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Review of Together for Mental Health and Talk to Me 2 Strategies

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Glossary

Acronym/Key word	Definition
2wish	Organisation offering bereavement support for those affected by sudden death in young people
ACE	Adverse Childhood Experience: potentially traumatic events that occur in childhood (0-17 years)
ANPs	Advanced Nurse Practitioners, who are educated at Masters' Level in clinical practice and have been assessed as competent in practice using their expert clinical knowledge and skills. They have the freedom and authority to act, making autonomous decisions in the assessment, diagnosis and treatment of patients
Ask Twice Campaign	A campaign to encourage conversations around mental health and well-being
Assessment and Treatment Teams	A community mental health service that assesses adults who are having a mental health crisis or need intensive home-based support and treatment
ADHD	Attention deficit hyperactivity disorder: a condition that affects people's behaviour. People with ADHD can seem restless, may have trouble concentrating and may act on impulse
ASD	Autism spectrum disorder: a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave.
Bereavement Support Grant	Funding available for the delivery of bereavement care in Wales
CAMHS	Child and Adolescent Mental Health Services: NHS services that assess and treat young people with emotional, behavioural or mental health difficulties
Connect 5 Training	Training to increase the confidence and core skills of front-line staff in having effective conversations about mental health and well-being, and help people manage mental health problems.

Crisis teams	Teams that offer support for those having a mental health crisis outside hospital
DPJ Foundation	A mental health farming charity based in west Wales
EMDR	Eye Movement Desensitization and Reprocessing Therapy: a psychotherapy that helps people heal from the symptoms of, and emotional distress that results from, disturbing life experiences
HEIW	Health Education and Improvement Wales is a Special Health Authority which sits alongside health boards and trusts as part of NHS Wales.
LPMHSS	Local Primary Mental Health Support Services: available to people of all ages and aimed at people who are experiencing mild to moderate, or stable, severe and enduring mental health problems.
LGBTQ+	Lesbian, gay, bi, trans, queer, questioning and ace (umbrella term covering a range of asexual and aromantic identities)
MDTs	Multi-disciplinary teams: a group of health and care staff from different organisations and professions that work together to make decisions around the treatment of patients and service users
National Advisory Group (NAG)	A group that advises Welsh Government on suicide and self-harm prevention and guides the implementation of the Talk to Me 2 strategy
NICE	National Institute for Health and Clinical Excellence, which offers Guidance, advice and information services for health, public health and social care professionals
Occupational Therapist (OT)	Occupational therapists help people with a wide range of (mental) health conditions enjoy everyday activities that improve their chances of recovery
Real-time Suicide Surveillance System	A central national repository for suspected suicides in Wales

RPBs	Regional Partnership Boards, which are responsible for developing health and care services across Wales
Shared Lives Scheme	A service for vulnerable adults, whereby individuals using adult placement services have the opportunity to be supported in carers' homes and local communities
S.P.A.C.E. Well-being Newport	A single point of access for children's emotional well-being, based in Newport
STORM (training)	Suicide prevention training for frontline staff
SUI	Suicidal/Death Ideation
Suicide First Aid Training	A course to teach suicide intervention skills
Time to Change Wales	National campaign to end the stigma and discrimination faced by people with mental health problems
WARRN (training)	WARRN (Wales Applied Risk Research Network) is a technique for assessing and managing serious risk (suicide or harm to others). Used in MH services to assess level of risk and also managing risk.
Well-being of Future Generations (Wales) Act 2015	Legislation requiring public bodies to put long-term sustainability at the forefront of their thinking.

1. Introduction

Aims and objectives

1.1 The aim of this review was to evaluate the Welsh Government's 10-year cross governmental strategy to improve mental health, Together for Mental Health (T4MH), and the action plan to reduce suicide and self-harm, Talk to Me 2 (T2M2). In particular this review sought to assess the extent to which observed outcomes are attributable to the actions developed and implemented as a result of the two strategies.

1.2 The main objectives of the review were to:

- Use existing evidence and data to assess the contribution that T4MH and T2M2 have made
- Identify gaps in the existing data that need to be filled to strengthen the contribution assessment
- Consider the progress made towards meeting the outcome and performance measures used within each Strategy and accompanying Delivery Plans
- Consider the impact of the COVID-19 pandemic on delivery of the strategies and resulting changes to ways of working
- Assess the impact that T4MH has had on improving outcomes for the diverse range of groups that are covered (to include people across the age spectrum, Black, Asian and Minority Ethnic groups, people living in poverty, among others to be agreed)
- Assess the extent to which a cross-government response has been developed in implementing T4MH
- Consider how the workforce in terms of numbers and skills has impacted on implementation of the strategies
- Assess the progress made with embedding/strengthening the 'active offer'[1] in mental health services

[1] The active offer refers to the need for service providers to proactively make services in Welsh available to service users, without users having to ask for this.

- Make recommendations to inform the development of the next strategy/strategies.

Together for Mental Health

1.3 Together for Mental Health[2] (T4MH) (2012) is the Welsh Government's 10-year cross-governmental strategy to improve mental health and well-being. It is the first mental health strategy for Wales that covers people of all ages. It focuses on prevention, early intervention and how to improve the lives of service users and their families using a recovery and enablement approach. It is committed to person-centred holistic care, engaging in all aspects of a person's life. Published in October 2012 following significant engagement and formal consultation with stakeholders, the strategy has been supported by a series of detailed delivery plans[3]. The third and final plan[4] was refreshed in response to the COVID-19 pandemic and was published in October 2020.

1.4 T4MH sets out a number of high-level outcomes aimed at significantly improving the quality and accessibility of mental health services for all ages. The strategy recognises that the causes and effects of poor mental health are complex, challenging, and multi-faceted, and therefore require an integrated, cross-government and cross-sector partnership approach to achieve these outcomes.

1.5 The six high level outcomes underpinning the 10-year strategy are:

- The mental health and well-being of the whole population is improved
- The impact of mental health problems and/or mental illness on individuals of all ages, their families and carers, communities, and the economy more widely, is better recognised and reduced
- Inequalities, stigma, and discrimination suffered by people experiencing mental health problems and mental illness are reduced
- Individuals have a better experience of the support and treatment they receive and have an increased feeling of input and control over related decisions

[2] Together for mental health: our mental health strategy | GOV.WALES
[3] Together for mental health delivery plan 2016 to 2019 progress report | GOV.WALES
[4] Together for mental health delivery plan 2019 to 2022 | GOV.WALES

- Access to, and the quality of preventative measures, early intervention and treatment services are improved, and more people recover as a result.
- The values, attitudes and skills of those treating or supporting individuals of all ages with mental health problems or mental illness are improved.

Talk to Me 2

1.6 In 2008, Welsh Government published Talk to Me, the national action plan to reduce suicide and self-harm in Wales. Talk to Me built on work already happening within Welsh Government to address poverty, homelessness, and inequality.

1.7 Its successor, Talk to Me 2[5] (T2M2) was produced in 2019. It identified the strategic aims and objectives to prevent and reduce suicide and self-harm in Wales, identifying priority care providers to deliver actions to benefit priority people, and outlines the national and local actions which are required to achieve them.

1.8 T2M2 contains 16 priority actions and six principal objectives, which are to:

- Further improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come in to contact with people at risk of suicide and self-harm and professionals in Wales
- Deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm
- Provide information and support for those bereaved or affected by suicide and self-harm
- Support the media in responsible reporting and portrayal of suicide and suicidal behaviour
- Reduce access to the means of suicide
- Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action.

1.9 The priority actions comprise a rolling programme of work which the National Advisory Group on Suicide and Self Harm Prevention (NAG) reviews and reports on

[5] T2M2 strategy 2015-2020 | GOV.WALES

annually. A mid-point review[6] of Talk to Me 2 was undertaken by Public Health Wales NHS Trust (PHW) in 2018.

The report

1.10 This report sets out the methodology used in the review. It then outlines its key findings, in line with the main objectives.

[6] T2M2 strategy 2015-2020 midpoint review | GOV.WALES

2. Methodology

2.1 The review was conducted by Opinion Research Services (ORS), between October 2021 and August 2022.

2.2 Given that isolating the strategies' direct causal impacts on progress towards meeting their outcome and performance measures was likely to be difficult, if not impossible, in light of competing influences, the review took a theory-based approach, known as a Contribution Analysis.

2.3 As described in more detail below, the first stage of this Contribution Analysis was the development of two separate Theories of Change for T4MH and T2M2. These were initially informed by a review of key documentation and available datasets and refined with strategic stakeholders in a series of in-depth interviews and workshops.

2.4 Once the Theories of Change were complete, focus groups and in-depth interviews were undertaken with strategic and operational personnel from mental health and suicide and self-harm prevention organisations across Wales, and those with lived/living experience of mental health and wellbeing issues. Using the Theories of Change as a basis, these explored people's experiences of providing and receiving mental health and wellbeing services across Wales, allowing the exploration of progress towards strategy outcomes and the development of the contribution story.

Documentation and data review: November – December 2021

2.5 This involved a review of key documentation and an in-depth analysis of primary and secondary data sets to inform ongoing data metrics; additional data collection requirements; the development of the project design; the questions to be included in the data collection stages of the review; views on the contributions made by the two strategies; the identification of any gaps in the existing data; and the initial Theory of Change (ToC) model (which was subsequently refined during the review).

2.6 Most of the data reviewed was publicly available, and some was provided by Welsh Government. After completing the review, an internal working paper was produced for Welsh Government which outlined the initial assessment of evidence and data availability for the review. The documentation and data review also informed the draft Theories of Change.

Scoping interviews: January – March 2022

2.7 Virtual scoping interviews were conducted with 18 strategic personnel from Welsh Government, the NHS, and mental health and suicide and self-harm prevention organisations. A purposive sample of participants who were felt to be ideally placed to inform the development of the ToC was identified by Welsh Government. Combined with the documentation and data review, the interviews gathered information to inform the initial Theories of Change for T4MH and T2M2.

Stakeholder workshops: March 2022

2.8 One stakeholder workshop was held with 11 members of the Delivery and Oversight Board[7], and another with 12 members of the National Mental Health Partnership Board[8]. The workshops reviewed and refined the initial Theories of Change and discussed priorities for the reviews going forward.

Regional focus groups: March 2022

2.9 Twelve virtual regional focus groups for strategic and operational personnel from mental health and suicide and self-harm prevention organisations were held across Wales: three for those in north Wales, three for those in southeast Wales, three for those in southwest Wales, and three for those in mid Wales. Stakeholders who had pan-Wales roles were invited to attend any of the workshops.

2.10 A list of around 100 stakeholders for possible inclusion in the workshops was provided by Welsh Government. Welsh Government drew the list from their database of key mental health contacts from across Wales, based on their understanding of the stakeholder's role and remit. ORS invited all these stakeholders via email to select a workshop to attend, based on their location in Wales (north, southeast, southwest, or mid Wales, or pan-Wales). If stakeholders were unable to attend, ORS invited them to name a delegate.

[7] The Delivery and Oversight Board has been established to: oversee the continued response to the mental health impact of Covid-19; strengthen oversight and assurance for the delivery of 'Together for Mental Health' strategy and associated delivery plan; and monitor evidence to inform the future programme of work and the successor to the Together for Mental Health Strategy.

[8] The National Mental Health Partnership Board has a line of accountability to the Delivery and Oversight Board and is the main mechanism for service user and stakeholder engagement.

2.11 Overall, 36 stakeholders attended the workshops from all the groups and organisations invited, including members of the Crisis Care Concordat Advisory Board; the Mental Health Ethnic Minorities Task and Finish Group; T2M2 regional leads; representatives from the Wales Alliance for Mental Health; CAMHS; prisoner and vulnerable groups mental health, health boards; and cross-government senior officials from Welsh Government.

2.12 The number of workshop participants may be slightly lower than expected, given the number invited. However, numerous stakeholders had already participated in interviews as part of the project, so may understandably have been unable to devote any more time to it. Stakeholders may also have been facing additional workload pressures linked to the COVID-19 recovery period.

2.13 We also interviewed three additional stakeholders who were unable to attend a workshop. In addition, written responses were submitted by the NHS Wales Health Collaborative[9], and one other stakeholder.

2.14 The regional events explored participants' views on progress towards strategy outcomes; the impact of COVID-19 on delivery; the impact of the strategies on improving outcomes for diverse groups; the contribution of the workforce on delivering the strategies; the active offer; and what the successor strategies to T4MH and T2M2 should prioritise.

Practitioner interviews: May – July 2022

2.15 Sixteen practitioners working in mental health and suicide prevention across Wales were interviewed: eight from southeast Wales; three from southwest Wales; three from north Wales and one from mid Wales. Welsh Government identified contact people in each health board to pre-identify prospective participants for these interviews. Participants were asked to discuss similar topics to the regional events.

[9] The NHS Wales Health Collaborative is a national organisation, working on behalf of the health boards, trusts and special health authorities that make up NHS Wales. Through facilitating engagement, networking and collaboration between NHS partners and other stakeholders, its teams work to support the improvement of NHS Wales's services across organisational boundaries and improve quality of care for patients.

