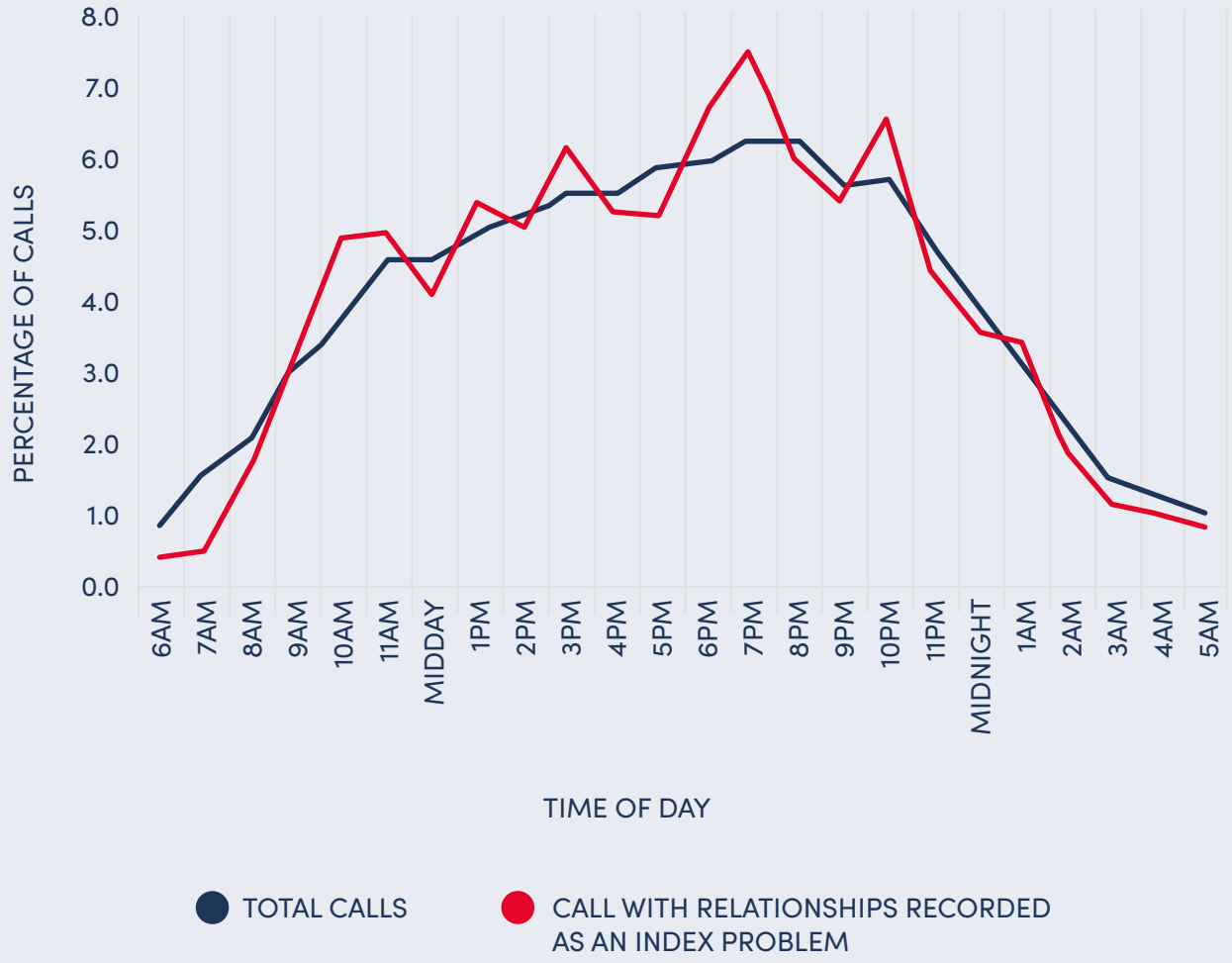


34.5 Time of Day of Calls

A total of 99.9% (1,025) of calls were able to record the time of day the call was received which identified 'relationships' as an index problem. **Figure 43** shows the time of day of calls where relationships had been recorded as an index problem versus total calls, shown from 6am to better display overnight calls.

The figure highlights a variation between relationships and total calls in that relationships calls are higher in mid-morning then peak between 7pm and 8pm. A higher proportion of calls (59%) occurred 'out of hours', but this was less than the proportion of the total number of calls (61%) received 'out of hours'.

Figure 43:
% of Calls by Time of Day - Relationships Versus Total Calls



34.5 Association with Other Index Problems

For 9.1% (93) of the 1,026 calls, where relationships was recorded as an index problem, there were no other index problems recorded. For 90.9% (933) of calls, where relationships were recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **25.7%** of calls where **domestic abuse** is an index problem also had relationships as an index problem,
2) **22%** of calls where **work or school** is an index problem also had relationships as an index problem,
3) **20.8%** of calls where **debt, money or concerns about benefits** is an index problem also had relationships as an index problem,
4) **19.1%** of calls where **harassment or bullying** is an index problem also had relationships as an index problem,
5) **17.8%** of calls where **loneliness and/or isolation** is an index problem also had relationships as an index problem,
6) **14%** of calls where **substance misuse** is an index problem also had relationships as an index problem,
7) **13.3%** of calls where **stress, anxiety or panic** is an index problem also had relationships as an index problem,
8) **11.7%** of calls where **drunkenness or intoxication** is an index problem also had relationships as an index problem,
9) **11%** of calls where **suicidal behaviour** is an index problem also had relationships as an index problem,
10) **10.2%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had relationships as an index problem,
11) **10.1%** of calls where **mental illness** are an index problem also had relationships as an index problem,
12) **9.7%** of calls where **confusion or strange behaviour** is an index problem also had relationships as an index problem,
13) **9.6%** of calls where **homelessness or concerns over housing** is an index problem also had relationships as an index problem**,**
14) **8.9%** of calls where **low mood or possible depression** is an index problem also had relationships as an index problem,
15) **4.8%** of calls where **gender identity** is an index problem also had relationships as an index problem,
16) **2.1%** of calls where **dementia** is an index problem also had relationships as an index problem.

35. Specific Index Problem - Substance Misuse

35.1 The Index Problem

Substance misuse can include illicit, non-prescribed drugs as well as the abuse of prescribed medications, particularly those affecting mood and mental state. The relationship between mental health and substance misuse is complex and multifaceted. There are some drugs of abuse that can induce altered mental states to such an extent that they result in impairments to thinking and emotion in which contact with external reality is lost. Whilst the pursuit of such altered states can be one of the motivations for substance misuse, for example using hallucinogenic drugs to induce perceptual illusions and heightened emotions, such states can be also become highly distressing. One possible consequence of substance misuse is substance induced psychosis, a state in which the person experiences hallucinations, delusional ideas and paranoid beliefs along with disorganised behaviour. Substance induced psychosis has been associated with suicidal thoughts, dangerous and violent behaviour, hospitalisation, and arrests. People with mental health problems may misuse substances as a way to relieve their distress, even though the ultimate result may be a rapid deterioration in their thinking, emotions and behaviour. The effects of substance misuse, with or without pre-existing mental health problems, can produce such changes to thinking that it causes increased distress and worrying behaviours. These changes can result in the person, or those around them, contacting police or ambulance services to deal with an immediate crisis involving agitation, aggression or suicidal behaviours. The recent Crime Survey for England and Wales found that around 9.4% of adults aged 16 to 59 and 20% of adults aged 16 to 24 had taken a drug in the last year, whilst drug related deaths in Wales are amongst the highest in England and Wales[117]. In the first 9 months of 2019 over 20,000 referrals were made to substance misuse treatment services in Wales[118]. As with suicide, middle-aged men are the generation and gender most likely to die by drug poisoning, despite their lower reported levels of drug use. This may be related to issues concerning poor mental health, addiction, financial instability, poverty and social welfare[119].

35.2 Data Overview

The term 'substance misuse' was the trigger word for call handlers as it is often used to describe addition or affected behaviour due to the injection or ingestion of legal or illicit substances or medications. The bespoke data collection documented where a caller had stated they had issues related to substance misuse, or that the person they were calling about had such issues. A total of **772** calls recorded substance misuse as an index problem.

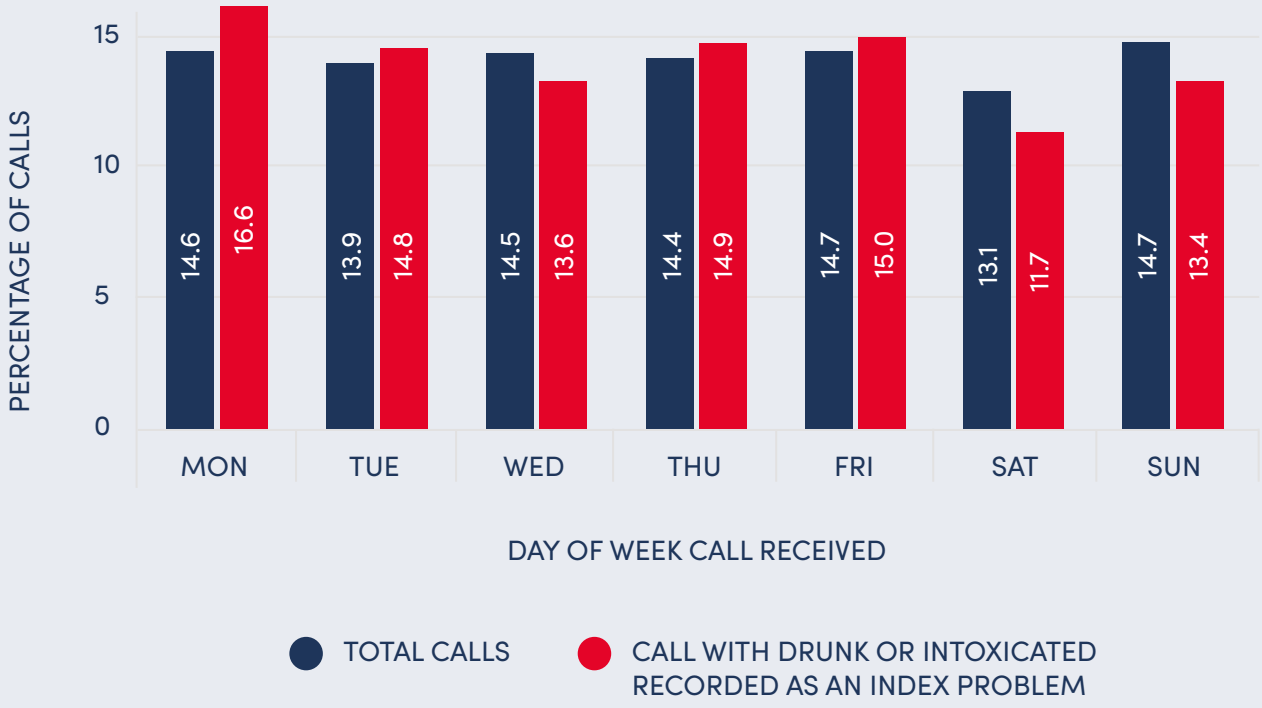
35.3 Day of the Week of Calls

A total of 99.9% (771) of calls were able to record the day of the week the call was received out of 772 calls which identified substance misuse as an index problem.

Figure 44 shows the proportion of calls received per day of the week and shows a lower proportion on Monday and a higher proportion on Saturday. The figure shows 70% of calls were received on a weekday compared to 72% of total calls and 30% of calls were received on a weekend compared to 28% of total calls, one of the biggest weekend proportions of any index problem.

Figure 44:

% of Calls by Day of the Week - Substance Misuse Versus Total Calls



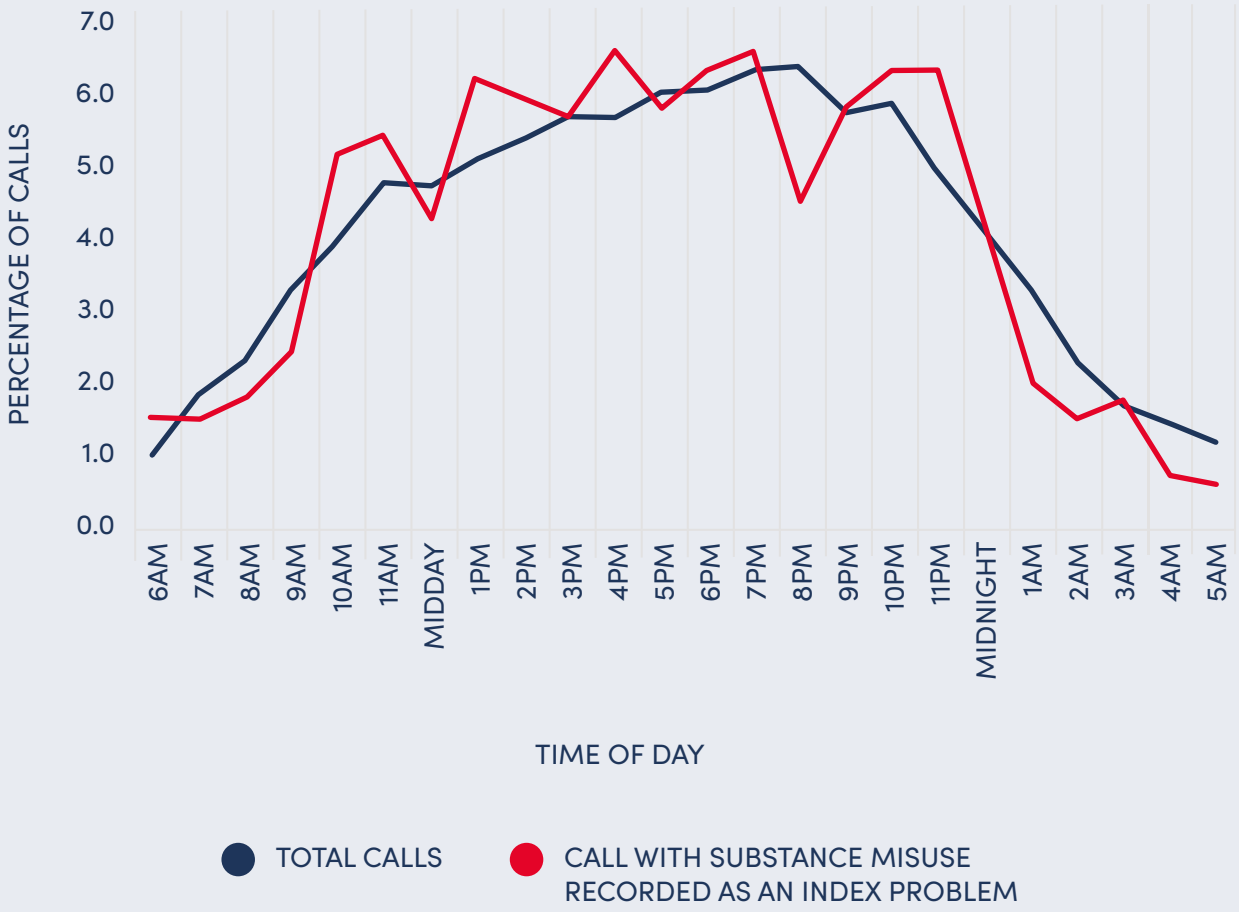
35.4 Time of Day of Calls

A total of 99.6% (769) of calls were able to record the time of day the call was received out of 772 calls which identified 'substance misuse' as an index problem. **Figure 45** shows the time of day of calls where substance misuse had been recorded as an index problem versus total calls, shown from 6am to better display overnight calls.

The figure highlights a variation between substance misuse and total calls in that substance misuse calls are higher during the day and peak later, between 10pm and midnight, before declining sharply. A higher proportion of calls (58%) occurred 'out of hours', but this was less than the proportion of the total number of calls (61%) received 'out of hours'.

Figure 45:

% of Calls by Time of Day - Substance Misuse Versus Total Calls



35.5 Association with Other Index Problems

For less than 9.3% (72) of the 772 calls, where substance misuse was recorded as an index problem, there were no other index problems recorded. For 90.7% (700) of calls, where substance misuse was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **15.7%** of calls where **drunkenness or intoxication** is an index problem also had substance misuse as an index problem,
2) **11.2%** of calls where **debt, money or concerns about benefits** is an index problem also had substance misuse as an index problem,
3) **10.5%** of calls where **relationships** are an index problem also had substance misuse as an index problem,
4) **7.8%** of calls where **domestic abuse** is an index problem also had substance misuse as an index problem,
5) **7.8%** of calls where **mental illness** is an index problem also had substance misuse as an index problem,
6) **7.7%** of calls where **confusion or strange behaviour** is an index problem also had substance misuse as an index problem,
7) **7.3%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had substance misuse as an index problem,
8) **7.2%** of calls where **suicidal behaviour** is an index problem also had substance misuse as an index problem,
9) **7%** of calls where **homelessness or concerns over housing** is an index problem also had substance misuse as an index problem
10) **6.6%** of calls where **stress, anxiety or panic** is an index problem also had substance misuse as an index problem,
11) **5%** of calls where **low mood or possible depression** is an index problem also had substance misuse as an index problem,
12) **4.8%** of calls where **gender identity** is an index problem also had substance misuse as an index problem,
13) **4.5%** of calls where **loneliness and/or isolation** is an index problem also had substance misuse as an index problem,
14) **4.1%** of calls where **harassment or bullying** is an index problem also had substance misuse as an index problem,
15) **3%** of calls where **work or school** is an index problem also had substance misuse as an index problem,
16) **0.6%** of calls where **dementia** is an index problem also had substance misuse as an index problem.

