

Eluned Morgan AS/MS
Y Gweinidog Iechyd Meddwl, Llesiant a'r Gymraeg
Minister for Mental Health, Wellbeing and Welsh Language

Kirsty Williams AS/MS
Y Gweinidog Addysg
Minister for Education



Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref

Lynne Neagle MS
Chair, Children, Young People and Education Committee
Welsh Parliament
Cardiff Bay
CF99 1NA

02 December 2020

Dear Lynne

Follow-up report on the Committee's report Mind over Matter – Two Years on

Thank you for the Committee's follow-up work on the Mind over Matter report which is timely with the appointment of the Minister for Mental Health, Well-being and the Welsh Language. The report provides the opportunity for a stocktake on progress, to highlight the key areas where we can best focus our attention until the end of this Senedd term.

We are pleased that the Committee has recognised the good work and progress that has been made and whilst there is more to be done, I think we can agree that much has been achieved over the last two years.

Whilst we have made progress, we recognise the concerns highlighted by the Committee about the pace of the progress on certain health related actions and the need to move to a whole system approach to support children and young people's mental health. Given the breadth of recommendations in the original Mind Over Matter report, we are sure that the Committee will understand that to make meaningful change it has been necessary to prioritise our approach to implementing the agreed recommendations. However, implementing the agreed Mind over Matter recommendations remains a key priority for this government and I hope the Committee will welcome the recent appointment of a dedicated Minister for Mental Health, Well-being and the Welsh Language. This appointment underlines our commitment to supporting the mental health of the nation and is intended to provide even more focus this important agenda. We agree that, now more than ever, our young people must be supported during these unprecedented times.

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400

Gohebiaeth.Eluned.Morgan@llyw.cymru
Correspondence.Eluned.Morgan@gov.wales
Gohebiaeth.Kirsty.Williams@llyw.cymru
Correspondence.Kirsty.Williams@gov.wales

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Whilst local health boards, local authorities and the third sector remain committed to providing the most appropriate support to children and young people during this time, it must be acknowledged that the whole system workforce remains under particular pressure in many areas due to the continuing Covid situation this year.

Reflecting the progress we have made to date on many of the Mind over Matter recommendations, particularly in our schools we have already agreed to review the membership and expand the scope of the Joint Ministerial Task and Finish Group on a Whole School Approach to Emotional Wellbeing and Mental Health (JMT&FG) which will become a 'Whole System' Ministerial Task & Finish Group to drive progress for the remainder of this Senedd term. Whilst the focus will remain around school age children, the whole system approach will better reflect the current work of the group and enable it to provide leadership and expand across the additional relevant areas. In particular, it will ensure the health and social services led actions are integrated with, and benefit from, the structured administrative and programme support that has been focussed around the Whole School Approach to date. The first meeting will be scheduled before Christmas and will meet more frequently in the new year to ensure that we keep momentum on the pace of delivery.

The extended Together for Children and Young People (T4CYP2) programme will continue to report its workstreams into both the newly focussed JMT&FG for the Whole System Approach and the Outcomes for Children Ministerial Advisory Group. This arrangement maintains and strengthens the links across Welsh Government policy whilst providing transparency and visibility to the progress of improvement for health, education, local authority and third sector stakeholders. The Committee will be receiving a direct response from the T4CYP programme which will outline the detail of agreed milestones for workstreams within its programme. We have also provided a high level summary of relevant T4CYP information under the various areas in the detailed annex.

We share the Committee's concern about the impact of the pandemic and the restrictions on the emotional mental health and well-being of children and young people. Officials are closely monitoring a range of surveys and information and we already know that children and young people have been disproportionately affected by the pandemic, and some of the increased anxiety experienced in the adult population is linked to worries about children - both their health and education. In response, we have recently revised our [Together for Mental Health Delivery Plan 2019-2022](#) to support the changing mental health needs as result of Covid-19. The revised plan reaffirms our commitment to prioritise the mental health and well-being of children and young people and we have accelerated a number of actions, including expanding tier 0 and schools counselling to help do this. On 9 October the Minister for Mental Health, Well-being and Welsh Language published a [written statement](#) which sets this work out in more detail.

We have also continued to position all age mental health services as 'essential services' as part of the NHS Operating Framework during the pandemic. This makes it very clear that whilst delivery models have needed to change, we expect services to be open and accessible. This includes access to crisis care, CAMHS support and immediate improvements needed to improve access to Tier 4 support when it is needed. Our action to do this is set out in our direct responses to the Committee and suggested next steps, which is attached at Annex A.

The prevention of suicide and self-harm remain a priority for us both and we are taking a number of actions to support this. This is underpinned by our *Talk to me 2* Suicide and Self - Harm Strategy and the work now underway through the National Coordinator on Suicide and Self Harm.

The Committee will also be aware that we commissioned the NHS Delivery Unit to work with Public Health Wales and Professor Ann John to review deaths by probable suicide and incidents of self-harm between 2015-2020 in young people up to 25 years. This was directly in response to concerns about the potential impact of Covid and the restrictions on young people. We shared previously with the Committee the findings from the review and we have committed to continue more focused surveillance during this period. We are also working with the police and the coroners to look at opportunities to improve data sharing and we will update the Committee on this work in due course.

It is important to understand that any potential increase in the number of young suicides may not be apparent until a formal trend analysis is undertaken in the medium term when data becomes available. To what degree Covid-19 is a contributory or key factor to any potential increase in number, will be a complex conclusion to reach. However, it is well evidenced that quarantine, local and national lockdowns, and social isolation more generally will have created an increase in risk factors and a decrease in protective factors. Alongside continued economic uncertainty we understand we must do everything possible to prevent an increased risk of young suicide.

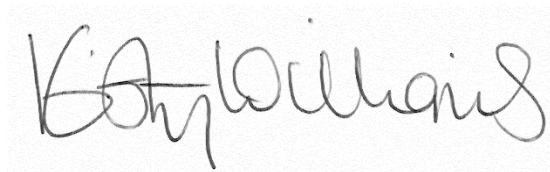
Prevention and the ability to intervene early is of course absolutely key. This is why we have significantly strengthened the Tier 0/1 support services alongside a range of regional approaches to reduce suicide and self-harm including bereavement support, training and awareness raising.

In addition to the Welsh Government guidance "Responding to issues of self-harm and thoughts of suicide in young people" published in September 2019 and alongside broader mental health funding, we have also committed an additional £500,000 per annum to tackle suicide and self-harm. This includes funding four new posts to drive forward this work and co-ordinate the multiple agencies with a role to play in this agenda. The new National Suicide Prevention Co-ordinator, supported by three Regional Co-ordinators, is joining up approaches and leading the development and implementation of new actions to prevent suicide and self-harm.

Yours sincerely,



Eluned Morgan AS/MS
Y Gweinidog Iechyd Meddwl, Llesiant
a'r Gymraeg
Minister for Mental Health, Wellbeing
and Welsh Language



Kirsty Williams AS/MS
Y Gweinidog Addysg
Minister for Education

Response to Committee's *What Happens next*

The Committee says:

*The Welsh Government must monitor the **whole-school approach guidance's** implementation and report to this Committee before the end of this Senedd.*

*Furthermore, **professional learning** – both in terms of initial teacher education and continuous professional learning – is a crucial foundation for the whole school approach guidance, and must be an area of priority for the work of the Task and Finish Group.*

*We will be scrutinising the **Curriculum and Assessment (Wales) Bill** during winter 2020 and spring 2021. We will explore the extent to which provision for the emotional and mental health of children and young people is made in the new curriculum, and will make our recommendations after considering all evidence available to us.*

*Significant progress has been made by the education sector to deliver our recommendations, but schools cannot do this alone. The whole-school approach must form part of a **wider whole-system approach**, and we think that more focus is now needed on delivering that in other sectors such as health and local government*

(Page 25)

Our response

We intend to publish the final version of the framework early in 2021 and are also considering what further work and support is needed to help schools, local authorities and other partners to effectively implement the framework. This includes how best to ensure monitoring and evaluation of our work locally by schools.

Supporting implementation of the framework, we have agreed to fund implementation leads, who will be embedded within the Public Health Wales Welsh Network of Healthy School Schemes. The leads will work with schools, local authorities and other partners to ensure consistent adherence to the guidance.

We are also considering the wider governance and accountability arrangements for the framework following the considerable comments received during the consultation and will include detail in the final published guidance. However, in line with the Committee's request we would be pleased to report activity to the Committee before the end of the current Senedd.

In relation to professional learning, the recent update to our National Mission action plan sets out the next steps in Wales' reform journey, ahead of the introduction of the new Curriculum for Wales in 2022. The plan highlights the progress following the first iteration of the action plan in 2017. Key achievements highlighted include the record investment in teachers' professional learning. Since 2018, this £31 million investment, awarded directly to schools, has allowed time and space for practitioners to work together across schools to prepare for the new curriculum. This funding can be used flexibly to allow schools to work together in ways that suit their own circumstances. The funding will continue during 20/21. A collection of [school focused case studies](#) on Hwb demonstrate a range of innovative approaches to maximise enhanced professional learning funding.

Significant returns on this investment include a broad range of professional learning developments including developing research, pedagogy and coaching, developing a professional learning vision and supporting development of aspiring leaders, with practitioners working within their own school and across their cluster. We have made and will continue to make significant investments in digital learning resources to support teachers' in their professional learning journey. We are already building on the successful resources on Hwb to provide high-quality blended and remote learning experiences. We are also working with HEI partners to develop a range of resources for all schools focused on Health and Well Being and Enquiry and Reflection. These resources will be made available via Hwb in due course.

We are working with HEI partners across Wales to significantly upscale our National Professional Enquiry Programme (NPEP). During 20/21, over 300 schools will be developing as professional enquirers, focusing on a range of continuity of learning themes including a range of 'Inclusion' focused enquiries linked to 'health and well-being' and 'vulnerable learners'. Enquiry outputs will continue to feed into the wider Curriculum for Wales Professional Learning Programme delivered by regional consortia. We continue to build upon these strong professional learning foundations as we move closer towards 2022.

In parallel with the revised National Mission action plan, we also published a document setting out shared expectations of what curriculum realisation means for practitioners and schools from 2022. Our evolving approach to professional learning will closely align to our shared expectations for curriculum realisation. Specifically, where the guidance implies or requires a change to practice, we will support this change by investing in appropriate professional learning. The two go hand in hand.

You will be aware from your attendance at previous Task and Finish Group meetings that we have commissioned Welsh Universities to develop a range of professional learning modules in this field. Originally planned for completion earlier in the year, the Covid19 pandemic delayed work, which is now due to be finalised before the end of 2020. Following finalisation of the modules all Initial Teacher Education partnerships will offer them to students as enrichment modules. They will also be made available to the existing workforce for use as part of their ongoing Professional Learning'.

In relation to the Curriculum, the Curriculum for Wales guidance was published in January 2020. It aims to help each school develop its own curriculum, enabling their learners to develop towards the four purposes of the curriculum – the starting point and aspiration for every child and young person in Wales.

There are four purposes at the heart of the new curriculum that are a starting point for all decisions on the development of the new curriculum and assessment arrangements in schools. One of the four purposes of the new curriculum is to support learners to become *healthy confident individuals*, who are building their mental and emotional well-being by developing confidence, resilience and empathy.

The mental and emotional well-being of learners has therefore being considered across all the areas of learning and experience (Areas) as part of the development process for the new curriculum.

The Health and Well-being Area recognises good health and well-being as a key enabler of successful learning. This area of learning and experience will support learners to understand how mental health and emotional well-being influence the way people think, feel

and behave. It will also help learners explore the connections between life experiences and mental and emotional well-being.

Each Area is organised into “What matters” statements. These articulate the fundamental principles or concepts which underpin the Area and enable learners to develop their knowledge, skills and experience. The Health and Well-being Area includes a “What matters” statement on mental health and emotional well-being, giving it parity with physical health and well-being. The descriptions of learning at every progression step signal the development of experiences, knowledge and skills that will support their mental and emotional health.

The Committee says:

*In its response to this report, and to enable us to review progress before the end of this Senedd, the Welsh Government should outline the steps taken this autumn term to deliver the National Early Help and Enhanced Support Framework, and provide a plan (including timescales and deadlines it is setting itself) for how a **consistent support offer** for the whole of Wales will be achieved between now and dissolution.*
(Page 29)

Our response

To support the improvement for these young people, funding has been provided by Welsh Government and as a result the agreed T4CYP programme objectives through to 2021/2022 remain to:

- Develop a national framework that describes the early help and enhanced support that should be available in all areas of Wales, with the aim of addressing the so-called ‘missing middle’. This will include working with Regional Partnership Boards.
- Continue to embed the Neurodevelopmental (ND) Pathway and standards developed through the first phase of the Programme.
- Support the development of a whole system response for children and young people with ND conditions. This work will include relevant linkages to implementation of the ALN Act provisions. The development of the Early Help Enhanced Support (EHES) national framework will seek to provide an early offer for children and young people and their families, who otherwise would be referred to the ND team.
- Work with wider partners through Regional Partnership Boards (RPBs) to align to the direction of travel already set by Welsh Government.
- Work with RPBs to undertake a mapping exercise of current provision, with a view to supporting the adoption of the Early Help and Enhanced Support National Framework at an RPB level.

Detailed milestones on what has been achieved this Autumn Term will be provided shortly by the T4CYP in its direct response to the Committee.

Work is already underway to identify RPB early adopters of the EHES framework implementation, with initial meetings scheduled before the end of the year.

We can confirm, following significant engagement with partners through the Summer, a more detailed framework, complete with digital based support will be developed for formal consultation this winter and agreed by the end of March 2020. The new coproduced framework will be embedded on a regional footprint, starting from April 2021.

There is also the intention to develop a more consistent offer in other areas. In order to facilitate setting common standards and expectations across Wales, the CAMHS Network, sitting under the All Age Mental Health Network of Wales, is currently revising the CAMHS service improvement framework. After a short pause during the early stage of the pandemic, the CAMHS Network has now recommenced its Peer Review programme virtually, which will provide a shared understanding and learning across CAMHS teams.

The committee will wish to note that I will be ensuring that CAMHS performance in every health board will be a regular feature in my conversations with Vice Chairs of health boards.

The Committee says:

Welsh Government should outline the steps taken this autumn term to improve crisis and out of hours care, and provide a plan (including timescales and deadlines it is setting itself) for how 24/7 access to age-appropriate crisis and out-of-hours will be achieved between now and dissolution.

(page 33)

Our response

We have made good progress in improving crisis care which has been supported by £3.4million of funding over the last 3 years (£1m 2018-19, £1.4m in 2019-20 and £1m in 20/21) with a further planned investment of £2.4m in 21/22. Improving crisis care will continue to be priority for the next 3 years, as set out in the *Together for Mental Health Delivery Plan 2019-22*. This funding is supporting a range of approaches including testing models of telephone triage, conveyance and crisis cafes. The learning from these approaches is being used to inform our longer term approach with partners.

The Mental Health Urgent Access Review was commissioned to better understand the needs of people presenting in crisis. Whilst the multi-agency review was delayed due to Covid-19, the final report was received on 22nd October. The final report is attached at Annex B.

The review highlights the broad range of needs of people presenting in crisis including social and welfare issues. It highlights the need for an all age multi-agency pathway and a subgroup has been convened to coordinate this work. We will provide more details and timescales following the first meeting of the sub-group on 10 December. Work has already commenced in the NHS, for instance to develop a mental health pathway via 111 and we will continue to prioritise crisis care the revised *Together for Mental Health Delivery Plan*.

Further work is already underway to improve the NHS responses for CYP in crisis and requiring in-patient or more specialist support. This is covered in the following section.

The Committee says:

In its response to this report, the Welsh Government should outline the steps taken this autumn term to improve inpatient care, and provide a plan (including timescales and deadlines it is setting itself) for how the new service specification and revised capacity will be implemented in full between now and dissolution.

(Page 37)

Our response

The Welsh Health Specialist Services Committee (WHSSC) has established a new CAMHS bed management panel which meets on a weekly basis. The panel aims to understand the current bed capacity of NHS and independent sector providers and any adverse effect of staffing issues, patient acuity and Covid 19 restrictions on that capacity. It also assesses current demand from community services for a CAMHS inpatient bed at an individual level and provides solutions to address any discrepancies between demand and capacity on a regular basis.

The Welsh Government has also directed WHSSC to consider a number of approaches to improve access to tier 4 support in Wales. In response, the Joint committee of WHSSC have also agreed that the National Collaborative Commissioning Units Quality Assurance improvement Team provide intensive operational support to the two Tier 4 NHS CAMHS Units for the next three months. This will enable a robust understanding of operational pressures and provide a focus on improvement of care quality. The team, by understanding the patient profile will also provide insights into how to improve the Tier 4 pathway, how to provide better support on discharge and provide alternatives to admission.

In addition, the QAIS leadership will work in partnership with the NHS Delivery Unit to undertake a review of age appropriate bed use over the last 12 months. This will enable an understanding into any change in the use of these beds during the pandemic, the part these beds in the CAMHS pathway, variation in the availability and operation of these beds across health boards and any access and discharge issues with these beds.

We are also working with health boards to develop nationally agreed rapid assessment protocols to minimise the time spent in these beds by young people.

This work to support mental health inpatient care for young people, should not be seen in isolation. The integrated work with RPBs outlined later (on page 10), including pilot of safe accommodation provision in Powys, is programmed to run alongside these developments.

The Committee says:

*In its response to this report the Welsh Government should outline the steps taken this autumn term to implement the **Matrics Plant** guidance, develop a **workforce plan** for mental health needs, and **undertake work on prescribing trends**. It should provide a plan (including timescales and deadlines it is setting itself) for how these three areas will be addressed fully between now and dissolution.
(page 41)*

Our response

We acknowledge there has been a significant delay in the publication of the final Matrics plant guidance and that it needs to be made available and implemented as a matter of priority. Following the first wave of Covid-19, NHS colleagues were able to recommence activity and Matrics Plant has been revised following the consultation at the start of the year. Publication will be before Christmas. We will of course ensure the Committee are informed of publication.

We can confirm that improving the psychological therapies workforce has been categorised as a phase 1 priority in the development of the workforce plan for mental health. The workforce plan is being developed jointly by Health Education and Improvement Wales (HEIW) and Social Care Wales (SCW), and as part of this work, the National Psychological Therapies Management Committee developing a national infrastructure for psychological

therapies to drive improvements in Wales. HEIW and SCW have been undertaking a mapping exercise with Health Boards throughout November to identify staff and posts and this will inform the Workforce plan for Mental Health scheduled for consultation in late 2021. Throughout October, HEIW and SCW led a joint, month long virtual conference to engage a wider range of stakeholders to inform the future mental health workforce in Wales.

We acknowledge that the planned work on prescribing trends outlined to the committee in our last response was unfortunately paused at the start of the pandemic. We had intended to explore options for further work involving prescribing for children and young people with emotional, behavioural, and mental health problems in the Spring. However, we have now agreed our next steps, outlined below.

The original study was based on ADHD prescribing data during 2003-2013 and we agree that sufficient time has passed to undertake a comparable study for data, likely to encompass years 2008-2018. We have previously announced our intention for future service development for adults and children to be informed by a demand and a capacity review of neurodevelopmental services with an independent review being commissioned and this will start early 2021. The prescribing trends work will be commissioned by the end of January and timetabled as further evidence to inform this demand and capacity review. The emerging work with outcomes by Improvement Cymru outlined later in this update (Page 10) will also ensure the interventions used are effective for children.

The Committee says:

In its response to this report, the Welsh Government should outline the steps taken this autumn term to improve transitions. It should provide a plan (including timescales and deadlines it is setting itself) for how a consistent approach across Wales to transitions will be achieved between now and dissolution.

(Page 45)

Our response

We remain fully committed to improving transitions for young people and ensuring young people have choice to move services, not based on a fixed point due to their date of birth, but at an appropriate time for their specific needs. We understand the need for young people to be fully involved in the transition process with access to a key member of staff ready to support them through the change.

To support this, our [Together for Mental Health Delivery Plan](#) includes our commitment to review both the current transitions guidance and the Young Persons Passport and to monitor its use. The timescales for this commitment were updated in the recent review of the delivery plan. The review of the guidance and passport is scheduled to be undertaken by March 2021 with monitoring plans through 2021/22. The National Youth Stakeholder Group provided feedback on the CAMHS to AMHS Passport document during 2019.

We have shared the [Review of evidence on all-age mental health services](#) with partners, including the CAMHS Network Board to consider across their workplan.

We continue to work with colleagues to bring in line the review of the CAMHS Transitions guidance alongside the development of the wider NHS Transitions guidance which will be published in the new year. Lessons from young people regarding the CAMHS Passport were fed in to inform the content of the wider NHS transitions work.

The Committee says:

In its response to this report Welsh Government should outline the steps taken this autumn term to improve support for looked after children. It should provide an outline of its and the MAG's priorities in this area, and a plan (including timescales and deadlines it is setting itself) for how they will be achieved fully between now and dissolution.
(page 49)

Our response

Since the start of lockdown in March and over the course of the pandemic to date, we have held one extraordinary Ministerial Advisory Group for Children, in the summer. The purpose of the meeting was to consider the impact of COVID on the delivery of the work programme and to identify the key priorities that should be delivered in the remainder of this Senedd Term. Whilst work across the programme will continue, the MAG recognised that targeted action is needed on a handful of key priorities to support children and families through the pandemic and maintain a focus on reducing numbers of children in care.

The Improving Outcomes for Children Programme (Workstream 3), sets out plans to ensure a wide range of therapeutic support is available for emotional and behavioural problems experienced by children and young people on the edge of care and for those who have been adopted.

We would like to highlight the joint health and social care activity which has continued over the pandemic. This included hosting an event for the Regional Partnership Boards (RPBs) with the Children's Commissioner around developing safe accommodation for children with complex needs within a *No Wrong Door* context. Following this event, at the end of October Welsh Government provided formal 'In Principle Offer of Support' through the Integrated Care Fund (capital) for the pilot provision of a therapeutic children's home in Powys. Development of the project is fully underway, scheduled to be purchased and refurbished during this financial year. This accommodation will offer wrap around multi-agency therapeutic support and specialist services to support the most vulnerable children across Powys – keeping them (where possible) within the County.

We are also working to develop the ICF guidance in relation to the bids we would like RPBs to make for this joint health and social care residential service. In addition, MAG members took forward work on mental health as part of the Improving Outcomes for Children work programme e.g. NSPCC and Voices from Care produced [Listen, Act Thrive](#).

We are continuing to make progress in improving mental health support for children and young people in the context of an increasing demand for services but we acknowledge there are still improvements to be made. We are clear that the only sustainable way of responding to rising demand and the multifaceted nature of mental health support is to ensure that there is good, universal support available as well as good access to specialised services. CAMHS, in common with wider NHS provision, does not provide priority treatment to any specific group or cohort, such as children and young people in care. Rather, the central tenet of NHS provision is that it is provided on the basis of the clinical need of the individual, with priority given to those with the greatest clinical need.

As the Committee will be aware, the T4CYP programme is undertaking work which will incorporate improvements for support and access for all young people, including those on the edge of care. To date, this has involved ensuring the targeted activity on the T4CYP Early Help and Enhanced Support Framework involved a broad range of stakeholders such as children's services and the National Youth Stakeholder group, which includes care experienced young people.

The Committee says:

In line with our previous calls, we need more transparent data on children and young people's access to mental health services during the pandemic and going forward. The Welsh Government's commitment to resuming the publication of routine data by the end of this year must be delivered, and an indication given of when work with the Royal College of Child and Paediatric Health to establish a useful outcome indicator for children accessing services will happen.

(Page 51)

Our response

Routine data publication recommence during the month of November.

Hospital activity statistics such as RTT and A&E, including sCAMHS data were published on 19th November. The Mental Health Measures data will next be published on the 25th November covering data up to September 2020. The Mental Health Measures Data will be split by age to identify waiting times for under 18s.

The mental health core dataset was agreed in 2018. Alongside the implementation of the WCCIS, the dataset will ensure that all health and social care partners collect the same information in the same way. The dataset brings a wide range of benefits which are already being implemented. Ultimately, the dataset offers improved service provision and integrated working.

All staff across health and social care have supported the development of common assessment, care and treatment and review documents. These are now being piloted before being rolled out across mental health services in Wales.

Improvement Cymru is leading on the implementation of outcomes-focused practice, which sees the service user at the centre. Following a series of successful pilots in 2019, this will now roll out across all mental health services throughout 2020-2021.