Service User Forum workshop: May 2022

2.16 Members of the Wales Mental Health and Well-being Forum[10] were invited to participate in a workshop. The Forum provided administrative support for the workshop, which was held over a morning and afternoon session on the same day. Nine members took part overall. The first half of the workshop covered an agenda set by ORS in partnership with Welsh Government, incorporating Forum members' experiences of the treatment they have received, including their level of input and involvement into it, and the impact of COVID-19 on it. We also sought to explore the experiences of those with protected characteristics and vulnerable groups, and Welsh speakers; views on inequalities, stigma, and discrimination experienced by people with mental health issues; and recommendations for improvement that can feed into future strategies. The second half of the workshop was an 'open' session where Forum members were invited to discuss issues which mattered to them. Additional written feedback was provided by a forum member after the event.

National Advisory Group (NAG) Workshop: July 2022

2.17 A workshop involving nine members of the National Advisory Group (NAG)[11] for suicide and self-harm prevention was held. This workshop assessed similar areas to the regional events and practitioner interviews, but specifically focused on T2M2.

Service user interviews: July – August 2022

2.18 The original intention was to undertake 20 in-depth interviews with adult service users and 16 with young service users. Recruitment of participants was initially sought through health boards, social media, and partner organisations but despite extensive efforts, little success was achieved in engaging with service users via these routes. In the end, three adult service users (aged 18+) and two young service users (both aged 17) were interviewed, with explicit consent having been

[10] A group of individuals from across Wales who either have direct lived experience of mental health and mental health services, or individuals that provide care and support for someone with mental health needs. The Forum was established in 2013 by the Welsh Government, and directly influences decision making at a local and national level.

[11] The National Advisory Group (NAG) was set up to oversee the implementation of Talk to Me 2 and to advise Welsh Government. It is attended by a wide range of statutory, voluntary and charity agencies who are involved in suicide and self-harm prevention in Wales.

obtained from all. Ultimately, it was the NHS Wales Health Collaborative that assisted with recruiting most of those who took part.

2.19 Interviews with service users explored their experiences of accessing mental health services; their overall views on the services they have used and the staff who have provided them; their experiences of accessing services in Welsh; the impact of COVID-19 on services; and what they feel Welsh Government should do to improve mental health services in future.

Analysis and reporting

2.20 Following the interviews and workshops, ORS researchers produced detailed notes which were used to create a qualitative analysis framework and extract the key findings from the data. Excel was used to organise the data into overarching and sub-themes (a manual approach was taken to ensure the data's full nuance and richness was captured), and once the final analysis was complete, an internal meeting was held to enable the whole review team to share and discuss the emerging findings from the analysis, including common themes and specific views.

2.21 The key findings from the interviews and focus groups, as well as the data and documentation review, are summarised in the remainder of this report. There is also a table of metrics, sources, and headline findings from the data review in Appendix 1.

Data caution note

2.22 The contribution analysis involved developing a theory of change for the two strategies, reviewing available data and literature on their intended outcomes and assembling an informed contribution story. To complement this, the focus groups and interviews with stakeholders, practitioners and service users were intended to gather the experiences of as broad a range of people as possible within a relatively small sample size. As such, the qualitative feedback reported here, while comprehensive, should not be seen as statistically representative of the views of stakeholders, practitioners, and those with living experience of mental health and well-being issues.

2.23 Moreover, the views expressed by participants in the focus groups and interviews may or may not be supported by available evidence; that is, they may or may not be fully accurate accounts of the facts. ORS cannot arbitrate on the correctness or otherwise of people's views in reporting them, and this should be borne in mind when considering the findings. We have, where possible, sought to triangulate the qualitative data with quantitative data and other published data/sources, but where this data does not exist or is inaccessible, the cautionary note above should be borne in mind.

3. Main Findings: Achieving the Strategy Outcomes for T4MH

3.1 The initial stakeholder interviews and focus groups undertaken in early 2022 began the process of developing and producing an initial Theory of Change (ToC) model, which was refined during the subsequent stakeholder, practitioner, and service user interviews. The final model for the T4MH strategy is presented on the next page.

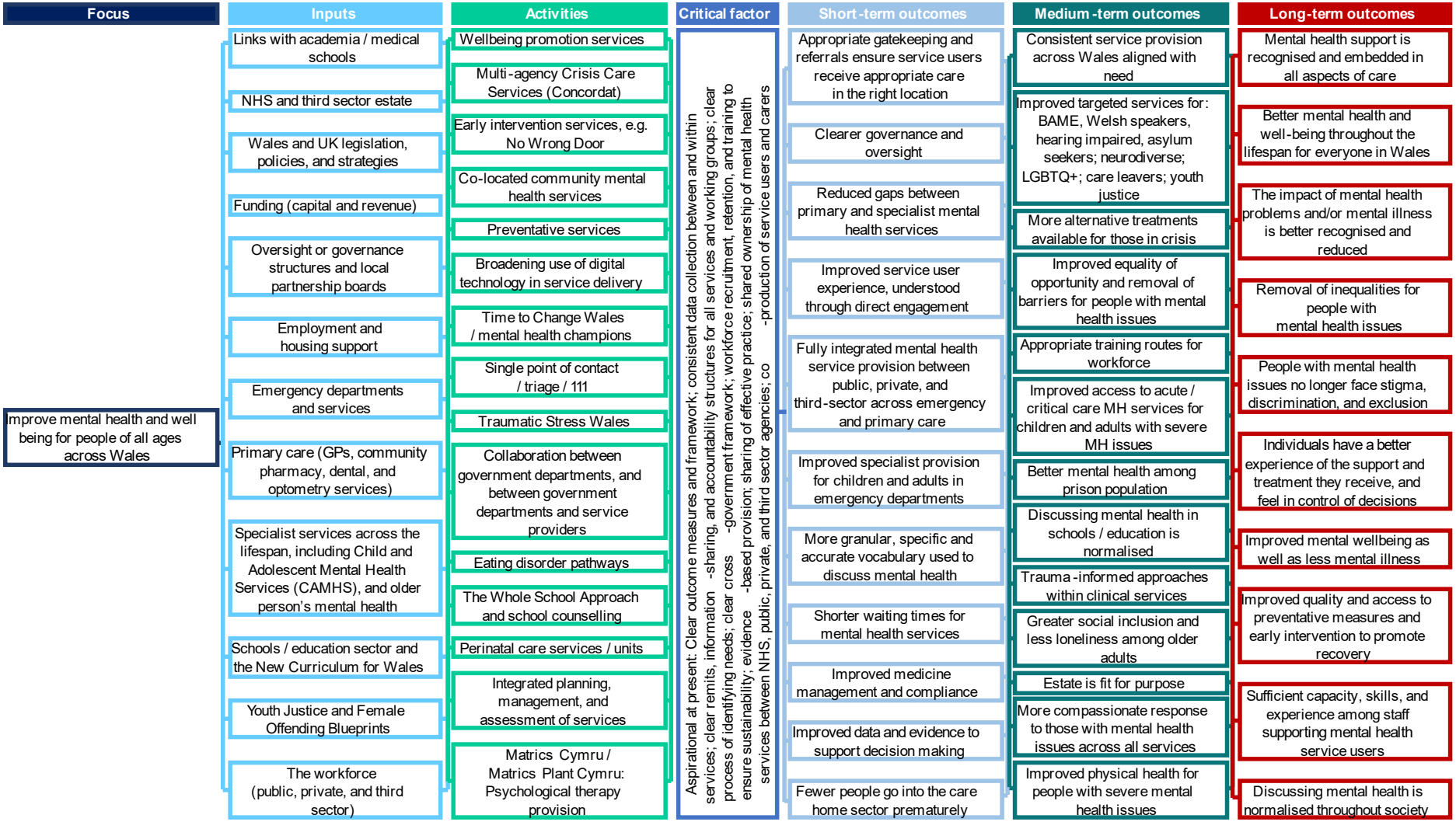
3.2 The following section seeks to address the following two key evaluation objectives, as evidenced by the views expressed in the qualitative discussions and, where possible, the findings from the literature and data reviews.:

- The extent of progress made towards meeting the T4MH outcome measures, (and the contribution the strategy itself has made to doing so); and
- The key data gaps that need to be filled to establish the success or otherwise of the strategy in meeting its outcomes.

3.3 As interviews and group discussions centred around the ToC, this section also uses the model as a framework. It begins with some overall thoughts about the T4MH strategy and its successes and challenges, before examining participants' views on the ToC's short-, medium- and long-term outcomes. These have been linked to the strategy's overall high-level outcomes where possible, which are as follows:

- The mental health and well-being of the whole population is improved
- The impact of mental health problems and/or mental illness on individuals of all ages, their families and carers, communities, and the economy more widely, is better recognised and reduced
- Inequalities, stigma, and discrimination suffered by people experiencing mental health problems and mental illness are reduced
- Individuals have a better experience of the support and treatment they receive and an increased feeling of input and control over related decisions
- Access to, and the quality of preventative measures, early intervention and treatment services is improved, and more people recover as a result
- The values, attitudes and skills of those treating or supporting individuals of all ages with mental health problems or mental illness are improved.

3.4 The section concludes with participants' thoughts around the extent to which data is available to evidence progress, and the key gaps that exist.


Focus
Improve mental health and well being for people of all ages across Wales
Inputs
Links with academia / medical schools
NHS and third sector estate
Wales and UK legislation, policies, and strategies
Funding (capital and revenue)
Oversight or governance structures and local partnership boards
Employment and housing support
Emergency departments and services
Primary care (GPs, community pharmacy, dental, and optometry services)
Specialist services across the lifespan, including Child and Adolescent Mental Health Services (CAMHS), and older person's mental health
Schools / education sector and the New Curriculum for Wales
Youth Justice and Female Offending Blueprints
The workforce (public, private, and third sector)
Activities
Wellbeing promotion services
Multi-agency Crisis Care Services (Concordat)
Early intervention services, e.g. No Wrong Door
Co-located community mental health services
Preventative services
Broadening use of digital technology in service delivery
Time to Change Wales / mental health champions
Single point of contact / triage / 111
Traumatic Stress Wales
Collaboration between government departments, and between government departments and service providers
Eating disorder pathways
The Whole School Approach and school counselling
Perinatal care services / units
Integrated planning, management, and assessment of services
Matrics Cymru / Matrics Plant Cymru: Psychological therapy provision
Critical factor
Aspirational at present: Clear outcome measures and framework; consistent data collection between and within services; clear remits, information -sharing, and accountability structures for all services and working groups; clear process of identifying needs; clear cross -government framework; workforce recruitment, retention, and training to ensure sustainability; evidence -based provision; sharing of effective practice; shared ownership of mental health services between NHS, public, private, and third sector agencies; co -production of service users and carers
Short-term outcomes
Appropriate gatekeeping and referrals ensure service users receive appropriate care in the right location
Clearer governance and oversight
Reduced gaps between primary and specialist mental health services
Improved service user experience, understood through direct engagement
Fully integrated mental health service provision between public, private, and third-sector across emergency and primary care
Improved specialist provision for children and adults in emergency departments
More granular, specific and accurate vocabulary used to discuss mental health
Shorter waiting times for mental health services
Improved medicine management and compliance
Improved data and evidence to support decision making
Fewer people go into the care home sector prematurely
Medium-term outcomes
Consistent service provision across Wales aligned with need
Improved targeted services for: BAME, Welsh speakers, hearing impaired, asylum seekers; neurodiverse; LGBTQ+; care leavers; youth justice
More alternative treatments available for those in crisis
Improved equality of opportunity and removal of barriers for people with mental health issues
Appropriate training routes for workforce
Improved access to acute / critical care MH services for children and adults with severe MH issues
Better mental health among prison population
Discussing mental health in schools / education is normalised
Trauma-informed approaches within clinical services
Greater social inclusion and less loneliness among older adults
Estate is fit for purpose
More compassionate response to those with mental health issues across all services
Improved physical health for people with severe mental health issues
Long-term outcomes
Mental health support is recognised and embedded in all aspects of care
Better mental health and well-being throughout the lifespan for everyone in Wales
The impact of mental health problems and/or mental illness is better recognised and reduced
Removal of inequalities for people with mental health issues
People with mental health issues no longer face stigma, discrimination, and exclusion
Individuals have a better experience of the support and treatment they receive, and feel in control of decisions
Improved mental wellbeing as well as less mental illness
Improved quality and access to preventative measures and early intervention to promote recovery
Sufficient capacity, skills, and experience among staff supporting mental health service users
Discussing mental health is normalised throughout society

To what extent has progress been made towards meeting the strategy's outcome and performance measures?

3.5 Positively, there was widespread support for having a strategy in place, and much good was thought to have come from it. In essence, it was said to have provided a framework of common goals for mental health and well-being services across Wales, and a 'guide' for what they should be striving for.

> '... Without that in place it doesn't allow for… consistent process or that goal… I would say that having these short-, medium-, and longer-term outcomes helps gives that common structure for everyone. And I think that probably helps to drive things forward'
>
> Stakeholder – 33

3.6 Specifically, several interviewees felt that that the strategy has been critical in facilitating more positive cross-sector working and underpinning and providing justification for service change, meaning services are in a *'much better place'* (Stakeholder – 31) than they were at its inception.