36. Specific Index Problem – Loneliness or Isolation

36.1 The Index Problem

Loneliness is caused not by being alone but by the subjective unpleasant feeling arising from a mismatch between a person's desired level of meaningful social relationships, and what they perceive they actually have.

The persistent subjective feeling of loneliness has been shown to be a strong independent indicator of multiple physiological changes and poor health outcomes[120]. Loneliness can lead to various psychiatric disorders like depression, alcohol abuse, sleep problems and personality disorders[121]. Recent studies suggest that loneliness is associated with a 26% increase in risk of early mortality placing it in a similar league to other well-known risk factors such as smoking and obesity[122].

Studies have shown that loneliness is especially associated with poorer physical and mental health amongst older people. In particular, loneliness amongst older people is associated with experiencing depression, and older people with a high degree of loneliness are twice as likely to develop Alzheimer's disease as those with a low degree of loneliness[123]. Lonely people may call the Police for companionship or because of fear or panic.

36.2 Data Overview

The term 'loneliness' or 'isolation' were the trigger words for call handlers as they are often used to describe issues with solitude, remoteness or inaccessibility, either by choice or circumstance. The bespoke data collection documented where a caller had stated they had issues related to loneliness or isolation, or that the person they were calling about had such issues. A total of **601** calls recorded loneliness or isolation as an index problem.

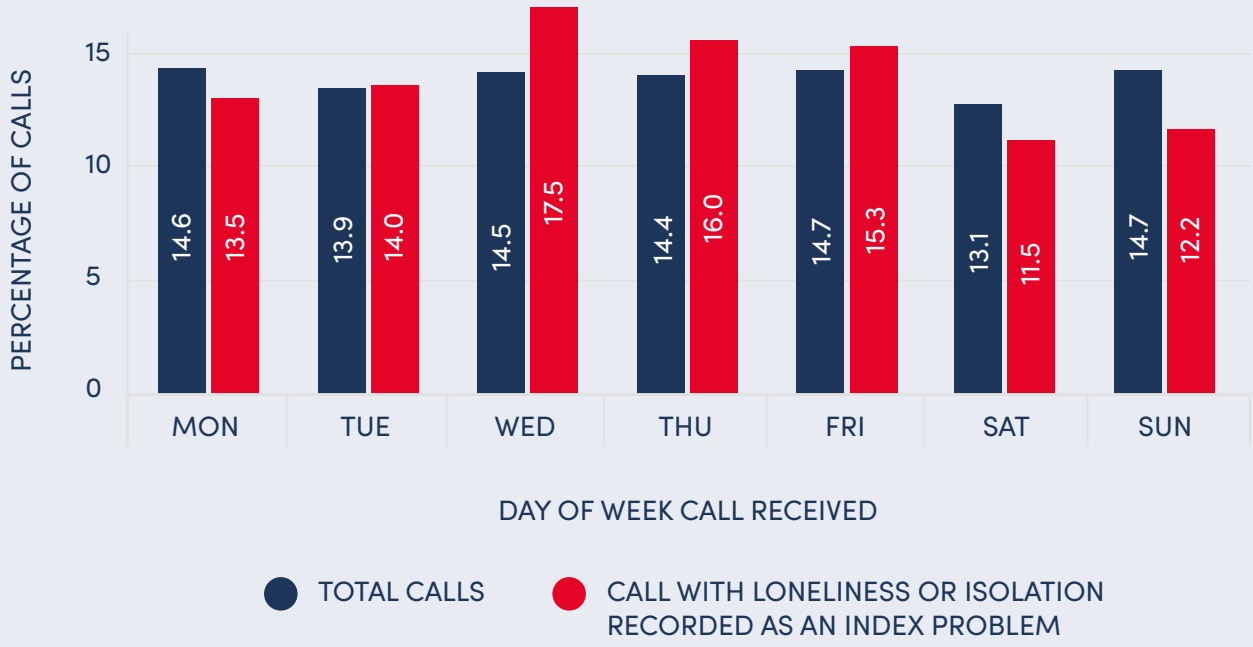
36.3 Day of the Week of Calls

A total of 100% (601) of calls were able to record the day of the week the call was received out of 601 calls which identified 'loneliness or isolation' as an index problem.

Figure 46 shows the proportion of calls received per day of the week and shows a lower proportion on Saturday and Sunday and a higher proportion on Wednesday and Thursday. The figure shows 76% of calls were received on a weekday compared to 72% of total calls and 24% of calls were received on a weekend compared to 28% of total calls, one of the lowest weekend proportions of any index problem.

Figure 46:

% of Calls by Day of the Week - Loneliness or Isolation Versus Total Calls

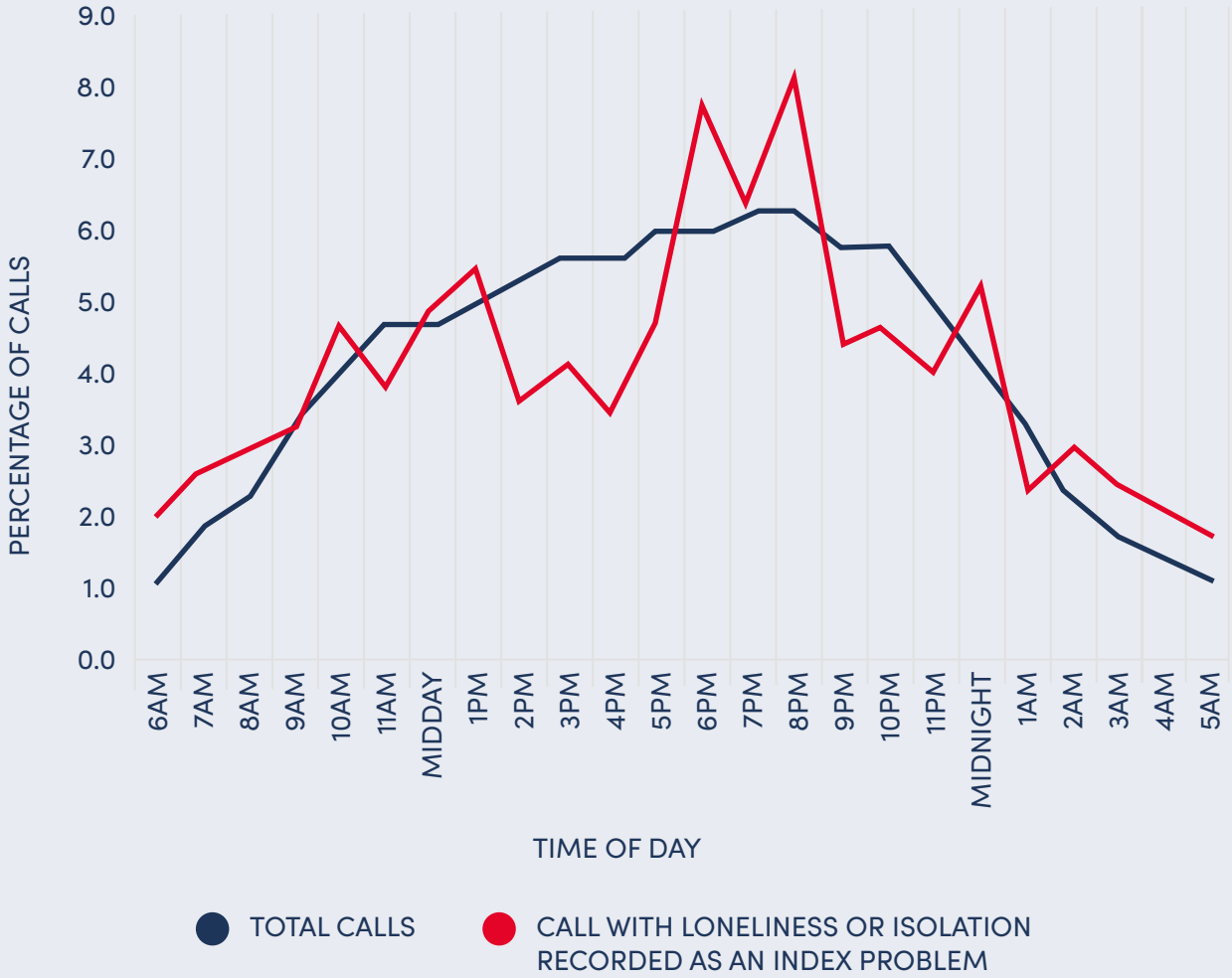


36.4 Time of Day of Calls

A total of 98.8% (595) of calls were able to record the time of day the call was received out of 601 calls which identified 'loneliness or isolation' as an index problem. **Figure 47** shows the time of day of calls where loneliness or isolation had been recorded as index problems versus total calls, shown from 6am to better display overnight calls.

The figure highlights a variation between loneliness or isolation and total calls in that loneliness or isolation calls are lower in the afternoon then show a pronounced peak between 6pm and 8pm. A higher proportion of calls (66%) occurred 'out of hours', from 5pm to 9am and this was more than the proportion of the total number of calls (61%) received 'out of hours'.
It was the highest proportional difference of any index problem.

Figure 47:
% of Calls by Time of Day - Loneliness or Isolation Versus Total Calls



36.5 Association with Other Index Problems

For less than 3.5% (21) of the 601 calls, where loneliness or isolation was recorded as an index problem, there were no other index problems recorded. For 96.5% (580) of calls, where loneliness or isolation was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **19.0%** of calls where **work or school** is an index problem also had loneliness or isolation as an index problem,
2) **18.0%** of calls where **debt or money or concerns about benefits** is an index problem also had loneliness or isolation as an index problem,
3) **16.5%** of calls where **dementia** is an index problem also had loneliness or isolation as an index problem,
4) **14.4%** of calls where **stress/anxiety or panic** is an index problem also had loneliness or isolation as an index problem,
5) **14.0%** of calls where **low mood or possible depression** is an index problem also had loneliness or isolation as an index problem,
6) **13.6%** of calls where **homelessness or concerns over housing** is an index problem also had loneliness or isolation as an index problem,
7) **10.4%** of calls where **relationships** is an index problem also had loneliness or isolation as an index problem,
8) **7.8%** of calls where **harassment or bullying** is an index problem also had loneliness or isolation as an index problem,
9) **7.8%** of calls where **mental illness** is an index problem also had loneliness or isolation as an index problem,
10) **6.9%** of calls where **confusion or strange behaviour** is an index problem also had loneliness or isolation as an index problem,
11) **6.8%** of calls where **self-harm or deliberate overdose** is an index problem also had loneliness or isolation as an index problem,
12) **6.4%** of calls where **drunkenness or intoxication** is an index problem also had loneliness or isolation as an index problem,
13) **6.3%** of calls where **suicidal behaviour** is an index problem also had loneliness or isolation as an index problem,
14) **5.6%** of calls where **low mood or possible depression** is an index problem also had loneliness or isolation as an index problem,
15) **5.3%** of calls where **domestic abuse** is an index problem also had loneliness or isolation as an index problem,
16) **3.5%** of calls where **substance misuse** is an index problem also had loneliness or isolation as an index problem.

37. Specific Index Problem – Domestic Abuse

37.1 The Index Problem

Domestic abuse refers to physical, sexual or emotional abuse and controlling behaviours, usually by a current or former partner but may also be family members. Studies have shown that women who have experienced domestic abuse have three times the normal risk of developing a mental illness[124]. Domestic abuse is associated with depression, anxiety and substance abuse[125]. Exposure to domestic abuse has a significant impact on children's mental health and many studies have found strong links with poorer educational outcomes and higher levels of mental health problems[126].

A review found that the Welsh 'Together for Mental Health' strategy seems 'more progressive' in its response to domestic abuse than other UK countries as it specifically acknowledges the priority of ensuring that those working within mental health services are trained to understand how domestic abuse and sexual violence can affect people's mental health[127].
People suffering from domestic abuse may call emergency services due to emotional distress or physical injury, or for fear for their own, or a family member's, wellbeing. Neighbours, friends, family or others may also call due to concern for a person's safety.

37.2 Data Overview

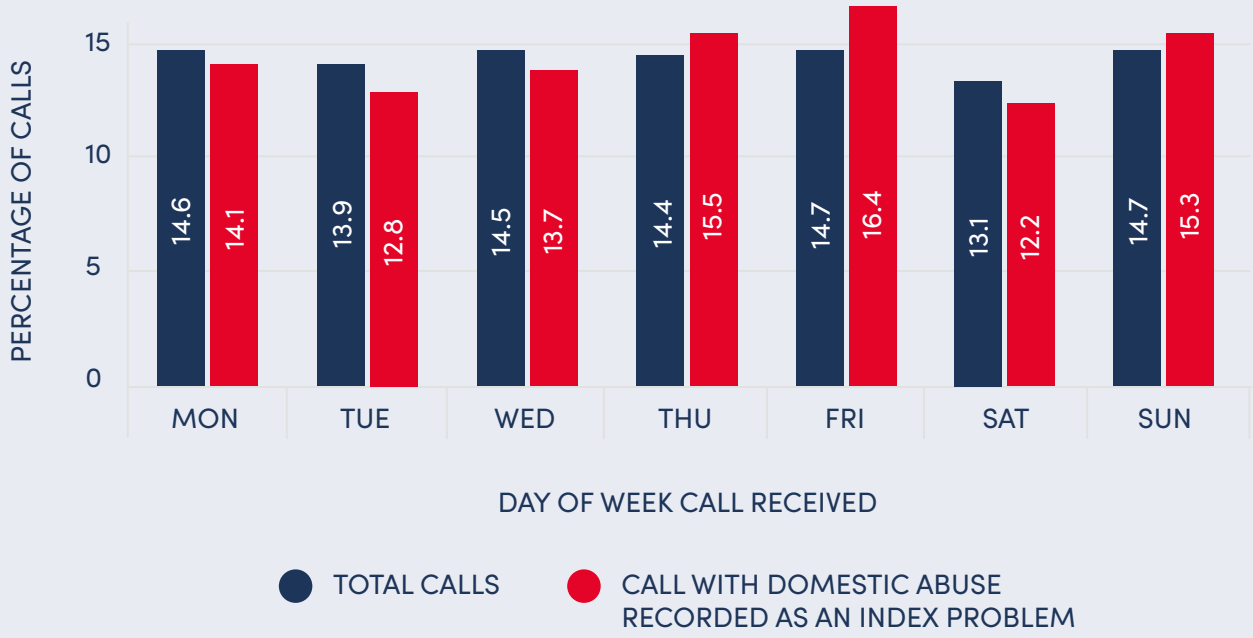
The term 'domestic abuse' was the trigger word for call handlers as it is often used to describe any type of controlling, bullying, threatening or violent behaviour between people in a relationship. The bespoke data collection documented where a caller had stated they had problems related to domestic abuse, or that the person they were calling about had such problems. A total of **548** calls recorded 'domestic abuse' as an index problem.

37.3 Day of the Week of Calls

A total of 100% (548) calls were able to record the day of the week the call was received which identified domestic abuse as an index problem.

Figure 48 shows the proportion of calls received per day of the week and shows a lower proportion on Tuesday or Saturday and a higher proportion on Thursday and Friday. The figure shows 72% of calls were received on a weekday compared and 28% of calls were received on a weekend, the same proportion as total calls.

Figure 48:
% of Calls by Day of the Week - Domestic Abuse Versus Total Calls



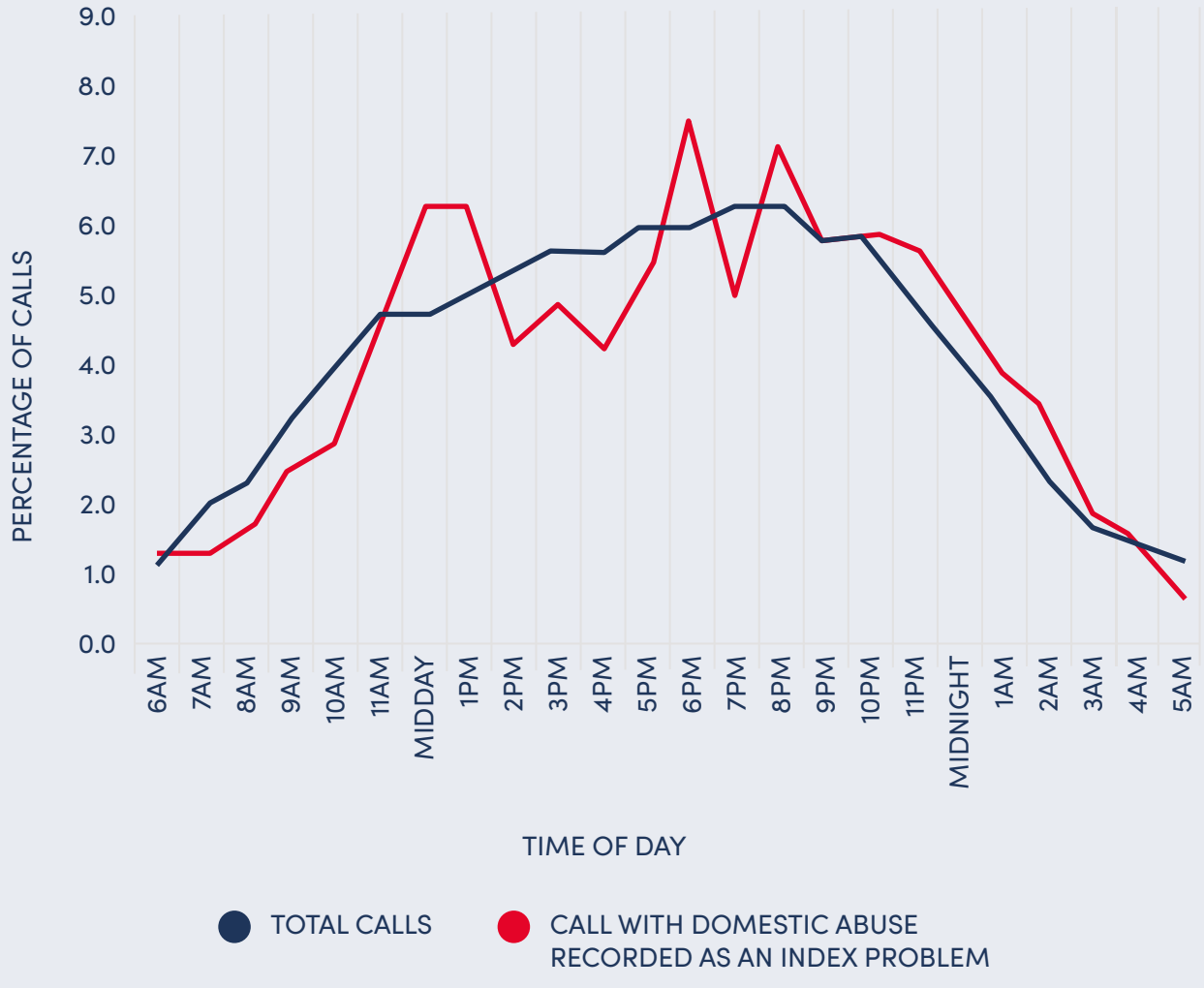
37.4 Time of Day of Calls

A total of 100% (548) calls were able to record the time of day the call was received which identified 'domestic abuse' as an index problem. **Figure 49** shows the time of day of calls where domestic abuse had been recorded as an index problem versus total calls, shown from 6am to better display overnight calls.