We have worked with partners to identify key reports that will support benchmarking, service development and planning.

All of the Specialist CAMHS services will have implemented CAPA (choice and partnership approach - outcome measures), although each Health Board is at a different stage of implementation. CAPA operates on a single point of access for referrals.

The Committee says:

We need not only better signposting but, crucially, to address the gaps in service provision for lower level/ therapeutic support for the missing middle.

(page 52)

Our response

We have invested an additional £2.7 million this year to provide immediate access to tier 0/1 support, in response to the higher levels of anxiety we are seeing through our analysis of surveys and wider evidence. This funding has delivered support for young people to access themselves, for instance through the Youth Mental Health toolkit, SilverCloud (16+) and the CALL helpline. We have also invested £1.252m to extend schools counselling, ensuring

[contacts](#) in every local authority were available online for young people not attending school in person.

We continue to highlight the provision available and have worked with partners such as schools, local authorities and health boards to indicate to young people where they may find support. We have also increased our communication activity across platforms to promote access to low level support directly with young people. Where young people do need the additional support of mental health services, all health boards have continued to process referrals.

The Committee will be aware Welsh Government funding to support the young people who do not meet the criteria for direct CAMHS Support is cross government including support through education and youth work provision. We also continue to support regions utilising Integrated Care Funding and Transformation Funding via Regional Partnership Boards for schemes such as:

- The North Wales Early Intervention and Intensive Support for Children and Young People (C&YP) project with three elements including a multi-agency drive to improve emotional health, wellbeing and resilience of C&YP through early intervention and prevention
- In Gwent RPB, the ICEBERG model is focussing on the environments where children spend their time for example: schools, community settings (e.g. youth services) and homes, to ensure that everything possible is being done to promote child's positive mental health in the context of their day-to-day life, and thus prevent the development of emotional health and wellbeing problems. This transformational plan will re design a framework of integrated services that meets the specific needs the child or young person is presenting with at the place and time they need them.

Both schemes above have been funded through the £100m Transformation Fund, the purpose of which is to speed up the development and scaling up of new models of health and social care provision and to demonstrate their value. Learning from all schemes will be shared widely with RPBs so that other areas may improve such provision in line with their population needs. [A midpoint evaluation of the Transformation Fund](#) was published in April 2020.

The Committee says:

*We are not reassured that sufficient provision for face-to-face health and support services are in place for situations in which lockdown restrictions are in force.
(page 52)*

Our response

Whilst there were limited options for face to face assessments at the start of the pandemic, this situation has changed significantly over recent months. However, all crisis services continued to operate face to face where necessary with decision being taken on basis of risk.

Since April significant progress has been made to roll out a new range of options for children and young people and their families. This has included direct telephone support in some areas, the use of digital appointments via Attend Anywhere. Increasingly LHBs have been offering more face to face appointments where the children and young people or their

families have preferred to receive support in this way – some have welcomed the option of digital appointments.

Health boards are working with partners to increase their accommodation options where social distancing requirements cannot be met in current locations.

Recognising the impact of service provision as a result of lockdown, we moved quickly early on in the pandemic to make additional funding of £1.252m available to local authority school counselling providers to improve and expand provision, and to enable them to maintain contact with existing and new clients during the lockdown. Funding was used to train counsellors in online delivery techniques and purchase software licenses to enable service delivery.

Whilst local health boards remain committed to providing the most appropriate support to children and young people in line with the requirements of the NHS Operating Framework it must be acknowledged that the workforce remains under particular pressure in many areas due to the Covid situation this autumn/winter.

The Committee says:

We would welcome further detail on how the single points of access are operating and a response to our request for information about enabling parents to refer directly.
(page 52)

Our response

All of the Health Boards operated single points of access (SPOA) during Covid-19. We continue to monitor this and as at 15 October I can confirm SPOA were functioning in all areas of Wales.

A rapid review of service changes and innovations to mental health services was conducted over the summer to ensure learning and best practice to be shared to inform services going forward.

The development of a pathway for more unified single point of access across CAMHS services is being taken forward as a matter of urgency under the development of the new Service Improvement Framework. Consultation on this document will begin as soon as possible.

We will continue to monitor the progress and retention of single point of access to services as part of the recovery planning following Covid-19.

Access to assessments and interventions within NHS mental health services, in parity with physical health services, continues to be primarily via referrals from primary care or similar professionals/clinicians. Whilst direct parent referrals may be possible as services develop and improve, it is key that parents, teachers and young people themselves have direct access or can signpost to a range of options to support mental health and wellbeing. sCAMHS is not always the most appropriate service for children with mental health needs. Services are developing their single points of access and early access and advice services which it is anticipated will be available to parents and all people working with children and young people.

We continue to work on increasing the support at this level as described earlier in our response and to improve our communications which, in the last few weeks, has included a campaign specifically targeted to 16-24 years old.

The Committee says:

We would welcome an update on how evidence of the impact of the first allocation of £3.5 million has been collected and assessed, and how the second allocation of £3.5 million (for which health board proposals were required by 7 September) will be spent. (page 52)

Our response

Early on Welsh Government recognised the importance of providing as much flexibility as possible for health boards in responding to the pressures associated with the current pandemic situation in mental health and therefore released the first six months of funding allocated to each health board to ensure the continuity and flexibility that was required at this time. Health boards were asked to retrospectively provide a high level overview on how the funding was utilised to respond to the pressures associated with the current pandemic situation in mental health.

Returns confirmed this funding had been utilised in a number of ways including: additional staffing from agency and redeployment, supporting extra care due to day care service closures, additional in-patient care capacity commissioned and reconfiguration of service models to provide them digitally.

The Committee may find it helpful to see the £3.5m allocation based on priority. There will be elements of proposals targeted at young people included within most priority categories.

Project	Amount requested 20/21
CAMHS	£330,495
Eating Disorders	£501,385
Perinatal	£222,488
Psych Therapies – all age provision (with £51,000 specifically focused on CYP)	£446,446
Crisis / Out of Hours – all age provision (with £253,000 specifically focused on CYP).	£991,217
Early Intervention in Psychosis	£92,166
Other (i.e. pharmacy, prison health, recovery services)	£300,011
Covid response	£367,848
Non specific Covid/ Delivery Plan priorities	£247,944

The Committee says:

Welsh Government states that £2 million has been invested in mental health inpatient capacity and we would welcome an outline of how much has been spent on children and young people mental health services specifically.
(page 53)

Our response

Total expenditure for surge beds for children and young people from 8 June up to 14 October 2020 is just under £225,000. Surge capacity was commissioned from CAMHS providers based both inside and outside Wales.

This figure does not include expenditure related to the costs of the NHS in patient CAMHS provision based in South or North Wales.



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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.

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- 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 Health 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.

Around 950 people a day in Wales seek support from the public sector for mental health or welfare concerns, 300 of these for an emergency



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 & METHODOLOGY

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‘[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 children³, young adults⁴, black and minority ethnic communities⁵, individuals identifying as lesbian, gay, bisexual or transgender⁶, asylum seekers and refugees⁷, women with perinatal problems⁸, less affluent and middle aged men⁹, armed forces veterans¹⁰, people with intellectual disabilities¹¹ and older adults¹².

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 2015¹³. 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

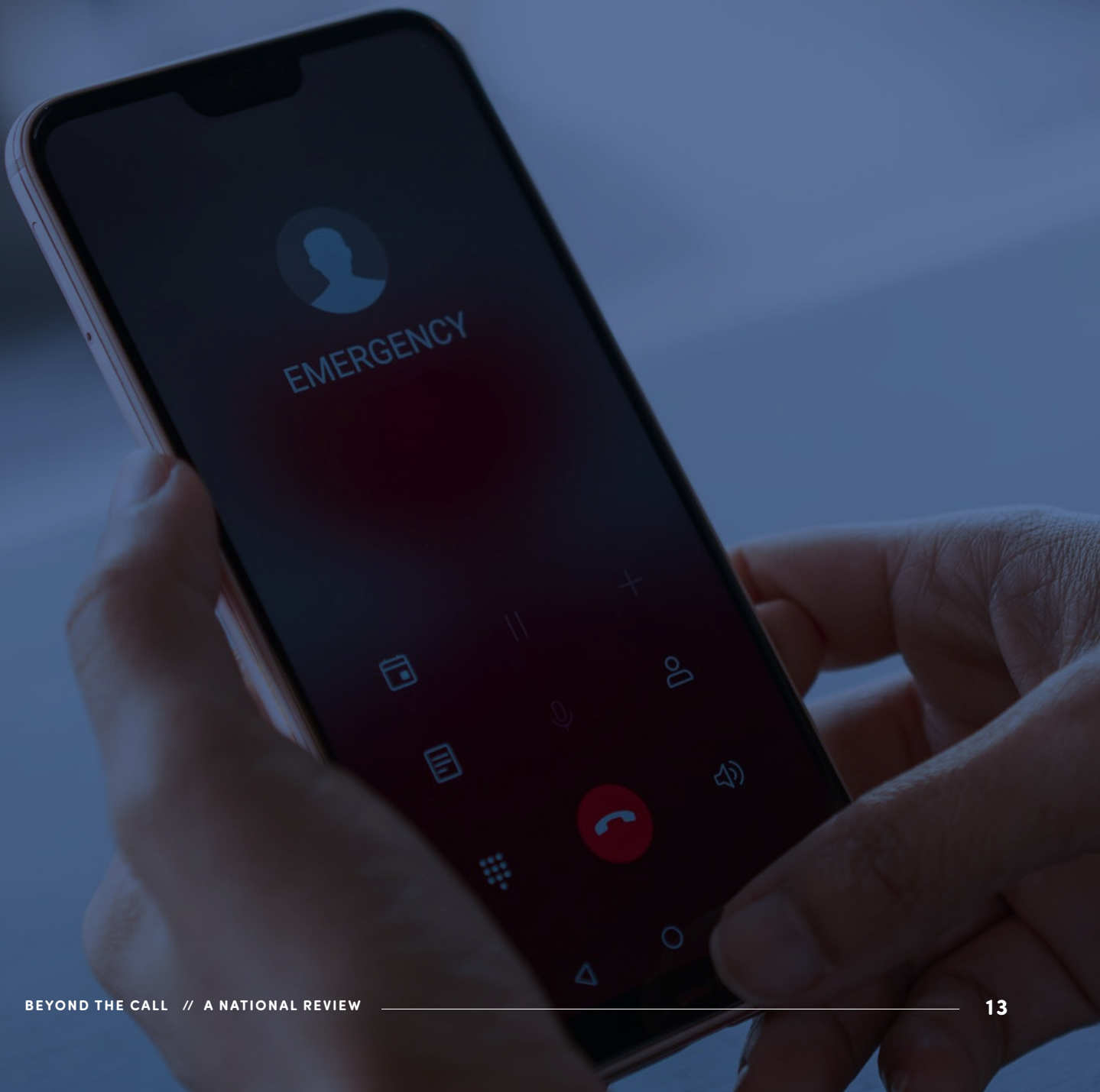
of Psychiatrists and Nursing and Healthcare Inspectorate Wales set out a vision to improve mental health crisis services and established ‘four core principles’ which were:

- 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.



PART B

PUBLIC SERVICES

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‘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 suggest 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 hours¹⁸. 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 services¹⁹.

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-operatives²⁰.

In Wales, many of these third sector organisations are members of the Wales Alliance for Mental Health, which has been the ‘collective voice’ in the ‘field of mental health’ for over twenty five years²¹. 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 admissions²⁵ and that, although ‘functioning’ was not ‘significantly increased’, self-esteem, social networking and satisfaction all improved for those cared for in a crisis house²⁶. 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 services³¹. 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 care³².

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 UK³⁴. 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 a 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 illness³⁵. 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 care³⁶. People who attend their GP more often have been shown to have higher rates of mental health conditions, including depression, anxiety and somatic disorders³⁷.

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 practice³⁸ and part of this relates to growing levels of 'multimorbidity', of which mental health is a key component³⁹. 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 services⁴⁰.

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 Wales⁴¹. In support of primary care the Welsh

Government are investing in third sector services⁴² and online provision⁴³ and many Health Boards operate additional services such as counselling⁴⁴ 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 Wales⁴⁵ 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 referrals⁴⁶.

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 Wales⁴⁹. 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 paediatric 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 services⁵⁰. Studies have proposed as a ‘reasonable estimate’ that one in call in every ten to ambulance services relate to mental health, 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 2020⁵³ 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 distress⁵⁴. 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 perspective⁵⁵, 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 needs⁵⁷. 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 concerns⁵⁹. 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 services⁶⁰.

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 population⁶¹. 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 2017⁶³. 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 studies⁶⁴, 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 referrals⁶⁶.

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 health⁶⁷. 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 care⁶⁸.

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 2020⁷¹. 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 distress⁷¹. Police forces deal with a ‘significant number of calls’ related to situations and events related to welfare concerns, mental health, social difficulties and distress⁷².

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 themselves⁷³.

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’ demand⁷⁴. The notion of ‘failure demand’ has been coined to describe non-urgent, non-traditional calls to police⁷⁵, 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^{6,77,78}.

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’ system⁷⁹, 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 suicide⁸⁰. 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 flag⁸¹, 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 month⁸². 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 police 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.

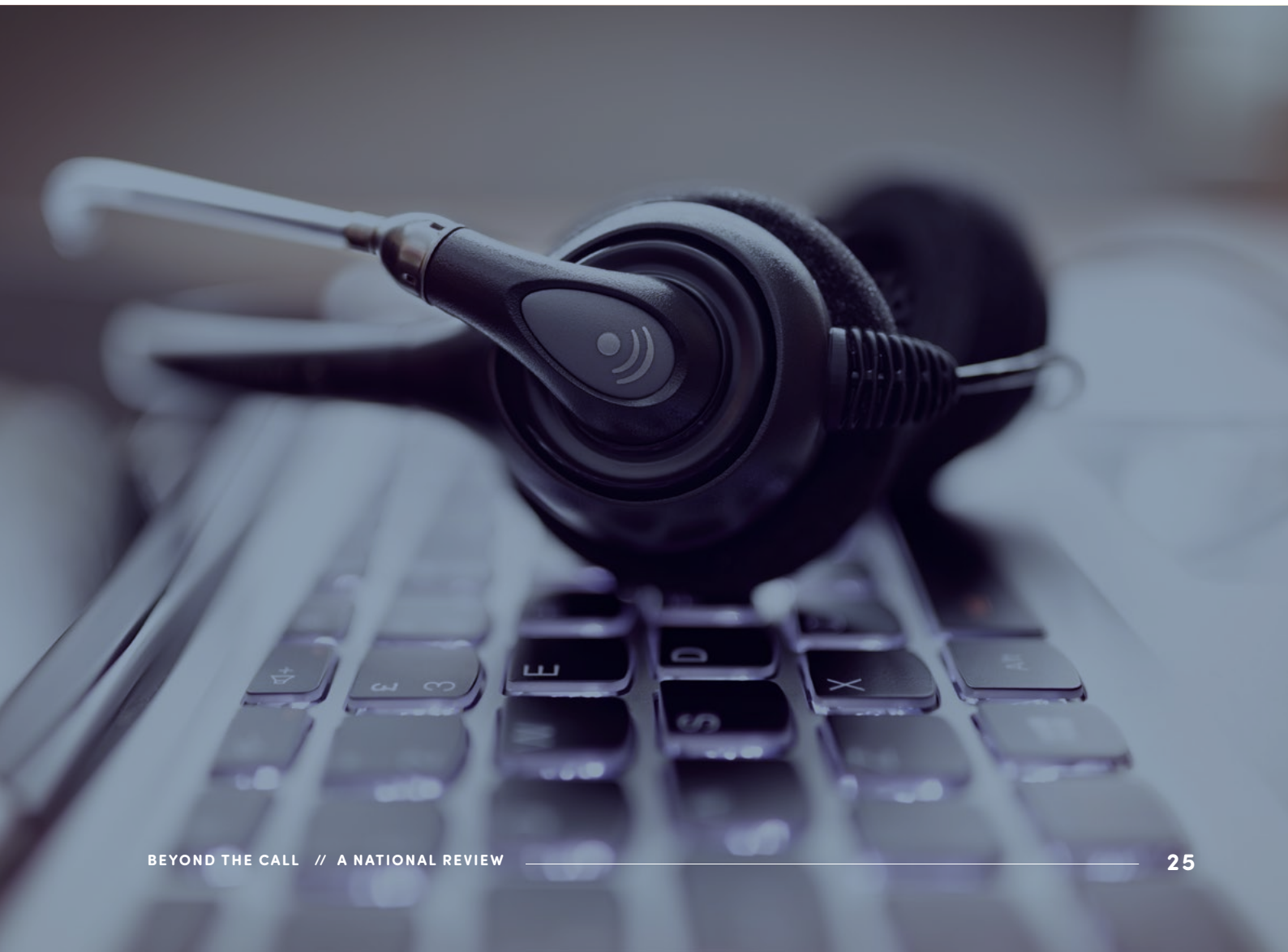
This ‘snapshot’ data evidenced that demand from ‘999’ and non–emergency calls was 9.4% of total calls across all four Welsh police forces. The proportion reported by the Police may be higher

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 persons⁸⁶.

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 service⁸⁸.



PART C

BESPOKE DATA COLLECTION

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‘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.

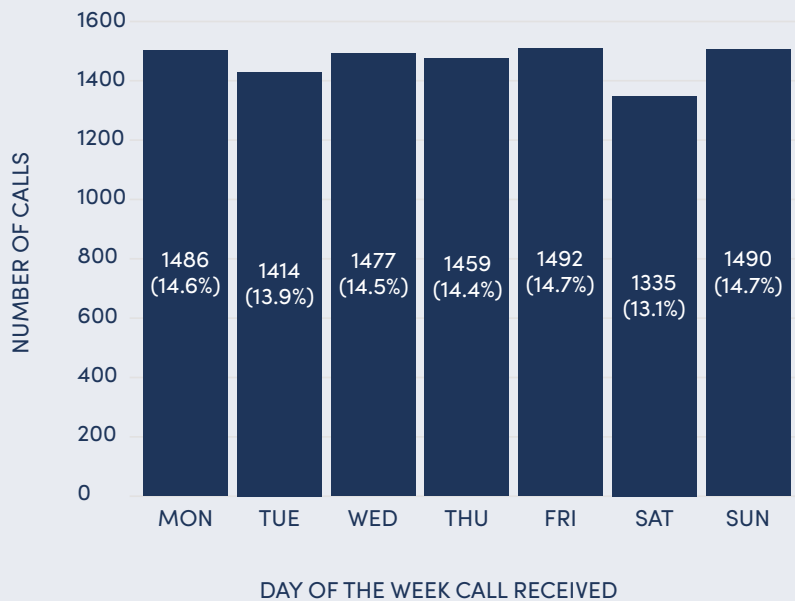
This information is a static picture of calls that is restricted to the collection period and does not take into account any seasonal or longitudinal differentials in demand.

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](#).

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

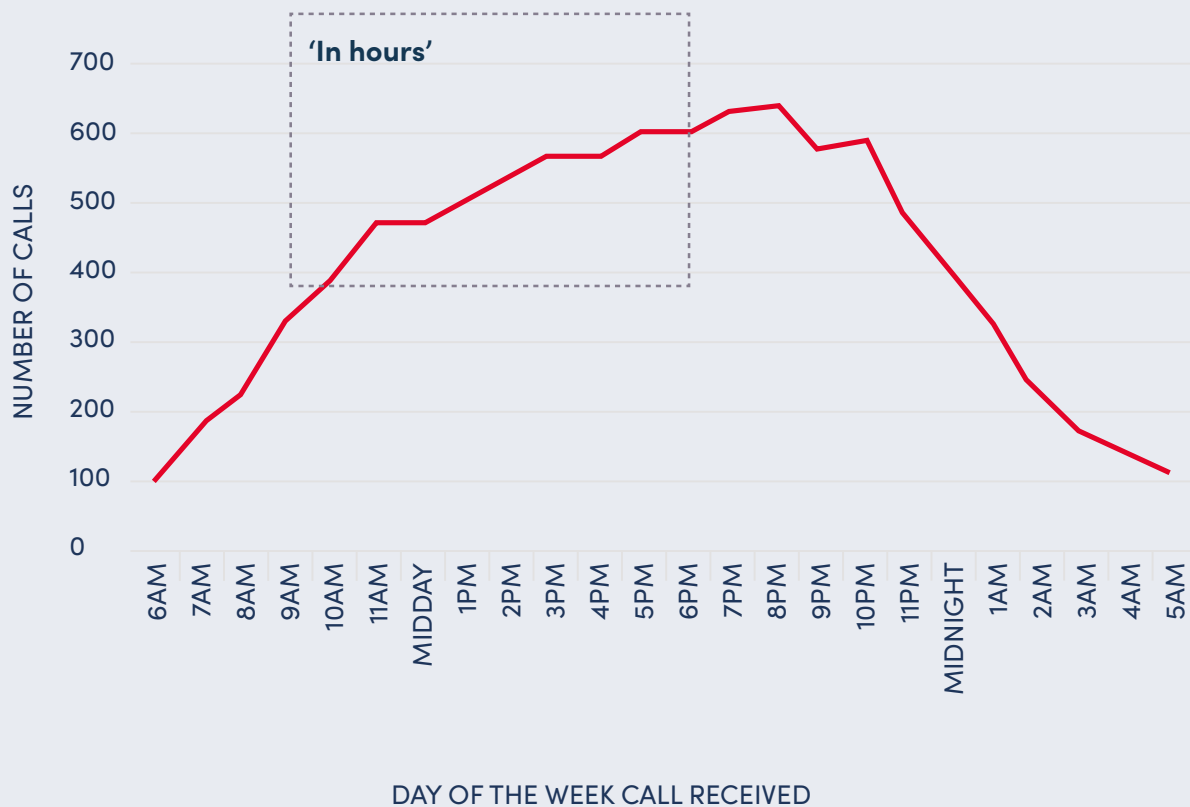


14. Time of Day of Call

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.