> 'I think T4MH is something that's discussed quite a bit when you look at any service improvement, service change… That tends to be very much the policy strategy that's brought into those conversations, into the justification for that change and how we're matching against that. So, yes, I do think it certainly has had an impact'
>
> Practitioner - 45

3.7 However, some argued that the strategy is too broad to be wholly effective given the complexity of mental health and well-being services. There was particular concern about its longer-term aims and objectives - especially the first overarching outcome to ensure 'the mental health and well-being of the whole population is improved' - and how these might be measured, and any success attributed to T4MH.

> '… The difficulty I have with this is that it's very broad… Mental health has a lot of different services in its spectrum, and this is a bit too broad stroke for me because certain areas will have met certain levels in terms of outcomes but in general our overarching mental health services wouldn't have done some of this,

or even touched some of the longer-term outcomes. I'm not sure even in terms of the strategy, how you would quite measure those or attribute them to the delivery plan'

Stakeholder - 32

3.8 Although difficult to directly attribute to the strategy, the data review does show some improvement in population well-being, at least pre-COVID, for certain metrics. For example, National Survey for Wales (NSW)[12] data shows that:

- Well-being (as measured by the Warwick-Edinburgh Mental Well-being Scale (WEMWBS)[13]) rose between 2016-17 and 2018-19 to a mean score of 51.4 before falling in 2020-21 to 48.9
- The percentage of people feeling lonely fell from 17% in 2016-17 to 13% in 2021-22; and the percentage of people sometimes feeling lonely was 51% in 2019-20, rose to 71% in 2020-21 then fell to 58% in 2021-22.

3.9 However, NSW data is less encouraging in relation to the headline measures of life satisfaction that contribute to the Welsh Government Healthier Wales goal[14] (one of seven). These are: 'life satisfaction'; 'feeling life is worthwhile'; 'feeling happy yesterday'; and 'feeling anxious yesterday'. The data shows that the three positive measures of 'life satisfaction', 'feeling life is worthwhile' and 'feeling happy yesterday' have changed little over time, and the first two fell between 2019-20 and 2020-21 (again, likely due to COVID-19). The negative measure of 'feeling anxious yesterday' has also increased consistently since 2014-15. This suggests that the long-term aim of improving the mental health and well-being of the whole population remains a work in progress, as does data collection in this area for the available data focuses on the broader concept of wellbeing; quantitative measures around the prevalence of poor mental health and mental health conditions are less available.

3.10 In terms of other overarching issues, one stakeholder described the strategy as inflexible inasmuch as while it has solved some of the problems identified at its inception, it has been unable to address others that have emerged in the meantime.

[12] National survey for Wales
[13] The Warwick-Edinburgh Mental Well-being Scale
[14] Well-being of Wales: 2021 | GOV.WALES

Another felt that, while the strategy and its outcomes are positive in principle, it has proved difficult to translate it/them into direct action within services that are entrenched in their own ways of working, and among staff who do not necessarily understand how to work toward specific strategic goals.

> ‘Outcomes, when you see them, look absolutely fine, but when you see them translated into actions it becomes much more blurred... It’s a useful document but its translating into action it actually fails on. We can talk about joining up or getting closer to local primary mental health services and the secondary sector… [but] they’re still two separate services... There is an inconsistency between child development and then on to adult and older people’s services; they’re all seen as separate and moving through them, it’s all new assessments and referral processes. It’s about the difficulties in getting services to change. We’re trying hard to embed outcomes in the work we do… Unfortunately, staff and managers struggle with what an outcome actually is...’
>
> Stakeholder - 32

3.11 Another issue raised by several participants (and one that is elaborated on later in this report) is that prior to the inception of the Delivery and Oversight Board in January 2021, T4MH suffered from a lack of governance and accountability. One stakeholder suggested that this, together with it being too broad in its intentions, had made it something of a ‘lame duck’ strategy. Another felt that it had resulted in pockets of good practice in mental health and well-being support not being identified, shared and rolled-out to other areas.

> ‘… The lack of governance around it, the lack of holding to account… has kind of made it into a lame duck strategy. All those things together and it being so broad in its intentions, kind of everything to everybody, have all contributed to it being a bit of a, “There’s the strategy over there, but we are doing this over here”’
>
> Stakeholder - 21
>
> ‘… Health boards and other services have taken forward a whole range of initiatives [which] has been great… You’ve had various good initiatives, but they’ve been very, very ad-hoc… What hasn’t happened is it hasn’t been shared

across Wales and it hasn't, if it's worked, been driven on an all-Wales basis… A lot of this stuff has been done despite the lack of leadership…'

Stakeholder – 34

3.12 Indeed, a disconnect between T4MH as a national strategy and some of the regional strategies in place in health board areas was noted. In particular, aligning national and regional activity and outcomes was sometimes said to be 'tricky'. This is echoed by the Welsh Government in its 2014 *Duty to Review Interim Report: Post-Legislative Assessment of the Mental Health (Wales) Measure 2010*, where it notes concerns around translating national measures, such as the Mental Health (Wales) Measure 2010, into local contexts – keeping the national standard whilst meeting local needs (Welsh Government, 2014).

3.13 Ultimately, the general feeling was that while some outcomes in all three categories (short, medium, and long) have been achieved and their success can be attributed to the T4MH strategy to greater or lesser degrees, others remain a work in progress and certainly behind where they should be as a result of the COVID-19 pandemic.

'In terms of the extent of the short-term, medium, and long-term, I would probably say partially achieved… I definitely think the Together for Mental Health strategy has been responsible for the ones that have been achieved, but bearing in mind, since the strategy, we've had COVID and various other things that have probably had a bit of an implication on some of the success...'

Stakeholder – 38

3.14 It was also stressed that the outcomes that require societal change are unlikely to have been achieved in the past ten years, nor are they likely to be in the next ten. Instead, it is a generational journey.

'… Some of this is whole societal level change, things in the strategy around that are not going to happen in a 10-year cycle. But they're the right things to include in it. We shall see demonstrable progression on that in a 10-year cycle to continue the next steps of the journey…'

Stakeholder – 8

Short-term outcomes

Fully integrated mental health service provision between public, private, and third sector across emergency and primary care

3.15 It was widely agreed that partnership working on a regional and local level has been 'driven by the strategy' and that this has involved positive activity and communication across all sectors to improve integration in mental health service provision.

> 'There's definitely more partnership working between health and social care, and third sector. We have a local Mental Health Partnership Board and there's the Regional Partnership Boards... We were having a lot of 'transforming mental health meetings' prior to COVID where we had service users represented, third sector services... We've also looked at investing in third sector employees…'
>
> Practitioner – 46
>
> 'There's definitely good communication between the services and we are all interlinking. I've got contacts with primary care mental health teams and also the third sector [and we're] working together on pathways; making sure the person gets the right care at the right time in the right place'
>
> Practitioner – 47

3.16 The detrimental impact of COVID-19 on integrated working (particularly between health and social care as a result of social workers being withdrawn from multi-disciplinary teams [MDTs] in some areas) was highlighted, however, and there was a sense that while progress is being made, services have yet to fully recover from this and re-establish the positive relationships developed pre-pandemic.

3.17 Greater commissioning of third sector services has also been seen in some areas (which one practitioner felt had been 'allowed' by the strategy), and while there are few 'provable' outcomes, anecdotal evidence shows that this has been beneficial in sharing resources and signposting service users.

3.18 With respect to service integration to benefit young adults, the often-difficult transitions between Child and Adolescent Mental Health Services (CAMHS) and adult mental health services were highlighted by stakeholders/practitioners and service users alike, and the increased focus on ensuring no-one 'falls through the gaps' praised.

3.19 Moreover, transitioning between adult services was said to be problematic by some service users, particularly as doing so often requires them to repeat their history of mental ill-health on numerous occasions. This was considered very difficult, and potentially off-putting in terms of seeking further help. Other issues were noted in terms of moving from secondary back to primary care, with relevant information apparently not being passed on; and a lack of follow-up that has led some to take drastic action to get help.

> '... Mental health teams discharge people from secondary care if they deem them to be recovered enough but what I'm seeing… is people floundering around with bipolar and schizophrenia and all those chronic health conditions, and not getting the support they still need'
>
> Service user - 4
>
> 'As soon as you show an inkling of getting better, you are just discharged. There is no like, "She is getting better, but it could get worse again so let's put a plan in place", it's like, "Oh, you are fine now. Goodbye". So, then you feel the need to do something to get care… you shouldn't have to feel that you have to cut yourself to get help'
>
> Service user - 6

Appropriate gatekeeping and referrals ensure service users receive appropriate care in the right location

3.20 Welsh Government data available on StatsWales in relation to access to primary care services centres on referrals to and assessments by Local Primary Mental Health Support Services (LPMHSS). It shows that, at the time the initial data review was undertaken, the number of monthly referrals to LPMHSS had decreased over time from a peak of 8,199 in October 2018 to 5,170 in April 2022.

3.21 In considering the aim to ensure people are receiving appropriate care in the right location, this could be viewed negatively if individuals who should be referred are being missed, but positive if the need has decreased or if more sensitive processes are leading to other appropriate options. It should be noted though, that the most recent figures (for September 2022) show an increase in referrals to 6,029.

3.22 As for secondary care, the data (from StatsWales and the NHS Wales Informatics Service [NWIS]) shows that:

- Referrals for treatment (to Adult Mental Health, Child and Adolescent Psychiatry and Old Age Psychiatry) have increased consistently over time since April 2012
- The number of admissions to mental health facilities has fallen consistently over time from a total of 9,997 in 2012-13 to 7,466 in 2019-20
- The number of patients with a mental illness in hospitals has fallen year on year from 1,597 in 2013 patients to 1,291 in 2019
- The average number of available beds fell from 1,704 in 2013-14 to 1,304 in 2020-21; the average number of occupied beds fell from 1,495 in 2013-14 to 1,055 in 2020-21; and the percentage occupancy was roughly constant at around 87.5% but fell to 78.7% in 2020-21, likely because of the pandemic.

3.23 These results could be positive if in-patient stays are being diverted to other appropriate services, or negative if patients are not receiving the service they require – though the increase in outpatient attendances over time (from 57,560 in 2015-16 to 73,315 in 2018-19) might be evidence of the former. This relates to the aim of the original T4MH strategy that 'primary care schemes and investment in community provision will help people to remain as independent as possible with inpatient care used only when needed and for the appropriate length of time'.

3.24 In the focus groups and interviews, some practitioners felt that current gatekeeping and referral processes (and their associated paperwork) are barriers to fully integrated mental health service provision that create unnecessarily long waiting times for some service users and increase staff workloads - mainly due to the duplication of assessments.

'… For example, if somebody's coming into secondary mental health services, they might have to go through a number of different hoops before they get accepted. They get accepted and then whoever picks that up, if it's a nurse they do their core, normal documentation; if it's an Occupational Therapist they've got their own full assessments to do as well. So, it's double the workload [to] take on somebody for care co-ordination…'

Practitioner – 46

3.25 Moreover, pathways into mental health services were frequently described as 'overly complex' and the timeliness of discharge remains an issue in terms of ensuring appropriate care in the right location.

3.26 More positively, though, practitioners across several areas said they were aware of work being undertaken to simplify pathways and ensure timelier referrals, and the increased use of multi-disciplinary assessments 'at the front door' were said to have helped ensure people receive the right care in the right location. S.P.A.C.E. Well-being Newport was also cited as a particularly effective access route into mental health and well-being support for children and young people, offering an alternative to the highly pressured CAMHS service.

'… Because there are no set criteria for you to access S.P.A.C.E., access to mental health support in Gwent is easily and readily available… If you have a need, ping it into S.P.A.C.E., and because CAMHS is not the only person around the table, then it's not a matter of, "You don't meet a criteria"… There's always someone there that will say "fine, I will work with this child"'

Practitioner - 51

3.27 Furthermore, some areas already have successful single point of access (SPOA) systems in place and others are working toward their implementation. These, it was felt, will significantly improve access and the way in which referrals are managed, and were welcomed by the service users interviewed as a means of 'bypassing' busy GPs. However, several participants said that a SPOA can only be wholly effective if the services it refers people to have the capacity to accommodate them in a timely way – which is often not the case.

‘You do have the SPOA now which is hugely helpful because you know a referral is discussed in a team… The difficulty of it is that there is nowhere near the amount of staff you need in the services to pick the cases up and they get bounced back… They just hardly have any staff in mental health areas...’

Practitioner - 41

3.28 Finally in terms of gatekeeping and referrals, it was said to sometimes be difficult for third sector workers - even those with significant experience in mental health and well-being - to refer their clients into services. Stakeholders thus urged consideration of how to improve access for those seeking to enter the system from non-medical routes.

‘Those workers… they face barriers to helping them access support because their expertise isn’t necessarily valued, and they don’t hold the right keys to the right gates… If this is about a no wrong door approach and getting people the support they need as quickly as possible, then how do we make sure people entering the system through other routes, through other services because of co-occurring issues they experience, how do they get that access without hitting a brick wall’

Stakeholder - 56

Shorter waiting times for mental health services

3.29 One area in which little progress was thought to have been made is reducing waiting times, with people continuing to experience lengthy waits for secondary care in particular. This was thought to be primarily due to demand for services outstripping their availability, an issue exacerbated by the COVID-19 pandemic. There was said to be little the T4MH strategy can do to address this issue; rather, making greater and earlier use of the third sector was suggested.

