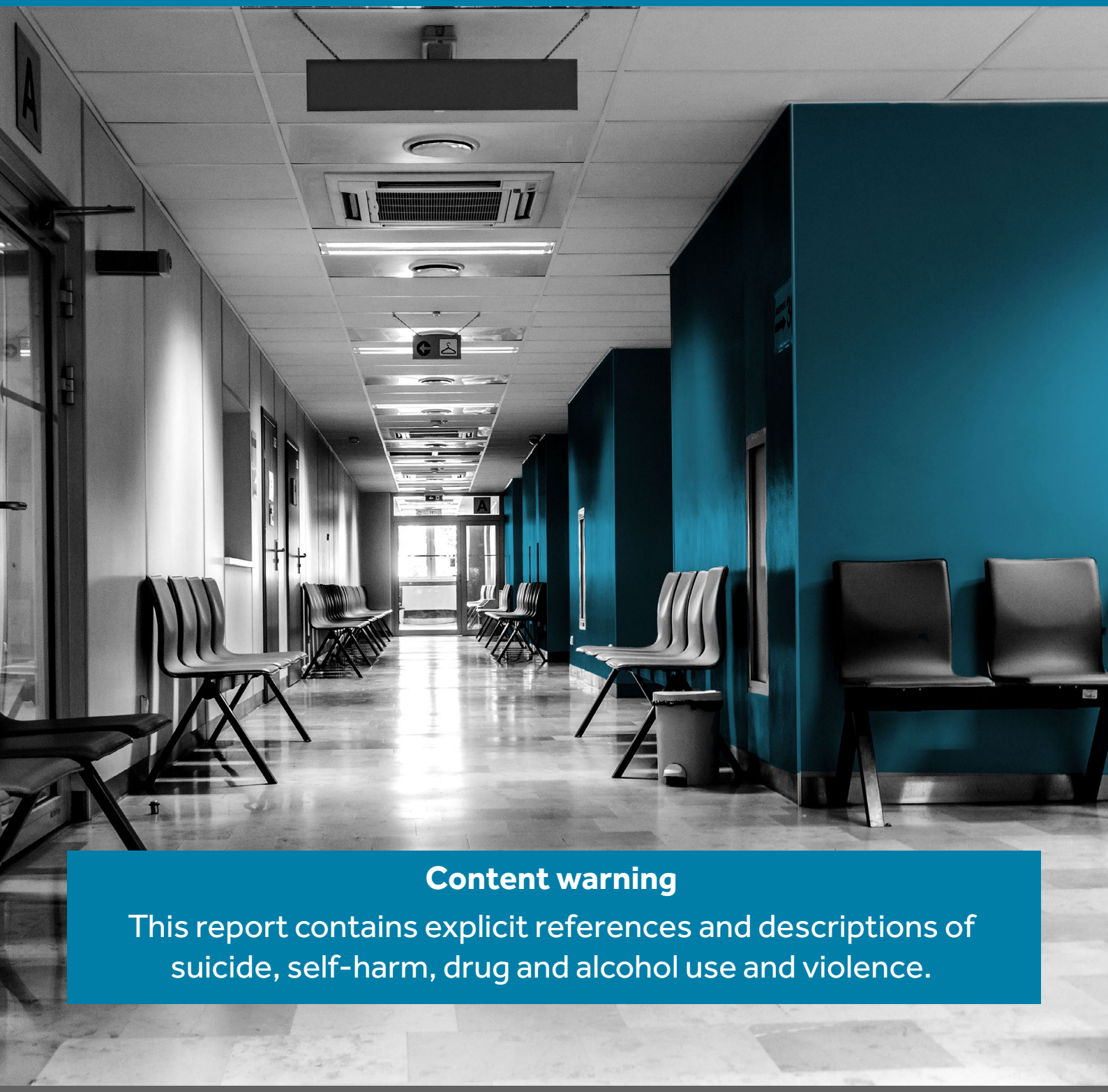
Investigative report

Mental Health ON HOLD

Access to mental health crisis care services for people experiencing homelessness



Content warning

This report contains explicit references and descriptions of suicide, self-harm, drug and alcohol use and violence.

Registered Charity No: 1004103

thewallich
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Section 1 Introduction

About The Wallich

The Wallich wants to create a Wales where people stand together to provide hope, support and solutions to end homelessness.

As Wales's leading homelessness and rough sleeping charity, The Wallich operates under three core objectives: **getting people off the streets; keeping people off the streets; and creating opportunities for people.**

Running more than 100 diverse projects, across 18 local authorities, The Wallich works with more than 7,000 people experiencing or at risk of homelessness every year across Wales.

About the Mental Health on Hold report

Following the concerning results of a staff survey, The Wallich decided to embark upon an investigation into the current landscape of crisis mental health provision for people experiencing homelessness in Wales.

What is a mental health crisis? According to Mind, mental health crisis is when you feel your mental health is at breaking point. For example, you might experience:

- Suicidal feelings
- Self-harming behaviour
- Extreme anxiety or panic attacks
- Psychotic episodes (such as delusions, hallucinations, paranoia or hearing voices)
- Hypomania or mania
- Other behaviour that feels out of control, and is likely to endanger yourself or others.

The Wallich has begun to build an evidence base around the intersection between mental health crises and homelessness. We want to understand what's working, what's not working and have made a series of recommendations to improve.

This evidence base is the start of an ongoing campaign called Mental Health on Hold, which aims to save lives and get better outcomes for the people we support with serious mental health needs.

Upon investigation, we found that the mental health emergency disproportionally affects people experiencing homelessness.

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Acknowledgements

Dedicated staff and the community of clients at The Wallich services across Wales.

Report published 28 March 2023.

Section 2
Report recommendations

Following our investigation, The Wallich is making a series of recommendations for the stakeholders affected by this report. We hope they are taken on board for the planning and delivery of future services.

For Welsh health boards

1. Community Mental Health Teams (CMHTs) must refocus on **partnership working** with local housing services, to ensure everyone at risk or experiencing homelessness is assessed for their mental health needs.
2. Local services should **respect and recognise the expertise** and experience of housing-related Support Workers who advocate on behalf of their clients. They spend a long time building trusting relationships, and should always be believed when they say a client needs further help.
3. All mental health and drug services must follow **the existing NICE guidelines** which state that an individual must not be "excluded from mental health services because of coexisting substance misuse or from substance misuse services because of coexisting severe mental illness".
4. Health boards should consider increasing provision of **out-of-hours services**. Specialists should be available to respond and de-escalate mental health crises at any time.
5. Health boards should review their **referral procedures** for local mental health services. They should identify and address potentially exclusionary practices to ensure there are no unreasonable barriers for people experiencing homelessness, or for those with co-occurring substance use needs.
6. Mental health services should use the **Trauma Informed Wales Framework** to inform service design, ensuring accessibility through a 'no wrong door' approach: wherever people present to the system, they will be supported into the most appropriate service.
7. In partnership with Welsh Government, all health boards should complete the rollout of the NHS 111 'Press 2 for Mental Health' to ensure 24/7 access to specialist mental health support. Once up and running, it should be promoted widely, including across the housing and homelessness sector.

For Welsh local authorities

1. All local authorities should **align strategies**. They should carry out a detailed assessment of local mental health needs and tie this into their long-term homelessness strategy. For example, when planning Housing First or Rapid Rehousing services, they must ensure there is adequate accessible mental health provision to help clients maintain stable tenancies.
2. Local authorities should use their unique position in both sectors (housing and mental health) to facilitate more **partnership working** between providers, collaborating to break down barriers and re-traumatisation for clients with multiple complex needs.

For Welsh Government

1. Welsh Government should consider **strengthening guidance and / or legislation** to bring mental health and homelessness services into greater alignment. For example, mandating local authorities and health services to work together to provide an initial mental health screening assessment to every individual upon presentation to homelessness services.
2. Lead on embedding the **Trauma Informed Wales Framework** across all public services, allowing a more holistic and compassionate approach to people whose poor mental health or substance use is a response to their experience of trauma. They should also set out the key deliverables and measures of impact for the framework (As Recommendation 11 of the recent **Senedd Health Committee report** into mental health inequalities).
3. Work with police forces and other emergency services to develop and spread **examples of best practice** when responding to mental health crisis incidents.
4. The Government should look at how it might better **enforce existing legislation** and guidance on mental health services and partnership working, rather than establishing more strategies and taskforces. Much of the existing policy framework is positive, however is not necessarily reflected in the reality of day-to-day provision.

For The Wallich

1. Improve our **reporting** of mental health crisis incidents on our case management system, through consistent use of tags and keywords.
2. Carry out regular **reflective practice** on serious incidents to ensure lessons are learned wherever possible and greater support is provided to staff affected.
3. Develop a robust process of ongoing **wellbeing checks** for staff and clients working, or living, in services affected by suicide.
4. Continue to invest in staff **training** and development around trauma awareness, mental health, and substance use. Consider whether training more mental health first aiders could be appropriate for supporting clients in crisis.
5. Increase the capacity and scope of our 'Reflections Network' to ensure every one of our clients can be seen quickly and easily by **trained councillors**. This is dependent upon securing long-term sustainable funding for the service.
6. Consider creating new roles in the organisation for people with **specialist knowledge** and / or qualifications in mental health care, to provide more in-house psychological support.

Section 3
Survey of frontline staff at The Wallich
Summary

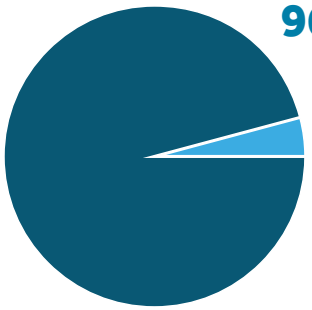
During the early pandemic, between March and October 2020, The Wallich's specially trained support staff helped more than 4,000 people experiencing homelessness. They continue to support some of the most vulnerable people in Wales.

The Wallich's staff say they are increasingly concerned and frustrated by their inability to get help and support for people in mental health crisis. They were surveyed in August 2022 about their experiences.

(Results based on 75 responses)

Full report in Appendix 1

1. Have you supported clients in severe mental health crises?



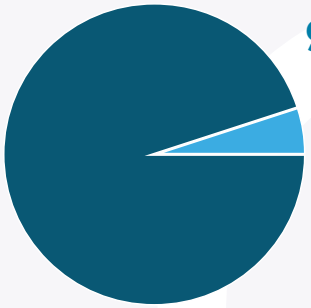
96% Yes

4% No

> "Mental health teams take too long to react. It can be over 10 weeks after an incident for first contact with the client.
>
> It feels like we are supposed to keep them safe in the meantime, which is very difficult. Obviously as a team we go above and beyond, but we are not trained to do mental health's job."