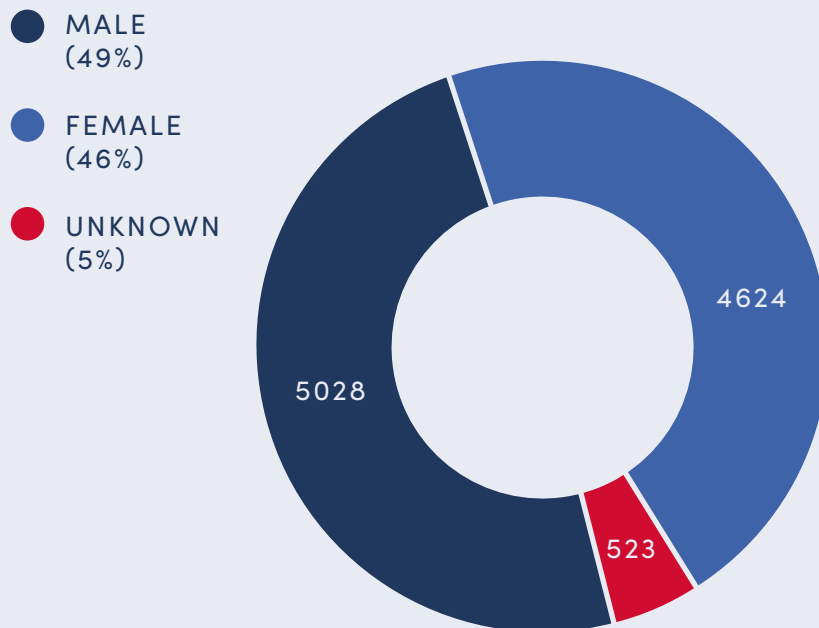
Figure 2:
Number of Calls Received by Time of Day



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% male⁸⁹. 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

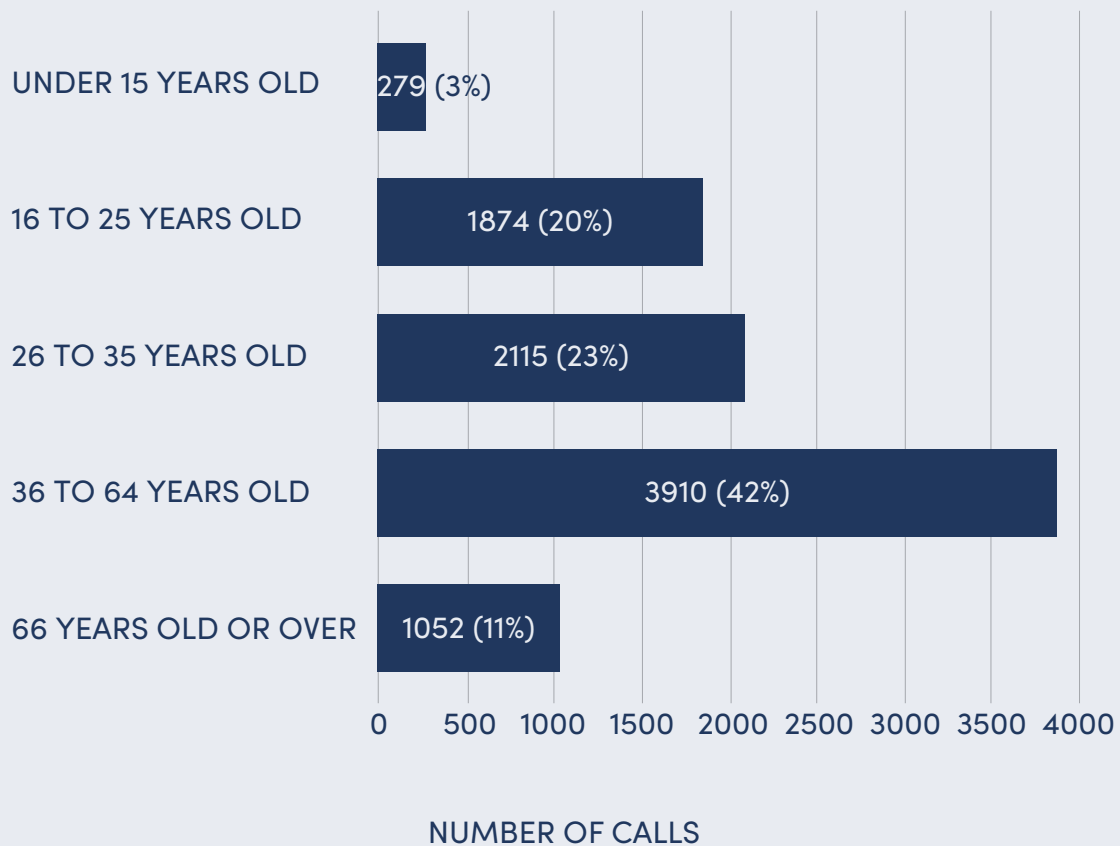


16. Age of Person with Index Problem

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 old⁹⁰.

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 on 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

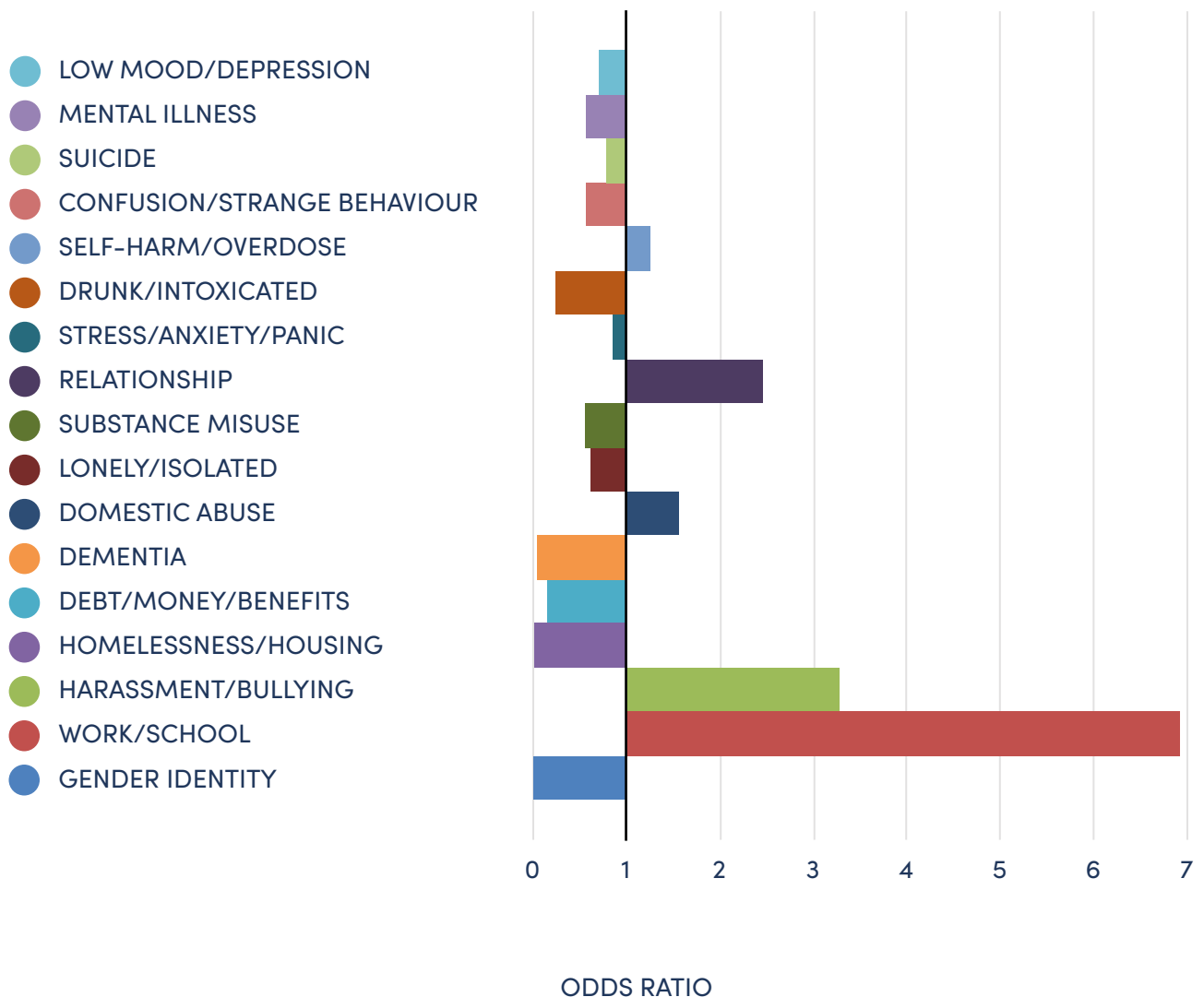


Figure 8 shows the Odds Ratio of each category where the person with the index problem was between 16 and 25 years old. The figure shows that the ratios are higher in the suicide and self-harm/overdose categories relative to the other age groups and lower in the dementia category.

Figure 8:
Odds Ratios by index Problem for 16-25 Year Old Age Group

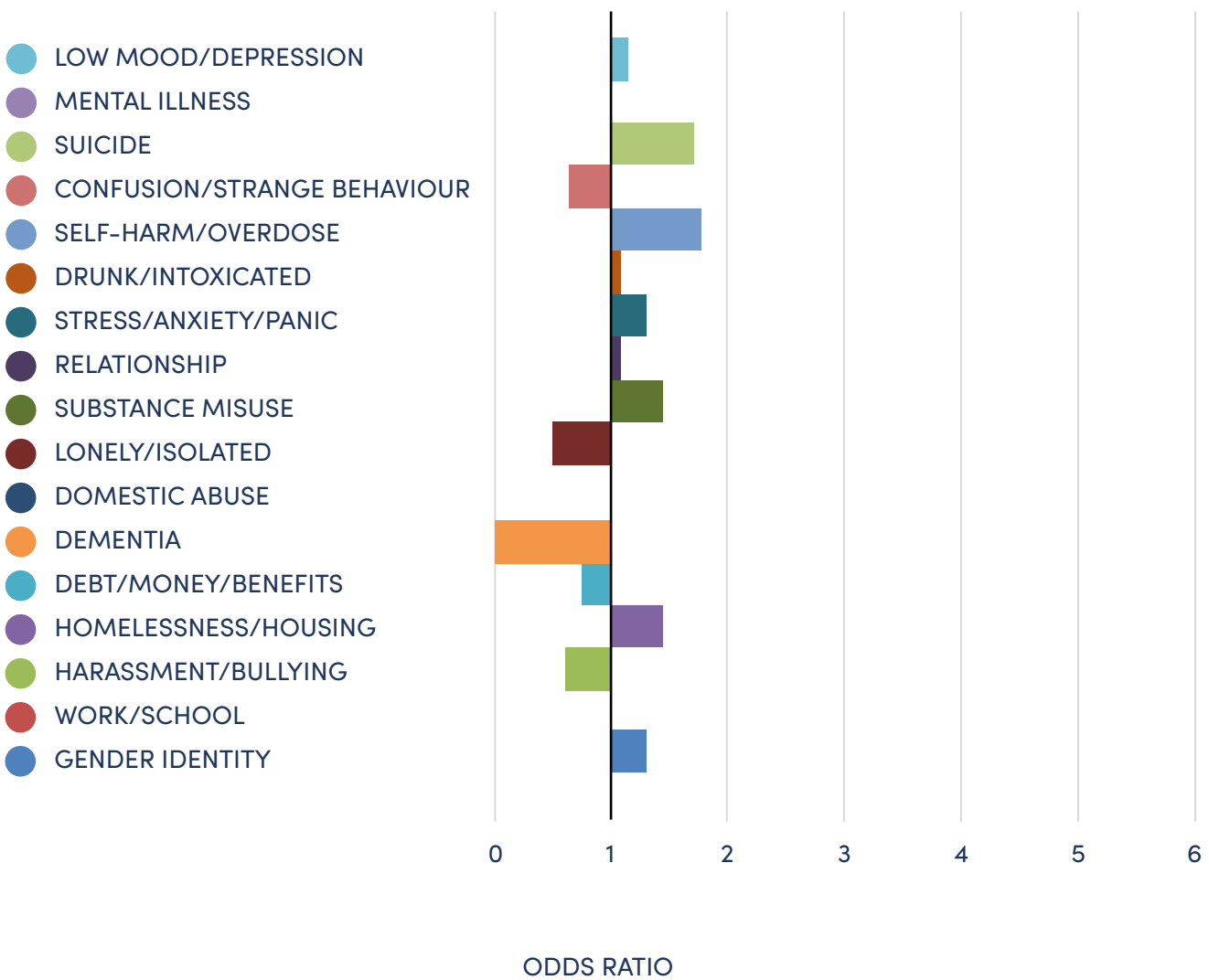


Figure 9 shows the Odds Ratio of each category where the person with the index problem was between 26 and 35 years old. The figure shows that the ratios are higher in the substance misuse and gender identity categories relative to the other age groups and lower in the dementia category.

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

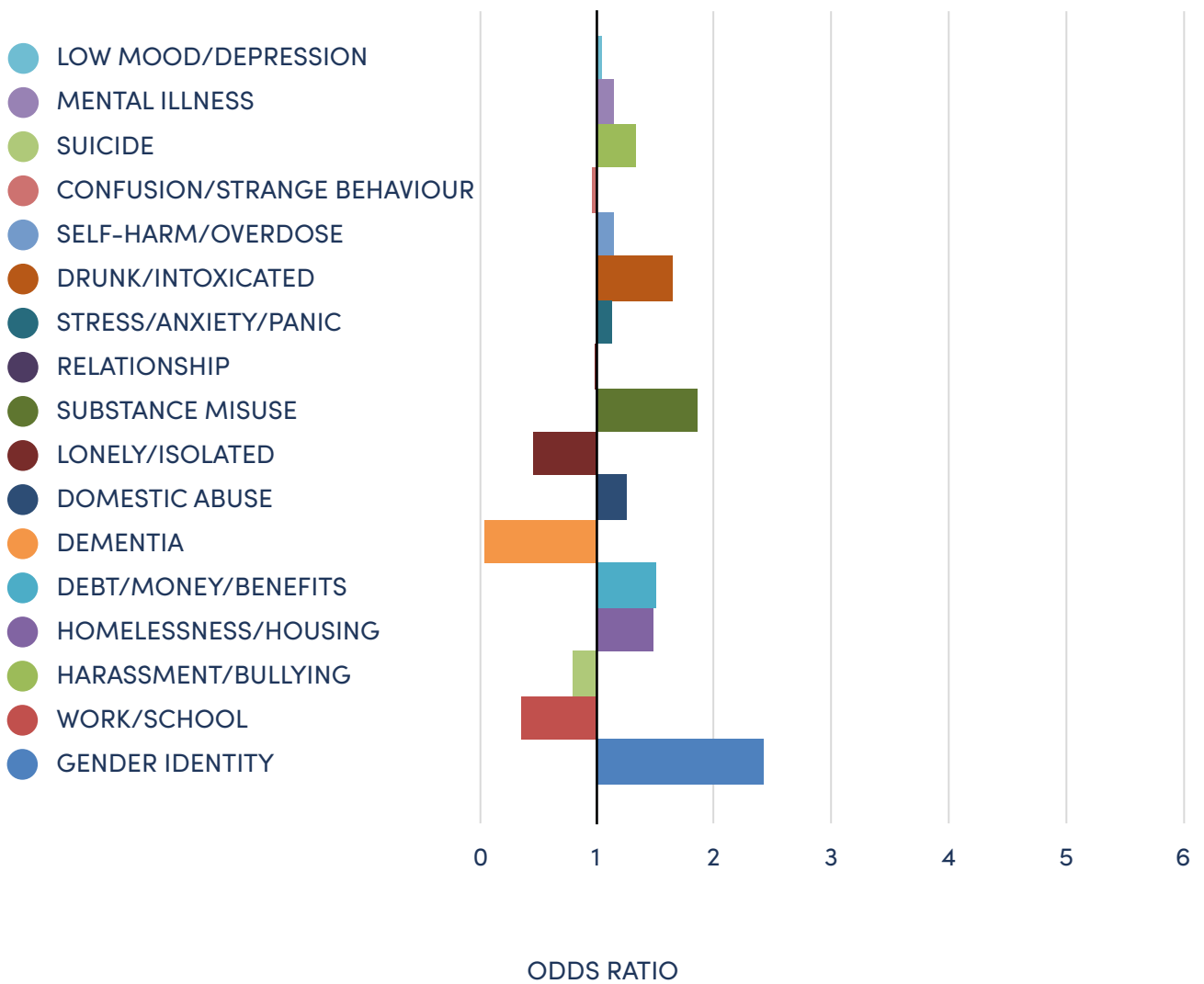


Figure 10 shows the Odds Ratio of each category where the person with the index problem was between 36 and 64 years old. The figure shows that the ratios are higher in the drunk/intoxicated and debt/money/benefits categories relative to the other age groups and lower in the dementia and work/school categories.

Figure 10:
Odds Ratios by index Problem for 36-64 Year Old Age Group

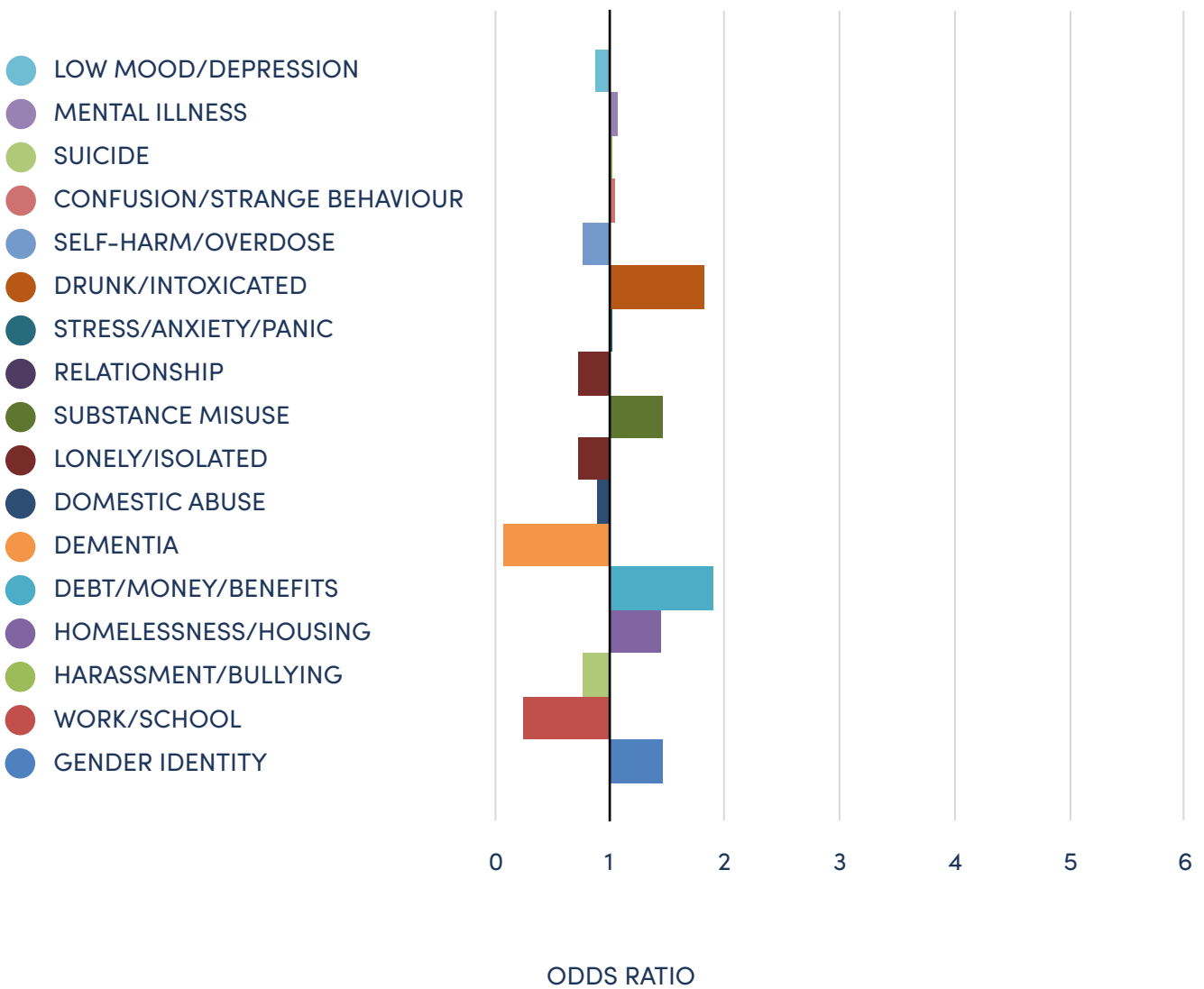
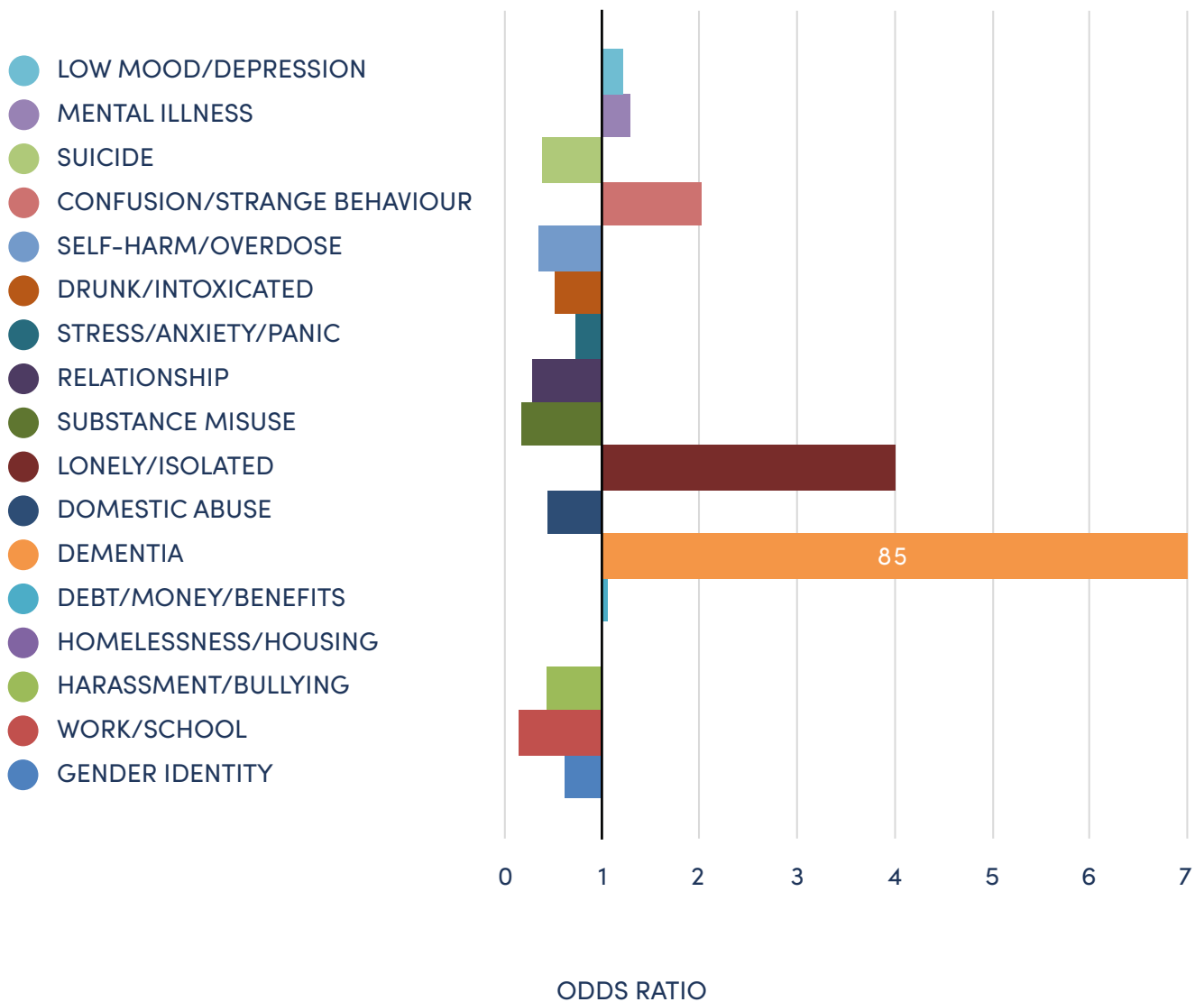


Figure 11 shows the Odds Ratio of each category where the person with the index problem was over 65 years old. The figure shows that the ratios are higher in the confusion/strange behaviour and lonely/isolated categories relative to the other age groups and lower in the substance misuse and work/school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

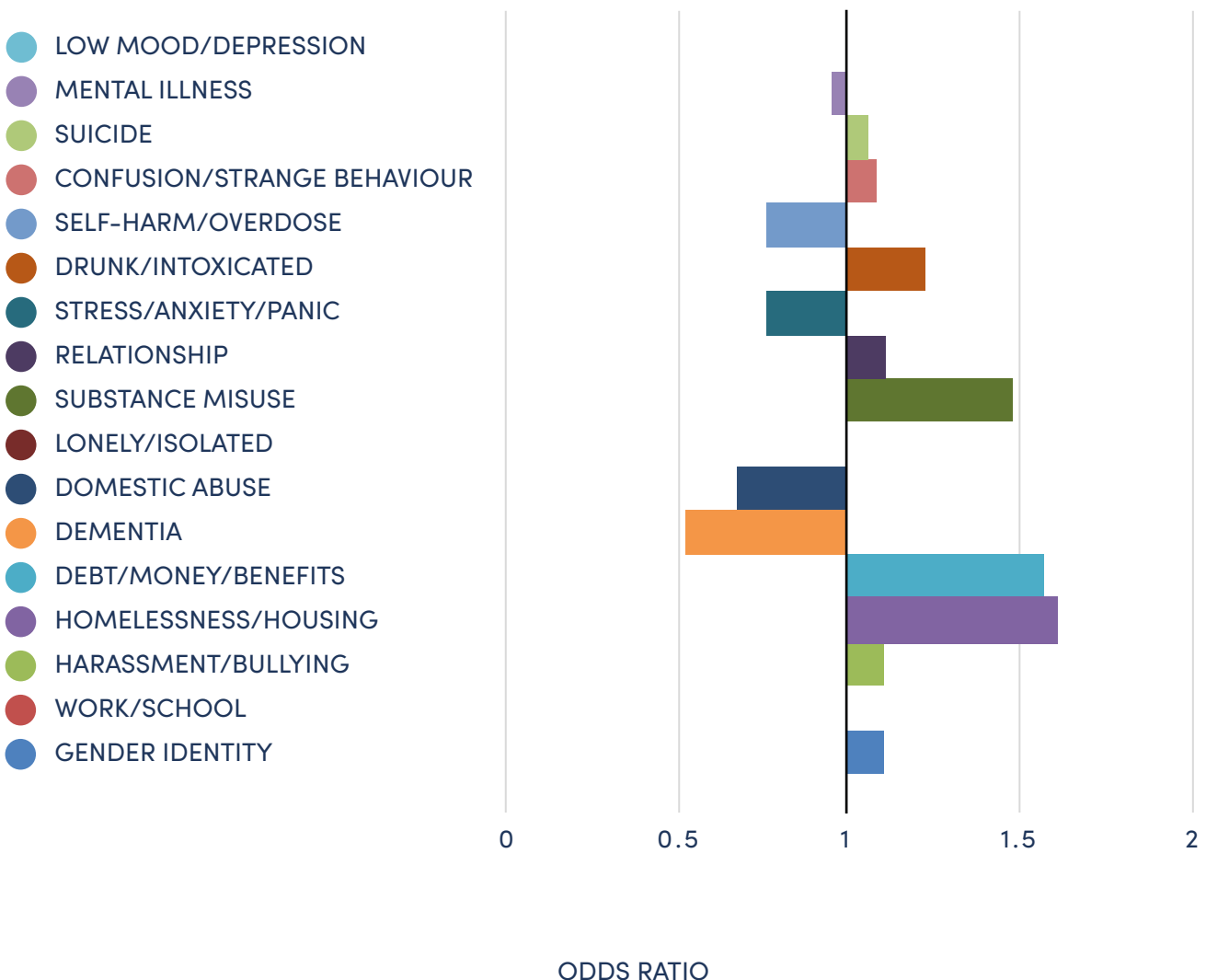


Figure 13 shows the Odds Ratio of each category where the person with the index problem was female. The figure shows that the ratios are higher in the dementia and domestic abuse categories