3.30 It is also worth noting the Welsh Government data for primary care (available on StatsWales) showing that:

- The percentage of LPMHSS assessments undertaken within 28 days of referral had increased steadily since 2013 to 82.7% in October 2018, but had

since dropped to 64.3% in April 2022. However, this percentage has steadily increased since, reaching 80.6% in September 2022.

- The percentage of therapeutic interventions starting within 28 days of assessment rose over time to 84.3% in October 2018, but had fallen back to 59.6% in April 2022. The number has since risen slightly to 64.9% in September 2022.
- Since January 2017, the percentage of outcome assessment reports sent within 10 days rose slowly over time before reaching 100% in April 2021. Since then, it has fallen back to 92.5% (September 2022), which is below the longer-term trend.

3.31 These reductions are likely due to the ongoing impact of COVID-19, but delays to assessments and interventions are clearly counter to ensuring timely access to services.

3.32 The negative impact of lengthy waiting times was highlighted by some of the service users interviewed; one in particular said that they were made to feel unimportant and not cared for.

> ‘It made me feel that I was not important and… that I was gaslighting myself. ‘I’m not important, no-one cares; look they are not showing interest and you don’t deserve the help…’’’
>
> Service user - 6

3.33 More positively, patients in some areas are now able to access support from primary care while they wait for psychological intervention for example.

> ‘… Primary care have now started different service provisions looking at things like trauma pathways which means they can do some of the work while the person is waiting so they’re not stagnant on a waiting list. It’s that inter-team working… so they’re not waiting two years’
>
> Practitioner - 52

Reduced gaps between primary and specialist mental health services

3.34 There was some positivity around the reduction in gaps between primary and specialist mental health services, which has been facilitated by multi-disciplinary meetings to discuss referrals and triage. This, it was said, has had a direct positive impact on service user satisfaction.

> '… That is something that more recently there's been a lot of work on… A lot more interface working between the two… Meetings [are] held between secondary care and primary care teams where they discuss referrals that have come in which they feel may be more suitable for the other service and they come up with an agreement... I think that's something that has improved and is still improving…'
>
> Practitioner - 45

3.35 The strategy was particularly thought to have helped integrate and develop better communications between primary and specialist mental health services. Indeed, it was said that:

> 'The strategy has really helped with that, to allow those conversations to take place… I know it sounds ridiculous, but I think sometimes services need that permission to open it up a little bit more and that it's okay to be having these conversations'
>
> Practitioner – 44

3.36 Conversely however, one service user highlighted that there are still persistent gaps between primary and secondary care, not least due to the ongoing lack of parity between physical and mental health.

> 'The biggest inequality is the lack of parity between mental health and physical health services, and the consequent void in mental health treatment between primary and secondary care. This has not been addressed at all. If anything, the proportion of people with mental health issues falling between the gaps has increased'
>
> Service user - 12

More granular, specific and accurate vocabulary used to discuss mental health

3.37 Some participants said that even though many people are now able to talk about their mental health more openly, the language and vocabulary used in discussing it needs to be further refined to ensure greater understanding of the issues, particularly in relation to distinguishing between mental well-being and mental illness, which were said to be very different things.

> ‘More granular, specific and accurate vocabulary used to discuss mental health. I’m not sure I’ve seen much evidence of that really happening on a national level. Certainly, mental health issues as a whole are being discussed a lot more openly but I’m not sure about the vocabulary being accurate around that’
>
> Practitioner - 48

Improved service user experience, understood through direct engagement

3.38 T4MH was said to have enabled service users to be more effectively and systematically involved in service delivery by giving services ‘permission’ to do so.

> ‘… It’s given services permission to maybe involve service users a bit more… [and] rather than try to create this perfect service that we think people in mental health service need… asking them “what would you like?” which is refreshing’
>
> Practitioner – 44

Medium-term outcomes

Consistent service provision across Wales aligned with need

3.39 Participants were generally either unsure whether, or unconvinced that, service provision across Wales is consistent. Indeed, some argued that provision is inconsistent even within their own health board areas, and that while this is sometimes necessary to ensure it is aligned with need, it can also be problematic in ensuring equity.

‘There is a tendency for people, even if guidance comes out… to deviate to their own area. And sometimes that’s necessary because we all have different populations… different levels of poverty, ways that you have to adapt. In some ways it’s necessary, in other ways it can be problematic’

Practitioner - 45

‘It’s not universal across all health boards. Some health boards have run forward with some things and they’re brilliant, others have not. What we haven’t got is a minimum service offer… What you have is great mental health services but spread around seven health boards. Not one health board has got fantastic mental health services’

Stakeholder - 7

3.40 Pan-Wales communication was thought to have improved through the greater use of digital platforms though, and there was hope that this will help facilitate better awareness of the work being done in different areas and, eventually, greater consistency in service provision.

3.41 Also in terms of consistency, the extent to which innovation in service delivery has been seen across Wales was thought to vary, and very much depends on the amount of focus given to, and the targeted and dedicated support made available, for this.

‘… Unfortunately, innovation is not systemic; it’s not across all health boards and it’s not universal. But where there has been dedicated support and focus, there has been some service change and innovation…’

Stakeholder – 7

Improved targeted services for: Black, Asian and Minority Ethnic, Welsh speakers, hearing impaired, asylum seekers; neurodiverse; LGBTQ+; care leavers; youth justice

3.42 While the strategy was thought to have had a positive impact in ensuring a focus on individuals and groups who may otherwise have been ‘less on people’s radar’ (Stakeholder – 8), more work was thought to be needed in all geographical areas to

improve targeted services for the above groups, as highlighted in the quotation below.

> ‘There’s been some improvement. It’s another area where still lots to be done. I think asylum seekers services have grown within our health board now, because it was one person for years who did everything, and now there is a team. Welsh speakers, I think we do have a tendency to print everything in Welsh and English now, but I’m not quite sure if we have got the staff with the ability to speak Welsh… Hearing impaired, no, not from a mental health perspective, I don’t think we have sufficient [offer] and our neurodiverse is better but still developing… And the LGBTQ+ as well, I think we’ve still got a lot more to learn, and change, and adapt in that way’
>
> Practitioner - 45

3.43 One particular issue raised by a practitioner in north Wales was that their secondary care services are so limited that patients are often being sent to England for treatment. Being away from families and friends can, it was said, prolong mental health issues, as can being unable to speak their preferred language in the case of first language Welsh speakers.

3.44 These issues are discussed in more detail in a subsequent chapter of this report.

Discussing mental health in schools / education is normalised

3.45 One interviewee suggested that, based on their personal experience, discussions around mental health and well-being have become increasingly common in school settings.

> ‘My children come home now talking about mindfulness and relaxation and yoga. They talk about being able to manage their frustration and their anger… I can see already between my eldest son and my youngest there’s been a shift… which is brilliant’
>
> Practitioner – 48

3.46 Indeed, a positive shift in mental health and well-being support for children and young people through the whole school approach to mental health and the focus on Adverse Childhood Experiences (ACEs) was commended and thought to be in no

small part due to the T4MH strategy. A couple of the young service users interviewed corroborated this, praising the excellent support they had received with their mental health issues at school.

> ‘My school was... amazing. They have been part of all my meetings. They feed back to my therapist when I am not doing well... So, I am very lucky in that respect. And they referred me to CAMHS originally’
>
> Service user - 6

3.47 However, although some improvement has been evident, it was argued that well-being activity within schools can be somewhat hit and miss, and that greater significance should be placed on emotional development by making it a compulsory element of the curriculum in the same way as religious and physical education.

> ‘… I think it should actually be mandatory on the curriculum about development of emotional coping skills. Speaking as a parent with children that have gone through primary and secondary over a decade, I can see there has been far more awareness and improvement… but it’s very much tokenistic’
>
> Practitioner - 50

3.48 Of course, Health and Well-being is now an Area of Learning Experience within the new Curriculum for Wales. The components of this Area are physical health and development, mental health, and emotional and social well-being, and it will focus on developing learners’ capacity to navigate life's opportunities and challenges; supporting them to understand how the different components of health and well-being are interconnected; and enhancing their motivation, resilience, empathy and decision-making abilities[15].

More compassionate response to those with mental health issues

3.49 In considering the high-level strategy outcome to improve the ‘values, attitudes, and skills of those treating or supporting individuals of all ages with mental health

[15] Health and Well-being: Introduction - Hwb (gov.wales)

problems or mental illness', the *Together for Mental Health Delivery Plan 2019-2022, Welsh Government Integrated Impact Assessment Summary* highlights that this improved since the strategies were introduced, but that there is still more to be done in this area (Welsh Government, 2019).

3.50 Indeed, several workshop/focus group and interview participants felt that some residual - often unconscious - stigma exists among clinicians and healthcare workers (A&E staff and GPs were specifically mentioned), who are not always adequately trained to help people with their mental health and well-being. Training is underway in some health boards (Cwm Taf Morgannwg and Swansea Bay were specifically mentioned) to address this though.

> '… Thinking about our young people… Some of them might end up in A&E, in crisis because they've self-harmed or whatever. And unfortunately, I have heard that people don't always feel they've been treated in the way they would like to be when they initially present in A&E. I think there's a lack of facilities for people who arrive with a mental health crisis. Also, a lack of understanding… We are working on specialist training in mental health for A&E staff, because… there's a lack of understanding of how vital it is that people are treated carefully... '
>
> Practitioner - 39

3.51 Moreover, it was strongly felt that training around mental health and well-being should be provided to both clinicians and administrative staff given the latter are often a service user's first point of contact and are expected to have sometimes very difficult conversations.

3.52 One particular issue raised by service users was that some staff are apparently yet to receive training in dealing with neurodiverse people with mental health or well-being issues. This, it was felt, needs to be addressed as it has led to misdiagnosis and poorer quality services.

> 'My daughter… was misdiagnosed with schizophrenia because they didn't understand the autism… If you've got [staff] who don't understand neurodiversity, then they see everything through the lens of mental health'
>
> Carer - 1

Appropriate training routes for the workforce

3.53 While training was generally said to have been improving pre-COVID, the move to primarily virtual learning during and since the pandemic has been problematic for some. It was also said that while individual professional groups have specific training, more general and basic training for whole workforces is not consistently provided across the board.

> 'I'd say there's been a lot more training opportunities but not necessarily routes and pathways. That's still very unclear in terms of the workforce as a whole. Individual professional groups tend to have more specific training routes but in terms of a basic level of training and development for the mental health workforce, that's not in place yet'
>
> Practitioner - 48

3.54 While there was a strong desire across the board for more training, ongoing pressures on resources and capacity were considered a significant barrier to achieving this. Releasing staff for development opportunities was said to be nigh on impossible when the system is under so much pressure, and the unaffordability of good quality training was also noted.

> '… We're still working at a deficit across all sites which obviously impacts our capacity, and that really impacts on how much training you're able to release staff for'
>
> Practitioner – 46

3.55 This is not to say that participants were wholly negative about training and development opportunities, for some highlighted the increased availability of, for example, psychological therapy and EMDR training, and ADHD and ASD assessment training. Also, in Cardiff and Vale, a mapping exercise has been undertaken to understand what training has been offered and taken up by third sector organisations/partners. This has been done in order to identify gaps and, crucially, to identify the impact of this training on service users. While the exercise was not undertaken directly in response to T4MH, it is an example of positive

activity that could be emulated elsewhere, or even encouraged in a successor strategy.

> ‘It’s about getting service user feedback into training needs. How do you measure and capture the impact of having the right skills and attitude in the roles? They’ve done a fairly decent piece of work in mapping that out and looking to improve’
>
> Stakeholder – 32

Better mental health among prison population

3.56 Few participants were able to comment on mental health among the prison population, but one highlighted the increased use of occupational therapists within prisons to assess for mental health and well-being issues and advise on training for prison staff in dealing with them.

Trauma-informed approaches within clinical services

3.57 There was some feeling that while the importance of trauma-informed approaches to mental ill-health is recognised, there is also a lack of understanding about what these mean in practice.

3.58 Nonetheless, many participants felt that mental health services as a whole are now much more trauma informed, which has in itself resulted in a more compassionate response to service users.

> ‘More recently there’s been more recognition of how childhood trauma and traumatic events can really impact on people’s health and well-being… What we need going forward is far more trauma-informed services, and less emphasis on the medical model which just labels you and then tries to dose you up on medication and leave you to your own devices…’
>
> Service user - 4

3.59 In relation to the issue of medication, however, a few service users were of the view that there is still an over-reliance on this, and that more consideration (and funding) needs to be given to holistic and therapeutic approaches (though it was acknowledged that these are scarce and that there are long waiting lists for NHS-provided services) and social prescribing.

'… Good health practice is far more than just prescribing medication; it's looking at a range of factors in the wider sphere like counselling, therapies, connection building, healthy relationships, exercise, encouraging healthy eating, personal activities, helping people to stay in work…'

Service user - 4

3.60 Training in trauma-informed approaches appears to have been provided across Wales, to the benefit of many staff groups providing mental health care. However, there was some sense that it has not yet reached community and inpatient rehabilitation settings in some areas, and that more trauma-informed interventions are required at this stage of a patient's journey.

3.61 Participants were uncertain as to whether the T4MH strategy bears any responsibility for the increased importance attached to trauma-informed approaches within mental health, but it certainly wasn't thought to have hindered it.