2. Have you sought support from Community Mental Health Teams (CMHTs) or local crisis teams for your clients?

> "There are great workers within the community supporting individuals in crisis, all pulling together to make the person safe.
>
> I believe the services which need to step up and take responsibility would be the Specialists / Psychologists / Psychiatrists at CMHT.
>
> They continue to do telephone assessments which do not help the service user. It often makes the process more difficult, and people are left on a long waiting list.
>
> Furthermore, once the initial assessment was done over the phone, it was very hard to get another appointment."



95% Yes

5% No

3. What was your general experience seeking this support?

66% **Really difficult** – and I was not satisfied with the support available

8% **No help was available**

6% **Not applicable** (I have not sought support from these teams)

3% **Straightforward** – appropriate support was available

17% **Somewhat difficult** – but appropriate support was available

> “Even once they pick up the referral, they have a three strikes policy.
>
> One client I worked with; they rang her father even though she no longer lived there – **Strike one**. Then they rang her on her mobile, but she didn't answer as she had anxiety and didn't recognise the number – **Strike two**. They then rang the project while she was out – **Strike three**.
>
> She then had to be re-referred. So much for understanding mental health.”

10. Thinking about access to mental health services for people experiencing homelessness, compared with the general population, I think that...

72% **People experiencing homelessness have worse access to services**

11% **Don't know**

4% **People experiencing homelessness have better access to services**

13% **People experiencing homelessness have equal access to services**

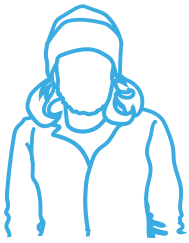
> “There needs to be a better working partnership between services or a better, secure referral service between our service and the crisis team. Clients are forced to make early morning calls to their GP if they are registered and are left with long hold times. It can make it difficult when clients either do not have access to a phone or have a phone and don't have the facility to charge the phone regularly.”

Section 4
Gathering evidence
Incident reporting at The Wallich

At The Wallich, we record all incidents, accidents and near misses on our case management system. Analysis of entries recorded in this event log paints a picture of the sorts of things our support services face on a day-to-day basis. The report can be extremely difficult reading at times, detailing shocking and heart-breaking stories of clients who have histories of complex trauma.

As an avenue for understanding the interplay between experiences of homelessness and mental health crises, we analysed 4,216 incident reports from 2019 to 2022, using keywords to assess the type and frequency of crisis events. This was not straightforward, as every crisis looks different, and staff have a free-text field to fill in the details in their own words, using a wide range of language to describe similar incidents. Nonetheless, we can use this data quantitively and qualitatively, to paint a broad picture of mental health crises in our services. The numbers are indicative rather than exhaustive, and we have provided a series of anonymised examples of incidents to demonstrate the nature of the crises facing our clients and staff.

Total incidents 2019-22
4,216



Overdoses
294

Suicide or self-harm
481

Erratic or aggressive behaviour
1,508

861 Ambulance called out

1,845 Police called out

284 Both ambulance and police called out

35 Community Mental Health Team (CMHTs) contacted

120 Crisis Teams contacted

Analysis: What do the incidents tell us? What does a mental health crisis look like?

Disclaimer: Some incident reports have been abridged as case studies for clarity and relevance. Case studies have also been anonymised for staff and client confidentiality.

Suicide and self-harm

Suicidal ideation and self-harming behaviours are some of the most extreme symptoms of individuals suffering from poor mental health, however our data suggests that they are far from uncommon amongst the people we support.

In the period from 2019-22, 481 incidents were tagged as involving self-harming behaviour. These involve a range of threatened and completed threats to harm themselves using knives, broken glass, ligatures, drugs, and a variety of other methods.

Our staff are trained to try and defuse the situation, and can treat minor injuries with first aid, but they are not necessarily trained to fully address the underlying mental health issues that lead to this behaviour.

Case study 1

"Client's mental health had been deteriorating throughout the day. Staff supported client to call the Crisis Team and disclosed suicidal feelings. Crisis Team told client she must contact her GP in the first instance, which client did, and was waiting for a call-back. While waiting for a call, client told staff she wasn't going to be alive by the end of the day and disclosed plans to take her own life. Staff tried to offer support, but client pulled out a large kitchen knife and started to cut her arm. Staff intervened and called 999 to request help.

Police arrived first and calmed client, before calling the Crisis Team and passing the phone over. Client was angry as she felt she had called earlier in the day and not been listened to. Call was ended and staff stepped in to support and calm the client by explaining that her situation had escalated.

The police left as client was much calmer. The ambulance service rang saying they were going to leave it in the hands of the Crisis Team as no significant injury. Crisis Team called back with an appointment for the next day. Staff will ensure welfare checks are completed throughout the night and the next day, and support client to attend the appointment."

We are deeply concerned about the physical risks to our clients arising from inadequate support for their mental health. Self-harm, planning or attempting suicide are serious signals that someone needs help to address the underlying causes of their depression, to rebuild emotional resilience and help them envisage a life worth living. Typically, this is only possible through a combination of medication and talking therapies.

Case study 2

"Client presented at the main office, he placed a blade on the table. He had made attempts to slice the tops of his forearm, between his wrists and elbow on both the right and left arm. There was bleeding, but the wounds were not deep. Staff administered first aid.

He was threatening to kill himself. Staff phoned 111. Operator spoke to client, he said he would throw himself off the nearest bridge if he did not get help; that he felt like he was not in his body; that he wanted to bang his head against a brick wall.

Mental health Crisis Team called back and told client to contact his GP; advised to tell them he'd had an assessment and needs mental health crisis support. Staff rang the GP surgery. Receptionist advised only one doctor out on a call and the surgery is closed for training this afternoon. Advised to ring 999.

Rang 999 and explained client's mental state (he wanted to end his life plus self-harm). Ambulance dispatched but it could take 4-6 hours. If he leaves the project, call 999 immediately. They advised for him not to be left alone and to ring back if he gets worse.

Staff checked what medication client had taken today: 5 x Clonazepam 2mg (should only take 2 per day) and 2 Pregabalin 150mg. Client did not want to remain in office for 6 hours and return to room. Staff agreed he could go to communal lounge, providing half hourly welfare checks. Client promised staff he would not attempt to harm himself further and would come to staff if he felt any worse. Half hour later, staff noticed door had been kicked in and dangerous debris / nails lying around. Client stated he could not remember what he had done, presented confused and stressed.

Welfare checks have continued. Ambulance rang twice to advise they will attend but very busy. During checks, client is sometimes sleeping, other times confused and scared."

Co-occurring substance use and mental health

As an organisation that supports many people who have experienced significant trauma or adverse life experiences, we believe that a significant driver of substance use is as a form of self-medication.

The exact drugs used might vary greatly, including stimulants like cocaine or amphetamines, to depressants like alcohol or benzodiazepam, as well as cannabis, opioids, and synthetic drugs like spice. Regardless of what exactly is taken, users may be seeking a high or a numbing to block out the pain of past trauma, negative emotions or painful memories.

In some cases, drug use may itself be a form of self-harm or deliberate risk-taking, as the individual seems not to care what will happen to them upon taking the substance

In the period we looked at, 294 incidents were flagged on our system as involving an overdose. These events are difficult to analyse as it is usually impossible to determine whether an overdose is accidental or deliberate, unless the individual recovers in order to tell us.

Case study 3

"Client returned to project and was heavily under the influence both drugs and alcohol. He thought everyone was looking at him and listening to him so asked to speak to a staff member alone. During a quiet 1-2-1 session, he told staff he had suicidal thoughts. He disclosed that he has tried killing himself by ligature, but the rope detached so the attempt was unsuccessful. Client said he was "hearing things in his head and people were whispering to him telling him horrible things and no one cares about him". Staff suggested he speak to the Crisis Team but he refused as he thinks no one cares and everyone would be better off if he were to die. Staff offered support and again signposted to relevant services. Plan for client to be reviewed every 20 / 30 minutes. Staff advised that if he leaves the project, contact 999.

During a welfare check, he disclosed that he had overdosed with 'a bit of everything'. Staff called 999 and ambulance arrived. Marks were identified around client's neck by the paramedic during assessment. They advised client he needed to go to the hospital for blood tests due to the overdose. The client became agitated and refused. Client began verbally abusing paramedics and declared he was going to do a 'runner'. The police were called.

Whilst waiting for the police, client became more agitated. He disclosed he had a bottle of vodka and he was going to go into the toilet and down the rest of it. Staff tried to reassure and told client he was not to leave until the police came as his mental health and life was at risk.

Police arrived and client tried to run out of the project. Police intervened and took client out to the ambulance."

As this demonstrates, poor mental health and substance use can be inextricably linked. Both can be understood as responses to trauma, which means both must be managed simultaneously in a trauma-sensitive way. Unfortunately, far too often we see our clients refused access to mental health services as a direct consequence of their drug use; either their presentation is judged to be wholly caused by substances, or otherwise they are seen as too high risk to be managed by mental health workers who do not have an expertise in drugs and their associated behaviours.

Case study 4

"Client had been discharged from hospital yesterday and returned to project. Overnight her mental health deteriorated which led her to consume alcohol. Client told staff she had taken an overdose (two boxes) of paracetamol. Client had written suicide notes and sent messages friends and family. Police had attended during the night but had left with no further action following from this.

Following handover, client was seen by staff screaming in the communal stairway. Staff spoke with client in her room, where she took her morning medication and handed the box to staff to store in her locker.

Client spoke of her experience in mental health ward. She stated she needed to go back, was discharged too soon and is constantly hearing voices, which alcohol helps to stop. Client said a doctor had told her that her issues were alcohol-related and this sent her into rage. She insisted that this is not the case, and she is going around in circles.

Client told staff she was going to smash three windows, which she proceeded to do, despite staff trying to calm and intervene safely. She was very angry, again saying no one listens to her. Client disclosed she hears a man's voice in her head and there is a man following her knocking on the windows, but no one believed her in hospital. She then went to smash another three small glass windowpanes.

Staff tried to put themselves between client and the glass due to concern at the harm she would cause herself. Staff were not successful in preventing this as they cannot restrain clients. Client's arm was bleeding heavily but she wouldn't allow first aid to be administered. Staff called 999.

Client then became upset that the police were coming, screaming in her room. Police attended. Staff do not feel threatened by client in any way, she has always been respectful. Staff believe she was frustrated that her mental health issues have not been sufficiently addressed and she wanted to harm herself. Staff do not believe client had capacity during this incident."