The figure highlights a variation between domestic abuse and total calls in that these calls peak at midday, dip in the afternoon then are higher overnight. A higher proportion of calls (64%) occurred 'out of hours' and this was more than the proportion of the total number of calls (61%) received 'out of hours'.

Figure 49:

% of Calls by Time of Day - Domestic Abuse Versus Total Calls



37.5 Association with Other Index Problems

For 14.1% (77) of the 548 calls, where domestic abuse was recorded as an index problem, there were no other index problems recorded. For 85.9% (471) of calls, where domestic abuse was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **13.7%** of calls where **relationships** are an index problem also had domestic abuse as an index problem,
2) **9.5%** of calls where **harassment or bullying** is an index problem also had domestic abuse as an index problem,
3) **6.3%** of calls where **confusion or strange behaviour** is an index problem also had domestic abuse as an index problem,
4) **5.6%** of calls where **substance misuse** is an index problem also had domestic abuse as an index problem,
5) **5.6%** of calls where **drunkenness or intoxication** is an index problem also had domestic abuse as an index problem,
6) **5.3%** of calls where **homelessness or concerns over housing** is an index problem also had domestic abuse as an index problem**,**
7) **5.2%** of calls where **debt, money or concerns about benefits** is an index problem also had domestic abuse as an index problem,
8) **5.1%** of calls where **mental illness** is an index problem also had domestic abuse as an index problem,
9) **5%** of calls where **work or school** is an index problem also had domestic abuse as an index problem,
10) **5%** of calls where **suicidal behaviour** is an index problem also had domestic abuse as an index problem,
11) **4.8%** of calls where **loneliness or isolation** is an index problem also had domestic abuse as an index problem,
12) **4.5%** of calls where **stress, anxiety or panic** is an index problem also had domestic abuse as an index problem,
13) **4.4%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had domestic abuse as an index problem,
14) **4.4%** of calls where **low mood or possible depression** is an index problem also had domestic abuse as an index problem,
15) **2.1%** of calls where **dementia** is an index problem also had domestic abuse as an index problem,

0% of calls where **gender identity** is an index problem also had domestic abuse as an index problem.

38. Specific Index Problem – Dementia

38.1 The Index Problem

It is predicted that by 2021 there will be over 55,000 people in Wales who have dementia. Diagnosis rates in Wales are estimated to be around 44% meaning that over 30,000 people in Wales may be living with dementia who have not been diagnosed[128]. Older people, who are more likely to have dementia, may find it difficult to 'navigate or access the healthcare system'[129]. Those with symptoms of dementia may also be more susceptible to emotional, physical or financial abuse[130].

Symptoms of the some of the many progressive neurological disorders, that can be classed as dementia, are aggression, withdrawal, wandering, disorientation, incoherent or repetitive speech and a typical behaviour may be upsetting, frightening or be misunderstood by the person themselves or others.

38.2 Data Overview

The term 'dementia' was the trigger word for call handlers as it is often used to describe any type of issue connected or possibly connected with a progressive neurological disorder. The bespoke data collection documented where a caller had stated they had difficulties related to dementia, or that the person they were calling about had such difficulties. A total of **334** calls recorded dementia as an index problem.

The proportion of index problems recorded as dementia was 1.6 % of the total index problems and less than 500 calls therefore detailing the day of the week or time of day that these calls were made would be statistically misrepresentative.

38.3 Association with Other Index Problems

For 13.5% (45) of the 334 calls, where dementia was recorded as an index problem, there were no other index problems recorded. For 86.5% (289) of calls, where dementia was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **9.2%** of calls where **loneliness and/or isolation** is an index problem also had dementia as an index problem,
2) **6.4%** of calls where **low mood or possible depression** is an index problem also had dementia as an index problem,
3) **4.6%** of calls where **confusion or strange behaviour** is an index problem also had dementia as an index problem,
4) **4.5%** of calls where **mental illness** is an index problem also had dementia as an index problem,
5) **3.7%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had dementia as an index problem,
6) **3.3%** of calls where **suicidal behaviour** is an index problem also had dementia as an index problem,
7) **1.4%** of calls where **harassment or bullying** is an index problem also had dementia as an index problem,
8) **1.3%** of calls where **domestic abuse** is an index problem also had dementia as an index problem,
9) **1.2%** of calls where **debt, money or concerns about benefits** is an index problem also had dementia as an index problem,
10) **0.9%** of calls where **stress, anxiety or panic** is an index problem also had dementia as an index problem,
11) **0.7%** of calls where **relationships** are an index problem also had dementia as an index problem,
12) **0.5%** of calls where **drunkenness or intoxication** is an index problem also had dementia as an index problem,
13) **0.4%** of calls where **homelessness or concerns over housing** is an index problem also had dementia as an index problem
14) **0.3%** of calls where **substance misuse** is an index problem also had dementia as an index problem.

0% of calls where **gender identity or work/school** is an index problem also had dementia as an index problem.

39. Specific Index Problem – Debt, Money, Benefits

39.1 The Index Problem

It is estimated that around 3 million people in the UK have severe problem debt. Worries about debt, money, benefits or employment are amongst the main reasons for calls to Samaritans[131]. There is a higher prevalence of anxiety, depression and other common mental disorders among individuals in debt[132]. Low income levels have been related to psychological distress[133], depression[134,135], and suicide[136]. A 2020 study found that people with mental health problems are more likely than the rest of the population to be in receipt of a benefit. The study found that reductions in benefit levels 'over recent years' have meant that people who are unable to work due to long term mental health problems have had a 'direct hit to their incomes'[137].

Analysis of people in receipt of Employment and Support Allowance found, in 2016, that 6% had attempted suicide in the past year, compared to 1% of those not in receipt of this benefit and, across their lifetimes, 43% of people claiming Employment and Support Allowance will have attempted suicide, compared to just 7% of people not claiming it[138]. Poor mental health may be the result or cause of unemployment, reduced working hours or debt.

While having a mental health problem may qualify some people for state benefits, individuals may have difficulty claiming these, or experience delays and disruptions in receiving payments. Lengthy hospital admissions may make it difficult to meet debt repayments, and may also result in reduced levels of state benefit. Medication side-effects can make it difficult to get 'on top' of finances, while the some mental illnesses can severely affect motivation[139].

39.2 Data Overview

The terms 'debt', 'money', 'benefits' were the trigger words for call handlers as they are often used by people to describe problems with such as the inability to pay rent, mortgage, bills or pay for essential items, have issues with gambling or loans, having anxieties over benefit payments or benefit assessment processes. The bespoke data collection documented where a caller had stated they had concerns about debt, had money issues or were concerned about benefit payments or that the person they were calling about has these concerns. A total of **250** calls recorded debt/money/benefits as an index problem.

The proportion of index problems recorded as debt, money or concerns about benefits was 1.2 % of the total index problems and less than 500 calls, therefore detailing the day of the week or time of day that these calls were made would be statistically misrepresentative.

39.3 Association with Other Index Problems

For 7.6% (19) of the 250 calls, where debt, money or concerns about benefits was recorded as an index problem, there were no other index problems recorded. For 92.4% (231) of calls, where debt, money or concerns about benefits was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **18.4%** of calls where **homelessness or concerns over housing** is an index problem also had debt, money or concerns about benefits as an index problem**,**
2) **13%** of calls where **work or school** is an index problem also had debt, money or concerns about benefits as an index problem,
3) **7.5%** of calls where **loneliness or isolation** is an index problem also had debt, money or concerns about benefitsas an index problem,
4) **5.1%** of calls where **relationships** are an index problem also had debt, money or concerns about benefits as an index problem,
5) **5%** of calls where **harassment or bullying** is an index problem also had debt, money or concerns about benefits as an index problem,
6) **4%** of calls where **stress, anxiety or panic** is an index problem also had debt, money or concerns about benefits as an index problem,
7) **3.6%** of calls where **low mood or possible depression** is an index problem also had debt, money or concerns about benefits as an index problem,
8) **3.6%** of calls where **substance misuse or concerns about benefits** is an index problem also had debt, money or concerns about benefits as an index problem,
9) **3.1%** of calls where **mental illness** is an index problem also had debt, money or concerns about benefits as an index problem,
10) **2.7%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had debt, money or concerns about benefits as an index problem,
11) **2.7%** of calls where **confusion or strange behaviour** is an index problem also had debt, money or concerns about benefits as an index problem,
12) **2.6%** of calls where **suicidal behaviour** is an index problem also had debt, money or concerns about benefits as an index problem
13) **2.4%** of calls where **domestic abuse** is an index problem also had debt, money or concerns about benefits as an index problem,
14) **2%** of calls where **drunkenness or intoxication** is an index problem also had debt, money or concerns about benefitsas an index problem,
15) **0.9%** of calls where **dementia** is an index problem also had debt, money or concerns about benefits as an index problem**.**
16) **0%** of calls where **gender identity** is an index problem also had debt, money or concerns about benefits as an index problem

40. Specific Index Problem – Homelessness or Housing

40.1 The Index Problem

Stable and decent housing is a key factor in an individual wellbeingand people with housing problems are at greater risk of mental health problems[140]. One in five adults have suffered mental health issues in the last five years, due to housing problems[141]. Children living in crowded homes are more likely be stressed, anxious and depressed, have poorer physical health, and attain less well at school[142].

People with poor mental health are one and a half times more likely to live in rented housing, and they are twice as likely to be 'unhappy' with their housing[143]. Mental ill health is frequently cited as a reason for tenancy breakdown and housing problems are often given as a reason for a person being admitted, or readmitted, to inpatient care[144]. Bereavement and relationship breakdowns are often a factor leading to homelessness[145].

The relationship between homelessness and mental health is well established[146] as it is with housing insecurity more generally[147]. The Housing (Wales) Act 2014 established a statutory basis for approaching homelessness with the aim of prevention, giving Wales the only nation to enshrine a duty to prevent homelessness in law[148].

In a Welsh survey of homeless individuals, one in three participants reported that they were receiving mental health support and all other respondents reported that they were experiencing some level of anxiety or depression[149].

40.2 Data Overview

The terms 'homelessness' or 'housing' were the trigger words for call handlers as they are often used by people to describe sleeping rough, having problems with insecure tenancies, potential eviction or housing unfit for habitation. The bespoke data collection documented where a caller had stated they were homeless or had concerns about housing or that the person they were calling about may have such concerns. A total of **228** calls recorded homelessness or housing as an index problem.

The proportion of index problems recorded as homelessness or housing was 1.1% of the total index problems and less than 500 calls, therefore detailing the day of the week or time of day that these calls were made would be statistically misrepresentative.

40.3 Association with Other Index Problems

For 3.9% (9) of the 228 calls, where homelessness or housing was recorded as an index problem, there were no other index problems recorded. For 96.1% (219) of calls, where homelessness or housing was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **16.8%** of calls where **debt, money or concerns about benefits** is an index problem also had homelessness or housing as an index problem,
2) **9.5%** of calls where **gender identity** is an index problem also had homelessness or housing as an index problem,
3) **8%** of calls where **work or school** is an index problem also had homelessness or housing as an index problem,
4) **5.9%** of calls where **harassment or bullying** is an index problem also had homelessness or housing as an index problem,
5) **5.2%** of calls where **loneliness and/or isolation** is an index problem also had homelessness or housing as an index problem,
6) **3.9%** of calls where **low mood or possible depression** is an index problem also had homelessness or housing as an index problem,
7) **3.5%** of calls where **stress, anxiety or panic** is an index problem also had homelessness or housing as an index problem,
8) **2.9%** of calls where **drunkenness or intoxication** is an index problem also had homelessness or housing as an index problem,
9) **2.6%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had homelessness or housing as an index problem,
10) **2.3%** of calls where **suicidal behaviour** is an index problem also had homelessness or housing as an index problem,
11) **2.2%** of calls where **mental illness** is an index problem also had homelessness or housing as an index problem,
12) **2.2%** of calls where **domestic abuse** is an index problem also had homelessness or housing as an index problem,
13) **2.1%** of calls where **relationships** are an index problem also had homelessness or housing as an index problem,
14) **2.1%** of calls where **substance misuse** is an index problem also had homelessness or housing as an index problem
15) **1.7%** of calls where **confusion or strange behaviour** is an index problem also had homelessness or housing as an index problem,
16) **0.3%** of calls where **dementia** is an index problem also had homelessness or housing as an index problem

41. Specific Index Problem – Harassment or Bullying

41.2 The Index Problem

Harassment is unwanted behaviour that affects a person's well-being and covers actions from unpleasant comments through to physical violence and can be persistent or a one-off incident. It is usually related to a personal characteristic such as age, gender, race, religion, sexual orientation or disability. The Equality Act 2010 protects disabled people from unfair treatment and this includes people with a mental illness. Bullying is a persistent, vindictive or humiliating attempt to undermine, criticise or humiliate an individual. Bullying and harassment are commonly reported causes of work-related stress[150].
A 2020 study has proposed that workplace sexual harassment represents an important risk factor for suicidal behaviour[151].

Young people who have experienced bullying are more likely to experience mental health issues and those who have mental health issues are more likely to be bullied[152]. Being a victim or perpetrator of bullying has been frequently associated with a range of behavioural, emotional and social problems, including suicide[153].

41.3 Data Overview

The terms 'harassment' or 'bullying' were the trigger words for call handlers as they are often used by people to describe being stalked, sexually harassed, intimidated, insulted, threatened or coerced. The bespoke data collection documented where a caller had stated they were being harassed or bullied or that the person they were calling about may be. A total of **220** calls recorded Harassment or bullying as an index problem.

The proportion of index problems recorded as Harassment or bullying was 1% of the total index problems and less than 500 calls, therefore detailing the day of the week or time of day that these calls were made would be statistically misrepresentative.

41.3 Association with Other Index Problems

For 3.9% (9) of the 220 calls, where harassment or bullying was recorded as an index problem, there were no other index problems recorded. For 96.1% (219) of calls, where harassment or bullying was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **9.5%** of calls where **gender identity** is an index problem also had harassment or bullying as an index problem,
2) **9%** of calls where **work or school** is an index problem also had harassment or bullying as an index problem,
3) **5.7%** of calls where **homelessness or concerns over housing** is an index problem also had harassment or bullying as an index problem,
4) **4.4%** of calls where **debt, money or concerns about benefits** is an index problem also had harassment or bullying as an index problem,
5) **4.1%** of calls where **relationships** are an index problem also had harassment or bullying as an index problem,
6) **4%** of calls where **stress, anxiety or panic** is an index problem also had harassment or bullying as an index problem,
7) **3.8%** of calls where **domestic abuse** is an index problem also had harassment or bullying as an index problem,
8) **3.2%** of calls where **loneliness and/or isolation** is an index problem also had harassment or bullying as an index problem,
9) **2.5%** of calls where **confusion or strange behaviour** is an index problem also had harassment or bullying as an index problem,
10) **2.2%** of calls where **mental illness** is an index problem also had harassment or bullying as an index problem,
11) **2%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had harassment or bullying as an index problem,
12) **1.9%** of calls where **low mood or possible depression** is an index problem also had harassment or bullying as an index problem,
13) **1.7%** of calls where **suicidal behaviour** is an index problem also had harassment or bullying as an index problem,
14) **1.2%** of calls where **drunkenness or intoxication** is an index problem also had harassment or bullying as an index problem,
15) **1.2%** of calls where **substance misuse** is an index problem also had harassment or bullying as an index problem,
16) **0.9%** of calls where **dementia** is an index problem also had harassment or bullying as an index problem

42. Specific Index Problem – Work or School

42.1 The Index Problem

In a well-researched area, being unemployed has been linked to mental illness and suicide[154,155,156,157]. A recent study found that people with mental health issues are less likely to be in work and are overrepresented in lower-paying jobs[158]. Specific occupations have been shown to have higher than average alcohol use, self-harm and suicide rates[159]. At the beginning of the 21st century professionals such as veterinarians, pharmacists, dentists and doctors were at the highest risk of suicide but over the last decade there have been significant reductions in rates for each of these occupations. Those who are now showing significant increases in suicide rates tend to be in manual occupations[160].