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

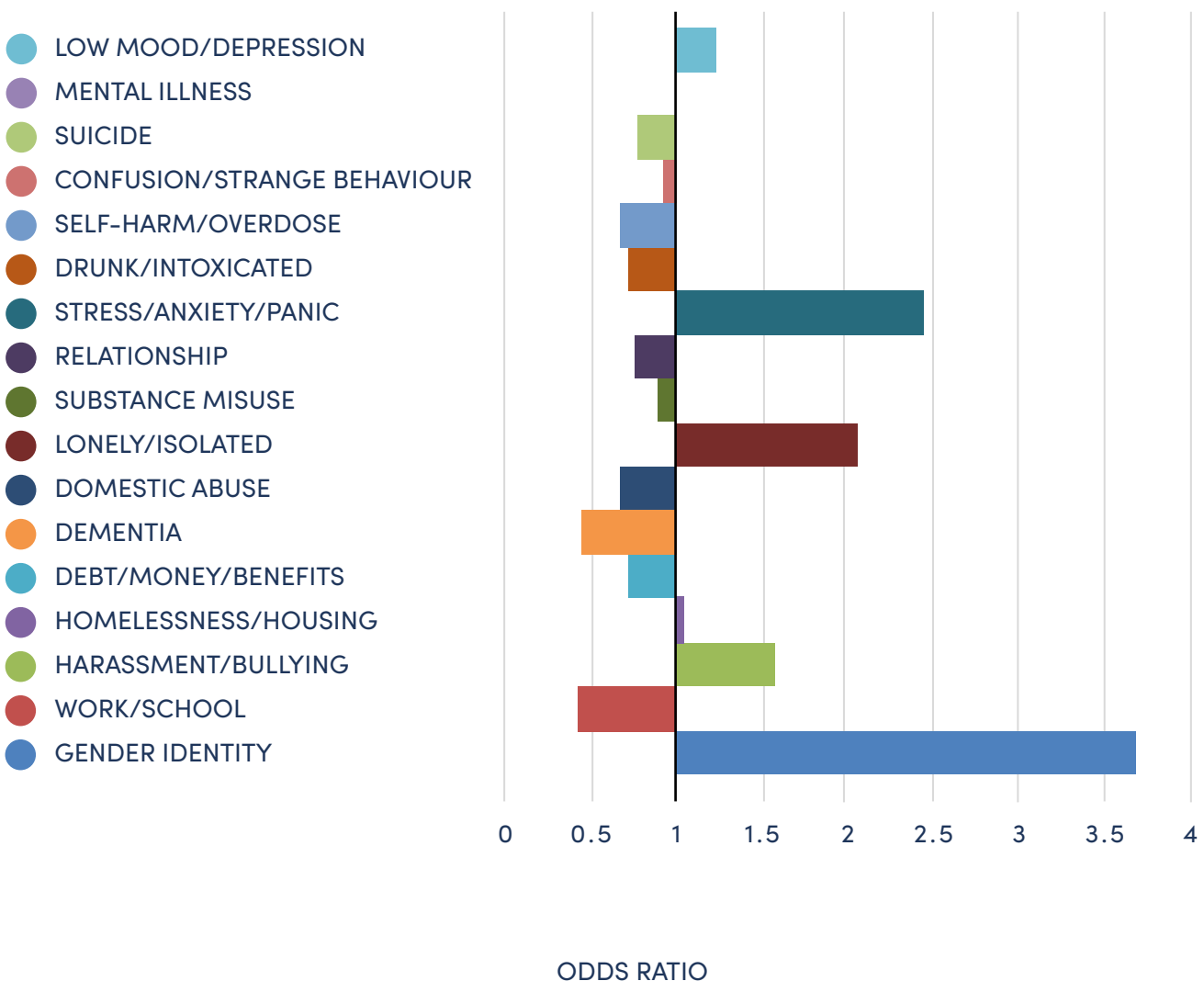


Figure 15 shows the Odds Ratio of each category where the caller was a friend or neighbour. The figure shows that the ratios are higher in the self-harm/overdose, drunk/intoxicated and work/school categories relative to the other type of relationships and lower in the domestic abuse and homelessness/housing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

Figure 15:
Odds Ratios by Index Problem for Type of Caller - Friends/Neighbour

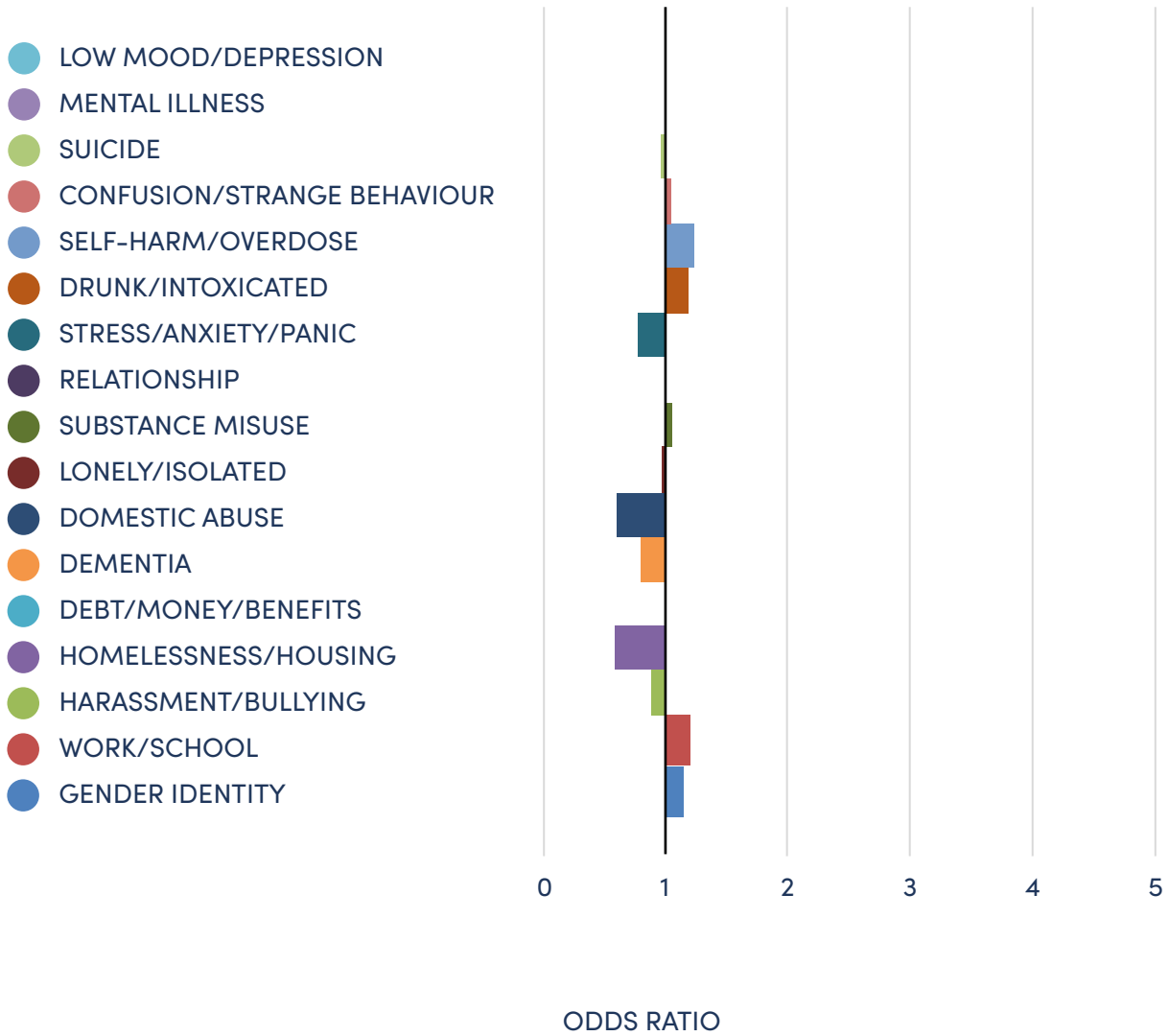


Figure 16 shows the Odds Ratio of each category where the caller was a parent or relative. The figure shows that the ratios are higher in the relationship and work/school categories relative to the other type of relationships and lower in the homelessness/housing categories.

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

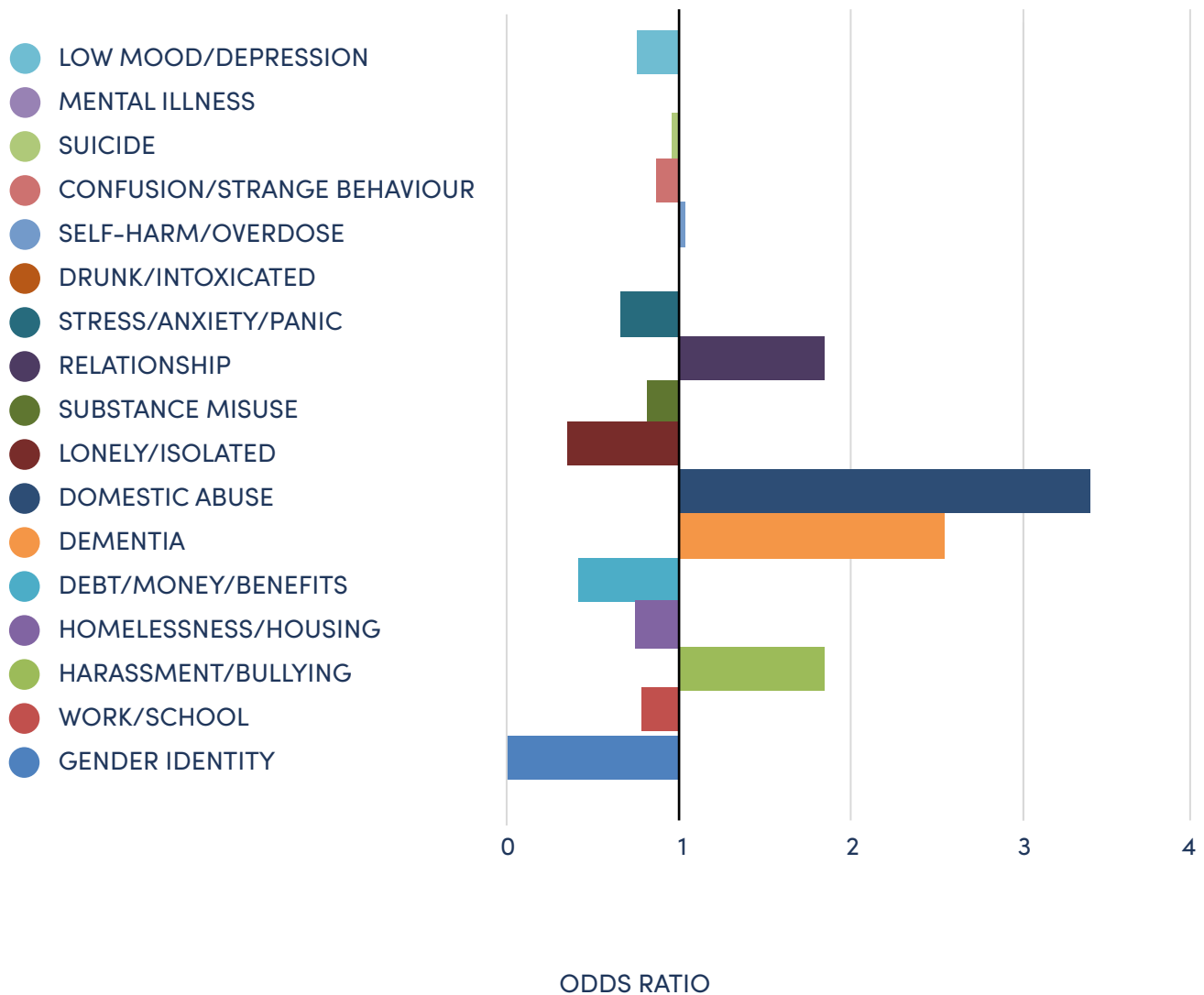


Figure 18 shows the Odds Ratio of each category where the caller was a professional. The figure shows that the ratios are higher in the suicide and self-harm/overdose categories relative to the other type of relationships and lower in the relationship, domestic abuse and gender identity categories.

Figure 18:
Odds Ratios by Index Problem for Type of Caller - Professional

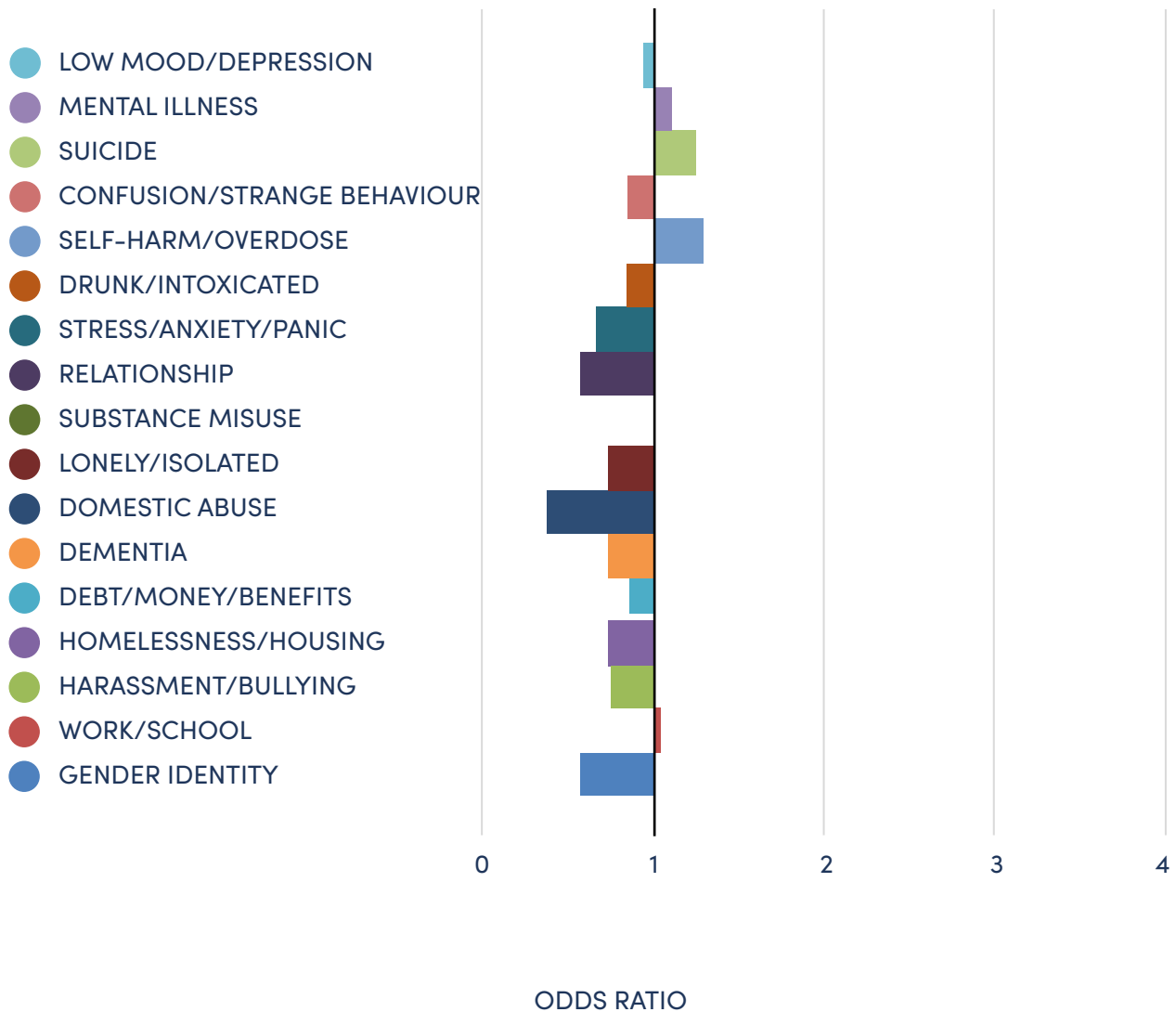
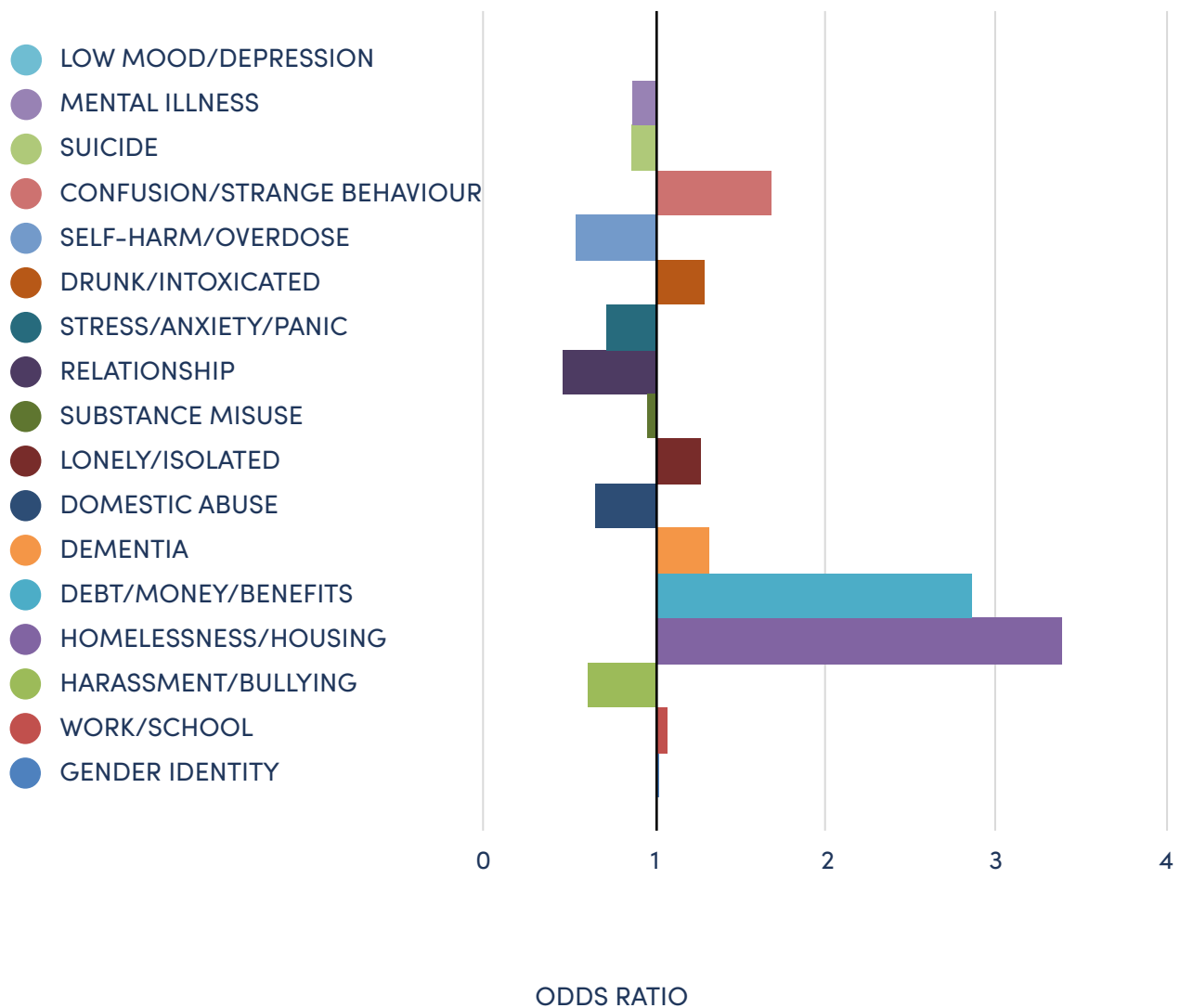


Figure 19 shows the Odds Ratio of each category where the caller was a member of the public or stranger. The figure shows that the ratios are higher in the confusion/strange behaviour, debt/money/benefits and homelessness/housing categories relative to the other type of relationships and lower in the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

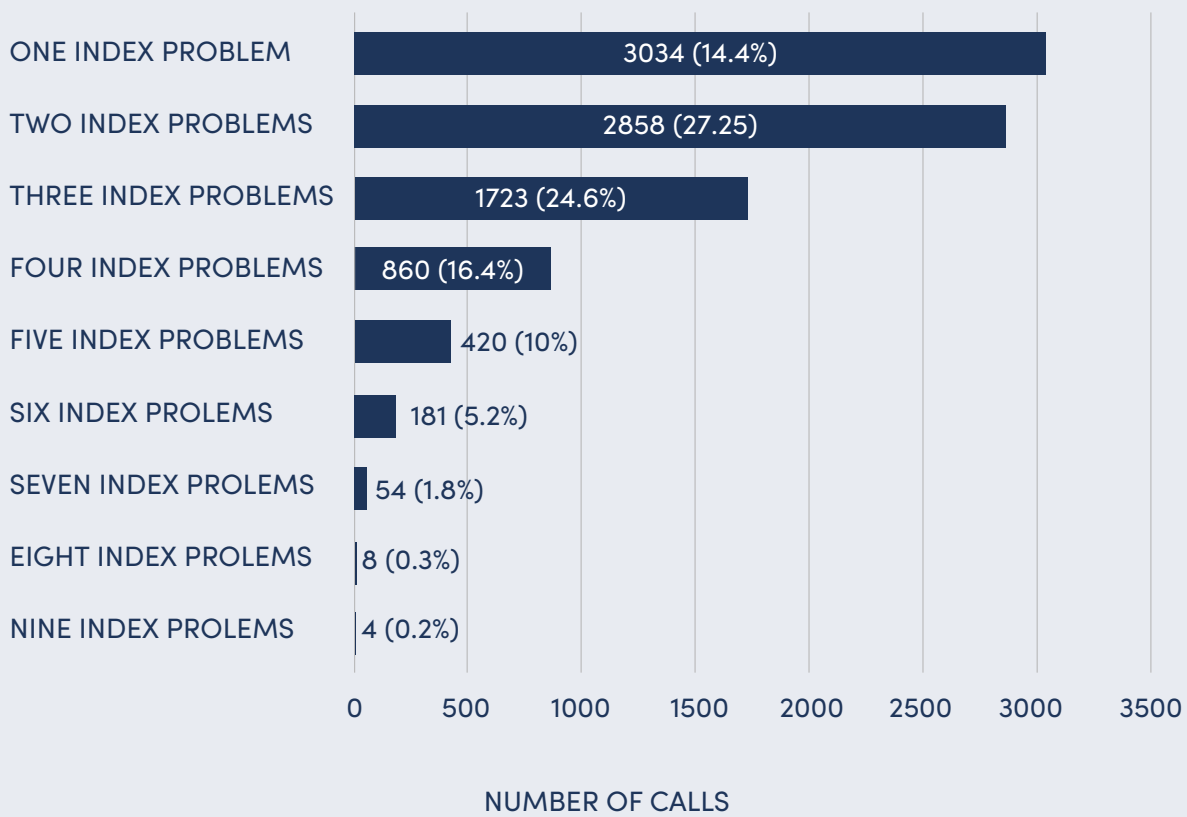
Figure 19:
Odds Ratios by Index Problem for Type of Caller - Public or Stranger