We believe that this practice went against the **formal guidance on dual diagnosis services** from the National Institute for Health and Care Excellence (NICE). Quality Statement 2 of the standard says that people should not be "excluded from mental health services because of coexisting substance misuse or from substance misuse services because of coexisting severe mental illness". The standard also recommends that where individuals are in contact with multiple different services, a named individual working within the mental health service should act as the care coordinator, liaising with the other agencies, and following up on missed appointments rather than discharging for non-attendance.

We are concerned that this vital standard is not being followed. Truly trauma-informed services strive to make themselves more accessible, rather than giving up on someone at the first signs of difficulty. There are no hard-to-reach people, only hard-to-reach services.

Psychosis

From our data, there were just four incidents which specifically mention the word 'psychosis', but a number of others which mention clients hallucinating, hearing voices or otherwise disassociating from reality. There are a variety of possible causes of psychosis, including schizophrenia or schizoaffective disorders, bipolar, and other serious mental illnesses, but it can also arise as a trauma-response, as in cases of PTSD.

Additionally, psychosis or other delusionary or hallucinatory symptoms may arise from taking drugs such as cannabis, amphetamines, cocaine, and even alcohol. As a result, where individuals present with both serious mental illness and substance use, it can be difficult or impossible to be sure of the precise cause.

Episodes of psychosis can sometimes include threats to hurt oneself or others, and when this occurs in our services, our staff will typically need help from the emergency services. However, that help is not always straightforward to access.

Case study 5

"10.25pm: Client feeling suicidal and made a gun sign to his head. Staff spoke with client a short while. Staff explained to 111 that client was feeling suicidal.

Client advised staff that if he went back to his room, he would shoot himself in the head and made another gun motion. Client was behaving erratically. He made motions to suggest he was flying and told staff he was a bird. He also began laughing loudly and inappropriately. 111 spoke to client directly but he was not making sense. He later became upset that he thought he had been speaking to the police and that they were coming to take him away.

Staff asked client to empty his pockets and checked his room to ensure that no weapons were present. Staff confiscated a stick with a sharp end. Staff advised 111 they had conducted checks to ensure no gun was in client's possession. 111 advised they would send an ambulance but there could be a wait. 111 also advised that police presence may also be requested by the paramedics, but they would assess the situation accordingly.

1.15am: 111 service called to check on client, advised there was still a wait for an ambulance.

2:14am: Client told staff that he was going out. Staff tried to encourage him to stay but he refused and said he was visiting a friend and wouldn't be long.

3:25am: 111 called again for an update and staff informed them that client had left site. Information was passed to the police.

3:40am: Police rang and asked for a description and details.

4.07am: Police arrived and asked staff for more details. Concerns about medication and his mental health were raised by staff. Police came back after search and said that they had found client. They were happy he wasn't going to harm himself and that he would return to project.

7:55am: Client returned to site – was calmer and making more sense. Staff discussed comments from night before and client states he doesn't remember. Staff to monitor throughout the day."

It is vitally important that people who have experienced episodes of psychosis, or have mental health conditions that mean they could be at risk of such an episode, must have a mental health assessment carried out by a professional and a care and support plan put in place.

Ideally, this safety planning process should be led by a mental health professional and involve all other partner agencies; including drug and alcohol services and housing support.

The reality is that the people we support across our homelessness services struggle to get an assessment and, in many cases, struggle even to see a GP, let alone get a diagnosis. These are often the first steps into, what appears to be, a convoluted and time-inefficient system.

Erratic or aggressive behaviour

Aside from the most dangerous emergencies, our staff support our clients through a wide range of other challenging situations.

Depending upon their mental health condition, it may lead individuals to behave erratically or aggressively. This can be confusing and upsetting for everyone involved.

Case study 6

"Client disclosed he was suffering from poor mental health and that as a result he had recently 'Bitten my mates nose off' and that he was 'Going to hurt someone real bad'.

He threatened staff with stabbing. It was explained that would effectively end his tenancy. Staff asked him how he wanted to be supported with his mental health and he continued to make threats of violence towards staff and others. Staff persisted with asking him how we could support him. He continued to be verbally threatening.

Staff asked if an ambulance would help, he said he would simply assault ambulance staff. Staff informed him that the only safe option was to get the police to attend and facilitate a mental health assessment. Client replied: 'Phone the police, I'll fight them too'. Staff returned to the office and dialed 101."

1,508 of the 4,216 incident records we looked at mentioned some sort of aggressive or threatening behaviour. Whilst not all of these will necessarily be directly related to poor mental health, it is clearly an exacerbating factor in a number of incidents that we saw.

Case study 7

"Client was behaving chaotically during the night, experiencing paranoia and hallucinations that put himself and others at risk. Staff noticed him say that he was going to stab the person underneath the lounge table with the fork in his pocket. Staff then saw client pull the fork out of his pocket and he continued to say that he was going to kill the person under the table.

The staff member felt concerned for own safety, and locked himself in the staff office - he was lone working. Two hours later, client was again heard talking aloud, saying that he was going to kill somebody, that he doesn't care anymore and was seemingly talking to somebody, saying: 'You should be scared of me, because I'm going to kill you'. Soon after, client knocked on the office door and said to staff that there was somebody in the lounge. Staff checked and found nobody there. Staff encouraged him to go to bed and the client agreed that this was best. Plan to perform welfare checks.

Shortly after, the police arrived after client had called them directly to report somebody in his room with blue paint all over them. Nobody was found and the police left."

Our staff are highly trained to manage these sorts of situations safely and defuse tensions. Nonetheless, it is not surprising that people suffering mental ill health, alongside other challenges such as homelessness or substance use, will get increasingly frustrated as they languish on long waiting lists for specialist support.

Case study 8

"Doctor from the mental health team attended project to section a client, along with mental health team and the police. 2 police officers stood out the front of the project, just in case the client jumped from his window. The other 2 officers went to the client's room along with the doctors.

When police were talking to client, explaining he needs to be sectioned, client started to shout and make threats stating he is 'not going anywhere'. Police explained to client that he is going, as they have a warrant to arrest him for his safety. The police continued to explain to the client that he is going to the hospital and is being admitted.

Client was terrified at this point and was shouting a lot. He picked up a glass and, due to the nature of this situation, the police thought client could possibly hurt himself or them with the glass. So they pulled out their taser and ordered him to face his window, so the police can then put handcuffs on him for his safety. Client eventually calmed down and the police and other professionals left the project to take him to the hospital."

What is clear, is that violent conduct from people in mental health crises will often have to tip over into an escalation and intervention from other emergency services, in order to keep everyone safe.

Depression and feelings of hopelessness

A different, but no less concerning symptom of languishing without the right support, are periods of depression and feelings of hopelessness. Clients appear to give up on the possibility of a better life, and express that nobody cares about them.

Case study 9

"Staff knocked client's door and there was no answer. Staff called again, no answer. Staff shouted to let client know they were entering his room. Client was lying face up on the bed, blue in the face, he had pulled a USB cord around his neck. Staff ran over and tried to get his attention and he looked at staff. Staff asked him to try breathing, whilst dialing 999. He started breathing more and loosened the cord.

Operator requested police and ambulance. Client said he had tried suicide with three bottles of vodka and beer, that it hadn't worked, and that he hadn't slept in three days.

Client got up, went out the front door and walked around the corner. Staff and client sat on the pavement whilst he had a cigarette. He told staff that they 'shouldn't have helped' him, and that he was 'sorry' for putting them through it. Discussed finding his dad dead from suicide, and that he knew how horrible it was.

Discussed how hopeless he feels. He can't see his children and feels like whatever he does, he will always be stopped from seeing his children. He doesn't see a future with anything good in it, and that 'life is just a burden'. We went back to his room where he tidied and said he was trying to think of other ways of suicide. Ambulance service called back to assess the situation; they escalated the call. The ambulance service assessed the client and tried to convince him to come with them. After lengthy discussions with the ambulance service and police, it was decided that since the client did not want to go with the ambulance service and presents as 'having capacity', they do not have the power to take him to the hospital or any other facility. They said if the client were to present as aggressive or threatening there may be the capacity to call the police to restrain him and section him. The police deem that he is safe as he is in his abode and staff here are responsible for his welfare."

It is hard for our staff to convince their clients otherwise, when it does feel like no more help is on its way, when a long waiting list only leads to a different waiting list. Following the coronavirus pandemic and over a decade of underinvestment in health services, we understand that waiting lists are long for a whole range of different services, however within this context we believe that even getting into a queue for the right mental health support is far too inaccessible for people experiencing homelessness and those with a history of trauma.

"It can take weeks to register with a GP and get an appointment to see the doctor. Then over 6 months to be contacted by the mental health team for the initial appointment - by which time our clients will usually have been re-housed or changed phone numbers. We have recently been advised there is a waiting time of over 18 months to be taken on by the Psychological Intervention Team after a mental health assessment."

The Wallich staff member on waiting times

Analysis: What happens as a result of mental health crises?

Attendance of police and ambulance services

Because of the difficulty accessing the right mental health support, far too often the only options available to our staff in an emergency is to call an ambulance or the police.

As we found in our initial staff survey, **81%** of respondents had called the police as a result of a mental health crisis. **68%** had called an ambulance. Both of these services have clear remits and can only act when someone has a physical injury, or a crime has been committed. By their very nature, where mental health crises occur, the risks to the individual or other people can be high. However, if addressed properly then nobody needs to get hurt or break any laws.

Case study 10

"Client previously attempted suicide whilst in B&B. He disclosed a recent attempt to end his life via drinking the previous day. Client was distraught and was unsure if they were staying in place of safety. Staff called CMHT who advised they could not assist unless client was willing to speak to them directly. Client then tried to take life by ligature - found by staff who removed and called 999.

The ambulance service arrived and assessed client and decided: As the client did not want to go with the ambulance service and presents as having capacity, they do not have the power to take him to the hospital or any other facility. If he were to present as aggressive or threatening, there may be the capacity to call the police to restrain him and section him. The police deemed that client is safe in his abode and staff are responsible for his welfare. If staff were to be in a similar situation, the police and ambulance service should be called.

Staff spoke with ambulance staff separately and asked he be admitted as an in-patient for his safety and for the welfare of other clients; there was no recourse to be able to do this via police or ambulance. They could only act if further incidents occurred. Staff to perform welfare checks throughout the night."

* 2019-2022.

Our staff record against each incident, regardless of whether emergency services were called. This presents reliable data on callouts, although we cannot always be certain when they are mental health related.

In the period 2019 to 2022, 861 incidents led to an ambulance callout. On 1,845 occasions, the police were involved. On 284 occasions, both police and fire services were called. In each case of mental health crisis where emergency services are called, the opportunity to prevent the situation deteriorating that far had obviously been missed.