A 2020 study with secondary school pupils found that one in seven were 'suffering from mental health problems'. The study found that girls and year 11 pupils are particularly affected, with emotional problems such as anxiety and low mood on the rise[161]. Studies have also shown that children who have had their schooling disrupted, either from exclusion or transfer, are more likely to join a 'gang' and therefore more likely to self-harm and have social and emotional health issues[162].

42.2 Data Overview

The terms 'work' or 'school' were the trigger words for call handlers as they are often used by people to describe issues with employment or education including income, fulfilment, repression, stress or abuse. The bespoke data collection documented where a caller had stated they had issues arising from being unemployed or issues at work, school or college or the person they were calling about had. A total of **100** calls recorded work or school as an index problem.

The proportion of index problems recorded as work or school was 0.5% of the total index problems and less than 500 calls, therefore detailing the day of the week or time of day that these calls were made would be statistically misrepresentative.

42.3 Association with Other Index Problems

For 2% (2) of the 100 calls, where work or school was recorded as an index problem, there were no other index problems recorded. For 98% (98) of calls, where work or school was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **5.2%** of calls where **debt, money or concerns about benefits** is an index problem also had work or school as an index problem,
2) **4.1%** of calls where **harassment or bullying** is an index problem also had work or school as an index problem,
3) **3.5%** of calls where **homelessness or concerns over housing** is an index problem also had work/school as an index problem,
4) **3.2%** of calls where **loneliness and/or isolation** is an index problem also had work or school as an index problem,
5) **2.1%** of calls where **relationships** are an index problem also had work or school as an index problem,
6) **2%** of calls where **low mood or possible depression** is an index problem also had work or school as an index problem,
7) **1.8%** of calls where **stress, anxiety or panic** is an index problem also had work or school as an index problem,
8) **1.7%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had work or school as an index problem,
9) **1.4%** of calls where **suicidal behaviour** is an index problem also had work or school as an index problem,
10) **1.3%** of calls where **mental illness** is an index problem also had work or school as an index problem,
11) **1.1%** of calls where **confusion or strange behaviour** is an index problem also had work or school as an index problem
12) **0.9%** of calls where **domestic abuse** is an index problem also had work or school as an index problem,
13) **0.7%** of calls where **drunkenness or intoxication** is an index problem also had work or school as an index problem,
14) **0.4%** of calls where **substance misuse** is an index problem also had work or school as an index problem,

0% of calls where **gender identity or dementia** is an index problem also had work or school as an index problem.

43. Specific Index Problem – Gender Identity

43.1 The Index Problem

A person's sex describes biological differences between the female and male genitalia and sex is usually assigned at birth. A person's gender describes a person's internal sense of their identity. A transgender person self-identifies their gender as being different to the sex they were assigned at birth[163]. Poor mental health and psychological distress are disproportionately higher among transgender people[164]. Some transgender or gender diverse young people find it especially hard to ask for help. This might be because of discrimination by health professionals in the past, worries about privacy, or difficulty talking to strangers about their issues[165].

A study has reported that, of the proportion of people who are lesbian, gay, bisexual or transgender, 52% said they've experienced depression in the last year, 13% of 18-24 years olds said they've attempted to take their own life in the last year, 16% said they drank alcohol 'almost every day' over the last year, 13% of 18-24 year olds had taken illicit drugs at least once a month, 13% have experienced some form of unequal treatment by healthcare staff and 14% have avoided healthcare treatment for fear of discrimination[166].

43.2 Data Overview

The terms 'gender identity' was the trigger word for call handlers as it is often used by people to describe issues of personal identity. The bespoke data collection documented where a caller had stated they had issues arising from gender identity such as persecution or mistreatment or a person they were calling about had. A total of **21** calls recorded gender identity as an index problem.

The proportion of index problems recorded as gender identity was 0.1% of the total index problems and less than 500 calls, therefore detailing the day of the week or time of day that these calls were made would be statistically misrepresentative.

43.3 Association with Other Index Problems

For 14.3% (3) of the 21 calls, where gender identity was recorded as an index problem, there were no other index problems recorded. For 85.7% (18) of calls, where gender identity was recorded as an index problem, other index problems were recorded as shown below in descending order:

1) **0.9%** of calls where **harassment or bullying** is an index problem also had gender identity as an index problem,
2) **0.9%** of calls where **homelessness or concerns over housing** is an index problem also had gender identity as an index problem,
3) **0.5%** of calls where **loneliness and/or isolation** is an index problem also had gender identity as an index problem,
4) **0.4%** of calls where **stress, anxiety or panic** is an index problem also had gender identity as an index problem,
5) **0.3%** of calls where **self-harm behaviour or deliberate overdose** is an index problem also had gender identity as an index problem,
6) **0.3%** of calls where **mental illness** is an index problem also had gender identity as an index problem,
7) **0.2%** of calls where **low mood or possible depression** is an index problem also had gender identity as an index problem,
8) **0.2%** of calls where **suicidal behaviour** is an index problem also had gender identity as an index problem,
9) **0.1%** of calls where **confusion or strange behaviour** is an index problem also had gender identity as an index problem,
10) **0.1%** of calls where **substance misuse** is an index problem also had gender identity as an index problem,
11) **0.1%** of calls where **relationships** are an index problem also had gender identity as an index problem,
12) **0.1%** of calls where **drunkenness or intoxication** is an index problem also had gender identity as an index problem,

0% of calls where **debt, money or concerns about benefits, domestic abuse, work or school or dementia** is an index problem also had gender identity as an index problem.

PART D

CONCLUSION AND RECOMMENDATIONS

Contents

> **WHATEVER THE PRESENTING CONCERN…A SPEEDY, APPROPRIATE AND SUPPORTIVE RESPONSE IS CRUCIAL.**
>
> **STATEMENT FROM: WELSH GOVERNMENT AND PARTNERS MENTAL HEALTH CRISIS CARE CONCORDAT (2015)**

44. Conclusion

This Review concludes an extensive examination of the issues regarding access to emergency services for those experiencing mental health and/or welfare concerns. The Review has noted some knowledge gaps pertinent to crisis care such as that related to emergency social care, the ICAN service, police mental health flags and some index problems.

The Review has used publically accessible information, bespoke data collection and the most up-to-date studies available to provide the detail presented. In the Review there are qualifications for the data used, specifically where inferences have been made from historic data, one off data requests or self-declared mental health demand. The Review found that inconsistent data and imprecise definitions between, and within, services rendered understanding this area of enquiry more problematic. Even progress made by the Police, to provide annual snapshot data, has shortcomings in terms of seasonal variances and real time information.

Recommendation:

Public sector services should ensure consistent real time data is acquired and shared regarding mental health/ welfare demand and adopt common definitions for mental health crisis and a range of welfare concerns.

The Review has established that demand on primary care, police, ambulance services and emergency departments, as well as NHS mental health services for those in crisis is considerable.

The Review estimates that every day in Wales there are **941** calls/attendances/referrals for mental health or welfare concerns:

319 of these are for emergency or immediate response services, such as:

- 142 presentations at Welsh emergency departments'
- 99 calls to the Police '999' number'
- 73 calls to the Welsh Ambulance Services '999' number,
- 5 Section 136 Mental Health Act assessments.

A further **298** of these are for an urgent response services, such as:

- 128 calls to Police '101' number,
- 53 referrals to NHS mental health crisis teams,
- 50 referrals to NHS psychiatric liaison services,
- 41 calls are made to the C.A.L.L. helpline,
- 14 'face-to-face' contacts by North Wales ICAN emergency department support service,
- 12 calls to NHS '111' service.

And an additional **324** are for standard response services, such as:

- 215 referrals made to NHS mental health primary care support services,
- 109 referrals made to NHS mental health secondary care support services.

These groupings are broad approximations and the figures have significant caveats. These numbers do not reflect individuals in police custody or people seeking support and advice from third sector agencies and the numerous helplines and online support sites that are available. The Review has shown that many agencies and organisations are striving to support people in crisis but that more may be achieved by shared endeavour. One study advocated a commissioning-led crisis model that works across a range of sectors such as social care, mental health care, acute care, ambulance services and police[167].

The Review has shown that four in ten calls may be appropriate for NHS mental health or substance misuse services such as suicidal behaviour, self-harm, substance misuse, mental illness and dementia. Nearly three in ten calls may be appropriate for health, social care and police partnership working such as domestic abuse, intoxication, confusion and harassment and that just over three out of ten may be appropriate for public and third sector collaboration such as stress, low mood, debt, loneliness and homelessness. The Review demonstrated that individual crisis is complex with many interrelated social, emotional and mental health issues.

Recommendation:

There should be effective collaboration between public and third sector services to improve outcomes for people experiencing a mental health crisis or seeking support for welfare concerns, codified through a national framework that includes multi-agency standards, whole system measures and indicators for success.

The Review revealed that people seek help at all times of day, although the majority seek help outside of normal office hours, and that different crisis triggers had certain patterns of demand. The Review has presented evidence that providing dedicated advice and support at these times and providing support for issues such as relationships, housing, debt, and substance misuse may avoid the use of emergency response services.

Recommendation:

The accountable Welsh Government departments and responsible public sector services must ensure that support is available and accessible, at the required times, to address urgent welfare concerns such as dementia, substance misuse, debt and homelessness.

The Review highlighted some actions that may support a more effective crisis response such as ensuring that people attending NHS mental health services know who to contact in crisis.

Recommendation:

NHS mental health secondary care services must ensure that individuals currently accessing services should have crisis plans in place building on the needs of the individual, personal resilience and preventative actions.

The Review highlighted the significant resources committed by Police when responding to missing person's appeals, especially from facilities caring for vulnerable persons.

Recommendation:

Public sector services that manage or commission facilities caring for vulnerable persons must ensure they have a robust 'missing person' protocol in place. These protocols should specify preventative measures to reduce missing person's calls to the Police, such as the proactive management of risk.

The Review noted projects in other parts of the UK, which demonstrated that a single point of access for people in crisis can be beneficial to individuals and professionals alike. This single point of access can ensure specialist mental health professionals are available to provide clinical triage, onward referral and effective signposting to individuals in crisis and authoritative advice to primary care staff, police officers and ambulance crews. Any new service would have to compliment and work closely with extant NHS crisis services and mental health workers in police control rooms.

Recommendation:

NHS Wales should facilitate access to specialist mental health professionals through a single point of entry, such as the NHS Wales 111 Service. This service must have robust links to third sector and self-help support and provide referral pathways to primary care, police and emergency medical personnel.

The traumatic events that occur in childhood and have a lasting effect on an individual's life are discussed in the Review. The Review finds hundreds of children and adolescents calling emergency services seeking support, especially around problems at school or with harassment or bullying issues. The Review evidenced the occasions where early communication, effective signposting, better support to family or carers and the fostering of resilience can minimise the impact of these adverse events.

Recommendation:

All public and third sector agencies should promote a trauma informed approach to crisis.

The Review has stated that, for some in crisis, a police, ambulance or emergency department response is the best outcome, however it also highlighted the many instances of missed opportunities to get individuals the support that best meets their needs before such services are required. Such opportunities as emergency department discharges, high intensity users and primary care consultations can be exploited to ensure effective signposting of individuals to support. The Review examined crisis cafés and sanctuaries and emphasised their advantages in providing alternatives to hospital admission. The importance of third sector partners in developing and providing preventative services has been clearly identified in the Review.

Recommendation:

The public sector should provide, wherever possible in partnership with the third sector, a range of crisis prevention or response services including crisis cafes or sanctuaries, high intensity user support, home treatment and primary care support.

The Review established that, in three out of five calls another person, other that the person with the index problem was calling for assistance. The Review revealed the numerous agencies that individuals could conceivably access when in crisis or seeking advice and the difficulties some people have navigating this complex landscape.

Recommendation:

The Welsh Government should deliver a national communication campaign to ensure individuals, carers and family members know where to go for support or advice for themselves and others in crisis.

The Review evidenced the many occasions where people may be excluded from services or deterred from seeking help either through fear, culture or attitude, through system complexity or through a lack of awareness and understanding.

Recommendation:

The Welsh Government, public sector and third sector agencies must ensure that the particular needs of vulnerable individuals are recognised and met when presenting in crisis. All agencies must engage with individuals or representatives from these groups to reduce barriers to accessing support in a crisis.

The Review recognises that every day staff in police forces, ambulance services or emergency departments go beyond the call of duty to care for those presenting with mental health or welfare concerns with empathy and compassion. The Review proposes support for these workers through promoting preventative measures and delivering early interventions, alternative approaches, clear pathways and multi-agency collaboration for persons in crisis.


EMERGENCY

PART E

APPENDICES AND REFERENCES

Contents

Appendix 1 – Expert Reference Group Membership

The following persons attended at least one Expert Reference Group meeting or workshop established as part of the Review:

- Will Adams, Public Health Wales
- Simon Amphett – CVUHB
- Kate Blackmore, WAST
- Stephen Clarke, WAST
- Adrian Clarke, NCCU
- Phil Chick, NHS Wales Delivery Unit
- Stephen Clinton, WAST
- Garry Davies – South Wales Fire Service
- Jason Davies, South Wales Police
- Richard David, Gwent Police
- Amanda Diggens, Dyfed-Powys Police
- Meinir Evans, BCUHB
- Andrea Grey, Public Health Wales
- Christopher Grey, South Wales Police
- Richard Jones , HDUHB
- Simon Jones, Mind Cymru
- Mydrain Harries, Mid & West Wales Fire Service
- Howard Hopkins, Torfaen Social Services
- Scott Howe, HIW
- Hanan L'Estrange-Snowden, Picker Europe
- Mark Lewis, South Wales Police
- Phil Lewis, CTMUHB
- Dean Loader, South Wales Fire Service
- Peter Martin, Mind
- Nick Mclain, Gwent Police
- Andrew Misell – Alcohol Change
- Alun Newsome, Coastguard Milford Haven
- Christopher O'Driscoll – Gwent Police
- Sarah Jane Paxton, Torfaen Social Services
- Roger Perks, Welsh Government
- Jonathan Salisbury-Jones, North Wales Police
- Dave Richards, Gwent Police
- Phillip Stylianides, Picker Europe
- Anna Sussex, Public Health Wales
- Peter Thomas, GP OOH services
- David Wastell, Public Health Wales
- Ross Whitehead, NCCU
- Amanda Williams, Gwent Police
- Dave Williams, ABUHB
- Nick Wood, ABUHB

Apologies for missing anyone from this list, unfortunately one attendance sheet was discarded erroneously.

Appendix 2 – Bespoke Data Collection Form & Explanatory Sheet

The form below is a reproduction of the bespoke data collection form developed for the Review. This data collection form was specifically designed as a single sided A5 sized sheet in order that it could be completed quickly by call handlers and not delay their requirement to dispatch an emergency vehicle or divert the call to an appropriate service.

WALES MH ACCESS REVIEW DATA COLLECTION SHEET

REF/INC NO:

DATE: (DD/MM/YY) ..... / ..... / .....

CALL **START** TIME: (24HR) ..... : .....

CALL **END** TIME: (24HR) ..... : .....

SEX of person with issue

○ MALE ○ FEMALE ○ OTHER

AGE of person with issue

○ 0-15 ○ 16-25 ○ 26-35 ○ 36-65 ○ 65+

WHO IS CALLING

○ PERSON WITH ISSUE ○ FRIEND/ NEIGHBOUR ○ PARENT/ RELATIVE ○ CHILD ○ PROFESSIONAL ○ PUBLIC/ STRANGER

ISSUES

Caller / person they are calling about has the following issues

TICK 1 MAIN & AS MANY OTHERS AS NEEDED

	MAIN	OTHER		MAIN	OTHER
SUICIDAL	○	○	DEBT/MONEY/ BENEFITS	○	○
SELF HARM/ OVERDOSE	○	○	HOUSING/ HOMELESSNESS	○	○
LOW MOOD DEPRESSION	○	○	WORK/ SCHOOL ISSUE	○	○
STRESS/ ANXIETY/PANIC	○	○	LONELY/ ISOLATED	○	○
SUBSTANCE ABUSE	○	○	RELATIONSHIP ISSUES	○	○
DRUNK/ INTOXICATED	○	○	DOMESTIC ABUSE	○	○
DEMENTIA	○	○	CONFUSION/ STRANGE BEHAVIOUR	○	○
DIAGNOSED MENTAL HEALTH	○	○	GENDER IDENTITY/ QUESTIONING	○	○
HARASSMENT/ BULLIED	○	○			

NOTES/OTHER ISSUES

(physical health, veterans, immigration, asylum seeking)

-MH

Explanatory Sheet

This sheet accompanied the A5 form to provide context for call handlers and minimise variation.

REF: is for incident ID or other internal reference number that can be matched to the sheet.

IMPORTANT: the aim is to try and list all the index problems/problems that the caller is identifying as possible reasons for their distress/call for help. This could mean the call handler ticking multiple boxes as the caller lists off their problems on the call. This is fine as we want as much information on causes for their distress as possible. What social, financial etc.... index problems are causing the callers mental health distress/problems.