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 %



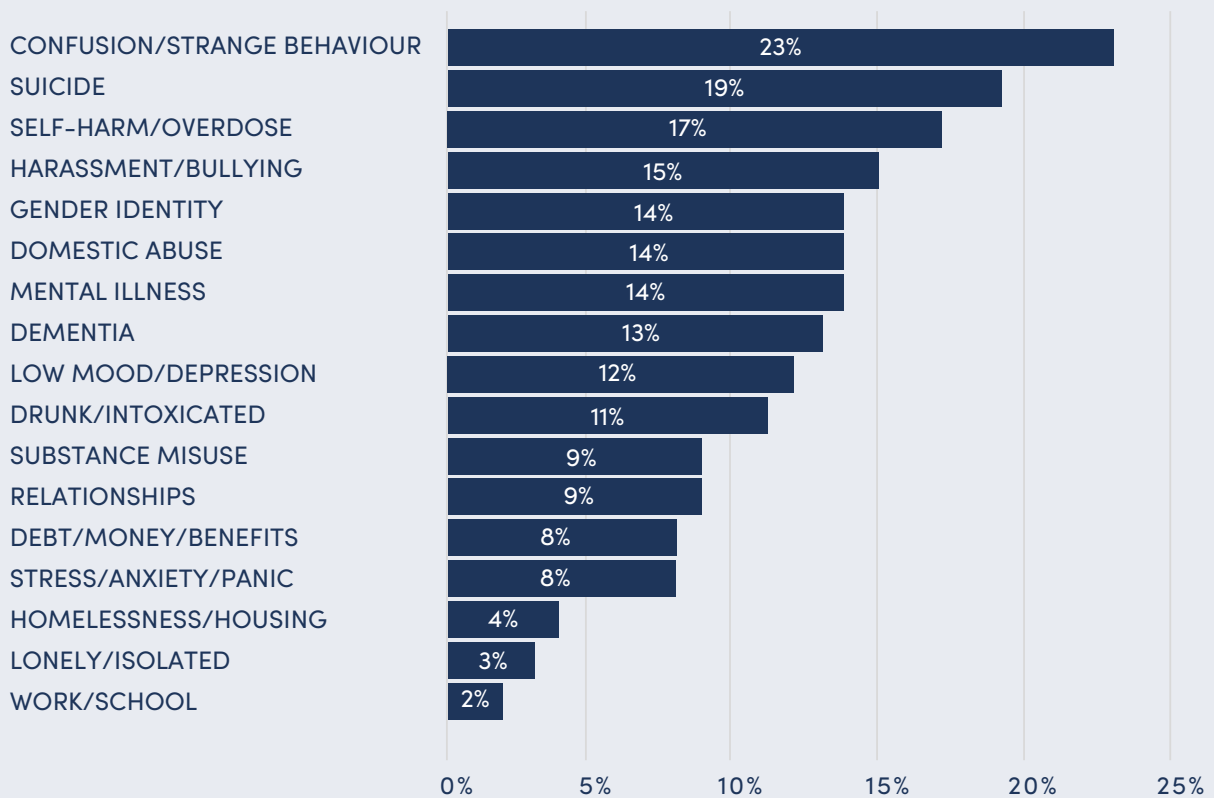
Across the seventeen categories the number of calls where only one index problem was recorded averaged 14% and ranged from 2% for work/school to 23% for confusion/strange behaviour.

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



PROPORTION OF 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 important⁹¹.

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

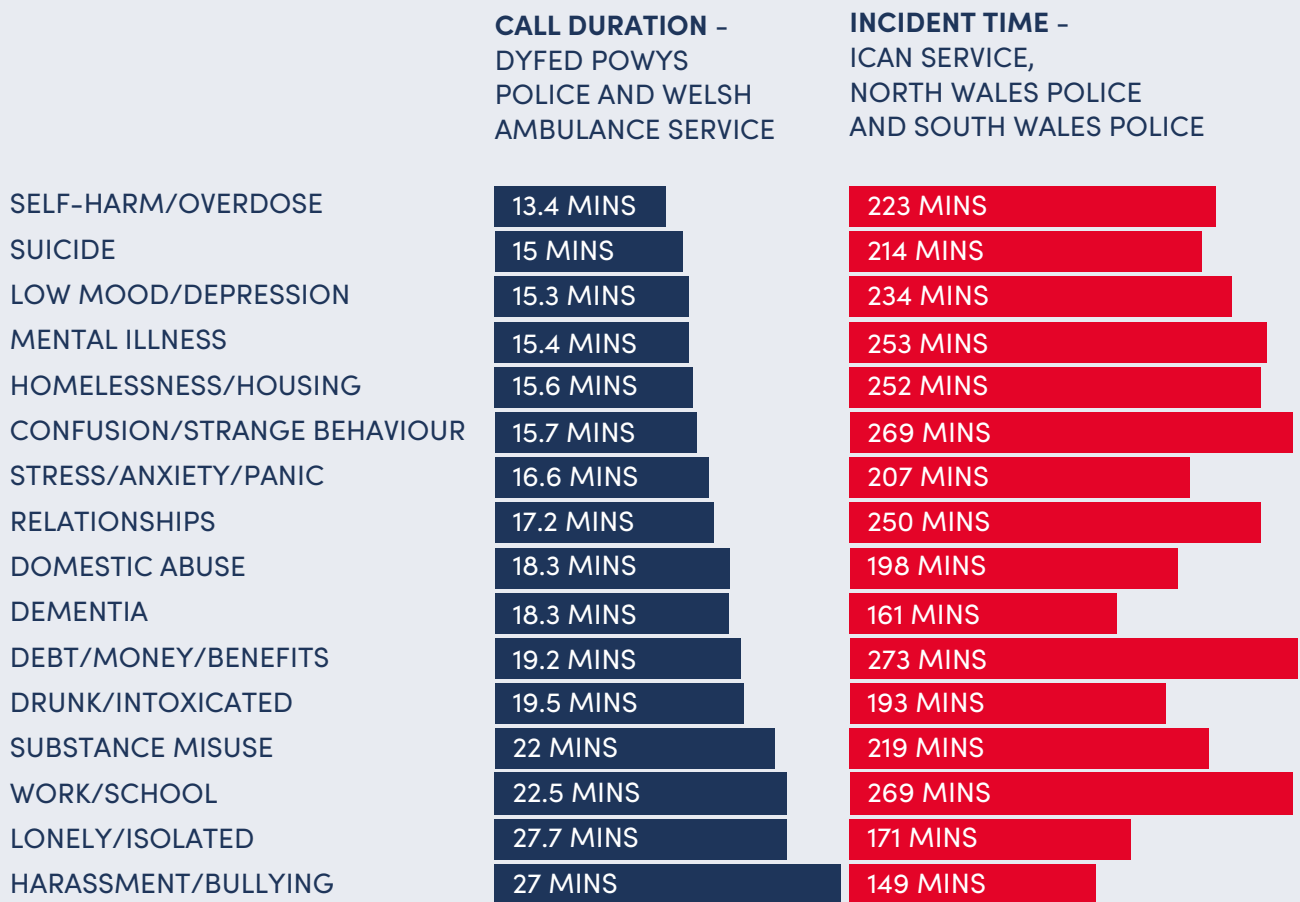
	Dyfed Powys Police	Welsh Ambulance Service	North Wales Police	South Wales Police	ICAN Service
Average call duration/ incident time in minutes	14mins	18 mins	121 mins	190 mins	228 mins

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

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.

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

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 casualties, ‘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 call⁹². 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

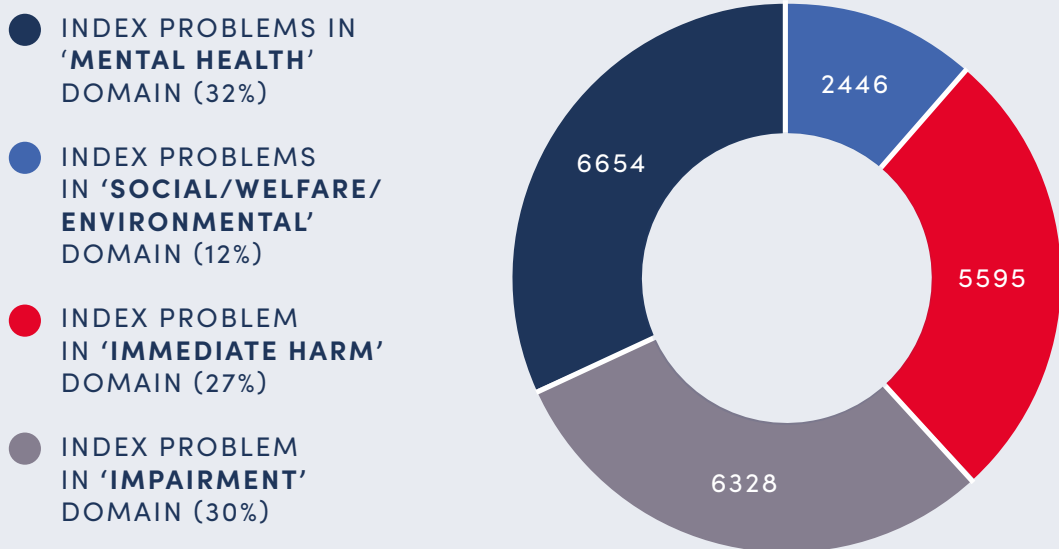
Index problems in ‘Immediate harm’ domain	Index problems in ‘Impairment’ domain	Index problems in ‘Mental health’ domain	Index problems in ‘Social/welfare/environmental’ domain
<ul style="list-style-type: none"> • Suicidal • Self-harm/Overdose • Domestic abuse 	<ul style="list-style-type: none"> • Drunk/Intoxicated • Confusion/Strange behaviour • Stress/Anxiety/Panic • Substance Misuse 	<ul style="list-style-type: none"> • Low mood/Depression • Mental illness • Dementia 	<ul style="list-style-type: none"> • 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%	

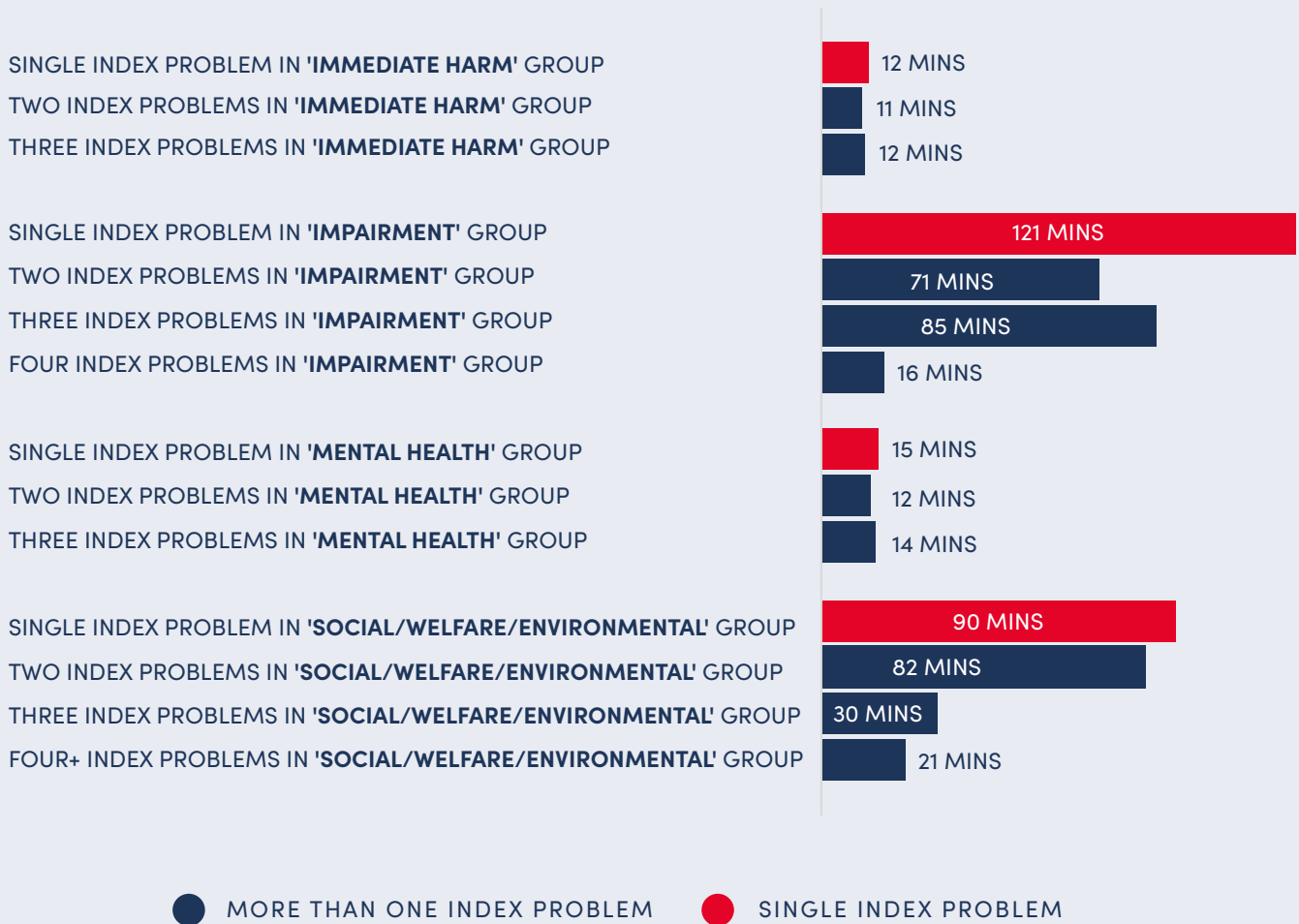
One of the main objectives of an emergency services call handler is to determine what action to take on the basis of an array of presenting features of the callers' situation. The call handler selects a response based on knowledge of appropriate or available responses. A call handler in emergency services 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 UK⁹³. People with depression typically have lots of negative thoughts and feelings of guilt and worthlessness; they often criticise themselves and lack confidence⁹⁴.

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 at increased risk of suicide⁹⁵, self-harm⁹⁶ or aggression⁹⁷, 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.

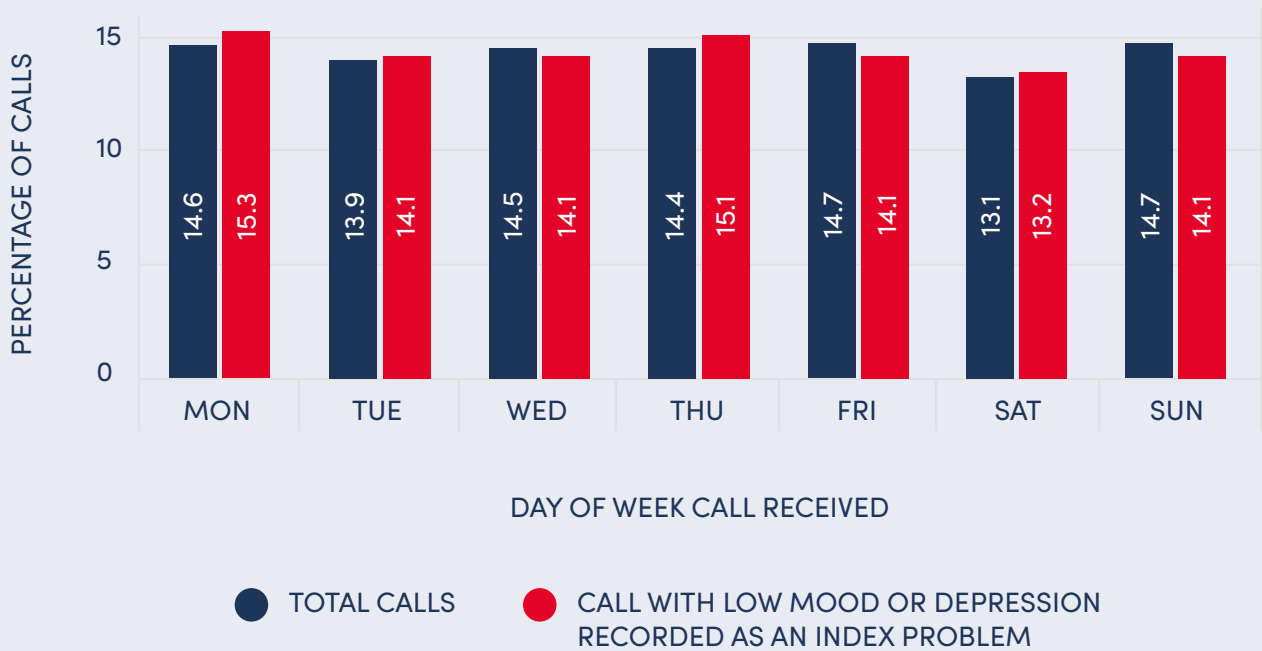
27.3 Day of the Week of Calls

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 27% 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



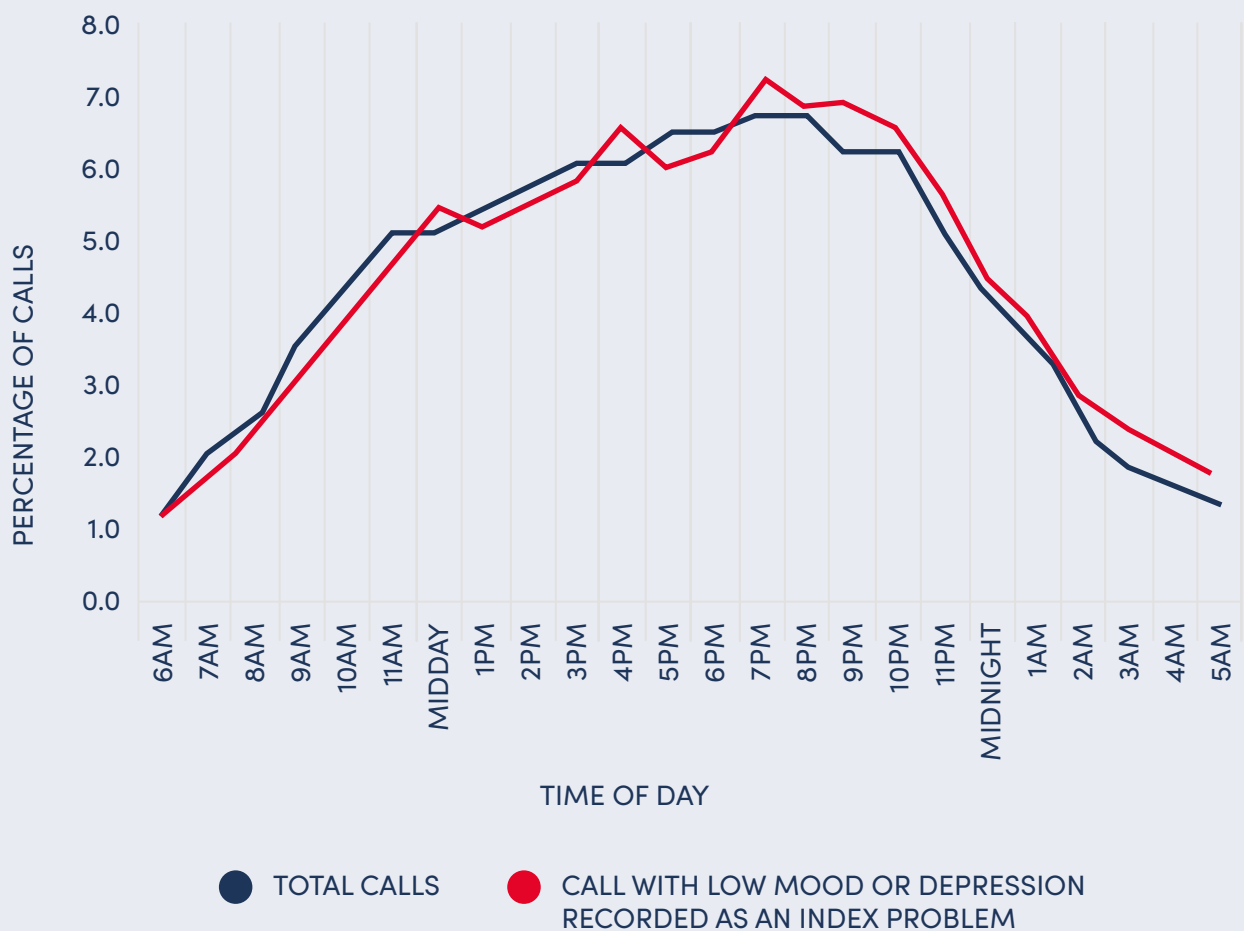
27.4 Time of Day of Calls

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 aversive 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 problems⁹⁸. 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 help⁹⁹.

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.