As ambulance teams can only treat physical injuries, they can only provide help or transport to hospital where a serious injury has occurred (for example, following self-harm or a suicide attempt). Police officers can restrain or detain an individual under the Mental Health Act 1983, but this is distressing and retraumatising. The last thing we want to facilitate is clients detained in police cells, as if being criminalised for their health condition.

Case study 11

"During a welfare check, client was asked if she would go to the doctors following distress. She said she wanted the doctor to come to her. The GP surgery advised that they would not be able to come out to her, as she is not house bound.

Client was asked if staff should get her an ambulance; she agreed. After making the call, she changed her mind. Client began screaming and shouting and was not very coherent. She left the office. She began screaming and shouting that she wanted to die and to be 'euthanised'. Staff rang 999. The operator could hear the client over the phone and advised that the police were en-route.

Three police officers arrived and spoke to the client. She was very agitated and was screaming and shouting.

Staff gave the police a background on the client, including that she was previously sectioned under Section 2 and 3 of the Mental Health Act. Police rang the mental health team. The operator asked if she was on any substances; she drinks alcohol, but was not physically dependent. Crisis Team said they would ring back.

Crisis Team advised the police to detain the client under Section 136 and take her for an assessment. Client was laying on the floor, face down, and was asked by the officers to stand up; she refused and said she was unable to walk. The police physically picked her up; she was resistant. She eventually started walking towards the police car with assistance from officers. Staff followed behind to the assessment centre. The police advised that they would stay with her until she is seen by the doctors."

In a properly functioning system, we do not believe it should be the role of police or ambulance services to respond to an individual experiencing a severe crisis. However, that is the reality at present, as the only option to prevent serious harm and save lives in an emergency.

CMHT and crisis services

We believe that the most appropriate services to respond to an individual experiencing a mental health crisis are the local Community Mental Health Teams (CMHTs) and other specialist crisis services provided by the seven local health boards. These services do exist, but are far too often inaccessible to the people we support across homelessness services. There is no distinct pathway from homelessness into mental health services, and despite having some of the highest levels of need, it can feel like our clients are the lowest priority.

Case study 12

"Client presenting as agitated and unstable in mood - evidenced by repeated conversations with herself, themes centred around her children being taken from her, being a victim of fraud, car theft. client has begun to make accusations towards other residents, and appears to be triggered by their familiarity e.g. 'you look like my ex partner's friend'. Client began to target clients and staff with more frequency and her delivery would increase in intensity. A call was placed to the Crisis Team, who have declined to attend. The police were called and requested to attend to maintain the safety of all clients. Police have attended and not deemed it appropriate to remove client. They did not feel it appropriate to section and have since left the project. Staff to remain vigilant and continue to monitor the presentation and wellbeing."

There are 35 incidents recorded which reference local CMHTs. 120 mention the local Crisis Teams. In far too many of these incidents, support staff report that they are unable to get the right support and are often directed elsewhere: to contact the GP, to call an ambulance or the police, or some other referral channel. Often, the mental health services disregard the concerns of our staff and suggest that service users are "fine" even where threats of suicide have been made.

As our initial staff survey found, 75% of our respondents felt that their expertise and knowledge was not respected by mental health services.

Case study 13

"Staff rang the CMHT and spoke with a nurse about a client's behaviour and suicidal ideation. It was advised that staff phone the client to ask: 1. If he planned to kill himself; 2. How he was going to kill himself; 3. If there were any protective factors such as what would stop him from killing himself, and 4. what help the client would like from CMHT.

Staff rang client and spoke with him. He told staff that he would not kill himself, but he said he would hurt somebody else. He said he was not taking his medication and he had flushed then down the toilet.

The nurse said his behaviour was bizarre and that staff should help find a way to take his anti-psychotic medication. They explained there was nothing they could do if the client would not go to CMHT in person - although they said the client could phone them directly at any time for support. The nurse stated that they thought that the client's behaviour would result in the police becoming involved."

Availability of provision out of standard working hours - 9am to 5pm, Monday to Friday – is a barrier. The reality is that mental health crises will not always occur during these hours, and clients on the edge should not have to wait until the morning, or the Monday after a weekend for help. There are some out-of-hours GP services in place in some areas, but otherwise the only option might be to call the emergency services or take the client directly to A&E.

Case study 14

“Staff spoke to client to find out what is wrong. He was suicidal and making threats about getting a gun to ‘Blow his brains’. Staff offered to take him to hospital, but he wasn’t committing. Staff phoned his doctors, to no answer. Staff phoned the Crisis Team, to no answer.

Due to the threat of being suicidal, staff had to ring 999 for an ambulance. Client told paramedic on the phone he would bring a gun into the doctor’s office if they did not take him seriously. Client disclosed he had paranoia - thinking people are recording him. Paramedics arranged a taxi to take him to hospital. Staff were told if he came back without being seen, call the ambulance back on 999.”

There is a lot more work to be done to develop effective partnership working across housing, mental health and substance use services, but it is only by working together to develop person-centred, trauma-informed support that is in the right place at the right time, that we can hope to relieve experiences of homelessness, and save lives.

Case study 15

“Client came into the office to use the computer. He was calm, but tearful, and stated he was feeling paranoid. He asked staff to stay with him. Client disclosed that he hates being on drugs as he can’t remember anything, he said he can’t carry on, is suicidal and wants to end his life.

Client agreed to go to hospital to be assessed, he stated that he ‘needs to be sectioned’. Staff phoned the Crisis Team, who stated that they would not section client; they believe is having a ‘come down’ from drug use. They advised to keep an eye on the client and take him to hospital, or phone an ambulance, if he tries to harm himself or takes an overdose.

Staff decided to take client to hospital to be seen by mental health professional. Checked into the waiting area to see mental health team but it was busy and he became anxious and paranoid. He said that everyone was laughing at him. Staff asked him if he wanted to wait outside where it was quiet, but he became more agitated. Client decided not to wait to be seen.

Back at the project, staff to support and perform welfare checks throughout the night.”

Section 5
What provision exists?
Freedom of information requests

In order to get an accurate picture of the current state of mental health service provision across Wales, we sent a series of questions to each of the seven health boards, as well as to the 22 local authorities, the four police forces, the ambulance service, and finally to Welsh Government itself. Find a summary of the responses to the 29 questions we sent in Appendix 2.

We received extensive responses to the majority of our questions, including links to a wide variety of policy and guidance documents and individual service specifications. Our first overall impressions from this huge wealth of information is that services are highly fragmented, with a real diversity of provision and referral routes across the different health board and local authority areas. This has the effect of making it less clear for clients and their support workers to get the right help at the right time.

Referral pathways

The most commonly mentioned pathways into services typically begin with a local GP service, who can then refer onto other more specialist mental health services. This is problematic for our clients for a number of reasons.

Firstly, many of our clients are not registered with a local GP at the point they present themselves to homelessness services. Once they are registered, there is sometimes a lack of trust due to previous experiences. Practically, they can still face difficulties getting a formal assessment of their mental health, or indeed any form of treatment besides medication, due to long waiting-lists and other pressures on overstretched GP services.

Regardless of whether our clients are registered with a GP, they are typically unavailable to respond to acute mental health emergency at short notice; especially on evenings or weekends

Welsh Government are currently in the process of rolling out a new single point of contact service where people calling 111 will be able to 'Press 2 for Mental Health' and will be put in touch with a mental health practitioner. This service is being introduced gradually by each health board. The long-term plan is 24/7 access to specialists in every part of Wales. Obviously, this will take time to bed in, and will need to be widely advertised to ensure everyone is aware. However, it does not in itself create new services or increase capacity.

When our clients experience severe mental health crises, our support workers may try and contact local services such as the GP surgery, CMHT or Crisis Teams. But if no help is available, they often have no choice but to call the police or an ambulance to prevent harm to the client or others.

* Based on 5-year data (excludes Dyfed Powys)

Police have the power to restrain or detain individuals under Section 136 of the Mental Health Act 1983, and can transport them to A&E or another place of safety, voluntarily or involuntarily. Even though this is not the same as being arrested, in practice it is likely to be extremely re-traumatising for people who have a history with the criminal justice system.

Each of the four Welsh police forces outlined their S136 processes. In some places, their process included custody nursing and mental health triage. We believe that in some particularly difficult cases, this may be the only realistic pathway to undergo a mental health assessment. This should not be acceptable.

Currently, there are undoubtable capacity issues in specialist mental health services, as there are across a whole range of NHS services in Wales. However, just getting a foothold in the system is a real challenge for our clients. Even with the dedicated advocacy of our support workers, their mental health is unlikely to improve.

Eligibility criteria

We asked a number of questions to ascertain what eligibility criteria is used to determine access to different mental health services.

Some health boards detailed a diverse list of services specifically targeting distinct cohorts, such as older adults, those on the autism spectrum or with learning disabilities, for example. Other health boards were more vague in their responses, however. They stated that there was no specific eligibility criteria for services beyond: 1. The presentation of suffering and; 2. Within the relevant catchment area.

None of the health boards referenced homelessness or trauma in their responses to these questions. We know that the people we support often present with a complex assortment of needs across mental and physical health, substance use, criminal justice, and housing. Often the common cause of all of these presentations is one or more traumatic experience in the client's past. There is an argument to be made for more dedicated mental health services that assist people experiencing or at risk of homelessness. These services should, in line with NICE Guideline 214, reduce barriers to access and engagement, including through outreach, low-threshold services, flexible opening and appointment times. Above all they should be holistic and person-centred, addressing the root causes of mental health and substance use, not just the immediate symptoms.

Co-occurring mental health and substance use

Many of our clients present with mental illness and co-occurring issues with drug and alcohol use. This is traditionally referred to as a 'dual-diagnosis' and leads to a parallel treatment programme from two distinct specialist services. Whilst this works for some individuals, the overall evidence of efficacy is mixed, as both conditions are often complexly intertwined.

We asked a number of questions about mental health services for those with co-occurring substance use issues, but from the responses we received it appears that the majority of services are separate, rather than providing integrated, holistic treatments. This is problematic because as mentioned previously, our clients are regularly rejected from mental health services as their drug or alcohol use is judged to be their primary need.

In many cases, it is just not realistic to expect complete abstinence before they can access mainstream mental health support

The National Institute of Health and Care Excellence (NICE) guidance, Quality standard 188 on 'coexisting severe mental illness and substance misuse', states that individuals must not be "excluded from mental health services because of coexisting substance misuse or from substance misuse services because of coexisting severe mental illness." Further to this, the standard states that people with these comorbidities must be assigned a care coordinator working within mental health services, to ensure that treatments from the different services are mutually supportive. Based on the evidence from our frontline staff supporting such clients on a daily basis, we don't believe this standard is currently being met across Wales.