'Trauma informed approaches, that's certainly something that seems to be at the forefront at the minute. I'm not sure if that's because of the strategy but it's certainly [improved]... Definitely a more compassionate response that people have…'

Practitioner - 44

More alternative treatments available for those in crisis

3.62 More alternative treatments were said to be available for those in crisis than ever before, especially within adult services. Home treatment, sanctuary services, and support houses were all mentioned as alternatives to A&E and hospital admission that are making positive differences where they have been introduced.

'… We now have a support house as an alternative for admissions… and I believe it's a model that Welsh Government are keen to expand on. The approach to that is moving away from the medical model; it's much more focused on relational security in support for individuals, a less clinical space, so I think that's been a really positive move. We've also got a robust model for home treatment, as an alternative to admission…'

Practitioner – 48

3.63 The Shared Lives scheme in Gwent was also mentioned, whereby service users stay with families or individuals who are happy to help with crisis support within their own homes. This was again said to have had very positive outcomes for those who have accessed it.

3.64 It is in the area of alternative treatments for those in crisis that COVID-19 has been considered a help rather than a hindrance in encouraging innovation through necessity. For example, in one area, COVID-related bed pressures and ward closures facilitated the speedier provision of a crisis house and the extension of crisis home treatment teams.

Improved physical health for people with severe mental health issues

3.65 Several participants agreed that healthcare services are now much more aware of the correlation between physical and mental health and of their responsibility in making sure people are treated holistically. Others, though, felt that too many professionals still view physical and mental health issues as distinct from each other, and do not recognise the impact of one on the other.

> '… People are waiting, say, four years for a hip replacement or knee replacement, and that's going to have a massive impact on someone's mental health in terms of anxiety, depression, isolation, lack of confidence. So, I think there's a lot of work to be done around that'
>
> Stakeholder - 26

> '… We need to look at a broader range of services so not just mental health but everything that effects someone's mental health, which could be their physical state as well'
>
> Service user - 2

Estate is fit for purpose

3.66 No participant considered the current mental health service estate to be fit for purpose. It was highlighted that unless they are sited within newbuild hospitals, mental health teams' premises are often of poor quality (within old asylum buildings for example) and are non-accessible for wheelchair users; that 'paper thin' walls at some sites compromise patient confidentiality; and that consulting rooms are in

short supply within psychology departments, meaning consultants are unable to see the volume of patients they otherwise might.

3.67 Moreover, although newbuilds were said to be fit for purpose in some ways, there was some concern that they have been designed with physical rather than mental health issues in mind.

> '… They're very medical in the way that they look, the aesthetics, the facilities. The facilities aren't there in terms of recovery … We don't have any facilities that are up to standard for groups to be run or for things like gym equipment, exercise outside, to enable people to improve their mental health through recovery work…'
>
> Practitioner - 48

3.68 Either way, a national review and mental health estates improvement programme was strongly recommended.

Long-term outcomes

Mental health support is recognised and embedded in all aspects of care

3.69 Opinion was divided about whether mental health support is embedded in all aspects of care. Some thought that there is some way to go in ensuring this, highlighting particular gaps in staff being able to provide support to patients directly, rather than always signposting them to other services.

3.70 Others, though, could see evidence of it through the establishment of mental health liaison services and teams within hospitals for example and in the widespread Connect 5 training being undertaken to raise awareness of mental health and well-being in healthcare settings.

Discussing mental health is normalised throughout society and people with mental health issues no longer face stigma, discrimination, and exclusion

3.71 One of the strategy's high-level outcomes is to ensure 'inequalities, stigma and discrimination suffered by people experiencing mental health problems and mental illness are reduced'.

3.72 In this context, it was widely agreed in the focus groups that society is now much more comfortable discussing and less likely to stigmatise mental health, and that

there is a developing awareness of the importance of safeguarding everyone's general mental well-being through offering good access to support.

3.73 This is corroborated in the '*Together for Mental Health Delivery Plan 2019-2022, Welsh Government Integrated Impact Assessment Summary',* which states that the profile of mental health has expanded considerably since the T4MH strategy was published. Crucially, mental health is now recognised as a topic that concerns everyone. This has helped put the focus on prevention at individual and community levels and in turn has reduced the stigmatisation around mental health issues and illnesses, allowing people to feel safe and supported when seeking support (Welsh Government, 2019).

3.74 The T4MH strategy and its associated political scrutiny was thought by some to have played a role in this, though it was acknowledged to be difficult to evidence and probably secondary to societal and cultural changes.

> '… It's hard to get evidence to demonstrate it, but… people feel more comfortable to talk about mental health… that's quite a big outcome from the strategy. Stigma has clearly reduced; I think organisations are more understanding of their role… They're probably some of the biggest outcomes I would see at the moment'
>
> Stakeholder – 12

3.75 Indeed, there was certainly thought to be merit in having a strategy for mental health in providing 'a vehicle for looking at what we need to do' (Stakeholder – 15) to focus on mental well-being.

> 'I think the focus we're giving to mental health probably off the back of having a plan… is really, really good. There have been some pretty strong commitments and… having that reference, that plan, that strategy is good…'
>
> Stakeholder – 17

3.76 A recent reported culture change is that young people have become much more willing to discuss and seek help with their mental health and well-being. The positive and consistently funded work done by Time to Change Wales and the fact that the stigma surrounding mental health has been broken down somewhat in the media was thought to have contributed hugely to this change, but it was recognised that

much more work is needed to break down barriers for the older generations, and in rural communities. Indeed, there was concern that some, mainly middle-age and older, people tend to self-stigmatise and/or not recognise their own mental health issues, nor do they feel able or willing to engage with mental health services to access help to deal with them.

> '… Still there are people living in the community that think it's ok to be stressed and very anxious. They don't call the doctor'
>
> Stakeholder – 35

3.77 One stakeholder also suggested that growing awareness and reduced stigma around mental health and well-being was more attributable to COVID-19 forcing the issue to the fore rather than to the T4MH strategy. It was also felt that the pandemic has encouraged some people to reach out to mental health support services inasmuch as mental health and well-being was discussed much more openly, especially during lockdowns.

3.78 It should be noted that while the greater awareness of, and openness around mental health and well-being was generally considered a positive thing, one stakeholder was concerned about its impact on referral numbers and waiting times for specialist services. They argued that mental health services have assumed too wide a role in society, which has led to *'enormous pressures on services... when in reality mental health services should be… just addressing those people who pass a threshold of need... people who go beyond what a school, employer, or family or friends would do to help people.'* (Stakeholder – 26)

3.79 On a related note, one service user was strongly of the view that there should be better support into work for those who have been long-term unemployed due to mental ill-health, as well as support for small and medium enterprises to understand how they can support employees with mental health issues, and promote the benefits of employing people with these issues.

The impact of mental health problems and/or mental illness is better recognised and reduced

3.80 One of the T4MH's key outcomes is around 'better recognition and reduction of the impact of mental health problems and/or mental illness on individuals of all ages, their families and carers, communities, and the economy more widely.'

3.81 Encouragingly, the impacts of poor mental health and well-being were thought to be better recognised in general, not least as conversations around these issues are now much more open and frequent. However, this was not thought to reach across to those experiencing more severe mental ill-health, many of whom still lack understanding and support from their communities and wider society.

> 'I do think generally in terms of mental health, the conversations have improved… but I think there's quite an emphasis on mild to moderate mental health issues, so there's almost this understanding that we're referring to well-being. I know there's a bit of a criticism around that, in terms of people with severe and serious mental health issues and how society or the community support those people'
>
> Practitioner – 48

3.82 There is data available that allows us to understand the causal factors for why children and young people are accessing support[16]. This shows that the most common main presenting issues on referral for those receiving counselling are, in order; 'family', 'anxiety', 'anger', 'stress' and 'self-worth'. Issues around 'anxiety' and 'self-worth' are increasing for children and young people (though the 'self-worth increase is recent, and the overall figure has decreased over time), but the number of children presenting with issues around 'family', 'anger' and 'stress' has fallen.

3.83 It is important to note though that each child or young person can only present with a single 'main' issue; for example, a number who in the past presented with 'stress'

[16] Counselling for children and young people | GOV.WALES

may see that stress manifested as anxiety and therefore present with ‘anxiety’, but the stress remains.

Improved access to acute / critical care mental health services for children and adults with severe mental health issues

3.84 The T4MH strategy was thought to have ensured a greater focus on those in crisis and to have fostered better partnership working across all sectors to provide better crisis services. Access to crisis provision was also said to have improved significantly following the introduction of a crisis pathway.

3.85 Again, ‘at the front door’ assessments by crisis teams were thought to have been a successful and beneficial development as ‘*they can offer intense support to prevent ward admission, and they can look at alternatives to ward admission’* (Practitioner – 52)

3.86 In terms of desired improvements, crisis services within CAMHS were thought to be both lacking in many areas and, where they do exist, often unsuitable for children and young people.

> ‘We have one CAMHS admissions bed on our adult ward, which certainly needs work in terms of having a specific setting for children to be admitted into’
>
> Practitioner – 48

3.87 Moreover, Mills et al. (2020), in their *National Review of Access to Emergency Services for those Experiencing Mental Health and/or Welfare Concerns,* stress that there is a clear weakness within emergency services: a lack of understanding or a deficit of data as to the extent and nature of the mental health demand (which corroborates the point made in paragraph 3.9 that available data tends to focus on broader concepts of wellbeing rather than specifically on the prevalence of mental ill-health and poor mental wellbeing). The NHS 111 service is not currently designed to provide specialised mental health support and therefore is not presently suitable for crisis care, it is suggested. Similarly, there is said to be a lack of training among ambulance staff for people experiencing mental distress (Mills et al., 2020), which is also relevant to the earlier medium-term outcome of ensuring appropriate training routes for the workforce.

Improved quality and access to preventative measures and early intervention to promote recovery

3.88 Another high-level T4MH strategy outcome is to ensure 'access to, and the quality of preventative measures, early intervention and treatment services are improved, and more people recover as a result'.

3.89 Some practitioners felt that access to prevention and, especially, early intervention within adult mental health has developed especially well in some areas during the lifetime of the strategy, and that even though COVID-19 changed processes to some extent, having an MDT working alongside primary care, with specially trained practitioners, has resulted in a better quality of service. The emphasis on prevention and early intervention within the strategy was thought to have helped drive forward activity in this area.

> '… Looking particularly at adult mental health: we've got our early intervention service that has certainly developed, and looking at more preventative measures [and] improved working relationships with primary care… People can just refer themselves and so early intervention [is] excellent; very, very good. After four to five years, because that's how long it takes to change the culture and community, we have just got to that side of it… On the side of primary care, bringing in more clinicians and mixing it up so you have the physios and the Advanced Nurse Practitioners and not just GPs – that has also allowed, even during COVID, MDT working'
>
> Practitioner – 41
>
> '… It's about mental wellness rather than mental illness, and not waiting until they're unwell… and I absolutely love that… I think it is a longer-term outcome in terms of staff understanding… [But] I think the strategy has certainly helped with that'
>
> Practitioner – 44

3.90 The greater involvement of occupational therapists within primary care (whereby individuals have an initial consultation with a professional within a GP surgery, who will then refer them to an occupational therapy team if any mental health or well-

being needs are identified) was also thought to have been key in improving early intervention.

3.91 However, there was concern that while prevention and early intervention activity has increased and improved, this has resulted in an overwhelming demand for services, which resource provision has not kept pace with. Moreover, it was suggested that early access to mental health and well-being support remains difficult even post-pandemic due to the ongoing effect of COVID-19 on GP appointment availability, and more generally the onerous process of accessing one.

> '… You have got to be quite able, confident, persistent, and well enough to ring a GP surgery at 8am... If you are a person who is experiencing a mental health issue, to go through that process of having to ring, to wait, to persevere, to then have to explain yourself to a GP receptionist who has to screen the calls, is very difficult …'
>
> Practitioner – 43
>
> '... You have to ring at certain times of the day and it's really hard to remember to do that and then you have to wait on hold for ages to get through… I was suicidal at the end of last year, and I struggled to speak when I was upset or stressed… So, getting through to a receptionist, then I had to repeat myself to another person, and then the doctor rang me, and I had to repeat myself again. That was really hard. It felt like everything was just going against me just getting through to speak to someone…'
>
> Service user - 5

3.92 The issue of high caseloads was raised by a few participants when considering barriers to prevention and intervention. For example, one occupational therapist said that while they make home visits to treat service users, they do not have the time to work with and educate them on, say, coping strategies for self-management and functioning – activity that was considered essential by one service user.

> '… They need to… educate [people] on how best to stay well and take control so they don't get these… constant cycles of being okay for a bit and then unwell again. I want to see far more emphasis on passing on tools and techniques for

self-management to educate people that they can do a lot to support themselves… There's still that emphasis on firefighting and not enough on health promotion…'

Service user - 4

3.93 A few participants highlighted the need to differentiate between definitions of prevention, as it means different things within different services. For example, one specialist practitioner argued that while working to reduce treatment times and readmissions would be preventative activity within their service area, this would not be viewed as prevention in the true sense of the term.