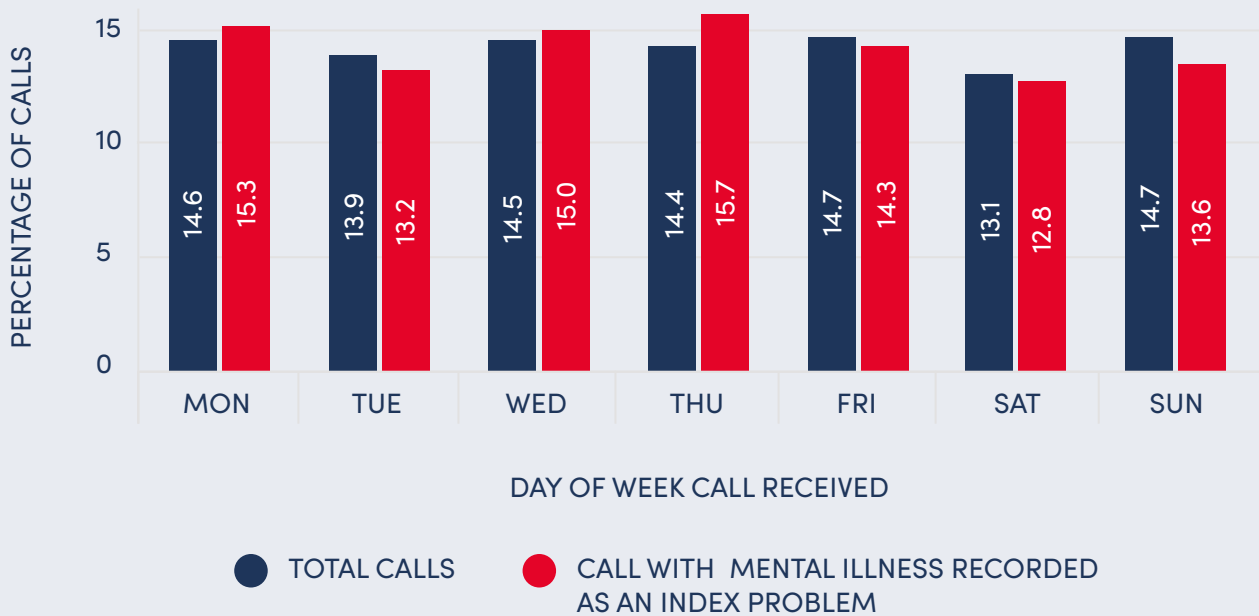
The bespoke data collection documented where a caller had stated that they, or the person the call was in relation to, had a potential, current or past diagnosis of mental illness. These statements are unverified and this data should not be taken as indicative of population prevalence of mental illness. 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 26% 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



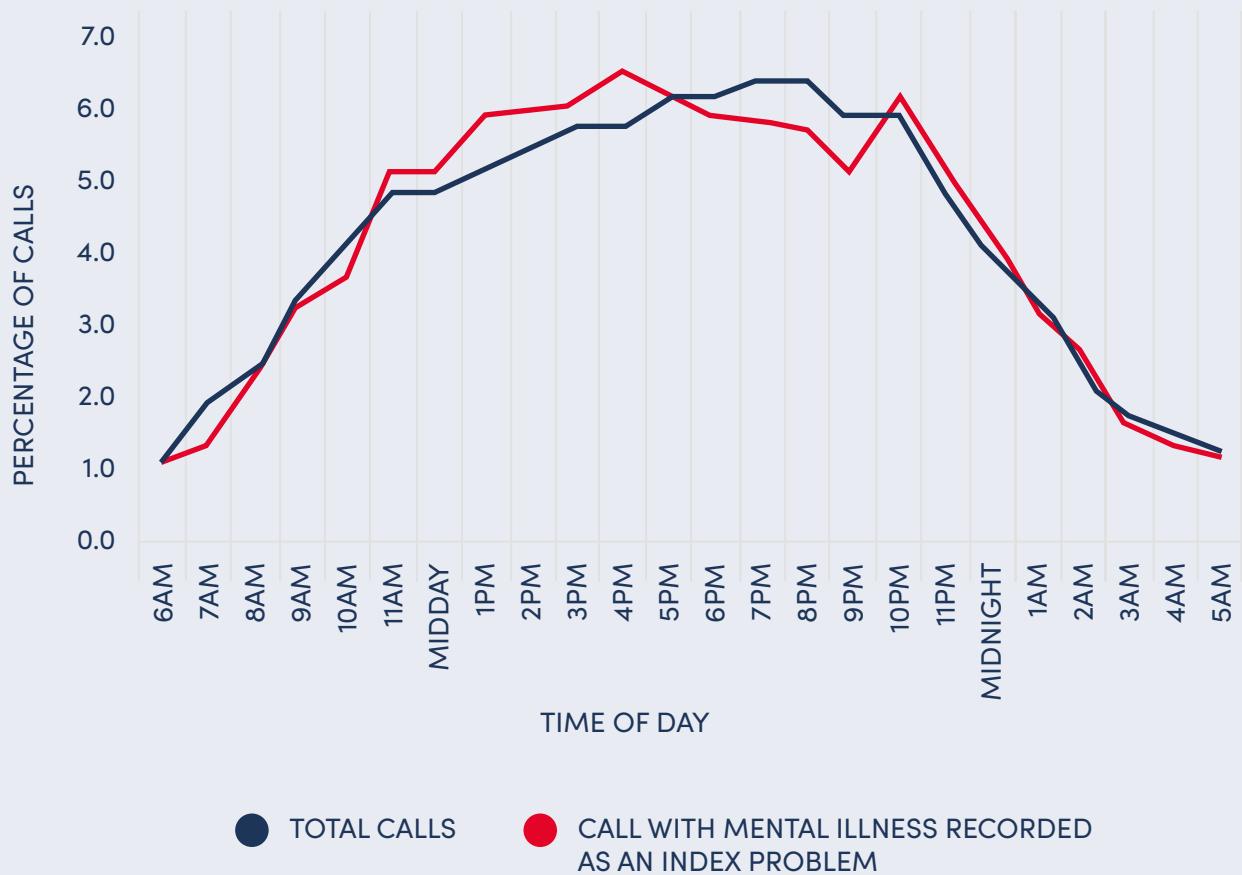
28.4 Time of Day of Calls

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 Wales¹⁰⁰. 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 months¹⁰¹. 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 death¹⁰² with similar findings reported in other areas¹⁰³. There are factors associated with a higher risk of suicide, such as men aged between 45 and 49 and male divorcees¹⁰⁴. 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 Policing¹⁰⁵. Police may be able to identify and signpost people presenting with suicidal thoughts and behaviours who are not known to mental health services¹⁰⁶.

29.2 Data Overview

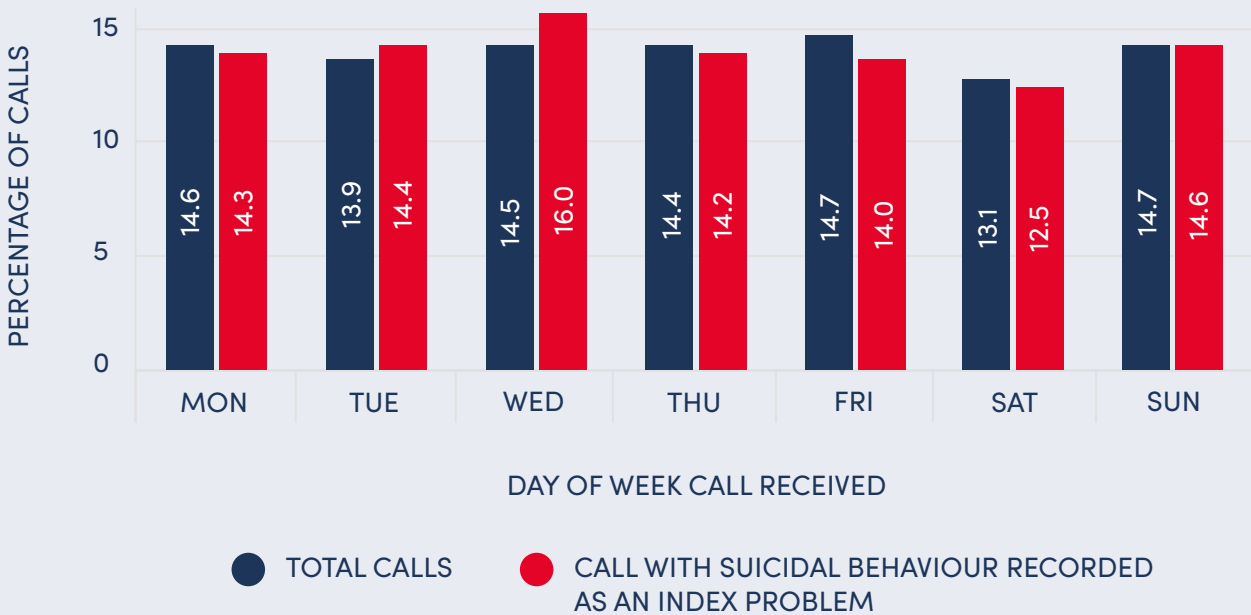
The term 'suicidal behaviour' was the trigger word for call handlers as it is often used by people to describe those contemplating or attempting to end their own life, although intent can be difficult to determine, so there is overlap with self-harm. The bespoke data collection documented where a caller 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

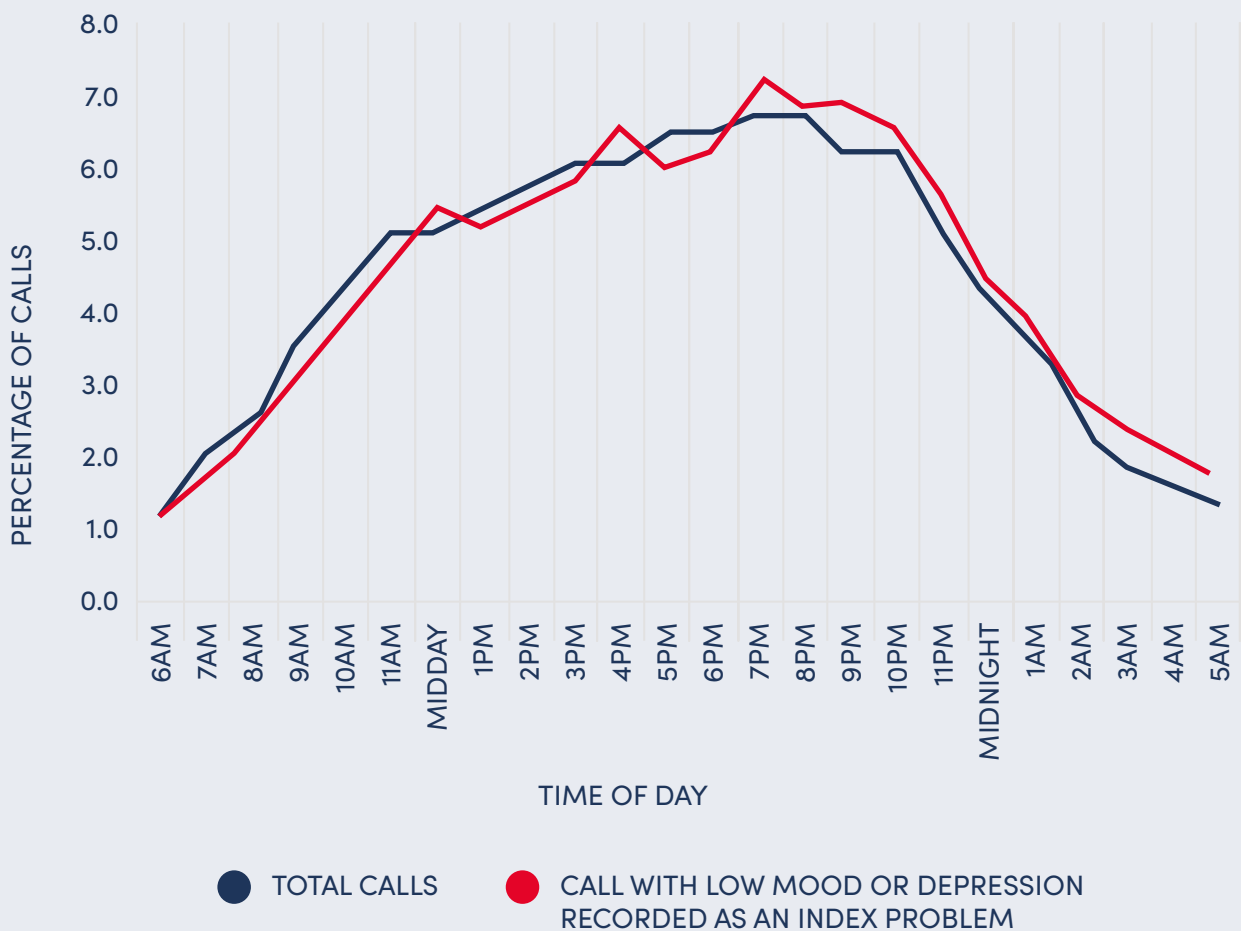


29.4 Time of Day of Calls

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

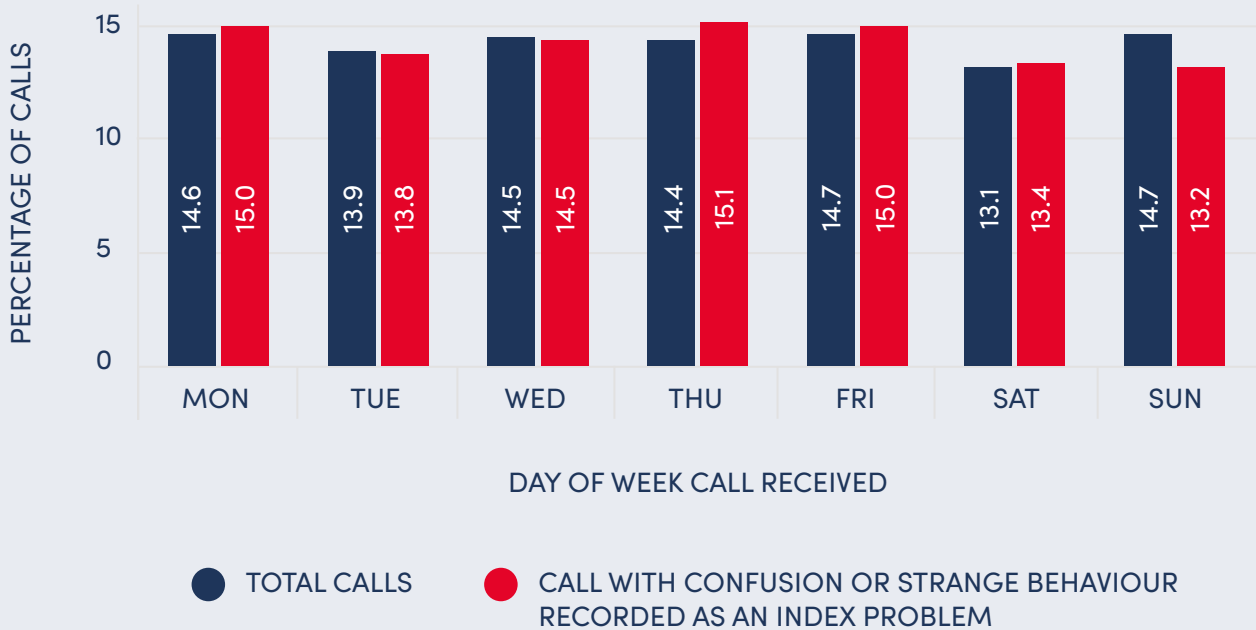
The term 'confusion' and 'strange behaviour' were the trigger words for call handlers as they are often used by people to describe unfamiliar or atypical conduct. The bespoke data collection documented where a caller had stated that they, or the person the call was in relation to, was confused or was 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

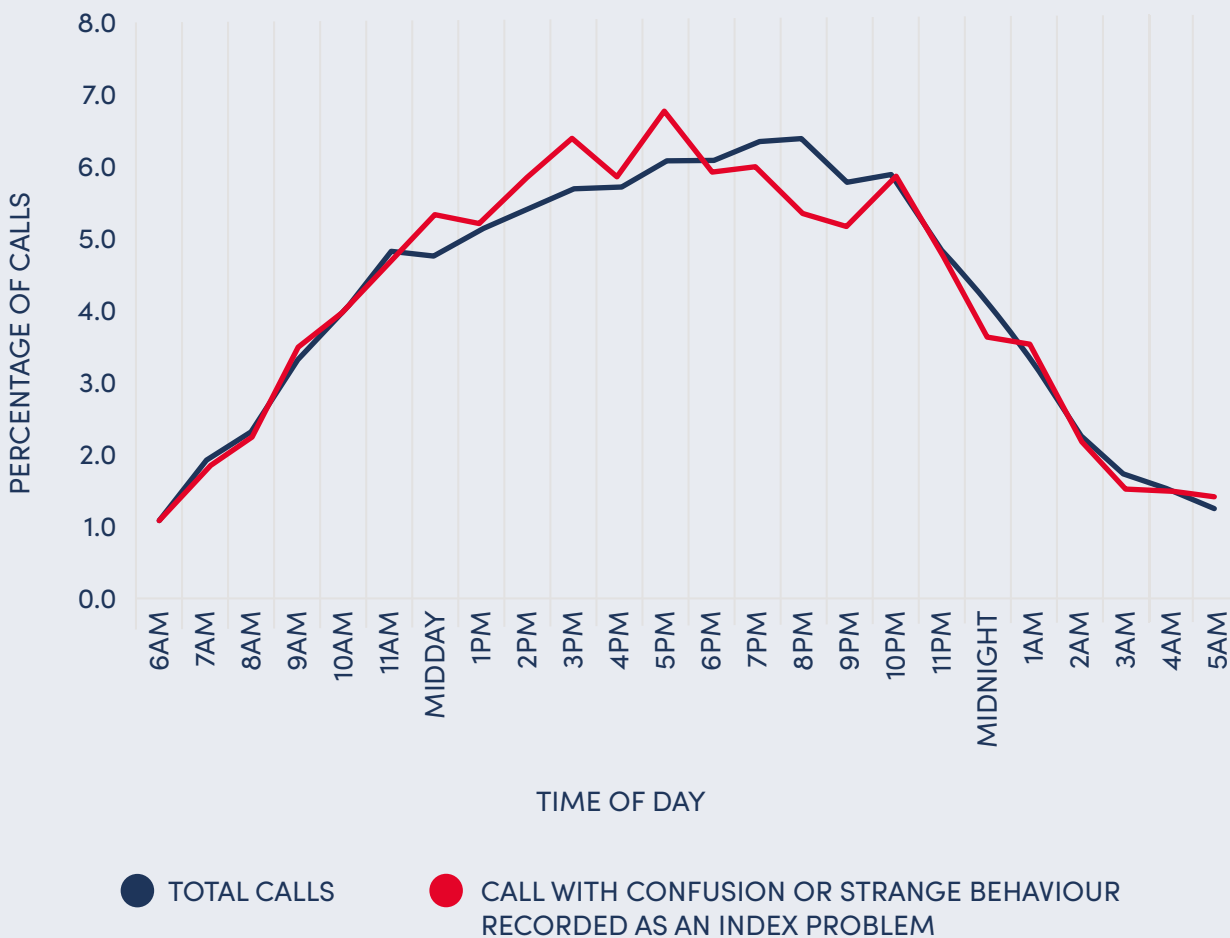


30.4 Time of Day of Calls

A total of 100% (2,939) of calls were able to record the 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.

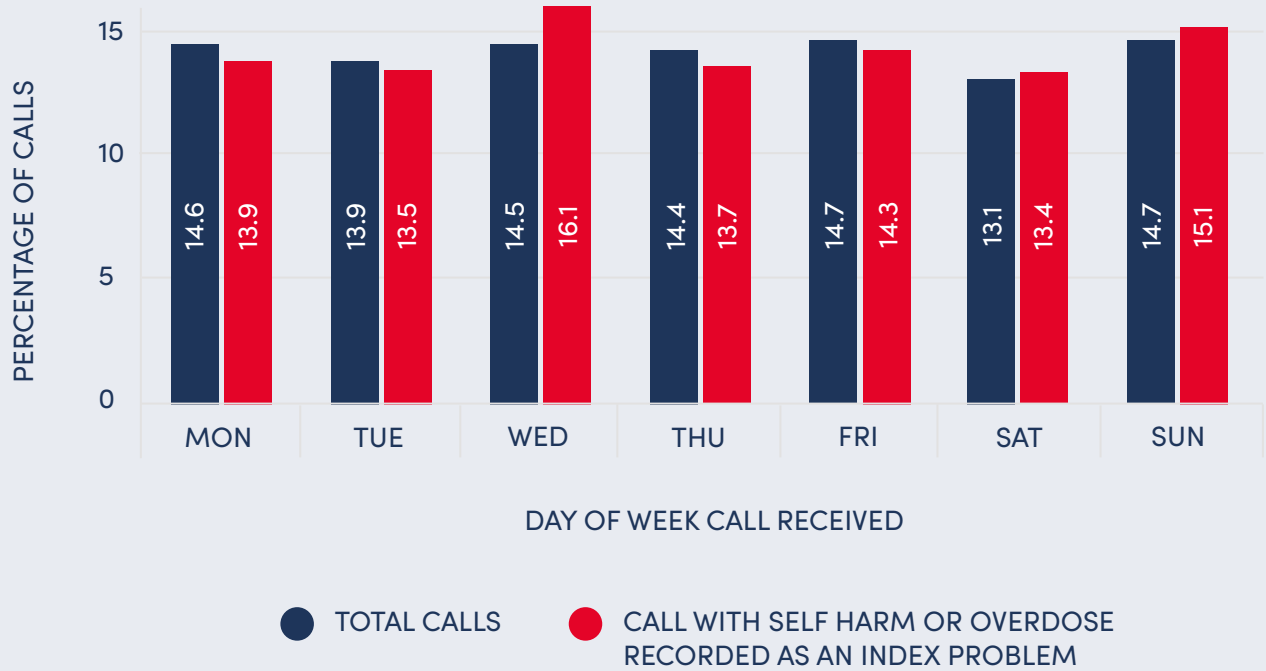
The bespoke data collection documented where a caller had stated they had self-harmed or deliberately overdosed, or that the person they were calling about had stated intent or were exhibiting signs or behaviour, which could indicate self-harm or deliberate overdose. A total of **2,081** calls recorded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



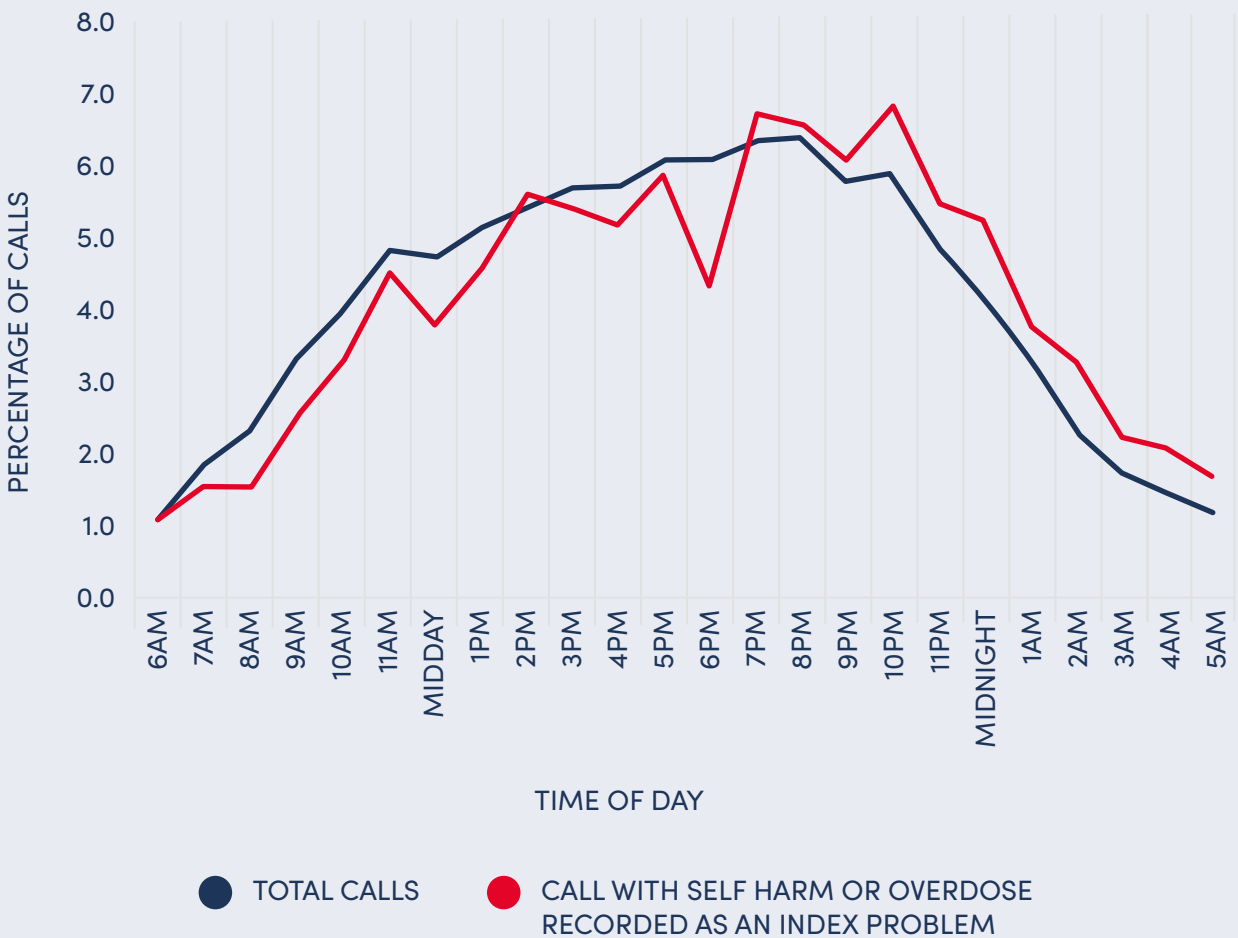
31.4 Time of Day of Calls

A total of 96% (1,998) of calls were able to record the 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 Studies¹⁰⁸ 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 safely provide support to intoxicated individuals without recourse to arrest or use of emergency departments.