EXAMPLE CASE: caller is asking for help because they're having thoughts and feelings of suicide, or have acted on these thoughts. In the course of the conversation it turns out the reason for the caller's feelings was due to relationship breakdown, money problems, housing index problems etc. The call handler can tick suicidal as the main index problem but can also tick relationship index problems, money & housing as other index problems.

SUICIDAL: caller describing the person they're worried about as/or themselves as: Any attempt to take one's life. Expressed thoughts & feelings to want to end their life. Expressed plan to end their life. Person caller is worried about described/mentioned trying to end their life.

SELF HARM/OVERDOSE: caller describing the person they're worried about as/ or themselves as: Any expressed thoughts & feelings to hurt or harm themselves. Taking or planning on taking tablets/liquid to overdose. Visual signs:- fresh cuts, scares, brushes, choke marks, bleeding etc anything that looks like an unnatural/unusual damage, break to skin, brushes should be considered a self-harming injury without a plausible explanation for the injuries. Person caller is worried about said they have self-harmed. Feeling pressured to self-harm due to peer influence/social media influence.

LOW MOOD/DEPRESSION: caller describing the person they're worried about as/or themselves as: feeling down, upset & tearful. Restless, agitated & irritable. Avoiding social activities & not doing anything they would usually enjoy. Difficulty making decisions/lack of concentration on tasks. Not having an understandable/coherent conversation with you. Isolating themselves say they feel down, worthless lost interest in things and cannot be bothered doing anything. Using alcohol or substances as coping mechanisms. The caller said the person they're worried about describing themselves as above, feeling depressed. They say they're feeling depressed due to work/school/exam pressures.

STRESS/ANXIETY/PANIC: caller describing the person they're worried about as/ or themselves as: Irritable, frustrated or quick to temper snap at people. Anxious and worried about tasks they have to do. Not sleeping or eating or over sleeping and over eating. Saying they feel like everything is against them, sense of dread, failure. Headaches, stomach aches, back aches and other associated physical health problems. Restless, poor concentration. The caller said the person they're worried about describing themselves as above, feeling stress, suffering from anxiety. They say they're feeling stressed/ anxious due to work/school pressures. Exam pressures. All other problems where the caller describes themselves as stressed, experiencing anxiety.

SUBSTANCE MISUSE: caller describing the person they're worried about as/or themselves as: using/consuming any type of legal medication, pain relief/illicit: heroin, cocaine, ecstasy etc/legal highs: nitrous oxide, mephedrone methamphetamine etc. They have been using any of these substances and have used too much and are now in physical/psychological distress. Person is unresponsive, vomited, had a seizure, injured themselves, aggressive, displaying violet behaviour after consuming it. Person has had a long history of misusing these substances above. Person is addicted to these substances. Social problems such as relationship breakdown, housing index problems, loss of job due to using substances above.

DRUNK/INTOXICATED: caller describing the person they're worried about as/or themselves as: violet/aggressive/unresponsive/vomited appears to have had a seizure. Appears intoxicated on any substance could be alcohol or another substance. We're not looking for history of substance/alcohol abuse (see above) but spontaneous over use/misuse of an intoxicating substance.

DOMESTIC ABUSE: caller describing the person they're worried about as/or themselves as: being in a domestic abusive/violet relationship. Causing harm to another person who they're in a relationship with: physical, sexual, psychological, financial, harassment, controlling. Caller hearing/seeing physical threats, violence, psychological, sexual, controlling, harassment/financial abuse by a perpetrator.

DEBT/MONEY PROBLEMS/FINANCIAL WORRIES/BENEFIT WORRIES: caller describing the person they're worried about as/or themselves as: struggling with money, can't see how they're going to pay their bills, provide support/money for their family/kids. Feeling like hurting themselves or others because of debt. Have admitted to gambling problems that has caused financial hardship/worries/problems with debt. They're on benefits and money has been reduced/stopped. They are on benefits and have recently had a PIP/fit for work assessment because they have long term health conditions and have failed to pass the assessment and have been found fit for work/so have lost their benefit money so struggling to pay bills/rent. The person is calling on behalf or themselves or someone else and reporting exploitation from someone else.

HARRASSMENT/ BULLIED: caller describing the person they're worried about as/ or themselves as: feeling bullied in the workplace or school or other environment. Pressured/harassed /bullied on social media: this could be verbal threats of violence/verbal harassment or sexting and other sexual harassment/bullying. The person is calling on behalf or themselves or someone else and reporting financial abuse.

DIAGNOSED MENTAL HEALTH PROBLEM: caller describing the person they're worried about or themselves: experiencing relapse/breakdown in their diagnosed mental health condition and their mental health problems have got/feel worse and need immediate help/support/ hospitalisation/ GP/crisis team/CMHT help. The caller describes the person or themselves as stopped taking their medication and it's made things worse. Phobias. Eating disorders/compulsive eating. Personality disorders. All disorders categorised under the DSM 5/ ICD 11.

HOUSING/HOMELESSNESS: caller describing the person they're worried about as/ or themselves as: struggling to maintain their home/house. Are being evicted or are homeless and this is causing serious worry, stress, anger, depression, psychological & physical health problems. The caller is describing the person they're worried about or themselves as living in extremely poor living conditions, could be council or private rented property and these conditions are impacting their health significantly both physically and psychologically requiring immediate help & support.

DEMENTIA: caller describing the person they're worried about as/or themselves as: and they're struggling to cope with the health. They're unable to cope with their dementia and are calling for help & support. Or the caller is calling on behalf of someone saying they're worried about the person's health and they have dementia. They're forgetting things and it is putting them at risk of harm or exploitation. They're vulnerable and need support from NHS social services.

LONELY/ISOLATED: caller describing the person they're worried about as/or themselves as: the caller is referring to themselves and they're phoning because they're isolated and need support because they cannot look after themselves. They have fallen or been physically injured and have no one to ask for help so are calling for support. Feeling lonely which is impacting on their mental health and saying they feel anxious, low in mood depressed. Or calling for someone else, worried

they're isolated, not going out, worried about them cooking cleaning for themselves. Safeguarding concerns and worried they're neglecting themselves. Worried the person is being exploited/abused due to their isolation. They're elderly and are being targeted for financial abuse due to their isolation.

RELATIONSHIP PROBLEMS: caller describing the person they're worried about as/ or themselves as: feeling they want to hurt themselves, or others, or want to end their life because of relationship problems or breakdown. The breakdown of the relationship has put them into financial problems/ housing problems/homelessness.

WORK/SCHOOL: caller describing the person they're worried about as/or themselves as: problems with work or school is impacting their mental health. Worried stressed, anxious pressures of work, from their box, school and or exams cause their mental health to deteriorate. Or caller is concerned about the person who is having these problems as stated above.

CONFUSION/STRANGE BEHAVIOUR: caller describing the person they're worried about as/or themselves as: appears/sounds delusional over the phone. Very anxious, stressed concerned about events/people/places that are not real. Or the caller is describing a person they're concerned about as acting strangely, or acting unusual, confused or not acting as they would do normally. They're confused and unsure if alcohol, substances or physical or mental health problems are related to the reason for the person's confusion. The confusion/strange behaviour may put the person at increased risk/danger. Appear to have compulsive behaviours that seem strange/are out of character for the person.

GENDER IDENTITY/QUESTIONING: caller describing the person they're concerned about as/or themselves as: struggling with their sexuality/identity. The person could be/have been very direct about their mental health distress/problems caused by their gender identify worries, anxieties, confusions, and questionings. Or the person has shown/displayed aggression, violence towards themselves or others. Overtly sexually active or actively increasing their risk taking behaviours like consuming drugs, alcohol, gambling and are calling because it is out of control and need help. Or because of their behaviour it has put caused problems with friends, family/personal relationships and this is causing distress. The caller is describing the person/themselves as experienced rejection, negative reactions and even hostility or violence from family members, friends, strangers, employers or their community because of their identity. They could be acting out of character around others. Experiencing depression, anxiety, self-harming behaviours. Possible eating problems or eating disorders putting their mental or physical at risk.

NOTES/OTHER INDEX PROBLEMS: Physical health problems. Behavioural conditions. Long standing physical health conditions. Sexual health diseases. Epilepsy. People who're seeking asylum, or are immigrants or migrants who're experiencing mental health problems. Veterans. Important note for this section, is if the caller/ person in distress directly refers to these or other problems outside of the list above that is affecting their mental health.

Appendix 3 - Bespoke Data Collection – Overview

This table details the bespoke data collection results by service

Data	Dyfed Powys Police	South Wales Police	Gwent Police	North Wales Police	Welsh Ambulance Service	North Wales ICAN Service	TOTAL
Total	1980	2058	2673	1362	1753	349	10175
Date	1977	2058	2673	1362	1753	67	10172
Start time	YES	YES	NO	YES	YES	YES	-
End time	YES	YES	NO	YES	YES	YES	-
Sex	1978	2058	2584	941	1753	347	9671
Age	1925	2043	2494	727	1699	131	9025
Who called?							
Person with index problem	550	708	-	-	781	271	2310
Friend/Neighbour	248	162	-	-	224	0	634
Parent/Relative	311	393	-	-	371	0	1075
Child	21	41	-	-	9	0	71
Professional	427	497	-	-	276	0	1200
Public/Stranger	436	235	-	-	51	0	722
Index problems							
Suicide	599	775	375	367	806	44	2966
Self-harm/Overdose	704	348	3	161	896	51	2163
Low mood /Depression	1253	307	429	43	497	282	2811
Stress/Anxiety/Panic	349	148	148	27	353	225	1250
Substance misuse	83	153	315	60	143	18	772
Drunk/Intoxicated	301	289	383	131	242	20	1366
Dementia	182	35	54	47	16	0	334
Diagnosed of Mental health	1196	585	591	228	397	34	3031
Harassment/Bullying	50	26	96	17	31	0	220
Debt/Money/Benefits	84	57	46	20	29	14	250
Homelessness/ Housing	51	110	0	9	40	18	228
Data	**Dyfed Powys Police**	**South Wales Police**	**Gwent Police**	**North Wales Police**	**Welsh Ambulance Service**	**North Wales ICAN Service**	**TOTAL**
Work/School	60	13	0	1	16	24	100
Lonely/Isolated	321	36	48	2	82	112	601
Relationship	166	184	463	11	187	15	1026
Domestic abuse	111	57	226	111	31	12	548
Confusion/Strange behaviour	1168	577	530	494	162	8	2939
Gender identity	5	5	3	0	8	0	21

Appendix 4 - Association between Index Problems - Summary

The table shows the association between index problems by percentage. The range of numbers of index problems in each category can make the percentages disproportionate. The table needs to be understood by reading down the row, such as 'low mood/depression' and across the columns, such as 'mental illness', and interpreted as '44% of calls which recorded mental illness as an index problem also recorded low mood/ depression as an index problem'

2: Also had this index problem

1: Percentage of people with this index problem	Number of index problems in this category	Low mood/Depression	Mental illness	Suicide	Confusion/Strange behaviour	Self-harm/Overdose	Drunk/Intoxicated	Stress/Anxiety/Panic	Relationship	Substance misuse	Lonely/Isolated	Domestic abuse	Dementia	Debt/Money/Benefits	Homelessness/Housing	Harassment/Bullying	Work/School	Gender identity
Low mood/	3288		44	35	33	27	15	32	9	5	10	4	6	4	4	2	2	0
Mental illness	3032	48		27	33	22	14	16	10	8	8	5	4	3	2	2	1	0
Suicide	2966	38	28		16	33	13	12	11	7	6	5	3	3	2	2	1	0
Confusion/Strange	2939	37	34	16		13	14	9	10	8	8	6	5	3	2	3	1	0
Self-harm/	2081	42	32	48	20		13	13	10	7	8	4	4	3	3	2	2	0
Drunk/Intoxicated	1367	36	32	28	29	20		9	12	16	6	6	1	2	3	1	1	0
Stress/Anxiety/ Panic	1250	36	31	24	32	26	10		13	7	14	4	1	4	4	4	2	0
Relationship	1026	28	30	32	28	21	16	16		11	10	14	1	5	2	4	2	0
Substance misuse	772	21	31	28	29	20	28	11	14		3	6	0	4	2	1	0	0
Lonely/Isolated	601	57	40	30	41	27	14	30	18	4		5	9	7	5	3	3	0
Domestic abuse	548	26	28	27	34	17	14	10	26	8	5		1	2	2	4	1	0
Dementia	334	63	40	29	40	23	2	3	2	1	16	2		1	0	1	0	0
Debt/Money/ Benefits	250	48	37	31	31	22	11	20	21	11	18	5	1		17	4	5	0
Homelessness/ Housing	228	56	28	30	22	24	17	19	10	7	14	5	0	18		6	4	1
Harassment/ Bullying	220	28	30	23	34	19	7	23	19	4	9	10	1	5	6		4	1
Work/School	100	66	39	41	32	35	9	23	22	3	19	5	0	13	8	9		0
Gender identity	21	38	38	33	19	29	5	24	5	5	14	0	0	0	10	10	0	

Appendix 5 - Index Problems by Postcode

Percentage of specific index problems by postcode compared to the proportion of total index problems by postcode (not all index problems could be matched to a postcode).

	PERCENTAGE OF TOTAL INDEX PROBLEMS BY POSTCODE/AREA	Call with domestic abuse recorded as an index problem	Call with mental Illness recorded as an index problem	Call with drunk/intoxicated recorded as an index problem	Call with substance misuse recorded as an index problem	Call with stress/anxiety/panic recorded as an index problem	Call with low mood/depression recorded as an index problem	Call with suicide recorded as an index problem
SA - South West Wales including Swansea, Neath, Port Talbot, Carmarthen and Pembroke	26.4	22.5	40.6	29.2	19.5	45.5	36.0	32.5
CF - South Wales including Cardiff, Bridgend and Merthyr Tydfil	18.5	7.6	16.4	18.1	16.0	16.4	7.7	27.0
LL - North Wales including Llandudno, Conway, Rhyl, St Davids and Wrexham	12.4	17.5	6.5	8.0	6.8	2.6	1.2	12.2
Newport	11.1	12.4	8.3	9.1	17.7	7.2	31.9	6.0
Caerphilly	8.7	12.0	5.2	10.8	15.2	6.9	3.9	4.9
Torfaen	5.7	8.4	3.8	6.1	8.7	2.7	2.6	2.8
SY - Central Wales including Newtown and Welshpool	4.6	2.4	8.9	5.3	3.2	9.5	8.4	5.3
Monmouth	4.4	4.6	3.6	4.1	5.3	2.9	2.3	2.5
Blaenau	4.2	8.0	2.6	5.4	5.3	3.0	2.0	2.6
CH - North West Wales including Mold and Flint	2.5	3.4	1.0	2.2	1.8	0.8	0.1	2.2
LD - Central Wales including Llandrindod Wells, Brecon and Knighton	1.6	1.0	3.2	1.8	0.3	2.7	3.5	1.8

Appendix 6 - Mental Health Triage Tool

This Mental Health Triage Tool is used by the Hampshire and Isle of Wight Mental Health Enhanced Service and is in line with the UK Mental Health Triage Scale[168].

UK Mental Health Triage Scale				
Triage Code/ Description	**Response Type/Time to Face to Face Contact**	**Typical Presentations**	**Mental Health Service action/Response**	**Additional Actions to be Considered**
A **Emergency**	**IMMEDIATE REFERRAL** Emergency Service Response	• Imminent self-harm to self, current actions endangering self or others. • Significant overdose/suicide attempt/violent aggression. • Possession of a weapon.	• Triage clinician to dispatch appropriate ambulance response (inc Mental Health Rapid Response Vehicle). • Triage Clinician to arrange appropriate police/ fire response.	• Keeping caller on line until emergency services arrive. • Inform others such as access to property be required. • Telephone Support until services arrive due to immediacy of the risk.
B **Very High Risk of Imminent Harm to Self or to Others**	**WITHIN 4 HOURS** Very Urgent Mental Health Response	• Acute suicidal ideation or risk of harm to others with clear plan or means. • Ongoing history of self- harm or aggression with intent. • Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control. • Urgent assessment under Mental Health Act. • Initial service response to A & E and 'front of hospital' ward areas.	• Crisis Team/Liaison/ face-to-face assessment AND/OR • Triage clinician advice to attend a ED (where the person requires medical assessment treatment).	• Recruit additional support and collate relevant information. • Telephone Support. • Point of contact if situation changes. • Establish safety planning/ worsening advice to be given.
C **High Risk of Harm to Self or Others and/or High Distress, Especially in Absence of Capable Supports**	**WITHIN 24 HOURS** Urgent Mental Health Response	• Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent. • Rapidly increasing symptoms of psychosis and/or severe mood disorder. • High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control. • Overt/unprovoked aggression in care home or hospital ward setting. • Wandering at night (community). • Vulnerable isolation or abuse.	• Crisis Team/Liaison/ • Community Mental Health • Team (CMHT) face-to-face assessment.	• Contact same day with a view to following day review in some cases. • Obtain and collate additional relevant information. • Point of contact if situation changes. • Telephone support and advice to manage wait period. • Establish safety planning/ worsening advice to be given.