75% **of our survey respondents found it difficult to access mental health support for clients with co-occurring substance use**

16% **felt that no help was available at all**

If this NICE quality standard was truly realised and embedded into all services across Wales, it would go a long way towards underpinning more holistic and person-centred support.

Partnership working and multi-skilling

We asked specific questions about the training and approaches taken by mental health staff when treating patients who also use drugs, and the answers were illuminating in their own way.

The majority of health boards responded by listing their partnership arrangements with dedicated drug and alcohol agencies, and whilst it is good to know that they refer on to other specialists, we were specifically interested in the training provided to staff specialising solely in mental health, to understand how they approach clients with co-occurring conditions. If the answer is only 'refer on to another agency', then it is likely that we are missing opportunities to provide more holistic treatment and care.

Far too often, our clients feel as though they are not taken seriously, and that their mental illnesses are dismissed simply as symptoms of substance use. They are passed from service to service with seemingly no one willing or able to take responsibility and meet their needs. Not only is this deeply retraumatising, it is largely irrelevant whether their substance use is as a result of poor mental health or their mental illness is a result of their substance use. Both deserve to be taken seriously. Partnership working is important, but by itself it is no guarantee of genuinely holistic, trauma-informed services.

Recording accurate and useful data

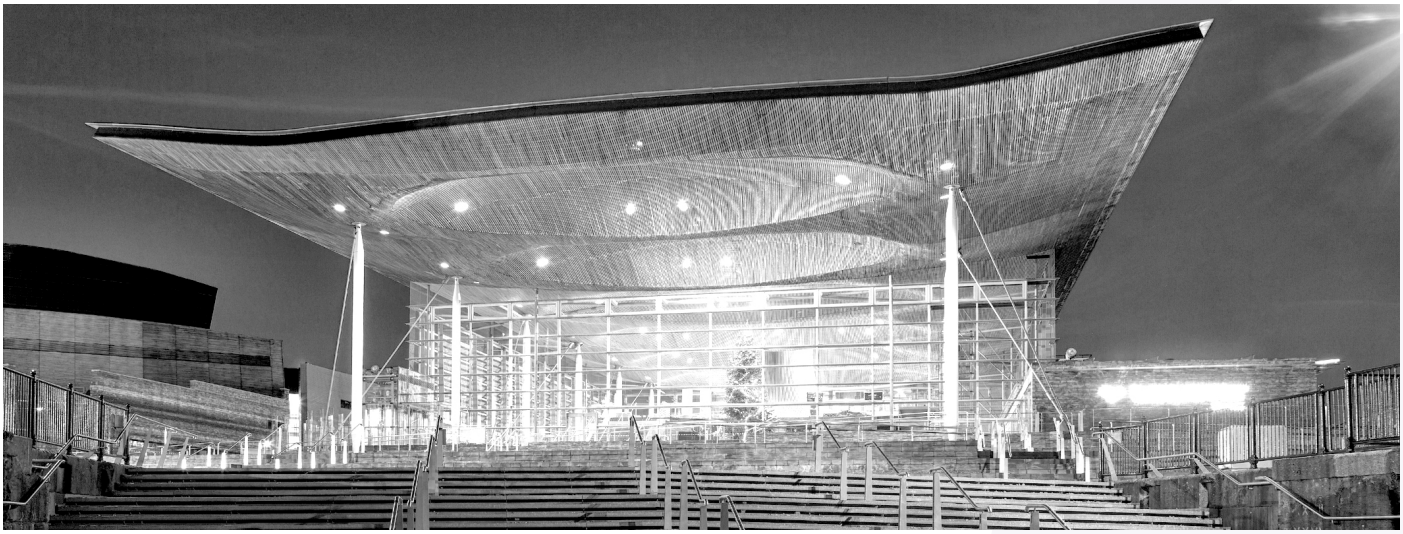
We asked each of the health boards, the police forces, and the ambulance service a number of questions about data: how many referrals or callouts had they received for patients experiencing a mental health crisis? How many had been rejected? How many in-patient mental health bed-spaces are available and how long is the average stay?

We received a great deal of data in response from some organisations. Others provided very little, claiming that the information was not recorded, or at least not in a way that was anonymised and able to be disclosed without breaching patient confidentiality. Each of the organisations seem to record information in a different way, making it very difficult to compare different areas and gain a clear national picture of service provision and levels of demand.

Another specific question we asked was on the numbers of patients seen by mental health services who were recorded as experiencing homelessness or having no fixed abode. Five of the health boards were able to provide annual figures, however the other two reported that this information is not routinely collected, meaning it is impossible to understand the full national picture of demand for mental health services amongst people experiencing homelessness. Our internal evidence suggest that demand is very high, but we need robust, reliable data collected and reported routinely for all parts of Wales.

Addressing mental health as a key pillar of ending homelessness

We strongly feel that access to the right mental health care at the right time is an essential prerequisite to permanently ending homelessness. People with experiences of homelessness, and more widely those with experiences of trauma, are disproportionately more likely to suffer from poor mental health than the general population. Without the right care and support, they are at greater risk of declining wellbeing to the point of crisis, at which point it is typically housing support workers like our frontline staff who respond, sometimes even saving lives.



The Welsh Government do recognise the importance of mental health when it comes to ending homelessness. In their **Ending Homelessness Action Plan**, they have a specific action for improving provision of homelessness services for people with mental health and / or neurodevelopment issues, and another action on provision for co-occurring substance use and mental health issues, in partnership with health boards and local authorities. We eagerly anticipate progress against these actions, as they directly address some of the issues raised in this report.

We asked Welsh Government, and the 22 local authorities, what assessment they have made of local and national mental health needs as part of their planning (and funding) for future homelessness services. The Welsh Government provided some reassurance that the mental health and homelessness policy teams are working closely together to develop joined-up thinking in this area. Most of the local authorities mentioned their partnership arrangements with health services, and their shared referral processes.

What we had hoped to see, but have not yet seen, is a series of detailed analyses of the cross-cutting mental health and homelessness needs within each local authority or health board area, for example as part of the local rapid rehousing transition plans. We are strongly supportive of rapid rehousing and Housing First approaches, but feel that without adequate mental health provision, easily accessible at the point of need, people will be less likely to secure and maintain tenancies: we will be setting them up for failure.

There was a lot more detail provided in the full responses from each organisation, and a lot of variety in the ways different organisations interpreted the same questions. This section has necessarily only provided a brief overview, but we will be following up with each of these organisations over the course of our Mental Health on Hold campaign.

Section 6
Expectation vs Reality

We have mapped our findings into:

- What crisis mental health service provision says it's supposed to look like
- The reality of what our staff and clients say they have experienced

The aim of this mapping is not to point blame, but is instead to try and find where the blockages are to accessing provision for our specific service user group.

What services said	What our clients and staff experienced
The majority of health boards highlight that the client's GP should be the first point of contact for individuals experiencing poor mental health. GPs can then refer them on to specialist services such as CMHTs.	Many clients are not registered with a GP when they present to homelessness services. Once registered, getting a mental health assessment and other treatment, besides medication, is delayed due to long waiting lists. Contacting a GP out of hours to respond to a mental health crisis is almost impossible.
A number of the health boards and the Welsh Government highlight that the new NHS 111 service 'Press 2 for Mental Health' will be a new streamlined pathway for individuals to self-refer into specialist services.	We understand that this service is the subject of an ongoing WG campaign, so it will take time to embed across all health board areas. We will advise staff and clients to use this service, but note that it does not in itself create any new provision.
Crisis Teams (sometimes called Crisis Resolution Home Treatment Teams) are 24-hr services designed to respond to urgent mental health crises, provide treatment at home, and if appropriate refer onto other services.	Our staff have real difficulties accessing the right support for mental health crises, particularly those occurring out of office hours - on evenings and weekends. Often there is no help available from any health services at those times.
All health boards claim that they carry out follow-up checks on patients admitted following self-harm or suicide attempts.	We have supported clients who are unable to get a mental health assessment, even after repeated self-harm or suicide attempts.
All health boards stated that services were not reduced or interrupted during the pandemic, although some services were amended to offer appointments by phone.	60% of our staff felt that it became even harder to access mental health services following the outbreak of the pandemic.
Different services outlined differing levels of eligibility criteria, but at least one health board claim that they do not turn people away for using drugs or alcohol.	Our staff's experiences show that clients are regularly turned away from mental health services due to perceived substance use.

Existing things that work well

It is important to note that there are examples of good practice in this area; innovative ideas and new ways of working collaboratively to help people experiencing homelessness and poor mental health.

Multi-disciplinary teams	Mental health & homelessness nursing	In-house counselling	Social services

Multi-disciplinary teams

A number of local authorities are in the process of developing their homelessness service provision to include multi-disciplinary teams (MDTs) comprising of specialists from the local housing team, health boards, criminal justice and social services. This is a direct recognition of the reality that people often present to services with a whole range of needs which require a response from a number of partners.

MDTs working in an 'assertive outreach' model are intended to be proactive in the community, going to people in temporary accommodation, as well as those sleeping rough, to identify their needs and fast-track them into the right services.

A variation on this model is the Occupational Therapy approach, which we are developing through a new '360' project in Swansea and Neath Port Talbot. This person-centred approach is designed to link different services together, and provide a single point of continuity for service users, rather than being passed from one agency to another without resolution. Provided the project can get sufficient buy-in from partner organisations, this approach could prove transformational for ending cycles of repeated homelessness for clients with the most complex, unmet needs.

Early evidence from multi-disciplinary teams is positive, but more work needs to be done to fully embed this collaborative approach in every local authority area. Current streams of funding and commissioning processes often encourage working in silos of housing and health, rather than working together to support the same client group with cross-cutting needs. Third sector organisations like ours have also gone as far as to source funding for multi-agency projects through grants like the Lottery Helping End Homelessness Fund. Finally, it is key to build this work on foundations of trusting relationships between clients and support services. Where clients are reluctant to engage with local authorities or probation, for example, a trusting relationship with another part of the MDT might still allow them to access the support they need.

Homelessness and mental health-specific nursing

In recent years we have seen an increase in community nursing, as specialist nurses are available to proactively visit people experiencing homelessness to address their mental and physical health needs. We've seen first-hand the impact they can make to improving health outcomes for the people we support, particularly in Bridgend and Swansea. Co-locating nursing and homelessness outreach services can be a really effective way to identify mental health problems and address them before they deteriorate to crisis point. Nurses who are part of the NHS system can fast-track clients towards getting a diagnosis, medication, or other more specialist care. There are undoubtedly many more examples of this approach working well in other areas, so we ought to encourage and expand it even further.