3.94 It should be noted here that while support for the prevention and early intervention agenda was widespread, a couple of participants felt that the strategy's emphasis on it was incorrect. Instead, they felt that there should have been (and should be in any successor strategy) a stronger focus on mental health services themselves, which are 'overwhelmingly for people with very serious problems' (Stakeholder – 26)

Sufficient capacity, skills, and experience among staff supporting mental health service users

3.95 Many participants said that investment in staff and training/development has improved over time and that the T4MH strategy has helped services identify and embed what they need in this area.

'Over the last few years, workforce development has been really difficult because training and development wasn't a priority, but I think in general over the last ten years, it has been progressively better. I think there [are] more opportunities for staff to invest in their own career development…'

Practitioner – 38

3.96 In terms of staff experience, one practitioner highlighted the importance of this in the context of several simultaneous retirements within their service, and the subsequent 'influx' of inexperienced, newly qualified staff. This, they said, has left a skills gap that will take some time to plug. Moreover, the same practitioner said that

inexperience is a particular issue within some inpatient units, as they have lost staff to community mental health teams.

Individuals have a better experience of the support and treatment they receive, and feel in control of decisions

3.97 In line with one of the strategy's high-level outcomes, stakeholders and practitioners generally agreed that service users' experiences of the support and treatment they receive have improved. Service users and their carers tended to agree with this, though all reported instances where they felt ill-treated by not being taken seriously, being told that their mental health was not sufficiently poor to warrant a referral or, in some cases, being blamed for the situation.

> '... There was just no follow up and when we did try to access services, there was push back and saying, "No, you're not bad enough and you don't meet our requirements" etc. That was hard'
>
> Service user - 7
>
> 'Some of the meetings were really not helpful… there wasn't any understanding, and [some] were quite insulting. We had someone who blamed it on my parents… There were others where I thought the meeting was quite constructive and where I could explain it and they would listen, and… they would agree to refer me on but that never happened…'
>
> Service user - 7
>
> 'There is a subconscious blame culture of, "You haven't been keeping up those techniques that have been learned"…'
>
> Service user - 3
>
> 'I was referred to CAMHS… and they said that basically I wasn't bad enough or severe enough and they couldn't help me… I had quite big issues that needed to be addressed… but they couldn't do anything apparently'
>
> Service user - 7

3.98 It was also felt that the workforce is now more skilled and aware of how to treat mental health service users and include them in decision-making. As a result, there

is much better engagement between staff, service users and carers. Furthermore, the importance of co-production in service delivery was said to be better recognised, though not universally yet.

> ‘That’s definitely, definitely improved. I’ve seen so much with service user involvement, co-production… Whether they are involved in setting up services, whether they’re asked what they would like from services, carer groups certainly... I think that’s improved from my point of view. They’re much more present. It seems to be always part of the conversation, which is lovely’
>
> Practitioner – 44

3.99 In relation to co-production, a couple of service users stressed that this will only be successful if all relevant organisations (including the third sector and the emergency services), service users and carers are involved, and if resources are dedicated to it to an equal extent across all health boards. Moreover, it was considered essential that staff understand what true co-production is.

> ‘They think that you coming along to a meeting and them offering you a place around the table is co-production but it’s not…’
>
> Service user - 8

3.100 Indeed, more work was thought to be needed in terms of inclusion and co-production, for while the strategy has helped drive forward improvements in individuals feeling in control of the decision-making process, a ‘culture of passivity’ remains among some mental health service users. This is perhaps something that is encouraged by service providers however, for most of the service user participants said that while they were keen to exert more control over the decisions made in relation to their care and treatment, this had not been possible.

> ‘It has all been decided for me by higher people than me. Recently, yes, but that’s just because I have a really good therapist… but before that there was nothing… ‘
>
> Service user - 6

‘They don’t listen to you. They think, “oh, you don’t know what you’re talking about. We’re the experts” That kind of attitude, I think, is very difficult’

Service user - 9

3.101 The latter allegation was disputed by several practitioners, though, who said that service users are, by and large, at least offered more control over their care planning.

‘… We are more inclusive of patients in their care planning, in deciding what treatment options they choose, given more options where we can… I think we’ve made improvements in that area’

Practitioner – 45

3.102 However, Welsh Government data (on StatsWales) shows that the percentage of patients in receipt of secondary mental health services who have a valid Care and Treatment Plan (CTPs) has fallen over time from 91.2% in July 2014 to 84.7% in April 2022.

3.103 A couple of practitioners argued that mental health and well-being awareness and placing service users at the heart of service provision is more embedded within primary care than in specialist secondary services. This was largely thought to be down to culture and service design within the latter, but there was a sense that much could be learned from primary care in moving from service-centred to person-centred care.

3.104 The overall message from the focus groups and interviews was that progress against this outcome has been broadly positive, but there are still some areas for improvement. In particular, there was clearly some tension between the narratives of practitioners and services users (with the former being more positive than the latter) which may need to be examined and addressed – and the data review did show a fall in the number of Care and Treatment Plans received by secondary patients.

3.105 Furthermore, the data review revealed the need to address and improve one particular aspect of the patient experience: transfers between secondary inpatient and community-based mental health care. The total number of delayed transfers of

care for all reasons has remained broadly constant since April 2012, at around 450 a month[17]. The most common delays, in order, relate to waiting for other health care, waiting for community care, and care home availability and selection.

Removal of inequalities for people with mental health and well-being issues

3.106 In terms of whether equality of opportunity has improved for people with mental health and well-being issues (in line with the desired strategy outcome to 'ensure inequalities, stigma and discrimination suffered by people experiencing mental health problems and mental illness are reduced'), some felt that it has (to some extent at least) and that the T4MH strategy has helped drive this. Achieving this outcome was generally considered a work in progress though, and, as a more societal change, something that will take time.

> 'I think improvement of equality of opportunity, removing barriers for people with mental health issues, I think the strategy has really helped with that. But I think lots more work could be done… so that it becomes more common place'
>
> Practitioner – 44

3.107 Others felt that while improvements were beginning to be seen pre-COVID, the pandemic has undone many of those as the services working to overcome barriers and ensure equality were 'completely shut off or stopped' (Practitioner – 41) Moreover, while it has reduced, stigma around mental health – even if it is in many cases unconscious – was said to still exist, which in itself reduces equality of opportunity for those suffering mental ill-health.

Where are the main gaps in the data needed to evidence outcomes?

3.108 Most stakeholders and practitioners raised the issue of how T4MH's outcomes are measured. While the Time to Change Wales campaign was cited as a good example of an evidence-based aspect of the strategy, many participants described the lack of embedded processes for data capture, measurement and reporting as one of its major flaws.

[17] Delayed transfers of care | GOV.WALES

‘What we struggle to do across Wales is [find] out what’s been achieved. So, we know what’s been done, we know what activities are happening, we know what initiatives are happening, but in terms of what difference it makes there’s a lack of data and information around that’

Stakeholder – 34

‘… The governance structure… hasn’t allowed things to be measured and monitored in a way that makes it easy to answer the question of achievement of outcomes. Along with that there is the lack of underpinning data and evidence in terms of achievement against the strategy’

Stakeholder – 32

‘If you asked the question “has the strategy been effective or not?”, the blunt answer is you don’t know because there’s no data set’

Stakeholder – 15

3.109 Indeed, the focus was said to have been so much on implementing the key activities outlined in the above Theory of Change, that the critical need to evaluate the impact of these activities, and their outcomes for individuals, has been all but forgotten. As such, the need for much more robust outcome measures in future was frequently stressed, not least to aid and standardise decision-making across the sector.

‘I don’t think we’ve done enough to test ourselves against the outcome indicators… All we can provide is a narrative update. “We said we would do this, and we’ve done it, we’ve implemented it”. What it hasn’t gone into is how has that changed outcomes for individuals?’

Stakeholder – 12

‘Improving data and evidence for decision-making; I think that’s still a massive need. I don’t think that’s been achieved. But I don’t know if everybody’s switched on to data collection, evidence, just being more transparent… I would say that’s one that definitely, definitely needs drilling down on… There needs to be tightening up around the decision-making because we’re making different decisions…’

Practitioner – 44

3.110 In relation to this, several participants highlighted that the volume and complexity of the T4MH outcomes and objectives can be daunting to try and evidence. One suggested that having a clearer, more concise set of outcome indicators might be preferable, and certainly easier to regularly report against. Another felt that the outcome measures that are monitored and reported disproportionally relate to those with a clinical diagnosis: waiting lists, care and treatment plans completed etc. It was thus recommended that any successor strategy should have at least some indicators that measure 'community-based' and/or 'softer' outcomes.

3.111 The disparate nature of the data that does exist was frequently raised as an issue: all the services and organisations working toward achieving the T4MH outcomes were said to be collecting and reporting data in a different way, and it is not widely shared between partners.

'The gaps for me are about how to collate it rather than about it not being available, because I think that it is available. I think services spend a huge amount of time gathering data of various types… but it's the difficulty in marrying that all up together'

Stakeholder – 28

3.112 This is not to say that there is no good practice in data collection; for example, a couple of occupational therapists, from personal experience, cited mechanisms by which they are able to base decisions on standardised and robust evidence.

'… We use standardised outcome tools in occupational therapy, so we can start with somebody at an assessment, we can do our intervention and then our evaluation and we look at that outcome tool again…'

Practitioner – 43

3.113 In considering using feedback from those with lived experience to establish outcomes and impacts, many participants said that while they *think* their service/activity is well received and has positive outcomes for service users, in the absence of a proper experience measure (preferable a nationally agreed one for consistency), any evidence they have for this is anecdotal. However, even when

such mechanisms are in place, it can prove difficult to evidence impacts and outcomes if service users are reluctant to engage with formal follow-up activity.

> '… People aren't great at getting back. They may tell you [that] you are wonderful, and you have changed their life, but you ask them to put it on a piece of paper and they suddenly haven't got a stamp…'
>
> Practitioner – 41

3.114 In terms of specific gaps, during the data review we were unable to source any data around the following outcomes: 'inequalities, stigma and discrimination are reduced'; and 'individuals with mental health problems (of all ages) will experience improved values, attitudes and skills from those supporting them'.

3.115 Moreover, while the data review highlighted clear trends in relation to some of the outcomes, the meaning of those trends is more ambiguous. For example, an increase in recorded numbers/referrals could be negative if it shows an increase in prevalence, or positive if it is a result of an improvement in identification, recording and diversion to more appropriate services. Furthermore, a fall in recorded referrals/admissions could be negative if individuals who should be referred/ or admitted are not receiving the services they require, but positive if need has decreased, or if increasingly sensitive processes are leading to other, more appropriate options. Without more precise data around underlying population mental health, there is no way of unpicking meaning in this way.

3.116 A lack of data being collected around the number of Welsh speakers accessing services was alleged by focus group/workshop and interview participants. In particular, there was some feeling that the question of preferred language is not being regularly asked of service users at the point of accessing a service, which hides potential demand for Welsh language services.

> 'It is assumed that if a person has not asked for a service in Welsh, then they do not want it, which is not the case. A person in crisis may not ask for a Welsh service, they'll take whatever help is offered to them… This lack of data makes it really difficult to adequately plan services'
>
> Stakeholder – 24

3.117 Moreover, there is apparently little evidence or understanding of Welsh speakers' experiences of mental health and well-being services, which was considered important in the sense that 'people who speak and think in Welsh are going to have different perspectives' Stakeholder – 26

3.118 Data relating to Black, Asian and Minority Ethnic and LGBTQ+ communities was also said to be lacking, making it difficult to know whether current services are appropriate and accessible to these groups of people.

> 'The aim is to improve targeted services for Black, Asian and Minority Ethnic people and LGBTQ etc… And yet when there's [a] lack of data collection, monitoring [and] reporting, how do you know those things have been improved?'
>
> Stakeholder – 36

3.119 A further issue is that older people tend to be grouped together in the 'over 65' age bracket, when more granular, stratified data is required to ensure needs-based service provision.

3.120 Overall, there was a strong sense that establishing direct causation between the achievement of outcomes and the T4MH strategy will be difficult in the absence of original baseline measures, and a national core dataset for mental health and well-being. Indeed, even with a set of baseline measures and a core dataset, establishing causation would, it was said, be difficult as it is nigh on impossible to isolate the impacts of T4MH from, say, the Well-being of Future Generations Act (Wales) 2015.

> 'One of the real gaps over the term of the strategy has been the availability of the core dataset. That's what makes it really difficult to answer these questions as the monitoring and the measurement of the strategy, by nature of not having that core data set, has been challenging. That was always intended to be what underpinned the strategy as a mechanism for measuring it'
>
> Stakeholder – 32
>
> 'The lack of clear baseline information and measurements has made it difficult to understand the direct contribution that the strategy has made… While we feel the strategy is the right approach to achieving better mental health and well-being for

all, it is difficult to know what attributed to the change. For example, has Together for Mental Health made the difference or is it the Well-being of Future Generations Act?'

Stakeholder – 32

3.121 It was acknowledged that there is now a core dataset in place, which will be beneficial in evaluating any future successor strategy. There was some concern, though, that the dataset focuses on mental health services only, and that the evaluation of future strategies should also consider data from, for example, early years, education, housing – as well as the national indicators from the Well-Being of Future Generations Act.