D **Moderate Risk of Harm and/or Significant Distress**	**WITHIN 72 HOURS** Semi-Urgent Mental Health Response	• Significant patient/carer distress associated with severe mental illness (but not suicidal). • Absent insight/early symptoms of psychosis. • Resistive aggression/obstructed care delivery. • Wandering (hospital) or during the day (community). • Isolation/failing carer or known situation requiring priority intervention or assessment.	• Liaison/CMHT face-to-face assessment.	• Telephone support and advice. • Secondary consultation to manage wait period. • Point of contact if situation changes. • Establish safety planning/ worsening advice to be given.
E **Low Risk of Harm in Short Term or Moderate Risk with Good Support/ Stabilising Factors**	**WITHIN 7 WEEKS** Non-Urgent Mental Health Response	• Requires specialist mental health assessment but is stable and at low risk of harm during waiting period. • Other services able to manage the person until mental health service assessment (+/- telephone advice) • Known service user requiring non-urgent review adjustment of treatment or follow-up • Referral for diagnosis (see below) • Requests for capacity assessment, service access for dementia or service review/carer support	• Out-patient clinic or CMHT • face-to-face assessment.	• Telephone support and advice. • Secondary consultation to manage wait period. • Point of contact if situation changes. • Establish safety planning/ worsening advice to be given.
F **Referral not Requiring Face-to-Face Response from Mental Health**	**Referral or Advice to Contact Alternative Provider**	• Other services (outside mental health) more appropriate to current situation or need.	• Triage clinician to provide advice, support. • Advice to contact other provider and/ or phone • referral to alternative • service provider (with or without formal written referral)	• Assist and/or facilitate transfer to alternative service provider. • Telephone support and advice.
G **Advice, Consultation, Information**	**Advice or Information only OR More Information Needed**	• Patient or carer requiring advice or information. • Service provider providing information (collateral). • Initial notification pending further information or detail.	• Triage clinician to provide advice, support, and/ or collect further information.	• Consider courtesy follow up telephone contact. • Telephone support and advice.

References

1. Welsh Government (2020) Together for Mental Health Delivery Plan: 2019-22. https://gov.wales/sites/default/files/publications/2020-01/together-for-mental-health-delivery-plan-2019-to-2022.pdf
2. World Health Organisation (2018) Mental health: strengthening our response https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response
3. Anderson, J. K., Howarth, E., Vainre, M., Jones, P., & Humphrey, A. (2017). A scoping literature review of service-level barriers for access and engagement with mental health services for children and young people. https://aspace.repository.cam.ac.uk/bitstream/handle/1810/266403/manuscript%20and%20tables%20revised.pdf?sequence=1&isAllowed=y
4. Salaheddin,K., Mason, B. (2016) Identifying barriers to mental health help-seeking among young adults in the UK: a cross-sectional survey. British Journal of General Practice, 66 (651): e686-e692. DOI: 10.3399/bjgp16X687313
5. Memon A, Taylor K, Mohebati LM, et al (2016) Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. BMJ Open 2016;6:e012337. doi: 10.1136/bmjopen-2016-012337
6. Snow, A., Cerel, J., Loeffler, D.N., Flaherty, C. (2019) Barriers to Mental Health Care for Transgender and Gender-Nonconforming Adults: A Systematic Literature Review, Health & Social Work, Volume 44 (3), 149–155, https://doi.org/10.1093/hsw/hlz016
7. Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. Clinical Psychology Review, 75, 101812.
8. Smith, M. S., Lawrence, V., Sadler, E., & Easter, A. (2019). Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK. BMJ open, 9(1).
9. Samaritans (2019). Out of sight out of mind: Why less well off and middle aged men don't get the support they need https://media.samaritans.org/documents/Lived_experience_report_FINAL.pdf
10. Williamson, V., Greenberg, N., & Stevelink, S. A. (2019). Perceived stigma and barriers to care in UK Armed Forces personnel and veterans with and without probable mental disorders. BMC psychology, 7(1), 75.
11. Whittle, E. L., Fisher, K. R., Reppermund, S., Lenroot, R., & Trollor, J. (2018). Barriers and enablers to accessing mental health services for people with intellectual disability: a scoping review. Journal of Mental Health Research in Intellectual Disabilities, 11(1), 69-102.
12. Knight, B. G., & Winterbotham, S. (2020). Rural and urban older adults' perceptions of mental health services accessibility. Aging & mental health, 24(6), 978-984.
13. Welsh Government and Partners (2015) Mental Health Crisis Care Concordat https://gov.wales/sites/default/files/publications/2019-03/mental-health-crisis-care-concordat.pdf
14. Wales Crisis Care Concordat National Action Plan 2019 – 2022 https://gov.wales/sites/default/files/publications/2019-10/wales-crisis-care-concordat-national-action-plan-2019-2022.pdf#:~:text=Wales%20Crisis%20Care%20Concordat%20National%20Action%20Plan%202019,are%20most%20involved%20in%20responding%20to%20and%20supporting
15. https://www.marketscreener.com/quote/stock/BT-GROUP-PLC-4003616/news/BT-58-of-999-calls-made-in-Wales-are-from-mobiles-according-to-new-surv--29178429/
16. Healthcare Safety Investigation Branch. Investigation into the provision of mental health care to patients presenting at the emergency department. 12017/006. Farnborough: Healthcare Safety Investigation Branch, 2018.
17. Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services. Policing and Mental Health. Picking Up the Pieces. London : Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services, 2018. p. 3

18. Walley,P. & Jennison-Phillips, A. (2020) A Study of Non-Urgent Demand to Identify Opportunities for Demand Reduction. Policing: A Journal of Policy and Practice, 14 (2), 542–554, https://doi.org/10.1093/police/pay034
19. NHS Providers. Addressing the Care Deficit. Mental Health Services. [Online] NHS Providers, March 2019. https://nhsproviders.org/mental-health-services-addressing-the-care-deficit
20. https://www.nao.org.uk/successful-commissioning/introduction/what-are-civil-society-organisations-and-their-benefits-for-commissioners/
21. http://www.mentalhealthwales.net/voluntary-sector/#:~:text=The%20Wales%20Alliance%20for%20Mental%20 Health%20provides %20the,of%20sharing%20information%20on%20matters%20of%20mutual%20interest.
22. Joint Thematic Review of Community Mental Health Teams (2019) Health Inspectorate Wales/Care Inspectorate Wales
23. Newbigging K, Rees J, Ince R, et al. (2020) The contribution of the voluntary sector to mental health crisis care: a mixed-methods study. Southampton
24. http://www.cavamh.org.uk/directories/mental-health-directory/adult-mental-health-general-services/cardiff-and-vale-university-health-board-cardiff-vale-of-glamorgan/crisis-house#:~:text=The%20Crisis%20House%20is%20a%20jointly%20funded%20project,to%20provide%20a%20holistic%20approach%20to%20promoting%20recovery.
25. Tony & Nambiar-Greenwood, Gayatri & Haigh, Carol & Mills, Catherine. (2011). A service evaluation of a community-based mental health crisis house in inner city Liverpool. Mental Health Review Journal. 16. 56-63.
26. Greenfield TK, Stoneking BC, Humphreys K, Sundby E, Bond J. A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. Am J Community Psychol 200
27. https://www.jcpmh.info/commissioning-tools/cases-for-change/crisis/what-works/crisis-houses/
28. https://www.frontlinenetwork.org.uk/news-and-views/2018/01/wrexham-s-crisis-cafe/
29. http://www.wales.nhs.uk/sitesplus/862/news/51725
30. https://www.hafal.org/2020/08/new-late-night-mental-health-sanctuary-service-launched/
31. https://www.england.nhs.uk/mental-health/case-studies/aldershot/
32. NHS England (2019) NHS Mental Health Implementation Plan 2019/20 – 2023/2 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf
33. MIND (2012) Mental health crisis care: commissioning excellence A briefing for Clinical Commissioning Groups November 2012 https://www.mind.org.uk/media-a/4372/commissioningexcellence_web-version-2.pdf
34. https://media.samaritans.org/documents/SamaritansImpactReport2018_19_WEB_low_res.pdf
35. Centre for Mental Health (2020) Integrated Care Systems and mental health https://www.centreformentalhealth.org.uk/publications/briefing-55-integrated-care-systems-and-mental-health
36. Kings Fund (2016) Understanding pressures in general practice https://www.kingsfund.org.uk/publications/pressures-in-general-practice
37. Saini, P., McIntyre, J., Corcoran, R et al. (2020) Predictors of emergency department and GP use among patients with mental health conditions: a public health survey. British Journal of General Practice 70 (690)
38. Baird B, Charles A, Honeyman M, Maguire D, Das P (2016). Understanding pressures in general practice [online]. The King's Fund website. www.kingsfund.org.uk/publications/ pressures-in-general-practice
39. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012). 'Epidemiology of multimorbidity and implications for health care, research, and medical education: a crosssectional study'. The Lancet, vol 380, no 9836, pp 37–4
40. Mental health and primary care networks Understanding the opportunities (2020) Kings Fund https://www.kingsfund.org.uk/publications/mental-health-primary-care-networks

41. https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Mental-Health-Measure/Part-1/referralsforalpmhssassessment-by-lhb-month
42. https://www.mind.org.uk/about-us/mind-cymru/active-monitoring/
43. https://gov.wales/ps13m-support-package-mental-health-services-all-wales
44. http://www.cardiffandvaleuhb.wales.nhs.uk/primary-care-counselling-service
45. https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Mental-Health-Measure/Part-2/careandtreatmentplancompliance-by-lhb-service-month
46. https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/Referrals/referrals-by-treatmentfunction-month
47. Joint Thematic Review of Community Mental Health Teams (2019) Health Inspectorate Wales/Care Inspectorate Wales https://hiw.org.uk/sites/default/files/2019-06/190207joint-thematic-review-community-mental-health-en.pdf
48. Welsh Assembly Government (2005) Policy Implementation Guidance on the development of Crisis Resolution/Home Treatment (CR/HT) services in Wales. Welsh Health Circular WHC (2005) 048
49. https://www.bbc.co.uk/news/uk-wales-46640692
50. Chalk, D., Black, S., & Pitt, M. (2016). Which factors most influence demand for ambulances in South West England?. Journal of Paramedic Practice, 8(7), 356-367.
51. Duncan, E.A.S., Best, C., Dougall, N. et al. Epidemiology of emergency ambulance service calls related to mental health problems and self-harm: a national record linkage study. Scand J Trauma Resusc Emerg Med 27, 34 (2019). https://doi.org/10.1186/s13049-019-0611-9
52. Planning to Safely Reduce Avoidable Conveyance Ambulance Improvement Programme (2019) NHS England and NHS Improvement
53. https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Performance/Ambulance-Services/emergencyambulancecallsandresponsestoredcalls-by-lhb-month
54. Mills S., Whitehead & R. Amber Review. 2018. Cardiff
55. Irving A, O'Hara R, Johnson M, et al Pilot Evaluation Of Utilising Mental Health Nurses In The Management Of Ambulance Service Patients With Mental Health Problems Emergency Medicine Journal 2016;33:677.
56. https://www.england.nhs.uk/2020/03/mental-health-crisis-services-rolled-out-across-england/
57. https://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/08/NHS-111-and-Concordat-briefing-for-local-areas-FINAL.pdf
58. https://www.southernhealth.nhs.uk/about/news/news-archive/mental-health-support-now-available-24-7-via-nhs-111-helpline/
59. https://www.england.nhs.uk/integratedcare/case-studies/new-mental-health-111-service-reduces-ae-visits-by-a-third/
60. https://www.england.nhs.uk/south-east/wp-content/uploads/sites/45/2018/11/Mental-health-and-ED-pressures-case-studies-of-schemes.pdf
61. Dorning H., Davies A., Blunt I. Focus on: People with mental illness and hospital use. Exploring disparities in hosptial use for physical healthcare. London. : The Health Foundation., 2015.
62. Dorning, H., Davies, A. & Blunt, I. Summary: People with mental illness and hosptial use. QualityWatch. [Online] Nuttfield Trust, 24 October 2018. [Cited: 27 02 2020.] https://www.nuffieldtrust.org.uk/qualitywatch/summary-people-with-mental-ill health-and-hospital-use/
63. https://www.mentalhealthtoday.co.uk/number-of-people-going-to-ae-for-mental-health-problems-climbs-by-50
64. Barratt H, Rojas-García A, Clarke K, Moore A, Whittington C, Stockton S, et al. (2016) Epidemiology of Mental Health Attendances at Emergency Departments: Systematic Review and Meta-Analysis

65. The Royal College of Emergency Medicine (2017)Frequent Attenders in the Emergency Department
66. https://www.wedfan.org/#:~:text=WEDFAN%20-%20the%20%22Welsh%20Emergency%20Department%20Frequent%20Attenders,of%20Emergency%20Medicine%20Guidelines%20for%20frequent%20attender%20services
67. Joint Commissioning Panel for Mental Health (2013) liaison mental health services to acute hospital
68. https://www.dvsc.co.uk/single-post/2018/12/21/Wellbeing-News-25---Message-from-BCUHB-on-ICAN-Centres
69. http://www.wrexham.com/news/hundreds-of-people-in-crisis-supported-by-i-can-volunteers-at-wrexham-maelor-emergency-department-174416.html
70. Quality care for older people with urgent & emergency care needs (2012) Silver book
71. https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Detentions-under-Section-135-and-136-Mental-Health-Act/section135136detentions-by-lhb-age-gender-quarter
72. https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/ SainsburyCentre_briefing36_police_final_small.pdf
73. Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services. Policing and Mental Health. Picking Up the Pieces. London: Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services, 2018.
74. Boulton, L., McManus, M., Metcalfe, L., Brian, D., & Dawson, I. (2017). Calls for police service: Understanding the demand profile and the UK police response. The police journal, 90(1), 70-85.
75. Walley,P. & Jennison-Phillips, A. (2020) A Study of Non-Urgent Demand to Identify Opportunities for Demand Reduction. Policing: A Journal of Policy and Practice, 14 (2), 542–554, https://doi.org/10.1093/police/pay034
76. Walley,P. & Jennison-Phillips, A. (2020) A Study of Non-Urgent Demand to Identify Opportunities for Demand Reduction. Policing: A Journal of Policy and Practice, 14 (2), 542–554, https://doi.org/10.1093/police/pay034
77. Lister, S., Wincup, E., Seddon, T (2007) Street policing of problem drug users Joseph Rowntree Foundation
78. Seddon, T. (2009). A history of drugs: Drugs and freedom in the liberal age. Routledge.
79. Kane E, Evans E, Mitsch J, et al. Police interactions and interventions with suspects flagged as experiencing mental health problems. Crim Behav Ment Health. 2018;28(5):424-432. doi:10.1002/cbm.2078
80. North Wales Police (2017) RMS warning Markers Guidance v1.5 https://www.north-wales.police.uk/media/655588/2018-1048-warning-markers.pdf
81. Police effectiveness 2017 data- https://www.justiceinspectorates.gov.uk/hmicfrs/police-forces/data/peel-assessments/
82. Gwent Police and Crime Plan Annual Report 2018/2019 https://www.gwent.pcc.police.uk/fileadmin/Documents/Transparency/Publications/FINAL_Annual_Report_2018-19_ENGLISH.pdf
83. Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services. Policing and Mental Health. Picking Up the Pieces. London: Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services, 2018.
84. College of Policing analysis: Estimating demand on the police service 2015
85. Bather P, Fitzpatrick R, and Rutherford M, The police and mental health, Sainsbury Centre for Mental Health, 2018,
86. Public Health England (2016) Working Together - how health, social care and fire and rescue services can increase their reach, scale and impact through joint working
87. https://www.southwales-fire.gov.uk/your-safety-wellbeing/at-home/our-partners/
88. https://www.mawwfire.gov.uk/eng/youth-zone/phoenix-project/
89. Gov.uk. Male and Female populations-2011. Accessed on 29th September 2020. https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/male-and-female-populations/latest