The Wallich Reflections Network

The **Reflections Network** is a specialist counselling service created and designed as a reactive service for service users across The Wallich, aiming to connect clients with a counsellor within 28 days of referral. Often it can be an extremely lengthy wait for our clients to access mainstream counselling through a GP referral, and those services are typically limited to six hour-long sessions. Conversely, our bespoke counselling service is not time-limited, and uses an integrative approach to address the underlying issues causing difficulties, taking as long as necessary to build trust and understanding.

Our team of 12 counsellors work in every area of Wales where we have projects, and are trained to support our service users in a trauma-informed way. Counselling with a neutral professional enables people to share difficult aspects of their lives without fear of judgement or being labelled. These subjects may be things that have never been spoken about and can be very challenging to keep with them for long periods of time. We believe that through this process, long-lasting positive changes can be achieved.

The Reflections Network is not currently funded through the main Housing Support Grant. It plays a vital part in the support of our clients, whose poor mental health and housing situation might deteriorate further without it. Ideally we would like to continue to expand this service to support more people, but that depends upon long-term sustainable funding.

Social services

It is also important to mention the good work happening within social service settings. Just like occupational therapists, social workers are often able to advocate on behalf of clients to access more specialist services. There are likely a number of factors in favour of this pathway, including stronger legislation and regulation, respect for the social worker profession - in comparison to the housing support profession - and a stronger culture of collaboration to ensure nobody falls through the gaps.

A good example is the strengthened safeguarding legislation (the Social Services and Well-being (Wales) Act 2014) which makes it clear that safeguarding is everybody's responsibility, not just the lead agency. This model could work well if applied to homelessness and mental health, to encourage more joined up working.

Section 7
Conclusion

The aim of this report was to present the evidence that is currently available on the dual crisis in homelessness and mental health. Staff across The Wallich reported real challenges getting the right support for clients in mental health crises; we wanted to understand what was going wrong and how to put it right.

It is also important to be clear that this report is not about blaming any one organisation or sector. All parts of the housing and health systems are under considerable pressure, following long periods of underinvestment, and of course the coronavirus pandemic. It is entirely understandable that services will manage their caseloads however they can, including through restrictive eligibility criteria and passing referrals on to other agencies. It is clear that there are structural disincentives built into the system, which inhibits genuine collaborative working and is in the best interest of clients and patients.

In our recommendations to health boards, local authorities, and Welsh Government, we have tried to focus on ways to re-incentivise partnership working, to develop holistic, person-centred services. The Trauma Informed Wales Framework is a great example of how this could work in practice, by putting questions of accessibility right at the heart of service design, thinking about how someone who had experienced trauma might prefer to engage. The feeling of constantly being turned away from services, of being left 'on hold', is something that repeatedly came up as retraumatising our clients. A 'no wrong door approach', where people are helped wherever they present, would be genuinely transformational.

We also recognise that it will take an alliance of policy makers and frontline workers to deliver the cultural changes we are calling for. The Welsh Government have led on a lot of great work in recent years developing strategies, both for ending homelessness, and addressing mental ill health. Unfortunately, the evidence in this report suggests that this work is not having the desired effect of making positive changes at the point of individual crisis.

The Mental health on Hold campaign hopes to draw attention to the work we still need to do to embed change, and The Wallich will work constructively with everyone across the sector to achieve this.

Ultimately, we are not really calling for anything particularly radical:

- **Fully implement existing NICE guidelines**
- **Promote trauma-informed, person-centred collaborative working**
- **Break down barriers to accessing mental health care for those with the most complex needs**

We must all be committed to ensuring that everybody experiencing homelessness and severe mental ill health is able to access the right support at the right time.

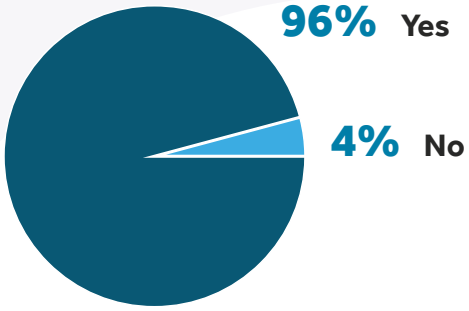
Appendix 1
Staff survey

During the early pandemic, between March and October 2020, The Wallich's specially trained support staff helped **more than 4,000** people experiencing homelessness. They continue to support some of the most vulnerable people in Wales.

The Wallich's staff say they are increasingly concerned and frustrated by their inability to get help and support for people in mental health crisis. They were surveyed in August 2022 about their experiences.

(Results based on 75 responses)

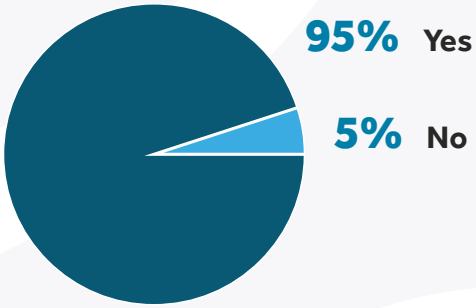
1. Have you supported clients in severe mental health crises?



> "Mental health teams take too long to react. It can be over 10 weeks after an incident for first contact with the client.
>
> It feels like we are supposed to keep them safe in the meantime, which is very difficult. Obviously as a team we go above and beyond, but we are not trained to do mental health's job."

2. Have you sought support from Community Mental Health Teams (CMHTs) or local crisis teams for your clients?

> "There are great workers within the community supporting individuals in crisis, all pulling together to make the person safe.
>
> I believe the services which need to step up and take responsibility would be the Specialists / Psychologists / Psychiatrists at CMHT.
>
> They continue to do telephone assessments which do not help the service user. It often makes the process more difficult, and people are left on a long waiting list.
>
> Furthermore, once the initial assessment was done over the phone, it was very hard to get another appointment."



3. What was your general experience seeking this support?

66% **Really difficult** – and I was not satisfied with the support available

8% **No help was available**

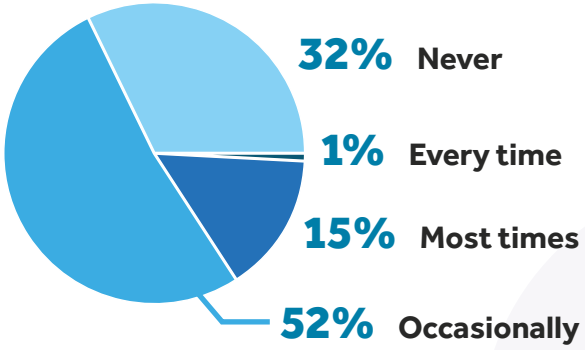
6% **Not applicable** (I have not sought support from these teams)

3% **Straightforward** – appropriate support was available

17% **Somewhat difficult** – but appropriate support was available

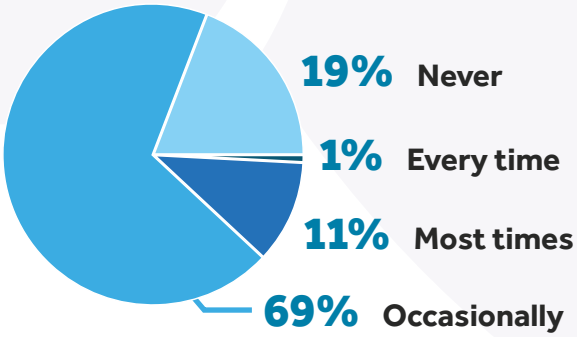
> “Even once they pick up the referral, they have a three strikes policy.
>
> One client I worked with; they rang her father even though she no longer lived there – **Strike one**. Then they rang her on her mobile, but she didn't answer as she had anxiety and didn't recognise the number – **Strike two**. They then rang the project while she was out – **Strike three**.
>
> She then had to be re-referred. So much for understanding mental health.”

4. When supporting clients in mental health crisis, how often have you needed to call an ambulance?

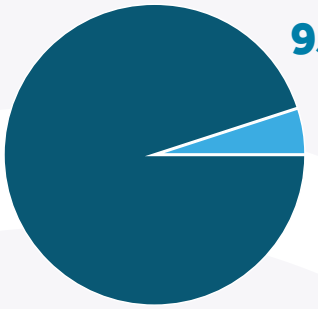


5. When supporting clients in mental health crisis, how often have you needed to call the police?

> “The client had self-harmed in the day and was under the influence of alcohol. I contacted the Crisis Team at approximately 6pm in the evening.
>
> They advised I'd need to call them after 7pm and to contact the local single point of contact (SPOC), who would not take a self-referral from a suicidal client as she was not known to them. I called the police, who would not attend as the client was in her home.
>
> I called NHS direct who, after a brief call with a mental health nurse, suggested I took the client to A&E to be seen.
>
> This resulted in a 10 hour wait in A&E and the client being discharged home.”



6. Have you supported clients in severe mental health crisis who have co-occuring issues with substance use?



95% Yes

5% No

> "It seems if you have mental health issues whilst on substances, you do not have mental health issues; in fact, most people use substances to deal with their mental health."

7. How did you find accessing mental health support for clients with co-occurring substance use?

16% **No help was available**

7% **Not applicable** (I have not supported a client with co-occurring mental health and substance use challenges)

2% **Straightforward** – appropriate support was available

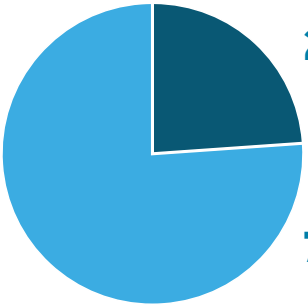
8% **Somewhat difficult** – but appropriate support was available

67% **Really difficult** – and I was not satisfied with the support available

> "The mental health professionals say that they will not treat the mental health issue until the substance use issues are addressed. However, when the substance use issues are addressed, the delays for accessing the appropriate mental health support are unacceptable and unsatisfactory.
>
> By the time many individuals are able to access this, they have already relapsed and this cycle repeats again."

> "Clients who have dual diagnosis are pushed between drug services and mental health services with no resolution in sight."

8. Do you feel there are appropriate referral pathways in your area for clients with severe mental health needs?



24% Yes

76% No

> Referral pathways in most areas are fairly clear, but actually getting through the process and receiving support from a CMHT is incredibly difficult for the people we work with.

> It's almost like mental health services have ceased to exist. It can take weeks to register with a GP and get an appointment to see the doctor.
>
> Then over 6 months to be contacted by the mental health team for the initial appointment – by which time our clients will usually have been re-housed or changed phone numbers.
>
> We have recently been advised there is a waiting time of over 18 months to be taken on by the Psychological Intervention Team after a mental health assessment.