32.2 Data Overview

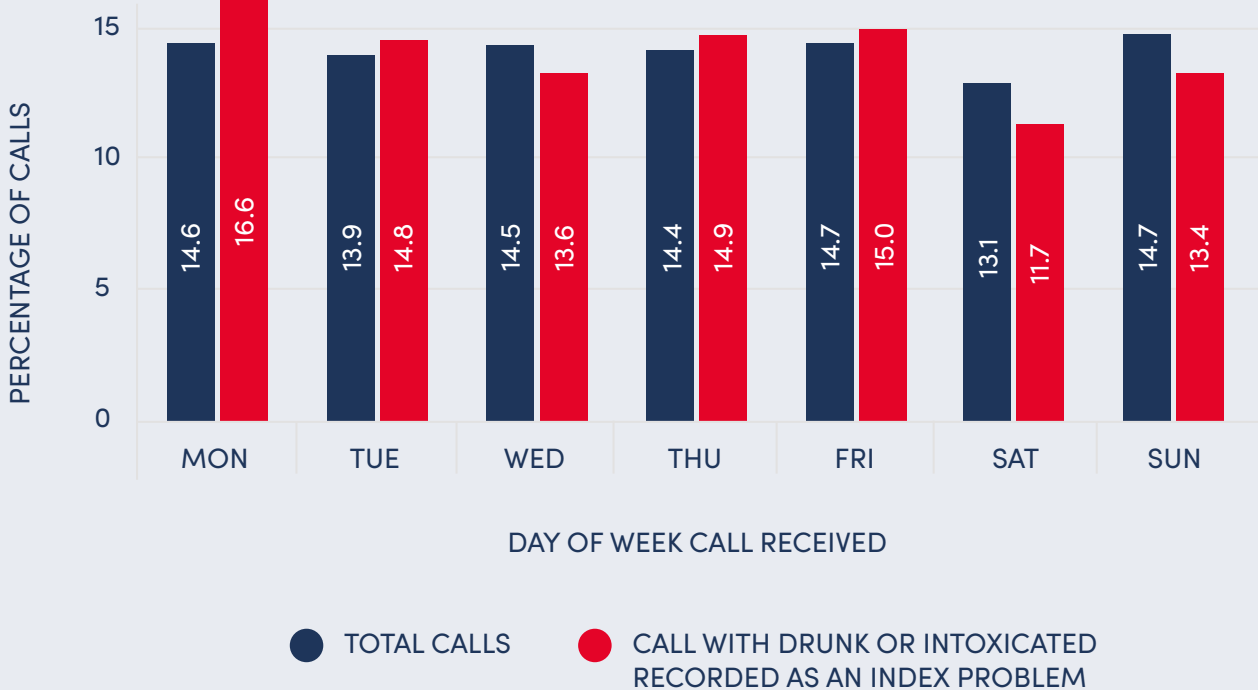
The term ‘drunk’ and ‘intoxicated’ were the trigger words for call handlers as they are often used by people to describe persons with severe cognitive and/or physical impairment due to alcohol consumption although there is overlap with substance misuse, confusion and strange behaviour. The bespoke data 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



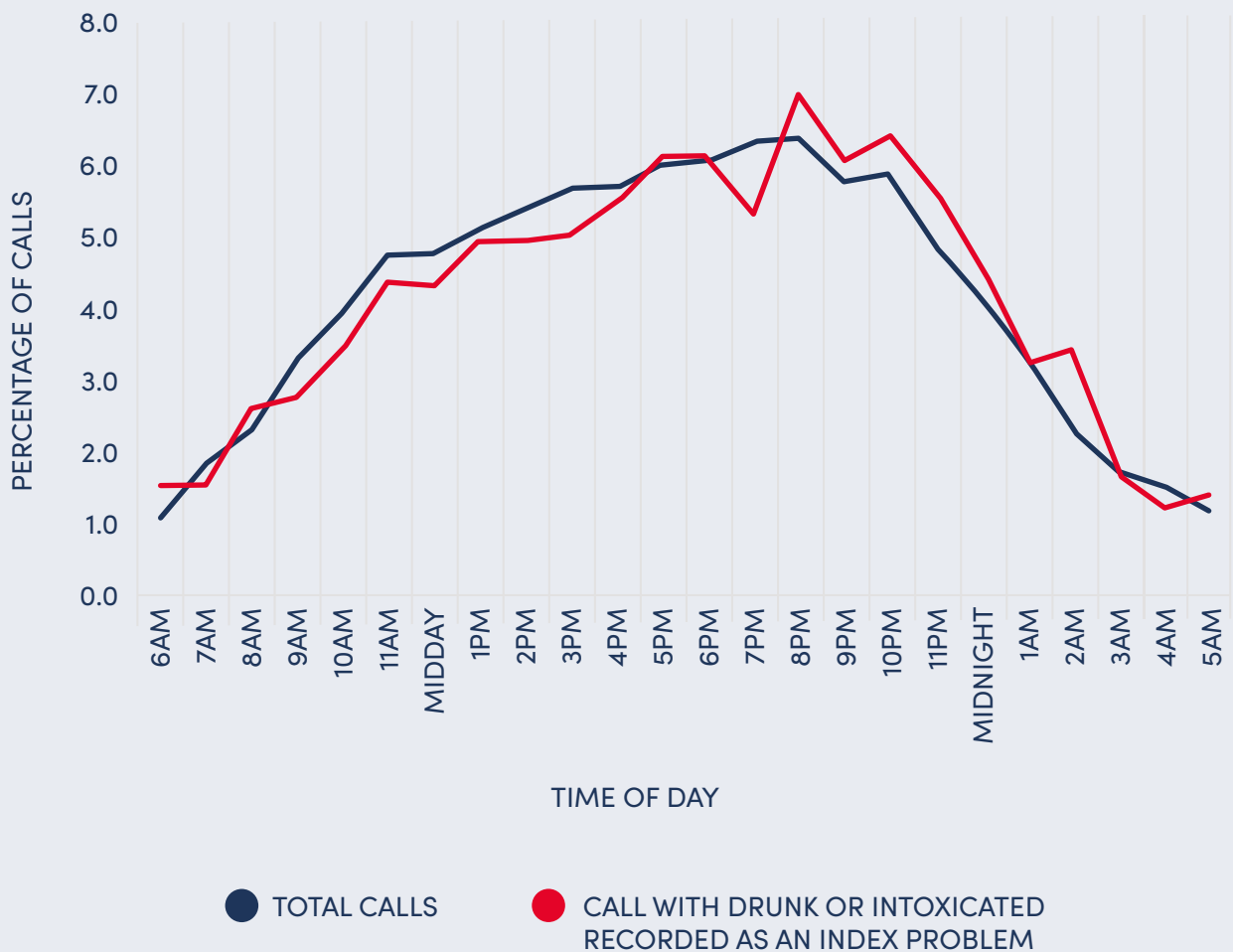
32.4 Time of Day of Calls

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 UK¹¹². 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.

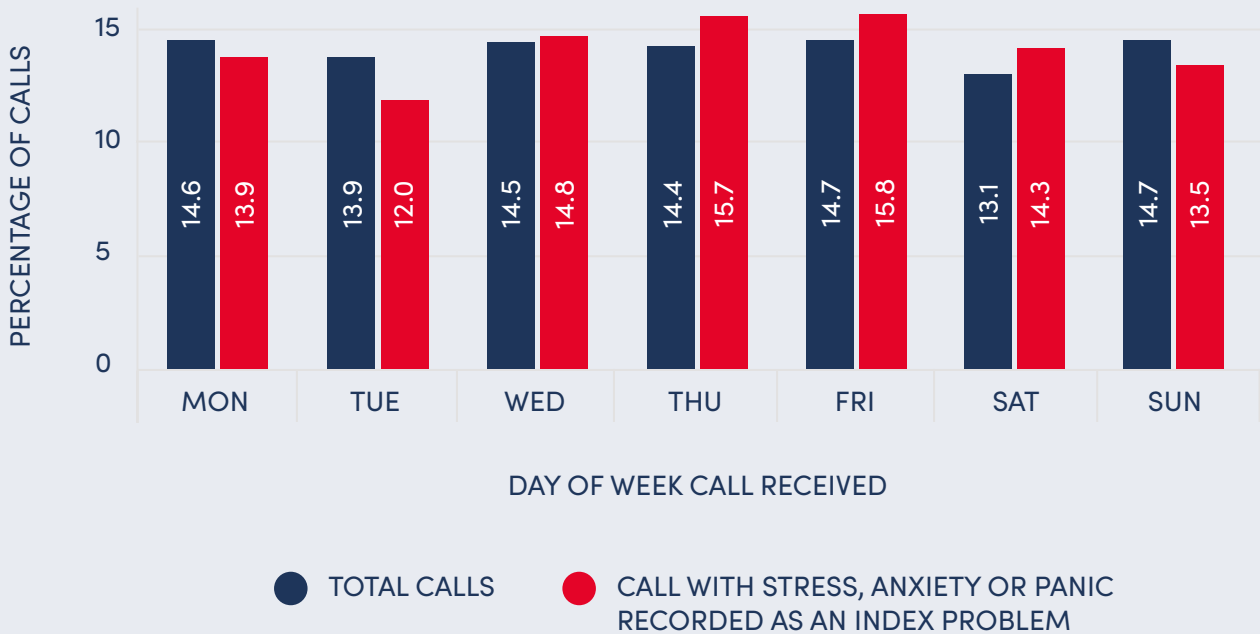
33.3 Day of the Week of Calls

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

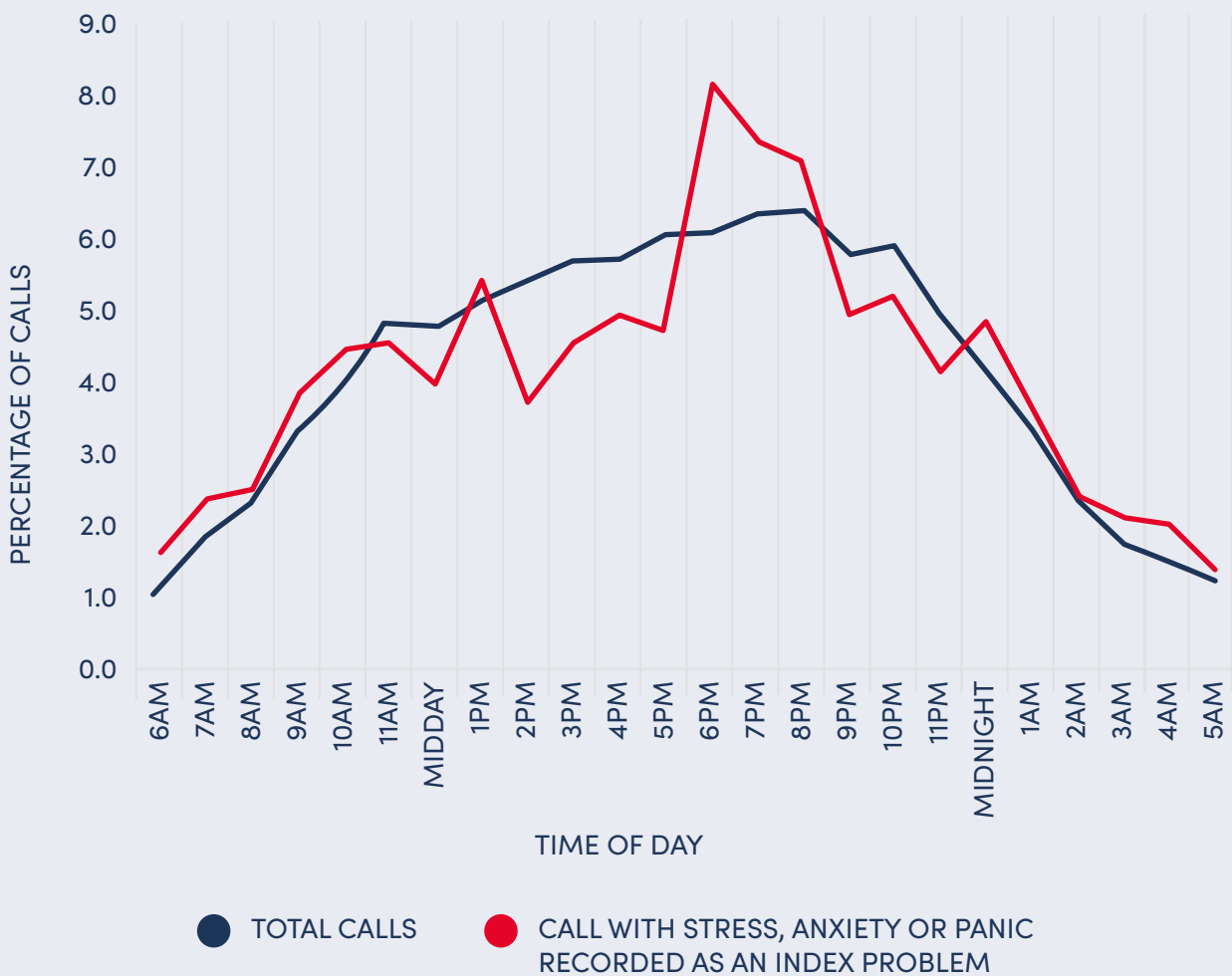


33.4 Time of Day of Calls

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 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

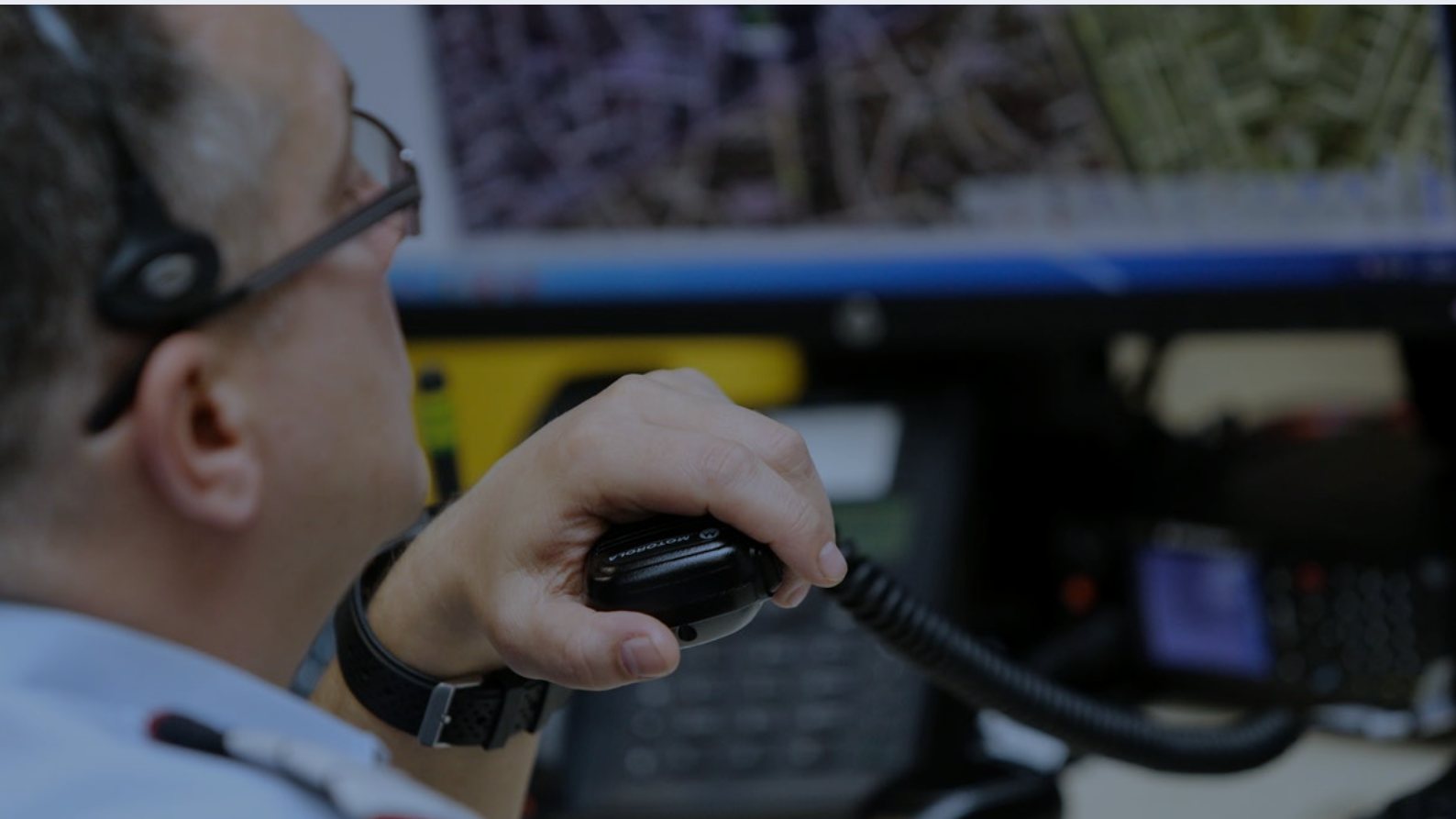
34.2 The Index Problem

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 people¹¹³.

Relationship issues can affect all ages, a survey found that the single biggest presenting problem for children attending mental health services were family relationship problems¹¹⁴. 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

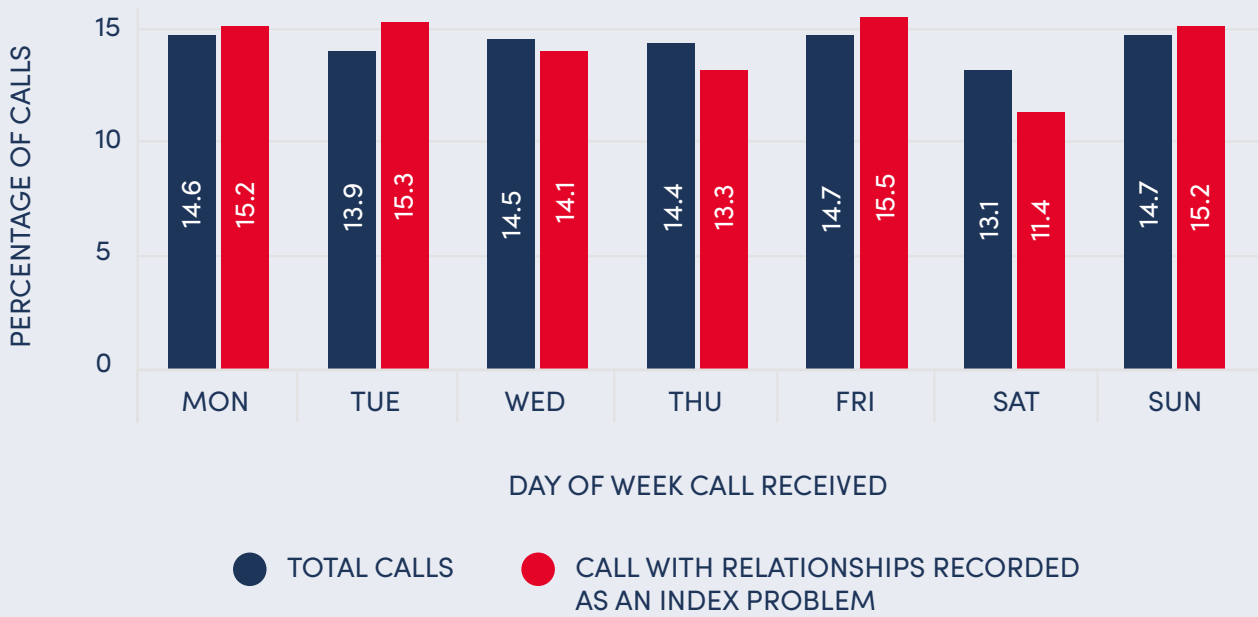
The term ‘relationship’ was the trigger word for call handlers as it is often used by people to describe interpersonal concerns, difficulties, fears, threats or pressures. The bespoke data collection documented where a caller had stated that they, or the person they were calling about, had an issue with 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 27% 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



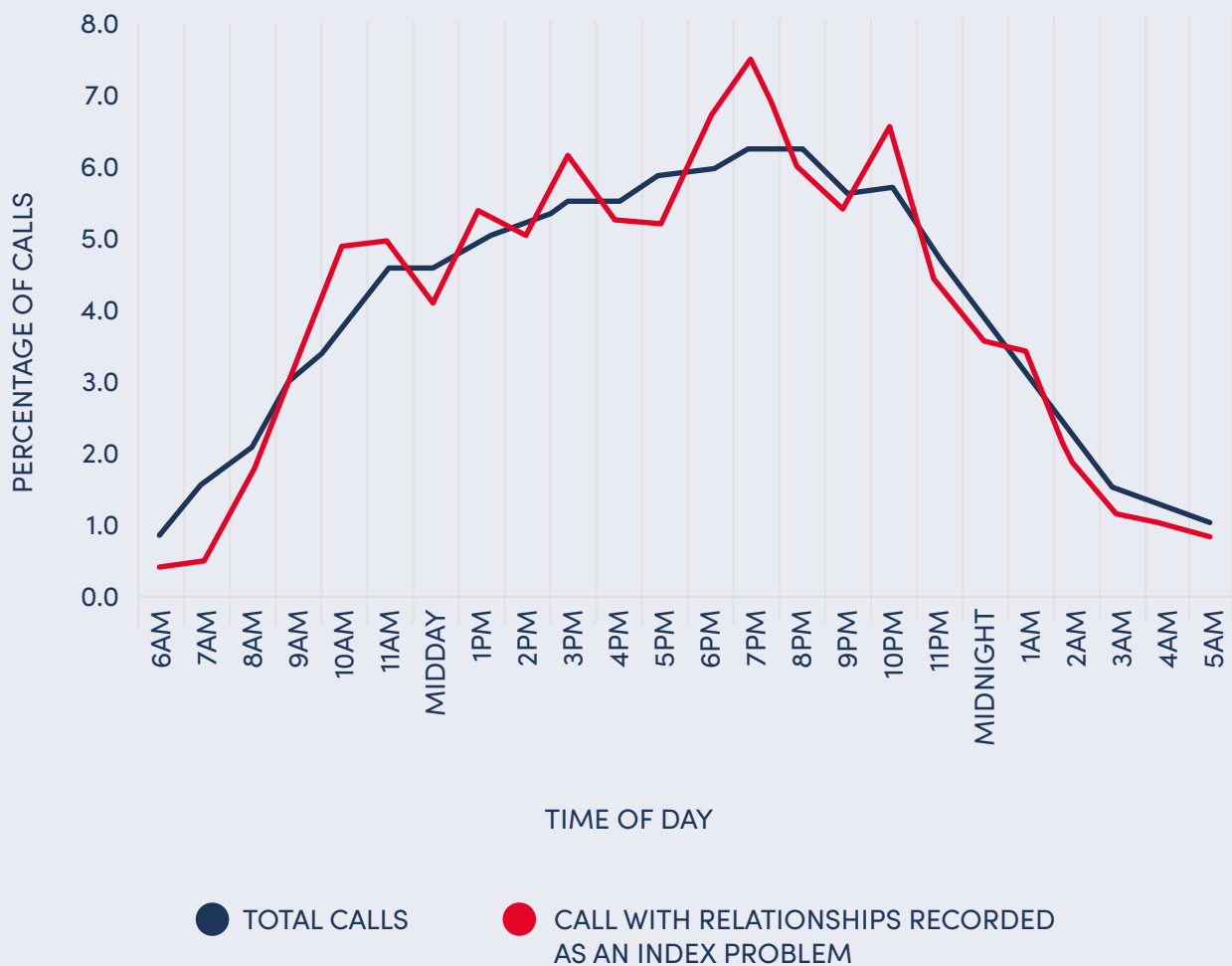
34.5 Time of Day of Calls

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 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 Wales¹¹⁷. In the first 9 months of 2019 over 20,000 referrals were made to substance misuse treatment services in Wales¹¹⁸. 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 welfare¹¹⁹.