90. Welsh Government StatsWales. Population estimates by local authority and age- mid-2019. Accessed on 21st September 2020. https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Estimates/Local-Authority/PopulationEstimates-by-LocalAuthority-Age
91. Mills S., Whitehead & R. Amber Review. 2018. Cardiff
92. Sands, N., Elsom, S. & Colgate, R. UK Mental Health Triage Scale Guidelines, UK Mental Health Triage Scale Project, Wales, 2015.
93. Mental Health Foundation. Mental health statistics: the most common mental health problems https://www.mentalhealth.org.uk/statistics/mental-health-statistics-most-common-mental-health-problems
94. National Institute of Care Excellence (2011) Depression in adults: Quality Standard https://www.nice.org.uk/guidance/qs8/resources/depression-in-adults-pdf-58302785221
95. Goldney, R. D., Dal Grande, E., Fisher, L. J., & Wilson, D. (2003). Population attributable risk of major depression for suicidal ideation in a random and representative community sample. Journal of affective disorders, 74(3), 267-272.
96. Singhal, A., Ross, J., Seminog, O., Hawton, K., & Goldacre, M. J. (2014). Risk of self-harm and suicide in people with specific psychiatric and physical disorders: comparisons between disorders using English national record linkage. Journal of the Royal Society of Medicine, 107(5), 194-204.
97. Dutton, D. G., & Karakanta, C. (2013). Depression as a risk marker for aggression: A critical review. Aggression and Violent Behavior, 18(2), 310-319
98. Public Health Wales (2015) Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population available at http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/ 7c21215d6d0c613e80 256 f490030c05a/d488a3852491bc1d80257f370038919e/$FILE/ACE%20Report%20FINAL%20(E).pdf
99. Mental Health Foundation (2015) Fundamental facts about mental health https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-15.pdf
100. https://www.ons.gov.uk/peoplepopulationandcommunity/ birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority
101. Office of National Statistics (2020) Personal wellbeing in the UK: April 2019 to March 2020 https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/april2019tomarch2020
102. Linsley, K. R., Johnson, N., & Martin, J. (2007). Police contact within 3 months of suicide and associated health service contact. The British journal of psychiatry: the journal of mental science, 190, 170–171. https://doi.org/10.1192/bjp.bp.106.021857
103. Walton, D., Li, J., Barnes, S., & Newcombe, R. (2017). Does prior contact with police reduce the likelihood of suicide? Examining the predictive ability of different incident types and the interaction effects. International journal of police science & management, 19(3), 148-158.
104. Samaritans (2012) Men, suicide and society https://media.samaritans.org/documents/Samaritans_MenSuicideSociety_ResearchReport2012.pdf
105. College of Policing (2020) Suicide and bereavement response https://www.app.college.police.uk/app-content/mental-health/suicide-and-bereavement-response/
106. Marzano, L., Smith, M., Long, M., Kisby, C., & Hawton, K. (2016). Police and suicide prevention. Crisis.
107. National Institute of Health and Care Excellence (2013) Self Harm: Quality Standard https://www.nice.org.uk/guidance/qs34/resources/selfharm-2098606243525
108. Institute of Alcohol Studies (2015) Alcohol's impact on emergency services http://www.ias.org.uk/uploads/Alcohols_impact_on_emergency_services_full_report.pdf
109. https://gov.wales/sites/default/files/statistics-and-research/2019-10/alcohol-consumption-national-survey-wales-april-2016-march-2019-646.pdf
110. https://www.streetpastors.org/our-network/united-kingdom/wales/
111. http://cardiffandvaleapb.org/download/EDARA_Aug2016_newsletter.pdf

112. Carver F & Jones F (2013). Common Mental Health Conditions in Primary Care. Scottish Universities Medical Journal Vol 2 Issue 2: page 13-19 available at http://sumj.dundee.ac.uk/data/uploads/volume2issue2/sumjv2i2p.13-19.pdf
113. Mental Health foundation (2016) Relationships in the 21st Century
114. Wolpert, M., & Martin, P. (2015). THRIVE and PbR: Emerging thinking on a new organisational and payment system for CAMHS. New Savoy Partnership Conference, London
115. Teo, A.R., Choi, H.J., & Valenstein, M. (2013). Social Relationships and Depression: Ten-Year Follow-Up from a Nationally Representative Study. PLOS One, 8(4).
116. Santini, Z.I., Koyanagi, A., Tyrovolas, S., & Haro, J.M. (2015). The association of relationship quality and social networks with depression, anxiety, and suicidal ideation among older married adults: Findings from a cross-sectional analysis of the Irish Longitudinal Study on Ageing (TILDA). Journal of Affective Disorders, 179, 134–141
117. Home Office (2019) Drugs Misuse: Findings from the 2018/19 Crime Survey for England and Wales available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832533/drug-misuse-2019-hosb211
118. https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Substance-Misuse/summary-of-quarterly-activity
119. Office National Statistics (2019) Deaths related to drug poisoning in England and Wales https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations
120. Mann, F., Bone, J.K., Lloyd-Evans, B. et al. A life less lonely: the state of the art in interventions to reduce loneliness in people with mental health problems. Soc Psychiatry Psychiatr Epidemiol 52, 627–638 (2017).
121. Mushtaq R, Shoib S, Shah T, Mushtaq S. Relationship between loneliness, psychiatric disorders and physical health ? A review on the psychological aspects of loneliness. J Clin Diagn Res. 2014;8(9)
122. Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: a meta-analytic review. Perspectives on psychological science, 10(2), 227-237.
123. https://www.ageuk.org.uk/our-impact/policy-research/loneliness-research-and-resources/loneliness-depression-and-anxiety-exploring-the-connection-to-mental-health/
124. Mahase, E. (2019) Women who experience domestic abuse are three times as likely to develop mental illness BMJ 2019; 365 :l4126
125. Trevillion, K., Oram, S., Feder, G., & Howard, L.M. (2012). Experiences of domestic violence and mental disorders: A systematic review and meta-analysis.
126. Gilbert, R., Kemp, A., Thoburn, J., Sidebotham, P., Radford, L., Glaser, D., & MacMillan, H. (2009). Recognising and responding to child maltreatment. The Lancet, 373(9658), 167–180.
127. Safelives (2019) Safe and Well: Mental health and domestic abuse https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf
128. Mental Health Foundation (2016) Mental Health in Wales: Fundamental Facts 2016 https://www.mentalhealth.org.uk/sites/default/files/FF16%20Wales.pdf
129. NHS Confedertaion (2016)What the evidence tells us about improving urgent care for older people: A literature review to support the independent Commission on Improving Urgent Care for Older People
130. Cooper, C., Selwood, A., Livingston, G. (2008) The prevalence of elder abuse and neglect: a systematic review, Age and Ageing, Volume 37, Issue 2
131. Samaritans (2019) Impact report 2018-19 https://media.samaritans.org/documents/SamaritansImpactReport2018_19_WEB_low_res.pdf
132. Dackehag, M., Ellegård, L. M., Gerdtham, U. G., & Nilsson, T. (2019). Debt and mental health: new insights about the relationship and the importance of the measure of mental health. European journal of public health, 29(3), 488–493. https://doi.org/10.1093/eurpub/ckz002

133. Dzator, J. (2013). Hard times and common mental health disorders in developing countries: insights from urban Ghana. The journalofbehavioralhealthservices&research,40(1),71–87
134. Andersen, I., Thielen, K., Nygaard, E., & Diderichsen, F. (2009). Social inequality in the prevalence of depressive disorders. Journal of epidemiology and community health, 63(7), 575–581
135. Wang, J. L., Schmitz, N., & Dewa, C. S. (2010). Socioeconomic status and the risk of major depression: the Canadian National Population Health Survey. Journal of epidemiology and community health, 64(5), 447–45
136. Qin, P., Agerbo, E., & Mortensen, P. B. (2003). Suicide risk in relation to socioeconomic, demographic, psychiatric, and familial factors: a national register-based study of all suicides in Denmark, 1981–1997. American Journal of Psychiatry, 160(4), 765–772
137. Mind the Income Gap (2020) The Money and Mental Health Policy Institute
138. McManus S et al (eds.) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. NHS Digital. 2016.
139. The Royal College of Psychiatrists and the Money Advice Trust (2011 Debt collection and mental health: the evidence report available at https://malg.org.uk/wp-content/uploads/2017/03/Debt-Collection-and-Mental-Health-TheEvidence-Report.pdf#:~:text=The%20Royal%20College%20of%20Psychiatrists%20and%20the%20Money,who%20says%20they%20have%20a%20mental%20health%20problem.
140. https://www.mentalhealth.org.uk/a-to-z/h/housing-and-mental-health
141. https://england.shelter.org.uk/professional_resources/housing_and_mental_health
142. https://www.health.org.uk/infographic/how-does-housing-influence-our-health
143. Office of the Deputy Prime Minister (2004) Mental health and social exclusion https://www.centreformentalhealth.org.uk/sites/default/files/mental_health_and_social_exclusion.pdf
144. Mental Health Network- (2011) Housing and Mental Health, NHS Confederation
145. Ross-Houle, K. et al (2017) An exploration of the role of alcohol in relation to living situation and significant life events for the homeless population in Merseyside, UK available at https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/FinalReport_0140.pdf?mtime=20181110131547&focal=none
146. Fox, A. M., Mulvey, P., Katz, C. M. and Shafer, M. S. (2016) 'Untangling the relationship between mental health and homelessness among a sample of arrestees', Crime and Delinquency, 65, 5, 592–613.
147. Dahlgren, G. and Whitehead, M. (1991) Policies and Strategies to Promote Social Equity in Health, Stockholm: Institute for Futures Studies.
148. MacKie, P., Thomas, I. and Bibbings, J. (2017) 'Homelessness prevention: reflecting on a year of pioneering Welsh legislation in practice', European Journal of Homelessness, 11, 1, 81–107
149. Rogers, M., Ahmed, A., Madoc-Jones, I., Gibbons, A., Jones, K., & Wilding, M. (2020). Interrogating the Prevention Approach of the Housing (Wales) Act 2014 for People with Mental Health Needs Who Are Homeless. Social Policy and Society, 19(1), 109–120. doi:10.1017/S1474746419000319
150. https://www.who.int/mental_health/in_the_workplace/ en/#:~:text=Harassment%20and%20bullying%20at%20work%20are%20commonly%20reported,the%20workplace%3B%20such%20actions%20may%20also%20benefit%20productivity.
151. Magnusson, L., Nyberg, A., Mittendorfer-Rutz, E,. Bondestam, F., Madsen, I.(2020) Work related sexual harassment and risk of suicide and suicide attempts: prospective cohort study BMJ 2020; 370 :m2984
152. https://www.anti-bullyingalliance.org.uk/tools-information/all-about-bullying/mental-health
153. Kim Y, & Leventhal B. (2008) International Journal of Adolescent Medicine and Health, 20(2), pp.133-154.
154. Almasi, K., Belso, N., Kapur, N., Webb, R., Cooper, J., Hadley, S., ... & Appleby, L. (2009). Risk factors for suicide in Hungary: a case-control study. BMC psychiatry, 9(1), 45
155. Amoran, O. E., Lawoyin, T. O., & Oni, O. O. (2005). Risk factors associated with mental illness in Oyo State, Nigeria: A Community based study. Annals of general psychiatry, 4(1), 19.
156. Andersen, I., Thielen, K., Nygaard, E., & Diderichsen, F. (2009). Social inequality in the prevalence of depressive disorders. Journal of epidemiology and community health, 63(7), 575–581

157. Corcoran, P ., & Arensman, E. (2011) Suicide and employment status during Ireland's Celtic Tiger economy. European Journal ofPublicHealth,21,209-214
158. Mind the Income Gap (2020) The Money and Mental Health Policy Institute
159. Wilhelm, K & Kovess, V & Rios-Seidel, C & Finch, A. (2004). Work and mental health. Social psychiatry and psychiatric epidemiology. 39. 866-73. 10.1007/s00127-004-0869-7.
160. Roberts SE, Jaremin B, Lloyd K. High-risk occupations for suicide. Psychol Med. 2013 Jun;43(6):1231-40. doi: 10.1017/S0033291712002024. Epub 2012 Oct 26. PMID: 23098158; PMCID: PMC3642721.
161. Wright B, Garside M, Allgar V, Hodkinson R, Thorpe H. (2020) A large population-based study of the mental health and wellbeing of children and young people in the North of England. Clinical Child Psychology and Psychiatry.
162. Childrens Commissioner for England (2019) The characteristics of gang-associated children and young people available at https://www.childrenscommissioner.gov.uk/wp-content/uploads/2019/02/CCO-Characteristics-of-Gang-Associated-Children-and-Young-People1.1.pdf
163. https://youngminds.org.uk/find-help/for-parents/parents-guide-to-support-a-z/parents-guide-to-support-gender-identity-issues/
164. The Lancet Public Health (2020) Transgender health, identity, and dignity Volume 5, ISSUE 4, e177, April 01, 2020
165. https://headspace.org.au/assets/Uploads/Resource-library/Young-people/Gender-identity-and-mental-health-web.pdf
166. Stonewall (2018) LGBT in Britain-Health Report https://www.stonewall.org.uk/lgbt-britain-health
167. Paton, F., Wright, K., Ayre, N., Dare, C., Johnson, S., Lloyd-Evans, B., Simpson, A., Webber, M. and Meader, N. (2016). Improving outcomes for people in mental health crisis: a rapid synthesis of the evidence for available models of care. Health Technologyl Assessment, 20(3),
168. Sands, N. Elsom, E, Colgate, R & Haylor, H. (2016) Development and inter-rater reliability of the UK Mental Health Triage Scale (In Press). International Journal of Mental Health Nursing

NATIONAL COLLABORATIVE
COMMISSIONING UNIT

UNIT 1 CHARNWOOD COURT
HEOL BILLINGSLEY
PARC NANTGARW
TREFOREST
CF15 7QZ

GIG.NCCU@WALES.NHS.UK
01443 744928

AGENDA ITEM
4.7

MENTAL HEALTH ACT MONITORING COMMITTEE

111 PERFORMANCE
(4th April 2023 - 12 May 2023)

Date of meeting	(07/06/23)
FOI Status	Open/Public
If closed, please indicate reason	Not Applicable - Public Report
Prepared by	Aaron Jones (Interim Clinical Service Group Manager, Mental Health, Rhondda & Taf Ely)
Presented by	Aaron Jones (Interim Clinical Service Group Manager, Mental Health, Rhondda & Taf Ely)
Approving Executive Sponsor	Executive Director of Operations
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
		NOTED

ACRONYMS	
111#2	111 press 2 telephone advice and support line
CTMUHB	Cwm Taff Morgannwg University Health Board
CMHT	Community Mental Health Team

GP	General Practitioner
MHA	Mental Health Act
CRHT	Crisis Home Treatment Team
LPMHSS	Local Primary Care Mental Health Support Services
SPOA	Singlet Point of Access

1. SITUATION/BACKGROUND

1.1 The purpose of this paper is to present performance data for the 111#2 telephone-based advice and support service in Cwm Taff Morgannwg University Health Board.

1.2 111#2 telephone-based advice and support line that will provide guidance for persons of all ages who are experiencing a mental health need. The National Mental Health 111#2 service has the aims of improving the health and wellbeing of people with an urgent mental health concern via a single point of contact to ensure people will receive the right help at the right time. The service will reduce barriers to accessing support and provide mental health care at the front door which is a well document challenge nationally.

1.3 In May 2019 the Welsh Government, through the National Crisis Care Concordat Group, commissioned the Director of Quality & Mental Health/Learning Disabilities at the NHS Wales National Collaborative Commissioning Unit to undertake a National Review to achieve greater understanding of the issues leading the public to access emergency services when experiencing mental health and/or welfare concerns. In October 2020 the 'Beyond the call' National Review was published by Welsh Government (**Appendix 1**).

1.4 Some of the findings of the publication were: -

- An increasing number of people with mental health needs do not fit into a clear referral pathway.
- People receiving care from CMHTs did not always know who to contact when in crisis 'out of hours'.
- In Wales the NHS 111 service was not currently designed to provide specialised mental health support.

1.5 Expected Outcomes of 111#2: -

- Improved Patient Experience / Patient Centred Approach
  - No wrong door – When a person contacts CTMUHB 111#2 MH Service they will receive an inclusive response.
  - Right Help, Right Time – Working towards a 24/7 approach.
  - Reducing Duplication – Users of CTMUHB Mental Health Service should not have to repeat their story. The person completing referrals will be a trusted assessor, therefore further assessments should only be additive to the patients care.
- Correct care for CTMUHB 111#2 Mental Health users
  - CTMUHBs 111 Contact First Centre is not skilled to deal with calls categorised as Mental Health, meaning the majority of MH categorized calls are referred to MH Crisis Teams, Hospital Emergency departments or GP Out of Hours teams. The CTMUHB 111#2 MH service will be able to provide information and advice, signpost to other organisations or arrange a 'warm' handover to a specialist mental health team. This would mean the caller would not need to repeat their story.

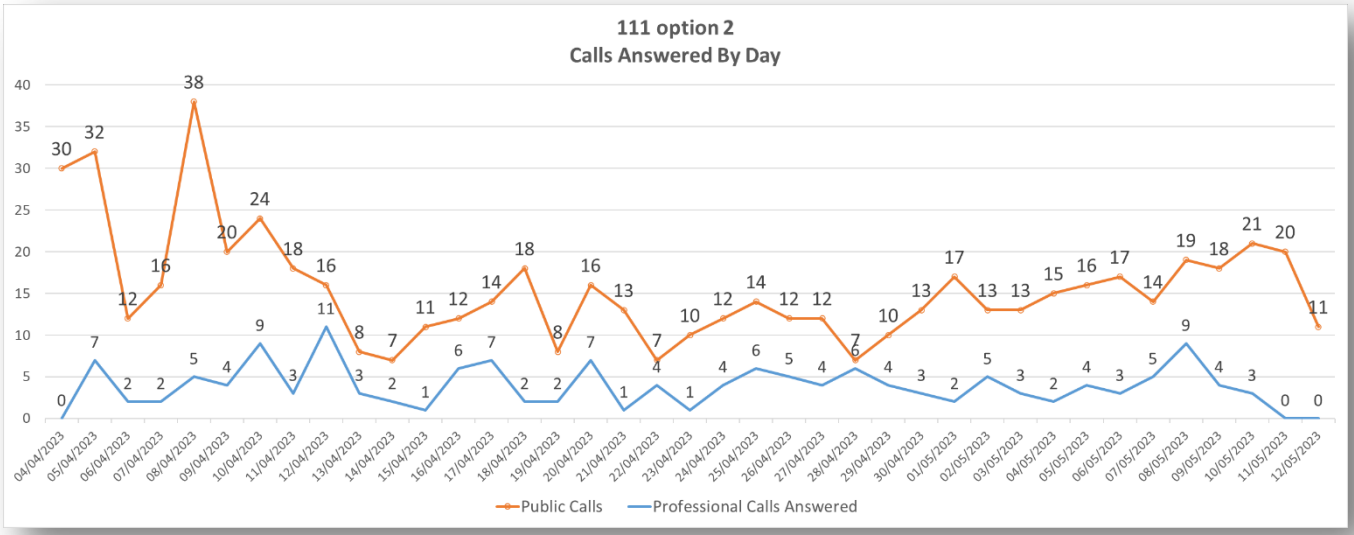
1.6 The CTMUHB 111#2 public and Police contact lines went live with a 15-hour service on 4th April 2023 08.30am to 00.30am increasing to a 24-hour service from 25th April 2023.