9. Do you feel that your expertise and knowledge of the personal situation of clients is appropriately respected by mental health services?

> They put as many barriers as they can to stop you supporting a client in the assessment. So, a client who is in mental health crisis attends the assessment without support and struggles to get their point across. Due to this, often their crisis is not taken on board and no support is offered.

25% Yes

75% No

> Trying to get help outside of office hours is nigh on impossible and not being treated like an overreacting emotional uninformed bystander, whilst also being expected to respond as a highly trained specialist, is very challenging.

10. Thinking about access to mental health services for people experiencing homelessness, compared with the general population, I think that...

72% People experiencing homelessness have worse access to services

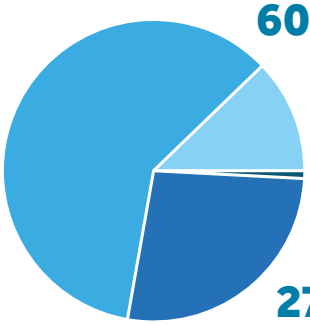
11% Don't know

4% People experiencing homelessness have better access to services

13% People experiencing homelessness have equal access to services

> "There needs to be a better working partnership between services or a better, secure referral service between our service and the crisis team. Clients are forced to make early morning calls to their GP if they are registered and are left with long hold times. It can make it difficult when clients either do not have access to a phone or have a phone and don't have the facility to charge the phone regularly."

11. How has your experience been of accessing mental health support for clients compared since the outset of the pandemic?



60% Worse than before

12% Don't know

1% Easier than before

27% The same as before

> "At one point, a client who I was supporting was told that the best place for them was to be was with The Wallich – even though we are not qualified mental health professionals and this person informed them that they felt suicidal and heard voices. This was not an isolated incident."

> "The pandemic has seen an increase in poor mental health and not enough staffing to cover the volume of people who need to be seen by these professionals."

Appendix 2 Summary of responses to FOI Requests

We submitted a series of FOI requests to each health board, police force and local authority in Wales, as well as to Welsh Government, and the national ambulance service. These questions were asked to establish the official position of each of these public bodies, as well as to gather data on the number of individuals in contact with services as a result of a mental health crisis.

We asked the following questions to each of the seven Welsh health boards:

Please describe the process through which individuals ought to seek emergency mental health care when experiencing a mental health crisis, such as an episode of psychosis or suicidal ideation.

Each of the health boards outlined the various referral pathways available for individuals in crisis, and what that looks like for people who are already in contact with local services, compared to those already known to 'the system'. There were some broadly similar approaches outlined.

Five of the seven health boards indicated that the first point of contact should be with a local GP service, who can then refer onto specialist services if judged appropriate. Four health boards also highlighted the new 111 service 'Press 2 for Mental Health', which is being introduced across Wales as a self-referral option. In the Welsh Government response, they indicated that they hope to rollout the 111 service across the whole of Wales by the end of 2022. We now understand the new deadline for this will be from April 2023.

A number of health boards also outlined referral processes where an individual presents through A&E, Police or other emergency services. These arrangements tend to be locally specific, but a number of responses mentioned mental health specialist services either collocated or accessible to emergency centres.

In summary, it appears that the typical route into specialist mental health care is via a referral from a GP, into a service provided by a Community Mental Health Team (or equivalent), and once individuals are known to local services, a crisis care plan can be put in place setting out who can provide care and support in an emergency. In some extraordinary cases, emergency services such as the police can undertake a mental health assessment (for example under S136 of the Mental Health Act), and refer directly into specialist services as a result. The national rollout of 111 'Press 2 for Mental Health' will add an element of self-referral to the process, and it appears that this will be in addition, rather than replacing traditional GP referral routes.

Please describe the remit and responsibilities of the health board's Community Mental Health Team (CMHT), and Crisis Team (if separate).

Six of the seven health boards indicated that they have separate CMHTs and crisis services (sometimes called Crisis Resolution Home Treatment Teams (CRHTTs) and in some cases, they provided separate policy and guidance documents setting out the specific remits of these services.

These broadly followed the same pattern. CMHTs are broad services, often including multi-disciplinary teams established through partnerships with local authorities and other health partners, designed to assess individuals, establish and coordinate an individualised care plan, and signpost or refer into other specialist services (such as drug and alcohol specialists, or Integrated Autism Services).CMHTs are typically only accessible in office hours (Monday to Friday, 9am to 5pm)

Crisis teams (including home treatment teams) are acute 24 hour services, designed to respond to urgent MH needs, and if possible triage towards other services, or treat individuals in their homes, to try and prevent admissions to hospital where possible. These teams also work to facilitate early discharge from inpatient units.

Is there a duty for the CMHT or Crisis Team to follow up on hospital admissions for patients who have attempted suicide?

All of the health boards confirmed that they do have processes for following up with patients who are discharged from hospital after an attempted suicide or other mental health crisis, typically within 48-72 hours.

Please outline when and how these responsibilities were amended or eased during the coronavirus pandemic, and when/whether the pre-pandemic regime resumed.

Each of the health boards confirmed that their crisis teams and CMHT services continued uninterrupted during the pandemic, albeit with some modifications to reduce the risk of transmission, including offering appointments via telephone or video-call, meeting outdoors, wearing PPE and maintaining a two-metre distance. All services have returned to in-person, face-to-face appointments, however some areas have maintained telephone or virtual services as an option for patients who prefer to communicate that way.

How many urgent referrals have been received by the health board for individuals experiencing mental health crises in the last five years? Please provide figures broken down by year, quarter and month where available.

This data has been provided by ABUHB, CTMUHB, HDUHB, PTHB and SBUHB. It is not recorded or was otherwise unable to be provided by BCUHB, and CAVUHB only provided figures for August 2022. Details below.

	2017	2018	2019	2020	2021	2022
ABUHB		11,244*	14,652	13,732	14,646	8,610*
BCUHB						
CAVUHB						76*
CTMUHB	981*	2,033	2,297	2,199	4,248	2,132*
HDUHB	2,926*	4,402	4,566	3,478	3,401	848*
PTHB		619	652	620	604	303*
SBUHB	2,064	2,149	2,082	1,695	1,412	

* Partial year data.

How many urgent referrals have been received by the health board for individuals experiencing mental health crises in the last five years, where the patient has been recorded as homeless or of having no fixed abode.

This data has been provided by ABUHB, CTMUHB, HDUHB, PTHB and SBUHB. It is not recorded or was otherwise unable to be provided by BCUHB. CAVUHB provided total figures for the past five years, but these were not broken down any further. Details below.

	2017	2018	2019	2020	2021	2022
ABUHB		109*	155	119	141	115*
BCUHB						
CAVUHB	171*					
CTMUHB	15*	23	20	22	27	6*
HDUHB	26	19	24	13	31	
PTHB			15	4	4	1*
SBUHB	4	7	8	10	18	

* Partial year data.

How many urgent referrals for critical mental health support have been rejected in the last five years? Please list the five most common reasons a referral was not accepted.

This data has been provided by ABUHB, HDUHB, PTHB and SBUHB. It is not recorded or was otherwise unable to be provided by BCUHB. CAVUHB provided total figures for the past five years, but these were not broken down any further. CTMUHB claim that no urgent referrals are rejected. Details below.

	2017	2018	2019	2020	2021	2022
ABUHB		319*	413	485	390	197*
BCUHB						
CAVUHB	388*					
CTMUHB						
HDUHB	88	92	54	13	58	
PTHB		39	29	36	42	15
SBUHB	843	906	943	807	517	

* Partial year data.

Please describe any specific thresholds or eligibility criteria that need to be met before a patient can receive support from the local crisis team.

The health boards outlined a number of specific examples of eligibility criteria, and details of how they target individuals in need of support. ABUHB for example lists individuals eligible for aftercare under Section 117, those presenting with a degree of risk or complexity that cannot be met by primary care or third sector organisations, individuals prescribed Clozapine or Lithium and not on a shared care protocol, and those requiring specialist interventions for eating disorders or accessing Dialectical Behavioural Therapy (DBT).

ABUHB also uniquely set out disqualifying criteria, including those whose primary diagnosis is alcohol or drug misuse rather than mental ill health, and where needs would be better met by Older Adult, Autism Spectrum or Learning Disability Services for example.

Other health boards are more vague, specifying only that the individuals should be adults presenting in the catchment area with acute mental health difficulties. HDUHB stated that no specific eligibility criteria is applied, and all patients are assessed and treated equally, irrespective of alcohol or substance use.

What is the average response time for urgent referrals to the local CMHTs, for each of the last five years?

BCUHB and CAVUHB each replied that they aim to respond to all urgent referrals within 48 hours, and all crisis referrals within 4 hours, however they were not able to provide details on actual response times or performance against those targets.

CTM UHB responded that this data is not recorded.

ABUHB, HDUHB, PTHB and SBUHB each provided average response times for the last five years, with averages varying from one hour to 24 hours.

	2017	2018	2019	2020	2021	2022
ABUHB		9 hours	9 hours	10 hours	11 hours	11 hours
BCUHB						
CAVUHB						
CTMUHB						
HDUHB	0.6 hours	1.7 hours	2.1 hours	2.5 hours	3 hours	
PTHB		1 day	1 day	1 day	0 days	0 days
SBUHB	1 hour	1 hour	1 hour	2 hours	2 hours	

How many inpatient bed spaces are available in the health board for individuals suffering severe mental health crises? What is the average length of stay for mental health inpatients.

Each of the health boards, with the exception of CAVUHB, provided details of the number of MH inpatient bed spaces available across their services, with numbers varying from 49 beds across PTHB, to 244 across SBUHB. CAVUHB did not give a clear response to the number of beds, only that they did have mental health inpatient beds at the Cedar Ward of Hafan y Coed.

All seven health boards also provided figures for the average lengths of stay in their mental health inpatient beds, from 16.4 days in ABUHB, to 286 days in SBUHB. A number of the health boards also broke down this data by different wards or specifically targeted services (such as those for older people). Other health boards explicitly excluded some specialist services.

	No of beds	Average length of stay
ABUHB	89	16.4 days
BCUHB	167	36 days
CAVUHB		6.81*
CTMUHB	188	36.2*
HDUHB	74	64.5 days
PTHB	48	41 days
SBUHB	244	286 days

* Not specified whether this reported in hours or days.

Please describe the principles and approaches taken by mental health professionals, when supporting patients who use drugs or alcohol.