35.2 Data Overview

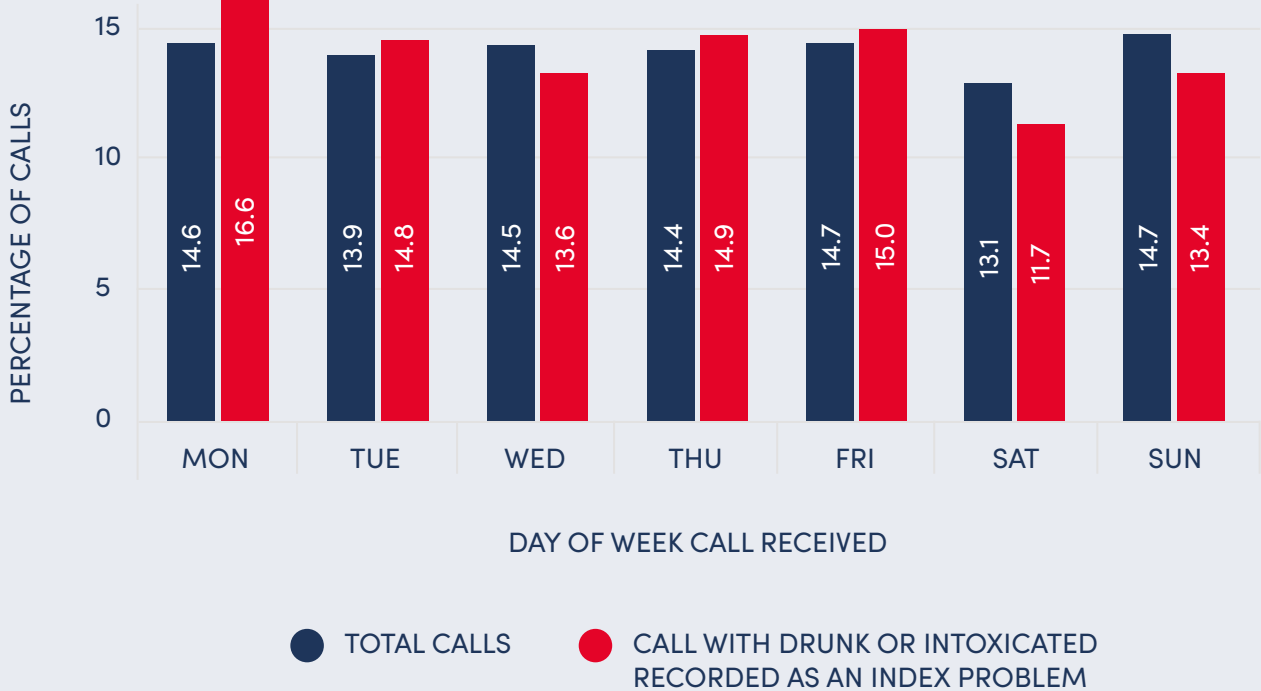
The term 'substance misuse' was the trigger word for call handlers as it is often used to describe addiction or affected behaviour due to the injection or ingestion of legal or illicit substances or medications. The bespoke data collection documented where a caller had stated they had issues related 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 28% 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

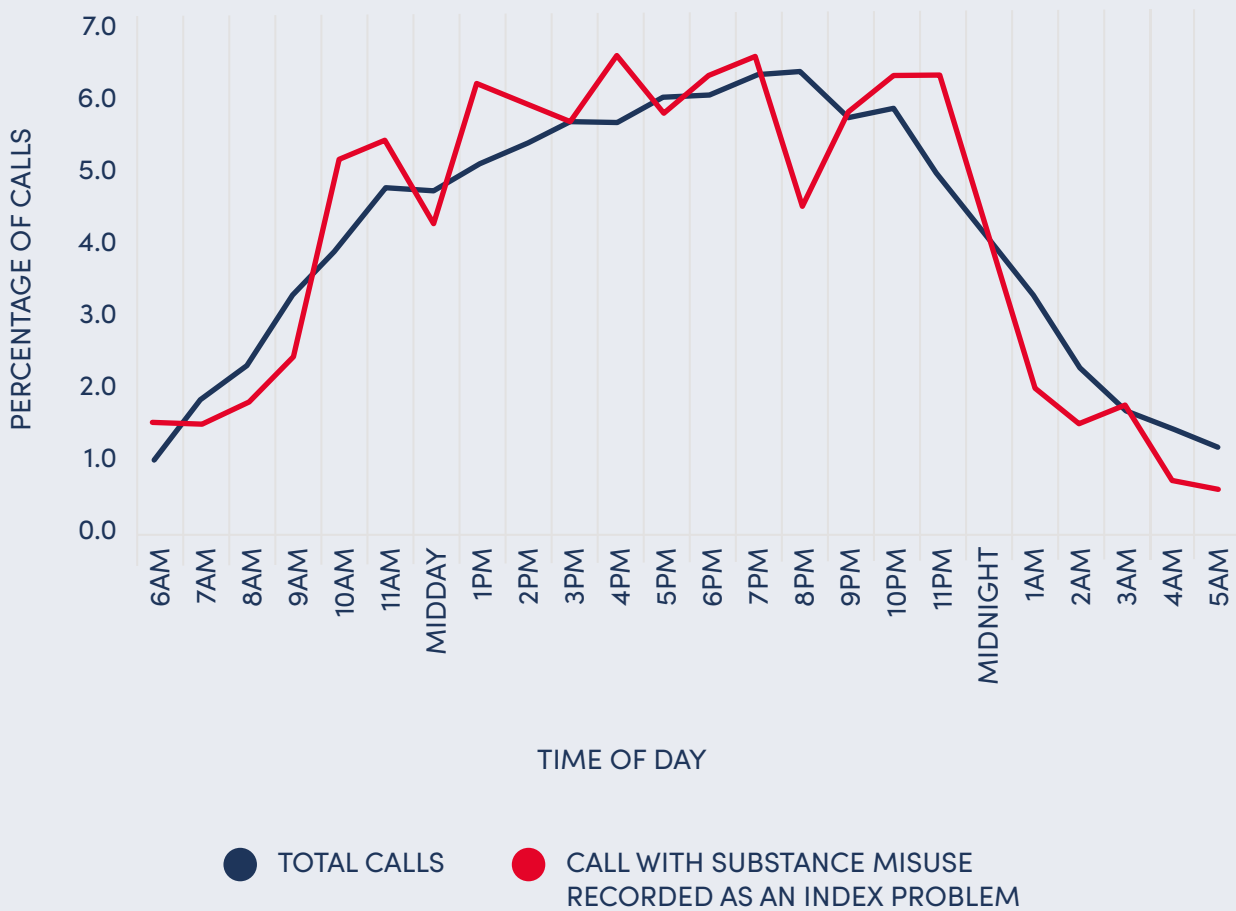


35.4 Time of Day of Calls

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 outcomes¹²⁰. Loneliness can lead to various psychiatric disorders like depression, alcohol abuse, sleep problems and personality disorders¹²¹. 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 obesity¹²².

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 loneliness¹²³. 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.

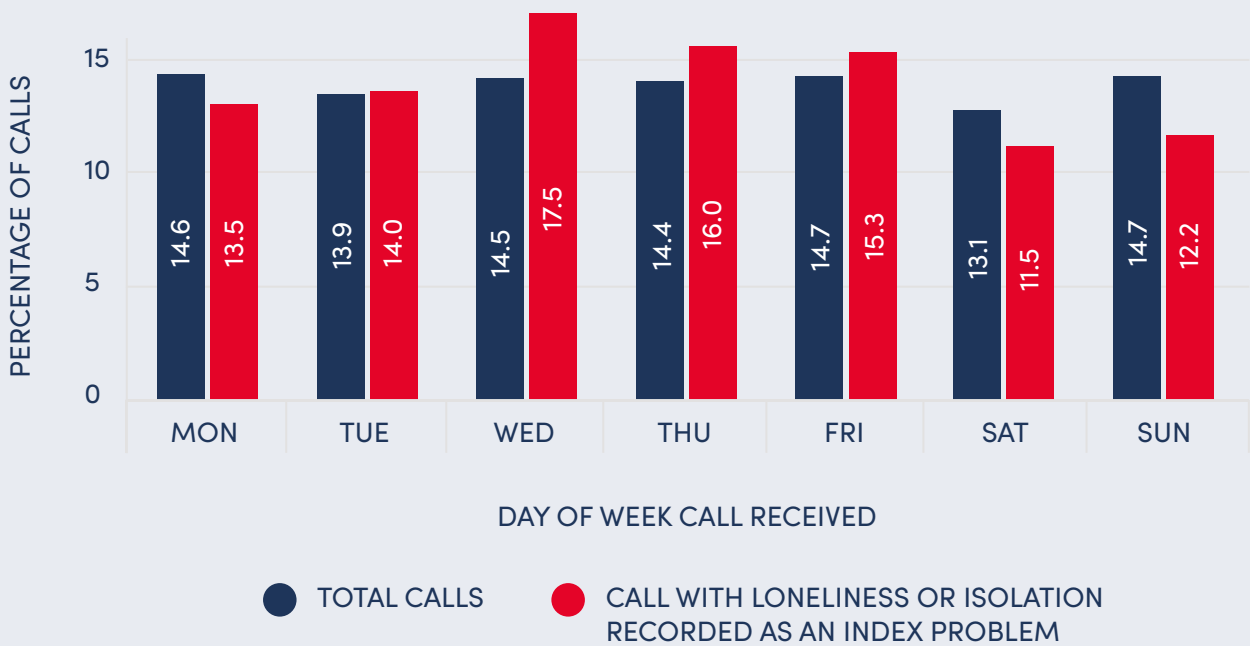
36.3 Day of the Week of Calls

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 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

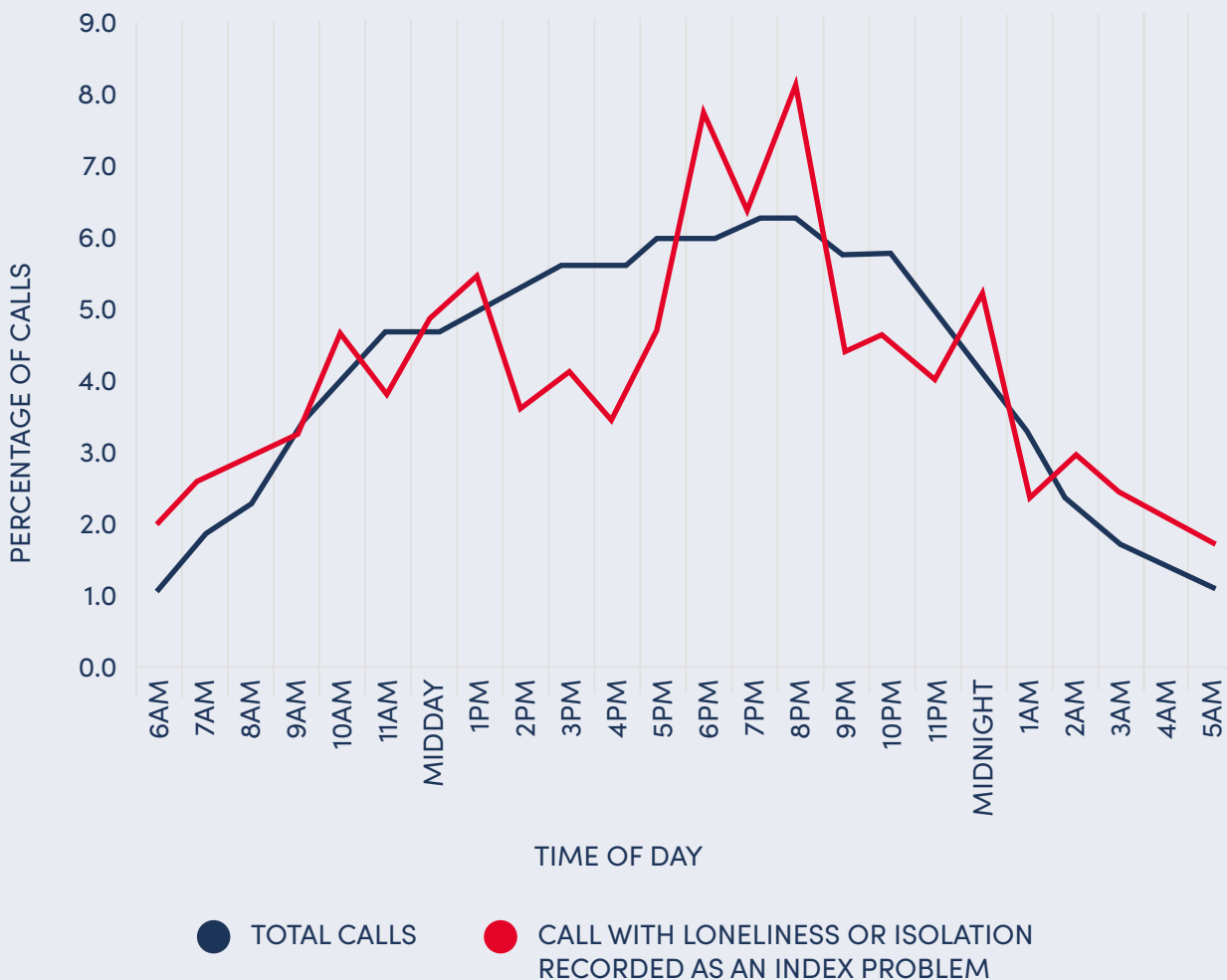


36.4 Time of Day of Calls

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 illness¹²⁴. Domestic abuse is associated with depression, anxiety and substance abuse¹²⁵. 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 problems¹²⁶.

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 health¹²⁷.

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

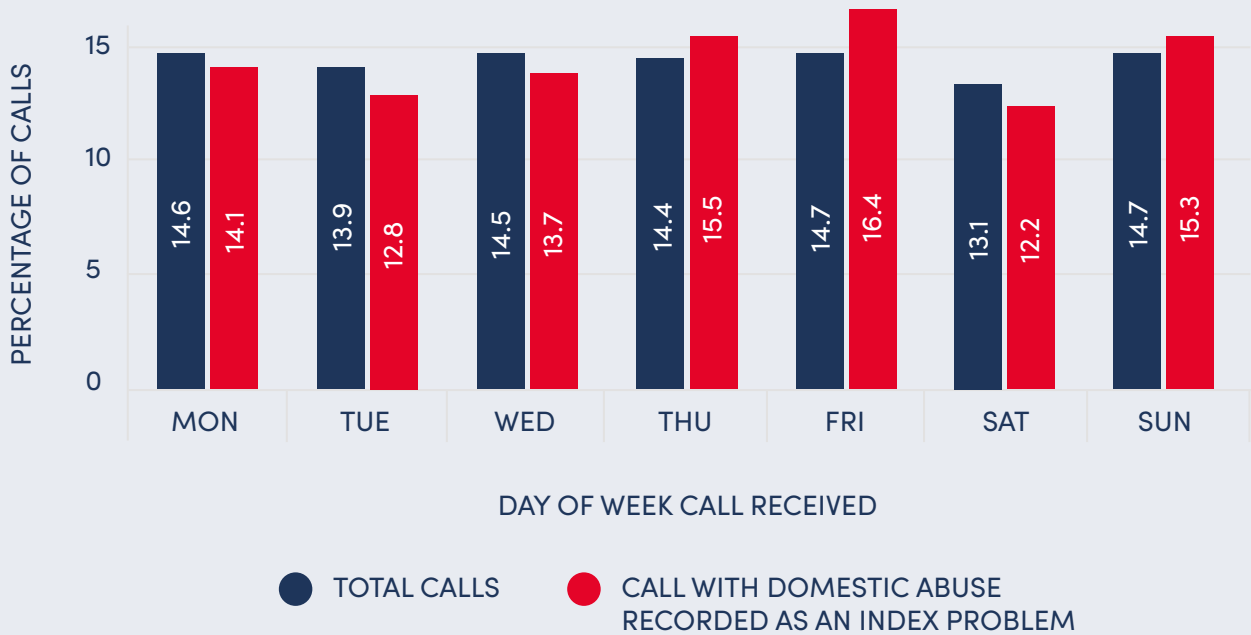
The term 'domestic abuse' was the trigger word for call handlers as it is often used to describe any type of controlling, bullying, threatening or violent behaviour between people in a relationship. The bespoke data collection documented where a caller had stated they had problems related to domestic 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



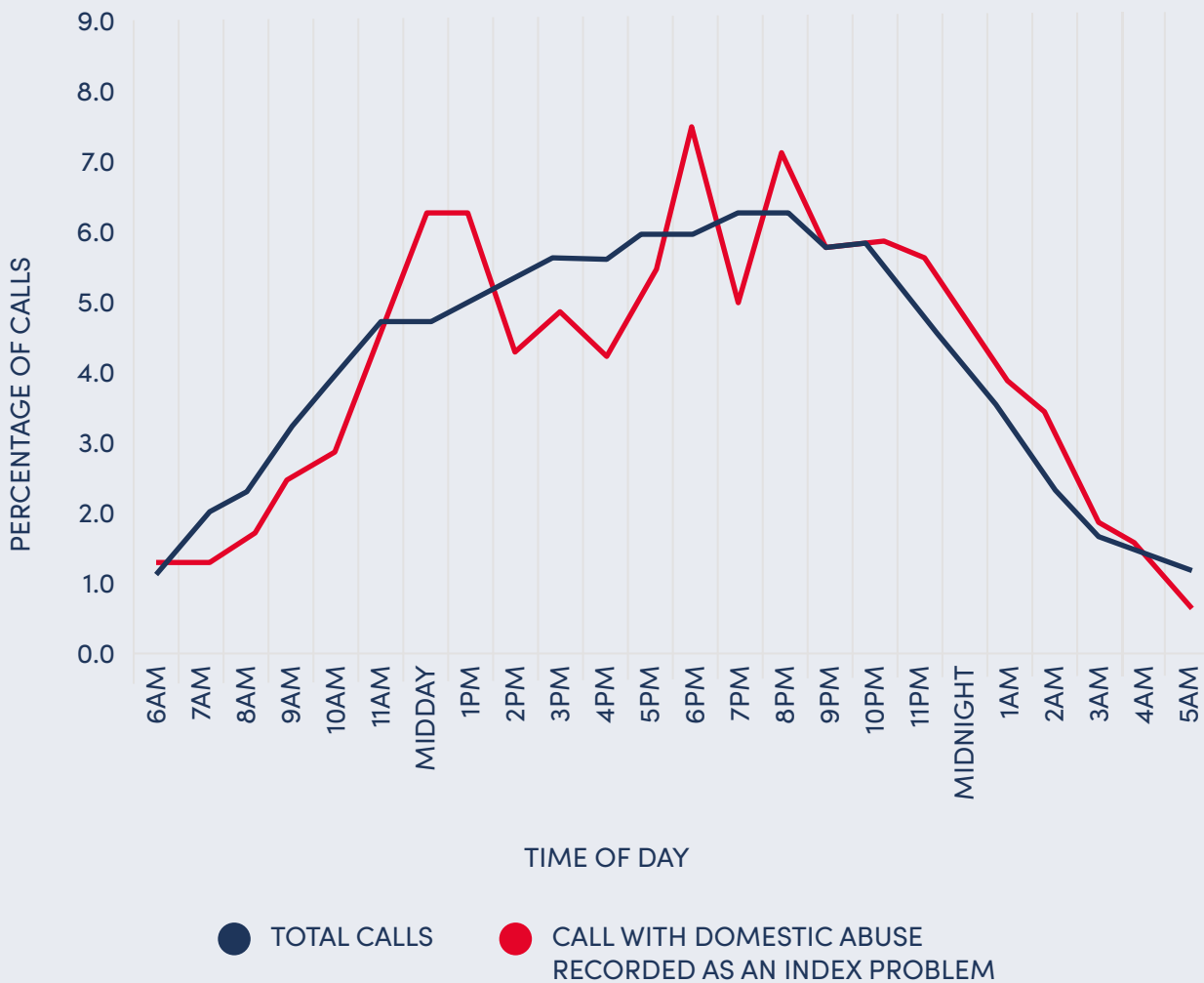
37.4 Time of Day of Calls

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 diagnosed¹²⁸. 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 abuse¹³⁰.

Symptoms of 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 Samaritans¹³¹. There is a higher prevalence of anxiety, depression and other common mental disorders among individuals in debt¹³². Low income levels have been related to psychological distress¹³³, depression^{134,135}, and suicide¹³⁶. 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 it¹³⁸. 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 motivation¹³⁹.

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 benefits as 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 benefits as 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 wellbeing and people with housing problems are at greater risk of mental health problems¹⁴⁰. One in five adults have suffered mental health issues in the last five years, due to housing problems¹⁴¹. Children living in crowded homes are more likely to be stressed, anxious and depressed, have poorer physical health, and attain less well at school¹⁴².

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 housing¹⁴³. 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 care¹⁴⁴. Bereavement and relationship breakdowns are often a factor leading to homelessness¹⁴⁵.

The relationship between homelessness and mental health is well established¹⁴⁶ as it is with housing insecurity more generally¹⁴⁷. 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 law¹⁴⁸.

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 depression¹⁴⁹.

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 stress¹⁵⁰.

A 2020 study has proposed that workplace sexual harassment represents an important risk factor for suicidal behaviour¹⁵¹.

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 bullied¹⁵². Being a victim or perpetrator of bullying has been frequently associated with a range of behavioural, emotional and social problems, including suicide¹⁵³.

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 jobs¹⁵⁸. Specific occupations have been shown to have higher than average alcohol use, self-harm and suicide rates¹⁵⁹. 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 occupations¹⁶⁰.

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 rise¹⁶¹. 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 issues¹⁶².

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 birth¹⁶³. Poor mental health and psychological distress are disproportionately higher among transgender people¹⁶⁴. 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 issues¹⁶⁵.

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 year 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 discrimination¹⁶⁶.

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

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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 police¹⁶⁷.

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 than 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.



PART E

APPENDICES AND REFERENCES

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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 Diggins, 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 McClain, 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	<input type="radio"/>	<input type="radio"/>	DEBT/MONEY/ BENEFITS	<input type="radio"/>	<input type="radio"/>
SELF HARM/ OVERDOSE	<input type="radio"/>	<input type="radio"/>	HOUSING/ HOMELESSNESS	<input type="radio"/>	<input type="radio"/>
LOW MOOD DEPRESSION	<input type="radio"/>	<input type="radio"/>	WORK/ SCHOOL ISSUE	<input type="radio"/>	<input type="radio"/>
STRESS/ ANXIETY/PANIC	<input type="radio"/>	<input type="radio"/>	LONELY/ ISOLATED	<input type="radio"/>	<input type="radio"/>
SUBSTANCE ABUSE	<input type="radio"/>	<input type="radio"/>	RELATIONSHIP ISSUES	<input type="radio"/>	<input type="radio"/>
DRUNK/ INTOXICATED	<input type="radio"/>	<input type="radio"/>	DOMESTIC ABUSE	<input type="radio"/>	<input type="radio"/>
DEMENTIA	<input type="radio"/>	<input type="radio"/>	CONFUSION/ STRANGE BEHAVIOUR	<input type="radio"/>	<input type="radio"/>
DIAGNOSED MENTAL HEALTH	<input type="radio"/>	<input type="radio"/>	GENDER IDENTITY/ QUESTIONING	<input type="radio"/>	<input type="radio"/>
HARASSMENT/ BULLIED	<input type="radio"/>	<input type="radio"/>			

NOTES/OTHER ISSUES
(physical health, veterans, immigration, asylum seeking)

-MH

BEYOND THE CALL // A NATIONAL REVIEW

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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, bruises, choke marks, bleeding etc anything that looks like an unnatural/unusual damage, break to skin, bruises 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 violent 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: violent/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/violent 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 job, 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 Scale¹⁶⁸.

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	<ul style="list-style-type: none"> Imminent self-harm to self, current actions endangering self or others. Significant overdose/suicide attempt/violent aggression. Possession of a weapon. 	<ul style="list-style-type: none"> Triage clinician to dispatch appropriate ambulance response (inc Mental Health Rapid Response Vehicle). Triage Clinician to arrange appropriate police/ fire response. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a ED (where the person requires medical assessment treatment). 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment. 	<ul style="list-style-type: none"> 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.

<p>D</p> <p>Moderate Risk of Harm and/or Significant Distress</p>	<p>WITHIN 72 HOURS Semi-Urgent Mental Health Response</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Liaison/CMHT face-to-face assessment. 	<ul style="list-style-type: none"> • Telephone support and advice. • Secondary consultation to manage wait period. • Point of contact if situation changes. • Establish safety planning/worsening advice to be given.
<p>E</p> <p>Low Risk of Harm in Short Term or Moderate Risk with Good Support/Stabilising Factors</p>	<p>WITHIN 7 WEEKS Non-Urgent Mental Health Response</p>	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Out-patient clinic or CMHT • face-to-face assessment. 	<ul style="list-style-type: none"> • Telephone support and advice. • Secondary consultation to manage wait period. • Point of contact if situation changes. • Establish safety planning/worsening advice to be given.
<p>F</p> <p>Referral not Requiring Face-to-Face Response from Mental Health</p>	<p>Referral or Advice to Contact Alternative Provider</p>	<ul style="list-style-type: none"> • Other services (outside mental health) more appropriate to current situation or need. 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • Assist and/or facilitate transfer to alternative service provider. • Telephone support and advice.
<p>G</p> <p>Advice, Consultation, Information</p>	<p>Advice or Information only OR More Information Needed</p>	<ul style="list-style-type: none"> • Patient or carer requiring advice or information. • Service provider providing information (collateral). • Initial notification pending further information or detail. 	<ul style="list-style-type: none"> • Triage clinician to provide advice, support, and/or collect further information. 	<ul style="list-style-type: none"> • Consider courtesy follow up telephone contact. • Telephone support and advice.

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NATIONAL COLLABORATIVE
COMMISSIONING UNIT

UNIT 1 CHARNWOOD COURT
HEOL BILLINGSLEY
PARC NANTGARW
TREForest
CF15 7QZ

GIG.NCCU@WALES.NHS.UK
01443 744928