1.7 This report presents the 111#2 performance data to the MHA Monitoring Committee for the period since go live **4th April 2023 to 12th May 2023**.

2. SPECIFIC MATTERS FOR NOTING OR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Summary Call Activity

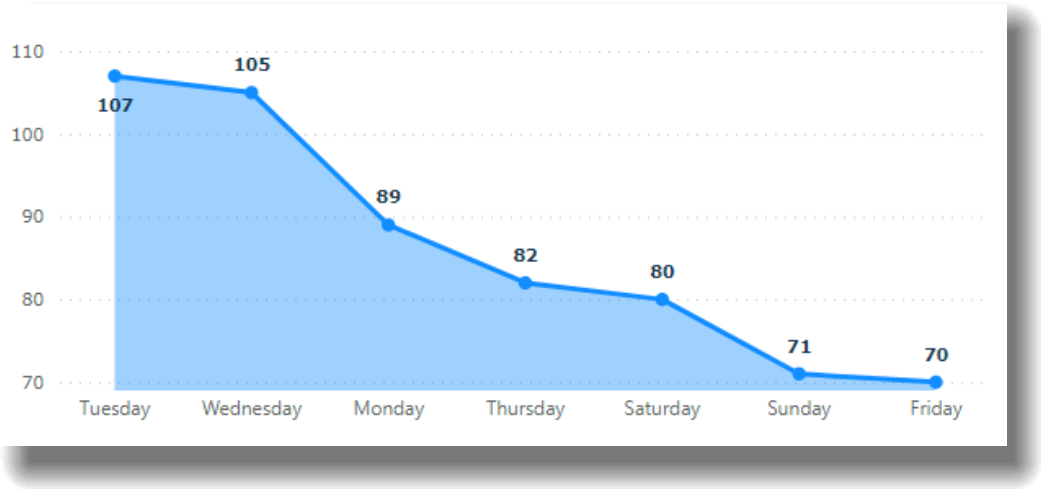
For the period 4th April 2023 to 12th May 2023 the CTMUHB 111#2 service answered a total of **604** Public calls and **151** police support calls. Giving a total of **755** calls answered.



The mean calls answered per day for the period 4th April 2023 to 12th May 2023 are

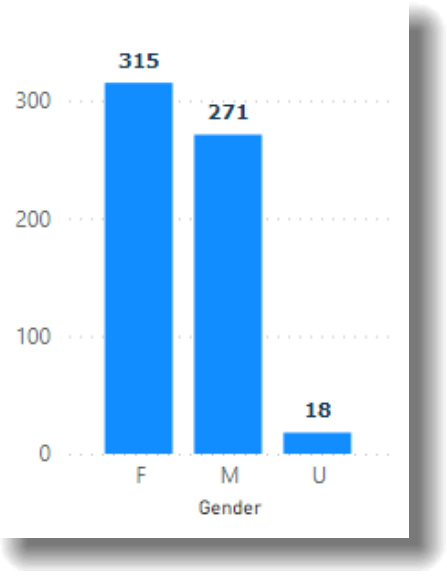
111#2 Line	Mean Calls Per Day
Public	15.5
Police	4.5

Public call activity by weekday for the for the period 4th April 2023 to 12th May 2023 shows that Tuesday is the most active day followed by a Wednesday, Friday being the least active.

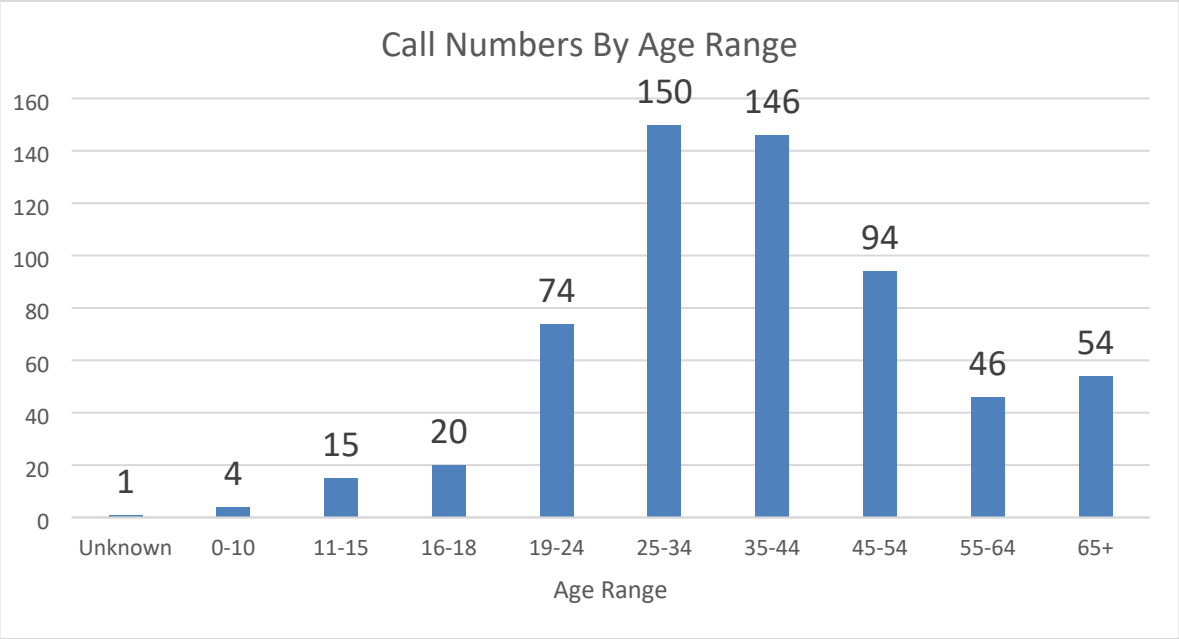


2.2 Summary Demographic Data

Of the 604 public calls answered 271 were recorded as a Male and 315 as Female, there was 18 that are classified as unknown.



For the period 4th April 2023 to 12th May 2023 the CTMUHB 111#2 the average age of caller was **40 years old**. For the 604 Public calls during this period the following chart gives you a breakdown of the activity by age band. The highest activity age band was ages 25-34 and the least activity age band was age band 0-10.



For the 604 Public calls during this period, post codes were captured, where possible, based on this data the area with the highest amount of activity to 111#2 is **Bridgend** followed by **Merthyr Tydfil**. The below is the top 10 areas by activity which accounts for 85% of the total activity.

Area	Public Call Numbers
Bridgend	257
Merthyr Tydfil	51
Mid Glamorgan	42
Rhondda Cynon Taf	34
Pontypridd	32
Aberdare	28
Maesteg	25
Treorchy	17
Pontyclun	16
Porthcawl	9

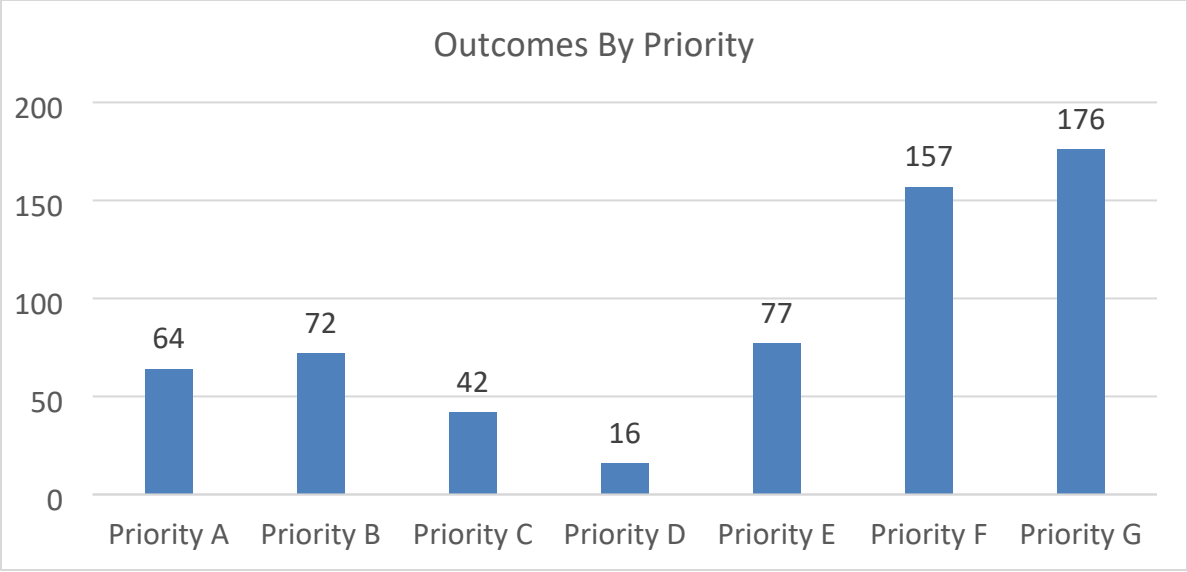
2.3 Summary of Outcomes

Where possible callers are asked to scale themselves on the subjective unit of distress scale (Suds) (**Appendix 2**) pre-111#2 triage and post 111#2 triage to benchmark and evaluate the progress made within the 111#2 call. The Sud rating range is from 0 (zero) meaning peace, serenity, total relief to 10 (ten) feeling unbearable bad.

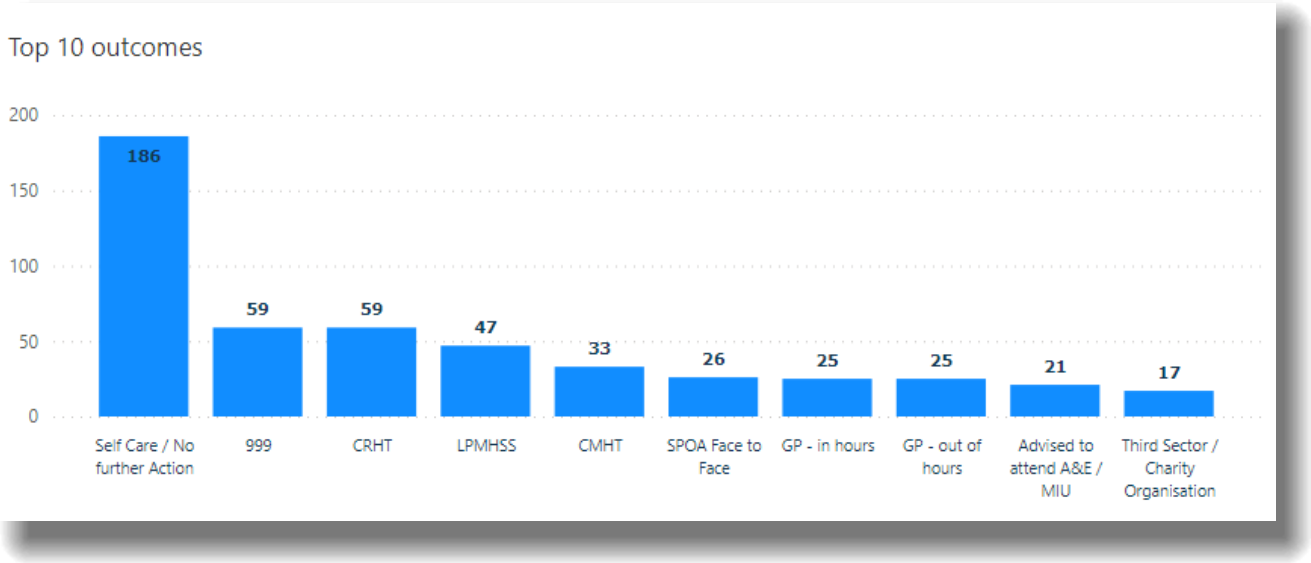
For the period 4th April 2023 to 12th May 2023 there was 327 recordings of the SUD score pre and post triage, with a range from a high of 10 to a low of 2. The average Sud score pre-triage was **5.6** compared with a post-triage Sud score of **4.3**.

The Mental Health Triage scale (**Appendix 3**) is the process of initial assessment that occurs at point of entry to the Mental Health Service. It is a clinical function in which a mental health screening assessment is undertaken to determine whether the person has a mental health related problem, the urgency of the problem, and the most appropriate service response. The triage scales are categorised from Priority A (emergency) through to Priority G (Advice, consultation, information).

For the period 4th April 2023 to 12th May 2023 the CTMUHB 111#2 triaged 604 public calls. The highest triage outcome for this period was priority G (Advice, consultation, information) with 176 outcomes followed by priority F (referral or advice to contact alternative provider) with 157 outcomes. The lowest being Priority D with 16 (Within 72 Hours semi-urgent mental health response.



Further outcome analysis of the 604 triaged public calls to CTMUHB 111#2 shows that the most popular outcome with **186** was **self-care / no further action**. Followed by 999 and Crisis Home Treatment referral with **59** outcomes each. The below chart provides analysis of the top 10 outcomes for CTMUHB 111#2 for the period 4th April 2023 to 12th May 2023.



3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Demand forecasting for 111#2 services across Wales was led by the National 111#2 programme team. The CTM UHB 111#2 staffing model was based on a forecasted demand of 40 calls per day. Current activity of the Public and Police support lines is on average 20 calls per day but has reported a high of 43 calls on one occasion for the period. This activity level when compared with cohort 1 rollout organisations is higher for a similar period whilst the service is still not being advertised nationally. Close monitoring of activity metrics will ensure we are able to respond in a timely manor both locally and nationally to ensure the service being offered does not deteriorate to a point that could deter use of the 111#2 service.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The MHA Monitoring Committee is asked to:

- **DISCUSS** & **NOTE** the report

Appendix 1 – Beyond the Call Nation Review

4.7.1 Beyond the Call national Review

Appendix 2 – Suds Scale

4.7.2 SUDS Scale.pdf

Appendix 3 – Mental Health Triage Scale

4.7.3 UK Mental Health Triage Scale.

MENTAL HEALTH ACT – FORWARD WORK PLAN 2023				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Agreed at Agenda Planning Session for March meeting. Deferred to June meeting.	Deferred Item	Organisational Structure for the New Mental Health Care Group Operating Model	Director of Primary, Community & Mental Health	7 June 2023
Agreed at Agenda Planning Session for March meeting. Deferred to June meeting	Additional Item	Amendment to the Standing Orders – Proposed Revision to the Terms of Reference (Membership – Care Groups Reference)	Director of Governance	7 June 2023
Requested via Email from SWP	Additional Item	111 Professionals Line/Performance Monitoring	SWP/Aaron Jones	7 June 2023
Requested via agenda planning from the Chair	Additional Item to be added as a substantive item moving forward	Case Example to Highlight the Use of the MHA and Outcome	Ana Llewellyn	7 June 2023
Action following the October 2022 meeting to receive a report from the Care Group on the review of breaches	Additional Item	Outcome from Review of Breaches from the previous two years in relation to themes and trends	Primary Care, Community & Mental Health Care Group	6 September 2023

Completed Activity from the Forward Work Programme

MENTAL HEALTH ACT – FORWARD WORK PLAN				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Action following the December 2022 meeting.	Additional Item	Update on the Place of Safety Room at Prince Charles Hospital to be included in the Operational Group Report	Chair, Operational Group	8 March 2023 - **Completed**
Action from the December 2022 meeting.	Additional Item	Further update on Fundamental Breaches to be brought back to the March 23 meeting within the Quarterly Activity Report/Breaches/Analysis of Unlawful Detentions	Chair, Operational Group	8 March 2023 – **Completed**
Action following the October 2022 meeting to review the number of IM's to be quorate.	Additional Item	Amendment to the Standing Orders – Schedule 2 – MHAMC Terms of Reference	Director of Governance	7 December 2022 – **Completed**
Request made by DPCMH at agenda planning meeting 2.8.22 to be added to the agenda for six months' time.	Additional Item	CAMHS – HIW Report and Update on Action Plan.	Chair/Clinical Lead Operational Group	7 December 2022 – **Completed**
Request made by the Committee at its meeting held in October 2022 for a written report.	Additional Item	Use of the MHA for patients with a Learning Disability – Activity and Compliance against Code of Practice	Chair/Clinical Lead Operational Group	7 December 2022 – **Completed** Update provided within the Operational Group Report**.**

Originally on forward work programme for March 2022 deferred to October 22	Additional Item	SWP Update on the Use of the Mental Health APP	South Wales Police	A verbal update was provided at the 12 October 2022 meeting - **Completed**
Request made by Committee at November 2021 meeting to receive further written reports to future meetings on the Mental Health and Learning Disability aspect of the commissioned placements	Additional Item	Individually Commissioned Placements, NHS Use and Assurance	Director of Primary, Community & Mental Health	8 June 2022 - **Completed**
Originally requested at August 2021 meeting for November 2021.	Additional Item	Data on Section 135/136 from the 2019/2020 activity to review as an example of a more typical year.	Head of Nursing, MH	8 June 2022 - **Completed**
Committee advised at the March 2022 meeting that an In Committee meeting would be held in June 2022	Additional Item	Conclusion of the review into the Fundamental Breach of the MHA	Director of Primary, Community & Mental Health	8 June 2022 - **Completed**