Responses to this question varied significantly across the seven health boards we asked. A number outlined examples of partnership working between local mental health services and specialist drug and alcohol teams. Where these multi-agency arrangements are in place, staff from both services collaborate to assess referrals on a case-by-case basis, when deciding how to structure the individual's support. Most services seem to reflect the traditional binary view of dual diagnosis, or consider whether mental health or substance use is the lead need or a secondary need, when deciding who has primary responsibility for coordinating support.

There is little detail in the responses as to how MH staff specifically (i.e. those directly employed by the health board) approach supporting patients who use drugs or alcohol, other than pointing to partnership arrangements with substance use services, or psychiatrists specialising in addictions. CAVUHB also shared operational policies for some of their services which explicitly prohibit the use of drugs or alcohol by patients.

How many patients have been refused mental health care, as a consequence of their use of substances, in the last five years?

ABUHB, CAVUHB, CTMUHB and HDUHB replied that they do not record this information.

BCUHB, PTHB, and SBUHB all claim that they never refuse mental health care as a consequence of patient substance use, and would instead signpost towards appropriate drug and alcohol services. PTHB specifically reference the NICE quality standards on coexisting severe mental illness and substance misuse.

How many patients have had mental health care withdrawn, as a consequence of their use of substances, in the last five years?

ABUHB, CAVUHB, CTMUHB and HDUHB replied that they do not record this information. The other three health boards reiterate that they would not withdraw care as a result of patients using substances.

We also asked each of the four Welsh Police Forces the following questions:

To how many emergency callouts have officers responded, where an individual was experiencing a severe mental health crisis, in the last five years/since 2017-18?

Each of the four police forces provided figures for the number of incidents recorded in the time period, with the National Standard for Incident Reporting (NSIR) tag 'mental health'.

Dyfed Powys and Gwent Police noted specific limitations impacting upon the quality of the data provided.

	2017	2018	2019	2020	2021	2022
Dyfed Powys	567	322	260	606	423	189*
Gwent		9,646	10,362	11,815	12,398	3,939*
North Wales		261	989	1,523	1,465	620*
South Wales	25,455*	32,872	35,254	22,659	22,523	10,829

* Partial year data.

Please describe the process by which an individual in contact with police officers would undergo a mental health assessment.

Each of the four forces provided details of their S.136 processes, where they attend an incident where an individual is deemed to pose a threat to themselves or others. Individuals may agree to go voluntarily with officers to attend A&E or to see the crisis team, or if appropriate they may be detained and transported involuntarily.

Dyfed Powys and Gwent Police outlined their own internal arrangements, including custody nursing and mental health triage services.

How many individuals in contact with the police have undergone a mental health assessment in the last five years?

Dyfed Powys Police were unable to provide figures for this question, however the other three forces did provide data of the numbers of assessments carried out.

	2017	2018	2019	2020	2021	2022
Dyfed Powys						
Gwent				440*	701	335*
North Wales		719	819	501	593	297*
South Wales		958	801	633	802	303

* Partial year data.

We also asked the following questions to each of the 22 local authorities in Wales:

What support do you provide to people who experience severe mental health crises, including suicidal ideation or attempts, psychosis, or putting others at risk of harm?

Most of the local authorities pointed to local partnership arrangements with their regional health board, and in some areas the responses suggest a considerable level of integration between adult social care or mental health specialists employed by the LA, and the health board. Blaenau Gwent, Caerphilly, Cardiff, Torfaen and Wrexham each responded giving specific details of multi-agency working, for example co-locating staff within CMHTs. Other authorities were more vague, referring to services run by the health boards, but not were not explicit about their own roles

Another key thread was reference to the provision of Approved Mental Health Professionals under the Mental Health Act 1983. Each Local Social Service Authority is obliged to maintain a register of AMHPs who are able to consider the needs of individuals who may require hospitalisation for their own safety. Some other local authorities talked about care co-ordinators, patient advocates, and other such roles created to discharge responsibilities under the Mental Health (Wales) Measure2010 or the Social Services and Well-being (Wales) Act 2014.

Despite there being no mention of housing or homelessness in this specific question, a number of local authorities took this opportunity to outline services commissioned under the housing support grant with specific focus on support for people with co-occurring homelessness and mental ill health.

Finally, two local authorities declined to answer the question, referring us instead directly to the local health board as the service operator.

Please describe any partnership arrangements with other organisations which create referral pathways for people to access support for severe mental health needs, and outline any thresholds or criteria used to determine eligibility.

Once again, most local authorities referred to their partnership arrangements with community mental health and drug and alcohol teams. A number of authorities outlined their single point of access or shared referral systems, including multi-agency meetings which assess referrals against criteria in the Mental Health (Wales) Measure 2010, and the Social Services and Well-being Act 2014.

The typical referral pathway is via the GP, however a number of local authorities referenced options for self-referral, via police or probation, third sector partnerships, and through 111 – "Press 2 for Mental Health". Ceredigion mentioned case management through the shared 'Welsh Community Care Information System (WCCIS) used by health boards and local authorities across the country (although no other organisation specifically mentioned this system in their responses).

Once again, two local authorities declined to answer the question, referring us instead directly to the local health board.

What consideration has the local authority given to community mental health needs in the context of delivering housing and homelessness services, such as Housing First or rapid rehousing?

Once again, most local authorities outlined their partnership working arrangements between housing and mental health staff, including HSG commissioned services for people experiencing homelessness and poor mental health. A number of authorities also responded that they are in the process of updating their mapping of community needs in order to more closely reflect reality since the pandemic. A number of local authorities referenced their draft rapid rehousing transition plans, which are not currently all available (despite being due by the end of September 22).

Gwynedd mentioned a successful bid for Regional Integration Funding (RIF) to provide dedicated mental health tenancy support workers. On the other hand, Merthyr Tydfil highlighted that CTMUHB have a dedicated homelessness team to support access to mainstream services.

We asked a series of questions directly to the Welsh Ambulance Services NHS Trust;

How many ambulance callouts have been made for patients experiencing severe mental health crises in the last five years?

The Ambulance Service provided annual figures for 2018-21, plus a partial year's figures for 2022, of the number of incidents coded as "25 - Psych / Abnormal Behaviour / Suicide". They noted that this coding might not necessarily capture all incidents related to Mental Health crises. The average number of annual incidents was fairly stable, at around 14 and a half thousand.

	2018	2019	2020	2021	2022
Code 25 Incidents	14,737	14,532	14,535	14,134	6,413*

* Partial year data.

How many ambulance callouts have been made for patients experiencing severe mental health crises, where the patient has also been under the influence of drugs and/or alcohol, in the last five years?

The Trust did not specifically respond to this question, as they do not record whether or not a patient is under the influence of drugs or alcohol at the time of the incident.

What is the average ambulance response time for patients experiencing severe mental health crises, for each of the last five years?

The Trust provided average response times for the above coded incidents, and the progression shows a steady increase in average response times from 1hr56 in 2018, to 4hr19 in the first half of 2022.

	2018	2019	2020	2021	2022
Average response time for Code 25 Incidents	01:56:50	02:09:29	02:06:37	03:25:38	04:19:38*

* Partial year data.

Please describe any partnership arrangements for collaborative working with local mental health services.

The Trust replied that they meet regularly with all health board mental health services through various forums, including the National Crisis Care Assurance and Advisory Board.

Please describe the training provided to ambulance response staff for supporting patients experiencing severe mental health crises.

The Trust replied that trainee EMTs are required to complete mental health e-learning modules, as well as a half day of training with the Trust's Head of Mental Health.

Finally, we submitted the following questions directly to the Welsh Government:

Please outline the statutory and policy framework underpinning the duties and responsibilities of Community Mental Health Teams (CMHTs) in Wales.

WG confirmed that CMHTs deliver local services within tier 2 of the whole system model, as set out in parts 2 and 3 of the Mental Health (Wales) Measure. Their role is to screen and assess people referred to tier 2 services, and deliver a range of health, social care and psychological interventions, having taken into account their specific needs.

Please outline when and how these responsibilities were amended or eased during the coronavirus pandemic, and when/whether the pre-pandemic regime resumed.

All Mental Health Services were classified as essential services during the pandemic, and responsibilities remained unchained, however delivery models were adapted in line with restrictions, for example providing support over the phone or online. Some CMHTs were also consolidated into fewer locations.

What guidance or training is available to staff working in mental health services to support patients/clients who also use drugs or alcohol.

The WG pointed towards a service framework for the treatment of co-occurring mental health and substance use issues. The guidance is intended to create more integrated and collaborative practice. Traumatic Stress Wales are also in the process of developing 'Stabilisation' training for staff working with those who use drugs and alcohol.

What assessment has been carried out of the future funding needs of CMHTs, in order to meet projected demand for mental health services, as well as supporting delivery of related strategies such as the Ending Homelessness Action Plan.

All health boards are required to assess local needs and future demands as part of routine planning processes. Officials in the Mental Health Policy Team work across government using data from the health boards, as well as other evidence from the WG's Knowledge and Analytical Services, which feeds into the budget setting process. This team also works on wider policies and action plans, including the EHAP.

Please provide an update on progress made against the national action plan for the Wales Crisis Care Concordat, specifically actions against core principles two and three, on access and quality of crisis services.

A new national Action Plan has been developed for 2022, which will be delivered alongside seven local multi-agency crisis care forums (for each of the seven health board areas). Key areas of progress include the investment of an additional £6m from 2021/22 to improve access to crisis services, establishing alternatives to hospital admissions (such as Mental Health Sanctuaries), and the rollout of 111 Press 2 for Mental Health. WG also funded a MH Conveyance pilot to improve access to appropriate and timely transport for people in crisis.

Appendix 3
Useful links and further reading

Admission of patients to mental health facilities

Detentions under Section 135 and 136 of the Mental Health Act

Ending Homelessness in Wales: A high level action plan 2021-2026

Groundswell – 'Knowing where to turn': access to mental health support whilst experiencing homelessness

Law Wales – Mental health care for adults and children

Mental Health Act 1983

Mental Health Wales – A guide for mental health service users and their families

Mind – Crisis care

NICE Quality Standard 188 – Coexisting severe mental illness and substance misuse

Referrals and waiting times for Local Primary Mental Health Support Services

Social Services and Well-being Wales Act 2014

The National Standard for Incident Recording (NSIR)

Trauma-Informed Wales – A societal approach to understanding, preventing and supporting the impacts of trauma and adversity

Wales Crisis Care Concordat – National Action Plan 2022

Welsh Parliament Health and Social Care Committee – Connecting the dots: tackling mental health inequalities in WalesEnding Homelessness in Wales: A high level action plan 2021-2026