4. Main Findings: Achieving the Strategy Outcomes for T2M2

4.1 The initial stakeholder interviews and workshops undertaken in early 2022 began the process of developing and producing an initial Theory of Change (ToC) model, which was refined during the subsequent stakeholder, practitioner, and service user interviews. The final model for the T2M2 strategy can be seen later in this section.

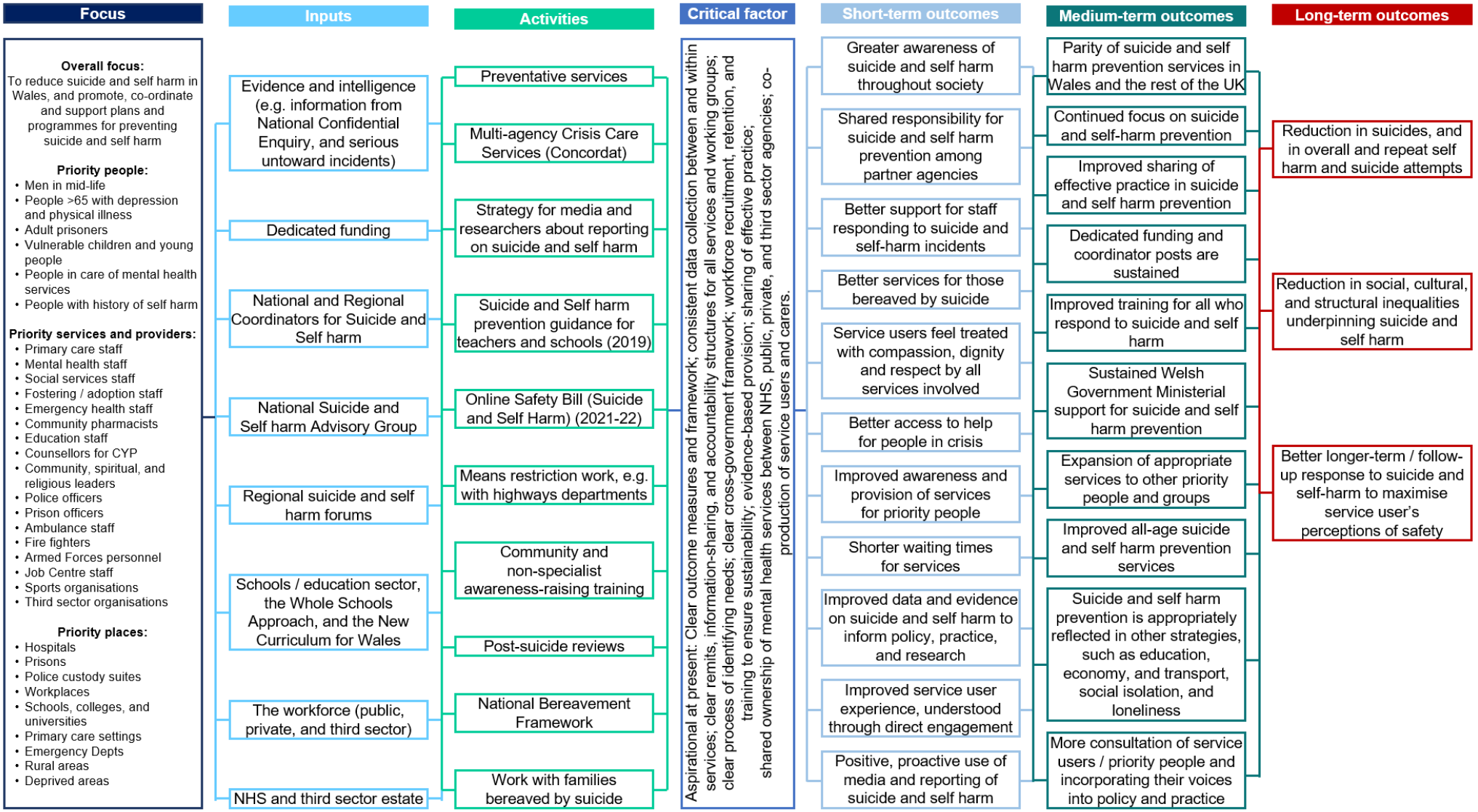
4.2 The following section seeks to address two of the key evaluation objectives, as evidenced by the views expressed in those interviews, namely:

- The extent of progress made towards meeting the T2M2 outcome measures, (and the contribution the strategy itself has made to doing so); and
- The key data gaps that need to be filled to establish the success or otherwise of the strategy in meeting its outcomes.

4.3 As all of the interviews and group discussions centred around the ToC, this section also uses the model as a framework. It begins with some overall thoughts about the T2M2 strategy and its successes and challenges, before examining participants' views on the ToC's short-, medium- and long-term outcomes. These have been linked to the strategy's overall high-level objectives where possible, which are as follows:

- Further improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come into contact with people at risk of suicide and self-harm and professionals in Wales
- To deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm
- Information and support for those bereaved or affected by suicide and self-harm
- Support the media in responsible reporting and portrayal of suicide and suicidal behaviour
- Reduce access to the means of suicide
- Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action.

4.4 The section concludes with participants' thoughts around the extent to which data is available to evidence progress, and the key gaps that exist.


Focus
Overall focus:
To reduce suicide and self harm in Wales, and promote, co-ordinate and support plans and programmes for preventing suicide and self harm
Priority people:
• Men in mid-life
• People >65 with depression and physical illness
• Adult prisoners
• Vulnerable children and young people
• People in care of mental health services
• People with history of self harm
Priority services and providers:
• Primary care staff
• Mental health staff
• Social services staff
• Fostering / adoption staff
• Emergency health staff
• Community pharmacists
• Education staff
• Counsellors for CYP
• Community, spiritual, and religious leaders
• Police officers
• Prison officers
• Ambulance staff
• Fire fighters
• Armed Forces personnel
• Job Centre staff
• Sports organisations
• Third sector organisations
Priority places:
• Hospitals
• Prisons
• Police custody suites
• Workplaces
• Schools, colleges, and universities
• Primary care settings
• Emergency Depts
• Rural areas
• Deprived areas
Inputs
Evidence and intelligence (e.g. information from National Confidential Enquiry, and serious untoward incidents)
Dedicated funding
National and Regional Coordinators for Suicide and Self harm
National Suicide and Self harm Advisory Group
Regional suicide and self harm forums
Schools / education sector, the Whole Schools Approach, and the New Curriculum for Wales
The workforce (public, private, and third sector)
NHS and third sector estate
Activities
Preventative services
Multi-agency Crisis Care Services (Concordat)
Strategy for media and researchers about reporting on suicide and self harm
Suicide and Self harm prevention guidance for teachers and schools (2019)
Online Safety Bill (Suicide and Self Harm) (2021-22)
Means restriction work, e.g. with highways departments
Community and non-specialist awareness-raising training
Post-suicide reviews
National Bereavement Framework
Work with families bereaved by suicide
Critical factor
Aspirational at present: Clear outcome measures and framework; consistent data collection between and within services; clear remits, information-sharing, and accountability structures for all services and working groups; clear process of identifying needs; clear cross-government framework; workforce recruitment, retention, and training to ensure sustainability; evidence-based provision; sharing of effective practice; shared ownership of mental health services between NHS, public, private, and third sector agencies; co-production of service users and carers.
Short-term outcomes
Greater awareness of suicide and self harm throughout society
Shared responsibility for suicide and self harm prevention among partner agencies
Better support for staff responding to suicide and self-harm incidents
Better services for those bereaved by suicide
Service users feel treated with compassion, dignity and respect by all services involved
Better access to help for people in crisis
Improved awareness and provision of services for priority people
Shorter waiting times for services
Improved data and evidence on suicide and self harm to inform policy, practice, and research
Improved service user experience, understood through direct engagement
Positive, proactive use of media and reporting of suicide and self harm
Medium-term outcomes
Parity of suicide and self harm prevention services in Wales and the rest of the UK
Continued focus on suicide and self-harm prevention
Improved sharing of effective practice in suicide and self harm prevention
Dedicated funding and coordinator posts are sustained
Improved training for all who respond to suicide and self harm
Sustained Welsh Government Ministerial support for suicide and self harm prevention
Expansion of appropriate services to other priority people and groups
Improved all-age suicide and self harm prevention services
Suicide and self harm prevention is appropriately reflected in other strategies, such as education, economy, and transport, social isolation, and loneliness
More consultation of service users / priority people and incorporating their voices into policy and practice
Long-term outcomes
Reduction in suicides, and in overall and repeat self harm and suicide attempts
Reduction in social, cultural, and structural inequalities underpinning suicide and self harm
Better longer-term / follow-up response to suicide and self-harm to maximise service user's perceptions of safety

To what extent has progress been made towards meeting the strategy's outcome and performance measures

4.5 Overall, the fact Wales has a suicide and self-harm prevention strategy was considered essential in providing a framework for activity in these areas. There was a definite sense that:

> 'People are always keen to be involved in a national workstream, especially when they feel it can benefit their service and support people more'
>
> Stakeholder – 25

4.6 In terms of what the strategy has achieved since its inception, the general feeling was that most progress has been made towards meeting its outcome and performance measures at a strategic level.

> '… My impression is that a lot of the higher-level outcomes have been achieved… I know that there are people that are appointed across Wales… who seem to be very proactive… There is a cross-party group and things are happening as far as that is concerned across different work streams… So, a lot of the strategic stuff has been achieved…'
>
> Stakeholder – 36

4.7 In particular, and as expanded on below, T2M2 was thought to have been essential in underpinning co-ordination and partnership working in suicide and self-harm prevention and making at least some progress toward meeting the strategy's short-, medium- and long-term outcomes.

> '… What I'm seeing… is that there is now a nationally co-ordinated approach. I could quite easily say in each of my areas how the work we're doing locally and then regionally is contributing… That's being done, or it's starting to work really well…'
>
> Stakeholder – 33

4.8 A few interviewees argued that while good progress has been made against many of the short-and medium-term strategy outcomes, there is some way to go in meeting the long-term ones.

'… For every point here, all the short-term, medium-term outcomes apart from the 'all age' in medium terms… I would say they've all improved. The long-term outcomes haven't been achieved'

Stakeholder – 31

4.9 Another couple were more critical of progress against the strategy outcomes, arguing that the ambition of delivery has not matched that of the strategy; that those responsible for delivering it have often been pulling in different directions; and that change has either been incremental or, in some areas, non-existent.

4.10 Moreover, it was said that initially, T2M2 was produced and rolled out, but without any resource attached to it. This meant that in its early days, there was a sense of knowing what needed to be done to fulfil its aims, but not having the resource to support, embed and drive the work forward.

'… I would say the delays in that kind of thing left the strategy a little bit stagnant for a while'

Stakeholder – 33

Short- and medium-term outcomes

Greater awareness of suicide and self-harm throughout society

4.11 The first objective of the T2M2 strategy is to 'further improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come in to contact with people at risk of suicide and self-harm and professionals in Wales'.

4.12 Encouragingly, there was general and widespread agreement that there is now a greater awareness of suicide and self-harm throughout society, which was largely attributed to the relative openness with which these issues are now discussed in the media, on social media, in mainstream television programmes, and by well-known figures like Princes William and Harry and various celebrities.

'It's something that we might not be able to properly measure but yes, there is a greater awareness in relation to suicide prevention and self-harm prevention… Hopefully the population is moving towards a more open way of discussing and

highlighting the needs associated with mental distress and trauma and anxiety and suicide. Hopefully by people starting that conversation and being able to feel that they can share it with understanding and likeminded people, that gives the people trying to support them more opportunity to openly understand and better meet those needs in a more planned and controlled way'

Stakeholder – 27

4.13 In terms of T2M2's contribution to this, while the growth in societal awareness was typically considered to be an organic process of cultural change, the strategy was thought to have complemented, and certainly not hampered, it.

4.14 Prevention activity directed at men was said to have been especially beneficial in raising awareness and the likelihood of greater openness in discussing difficult issues (though some service users stressed that women should not be neglected for while men are more likely to complete suicide, suicidal tendencies and attempts are certainly evident among women).

'…I notice more publicly there's more awareness. It definitely feels like it's better. I've seen a lot of promotion about it being ok, that validation for men to be more open and talk about self-harm and suicide. And more pro-active work like walks for awareness and things like that…'

Practitioner – 50

4.15 The Ask Twice campaign was mentioned by a few participants as something they have run via their website and social media. Activity like this was considered essential in raising awareness of how to have difficult conversations and the support available to those needing it.

'… The other thing we've been doing… is regular campaigns like 'Ask Twice' and where to find information about difficult conversations and signposting… You could save a life by having a conversation…'

Stakeholder – 35

4.16 Again, this campaign was said to be particularly impactful for men.

> '… There something around that persistency… You might say to a friend, "Are you okay?" [and they respond] "Yeah I'm okay" and then "No, are you really okay? … How are you feeling really?" Men appreciate those things …'
>
> Stakeholder – 36

4.17 Despite the general positivity reported above, the need to encourage earlier conversations around mental health and well-being was stressed to prevent progression to thoughts of suicide and self-harm. Moreover, it was argued that societal awareness, learning and cultural change in relation to suicide is too late if it only develops after an incident or incidents locally, which is often the case.

Shared responsibility for suicide and self-harm prevention among partner agencies

4.18 Having a national suicide and self-harm prevention strategy was thought to have helped develop a collective focus, whereby all relevant agencies and organisations in the statutory and third sectors have their own locally driven priorities but are working toward the same goals. Indeed, it was said that without the strategy:

> 'I think we would all be doing something very different'
>
> Stakeholder – 25

4.19 The establishment of the National Advisory Group (NAG) and regional forums (which were said to have been driven by T2M2) was considered especially useful in bringing individuals and organisations together. Indeed, the relationships forged through these fora were described as pivotal to the strategy's success.

> 'I think it's quite useful to think about the value in and of themselves of those structures… For the National Advisory Group, what it's done is bring people together in a common purpose and enabled collaborations beyond the meetings. It's allowed the sharing of understanding and expertise… Local connection, communications that can happen because you're meeting people, and it's also about increasing understanding and bringing our expertise… Those are really valuable things… which would not have happened without Talk to Me 2'
>
> NAG – 54

‘I think having the National Advisory Group… written into the strategy means that there’s a place where all these things get discussed… those are really the avenue by which local action has happened; they’ve developed local plans. I think the strategy made that happen, it wouldn’t have happened otherwise’

Stakeholder – 10

4.20 Related to this, a couple of interviewees were particularly pleased to see the beginnings of proper governance structures around the T2M2 strategy (including for the NAG and other forums). It was said that previously, while all relevant parties were all meeting, talking, and knew what needed to be done, there was a lack of strong leadership and direction because of a lack of governance.

‘… That accountability framework and governance has not been there… The strategy has been in place a long time with very little to performance manage it… If I had a penny for every time I said, “So, who’s in charge? Who’s accountable? Whose job is this? Who owns this bit of the work? Who should be leading on this?” … If we’re trying to implement a strategy in a co-ordinated way, we need to know who we’re reporting to and who’s in charge, and who’s going to make decisions if we have to make choices or prioritise… Things are happening now though…’

Stakeholder – 13

4.21 With particular regard to suicide prevention, the contribution made by bereaved families in driving improvements was noted. For example, the DPJ Foundation (a charity in West Wales supporting those in the agricultural sector with poor mental health) was mentioned as being fundamental in shifting perspectives. In light of this, it was said that:

‘… There’s something about there being a bottom-up approach… and the power that exists with that’

Stakeholder – 28

Better support for staff responding to suicide and self-harm attempts

4.22 It was said that the support offered by mental health service staff members to each other after a serious incident has always been strong, but some participants felt that

there are now more formal support systems in place as a result of the strategy. Moreover, the roll out of more and better postvention training for key staff was thought to be improving the help available to them following traumatic experiences.

> '… For staff who've experienced suicide within their teams, not only having debriefing, but actually having people trained in postvention so that they can support those staff through the aftermath because it's so distressing…'
>
> Practitioner – 46

4.23 Others disagreed that there is sufficient support available to affected staff, arguing that peer support from specially trained staff is not enough, and that those affected by suicide and self-harm often need 'professional' help in dealing with the aftermath.

> 'The difficulty is that if you have people with lived experience, they need more support than qualified staff… It's a great idea and great having them there… but there has to be greater support for people… because they don't know how they are going to feel after speaking to someone suicidal and then go home'
>
> Practitioner – 41

4.24 Indeed, a perception among clinical staff in particular was noted, whereby they feel that someone in their care contemplating, attempting or dying by suicide is simply something they have to deal with as 'part of the job'. More work was thought to be required in encouraging them to seek support, and to provide professional help when needed.

> '… In clinical practice... there's nothing that says that you have to get on with your day, but that's what staff do. And when you experience something like that, you'll carry it…Staff just think to themselves, "Oh, that's just part of the job". But it's not part of the job…'
>
> Practitioner – 44

4.25 It was also said that in some areas of practice (certain GP surgeries were explicitly mentioned), the support offered to affected staff has deteriorated to the extent that Suicidal Death/Ideation (SUI) incident reviews and debriefs are no longer being undertaken, mainly due to staffing issues.

Dedicated funding and co-ordinator posts are sustained

4.26 A lack of consistent funding was frequently raised as a constraining factor to achieving the T2M2 outcomes: more than one participant commented that mental health is always 'last in line', and as a consequence is *'nowhere near'* parity with physical health. A commitment to at least maintaining future funding was strongly desired, not least as this would allow the continuation of the national and regional suicide prevention co-ordinator roles (a desired medium-term strategy outcome).

4.27 Indeed, there was a sense that we are now at a stage where as much has been done as possible without adequate funding. Further improvements, it was said, will require properly funded system change, which in itself *'requires frameworks to be changed, it requires outcomes to be collected… To make change from here, those are the things that need to happen.'* Stakeholder – 10

Improved training for all who respond to suicide and self-harm

4.28 Mixed views were offered around the extent to which those responding to suicide and self-harm are adequately trained in doing so. Some said that ongoing WARRN and STORM training is extensive within their health board areas, meaning staff feel confident in managing difficult situations. Moreover, some health boards (Aneurin Bevan in particular) are either already delivering or planning to deliver training for partner organisations in having difficult conversations, especially around suicide, and signposting those in need (i.e., Suicide First Aid Training).

4.29 Others, however, felt that while there had been an increase in the training available pre-COVID (for example, two-day 'specialist training in suicide' was offered to clinicians in one health board area), the events of the past two years have curtailed this. Nonetheless, it was said that staff have remained keen to access any virtual training opportunities available to them during that time.

4.30 On a related note, the suicide and self-harm guide produced primarily for schools (but also for youth services and other partners) was praised, especially for the visual way in which it presents scenarios and practical guidance via flow charts. It was suggested that more of the guidance produced should be presented in this way.

'… Making accessible all those pieces of guidance in short format… What teachers and youth workers need is a few sides of A4 that give them a really clear diagram of what they need to know... They've produced the guidance, which is excellent… it's just how that plays out if I'm a busy practitioner…'

Stakeholder – 36

Continued focus on suicide and self-harm prevention

4.31 At a fundamental level, the very existence of a national suicide and self-harm prevention strategy has meant that a subject that previously received very little attention in the wider context of mental health is now being discussed. It was said that those who understand suicide prevention now have *'a place at the table'* (Stakeholder – 33). Furthermore, the strategy itself was thought to provide a good foundation to understand what suicide and self-harm prevention could and should look like in Wales, offering ambitious goals to work towards.

'… It's had a real impact on a lot of services and statutory agencies in terms of focusing some of their work on suicide and self-harm prevention, using this as a kind of foundation to do that'

Stakeholder – 33

4.32 The aforementioned national and regional suicide and self-harm prevention co-ordinators were also thought to have been integral in maintaining a focus on suicide and self-harm prevention and in driving forward the T2M2 strategy.

'I think there's been some national traction around Talk To Me 2. Having the national co-ordinator coming in in the last few years has been really helpful. I think that's helped with regional co-ordinating of suicide and self-harm networks and forums and so on… It has put the Talk To Me 2 plan on the radar…'

Stakeholder – 28

4.33 Most participants were positive about their introduction, though there was some feeling that the regional co-ordinators have not been as impactful as they might have been as their cross-county geographical footprint is too large. This has apparently led to some health boards funding their own co-ordinators to plug the gaps, meaning there is a:

'… Disconnect between what is happening regionally and health board-wise and indeed, local authority-wise as well'

Stakeholder – 32

4.34 One of the most common themes raised during the focus groups and interviews was that the current focus (both generally and within discussions at the regional forums) is very much on suicide over self-harm, and that this must be addressed to ensure parity.

'… Like suicide falls off the radar when you're talking about mental health, self-harm falls off the radar when you're talking about suicide…'

Stakeholder – 13

4.35 Related to this, several participants suggested that suicide and self-harm should not be linked in one strategy for they are so fundamentally different.

'… There is a lack of parity between suicide and self-harm… We feel that there should be two separate polices. There are obviously links between them, but we think that the priority is around suicide… There's very little work or recognition locally or nationally around the need for support for self-harm… Even the document, if you were looking at it alphabetically it would be self-harm and suicide, but it's not. It's suicide and self-harm…'

Stakeholder – 36

'… I think it should be a twin strategy, where there is equal airtime given to self-harm as there is given to suicide because we're talking about different groups in society, different arenas and sectors where the intervention has to take place, and possibly different outcomes and different monitoring systems'

Stakeholder – 13

4.36 One NAG member was concerned about this, however, suggesting that a pragmatic compromise (i.e., another dual strategy) may be needed to accommodate people's limited time and ability to give sufficient attention to two separate strategies.

4.37 Of those who commented (all of those interviewed in relation to T2M2 were asked the question, and the issue was discussed at all relevant focus groups and workshops) the general preference was for separation, or at least a twin strategy.

Better services for those bereaved by suicide

4.38 The third objective of the T2M2 strategy is to provide 'information and support for those bereaved or affected by suicide and self-harm.'

4.39 Most of the discussions in this area were around the development of better services for those bereaved by suicide, and there were mixed views on whether the strategy has helped achieve this. Some of those working in this area felt strongly that it had.

> '…the better services for those bereaved by suicide… has certainly been a key part of the Talk 2 Me 2 programme, and I think it can be demonstrated that there are very good services for families bereaved by suicide... I think a number of those outcomes are being achieved and can be attributed to this strategy and the work that's being done'
>
> Stakeholder – 34

4.40 Specific mention was made of the Bereavement Support Grant offered by Welsh Government to organisations supporting people bereaved by suicide, as well as the success of the national and regional suicide and self-harm prevention co-ordinators and the contribution made by some third sector organisations like the Samaritans in driving improvements.

4.41 In relation to the third sector, there was some concern that information about existing services for those bereaved by suicide is still not kept up to date. Indeed, one practitioner said that they never refer to a third sector organisation until they have spoken to the service itself and established that it exists, as apparently half the time those they have found or been informed about are no longer available. Moreover, they alleged that many of those that do exist are often unresponsive when someone in need reaches out.

> '… There have been all these lists saying, "There is this, this and this" and then you phone up the number and the service doesn't actually exist, and it must be heart-breaking for a client to go through that... Consistently I can only think of two

services that I know will phone someone back. And that is pretty damning when you think how many services are on the list'

Practitioner – 41

4.42 More positively, a service is being piloted in Gwent whereby the third sector organisation 2wish provides support to anyone affected by a death by suicide, given they are more at risk of suicide themselves, and because of the effect such an event has on every aspect of their lives. The service was described as 'phenomenal'. (Stakeholder – 35)

Service users feel treated with compassion, dignity and respect by all services involved

4.43 The strategy's second objective is to deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm.

4.44 In thinking about appropriate responses, the service user experience was thought to be generally positive and actively improving. The vast majority of staff were said to treat people with dignity and respect, and to act with professionalism in the event of differences in opinion about how service users' needs should be met.

4.45 Residual stigma around mental health was thought to remain in some healthcare settings and among a minority of professionals, however. Time to Change Wales training is and will continue to be rolled out to overcome this.

'… Time to Change Wales did launch a new training model … because unfortunately we do have data showing that some healthcare professionals are stigmatising towards people [who] present with a mental health problem… It's very important for staff to develop that awareness around stigmatising toward mental health and how it impacts on their service users…'

Stakeholder – 36

4.46 On the issue of training, it was considered critical that those with lived or living experience are involved in co-producing, co-delivering and evaluating suicide prevention and self-harm reduction training, as well as awareness training aimed at ensuring practitioners react more compassionately and appropriately.

Better access to help for people in crisis

4.47 There was a strong sense among some practitioners and stakeholders that access to help for people in crisis has improved dramatically during the lifetime of the T2M2 strategy. A significant increase in the number of urgent assessment appointments available was noted, and the Assessment and Treatment teams were particularly praised for the 'gold standard' intensive, knowledgeable and person-centred care they provide. While external influences were said to have been the primary catalyst for their inception, the strategy was also thought to have helped 'push them through'.

> '… It's just a fantastic system... They get what they need at the right time from the right person; they're multidisciplinary; they're extremely well clued on suicide and self-harm prevention; and they deal with people who are at risk of suicide and are keeping them in their community and their own homes… I think they are phenomenal and the work that they do is phenomenal... There's been loads of things externally in terms of what's happened in health boards that's pushed that though; there's a massive gap that was needed and my understanding is that these sorts of conversations were taking place. Obviously, the strategy helped to push that through…'
>
> Practitioner – 44

4.48 An increase in funding for crisis services was said to have allowed these services to take a more holistic view of service users' well-being rather than focusing only on the active suicide risk at the time. This involves considering socioeconomic factors and linking with organisations such as Citizens' Advice and local authority housing departments to try and address these.

> '…If people are presenting in acute crisis and suicidal ideation is exacerbated by the factors that we know contribute, we're more able to use that sort of holistic approach and response more quickly because we've got direct links with other support services'
>
> Practitioner – 49

4.49 Despite this positivity, though, one service user was of the view that while crisis care is good for those in secondary care, it is poor for everyone else and especially those without a diagnosed mental health condition. They also said that those who are able to access it are often *"dumped"* after a few days, with no-one taking responsibility for their ongoing care or helping them deal with the trauma of having had a crisis. This service user strongly desired more funding specifically for suicide and self-harm prevention services for those who are vulnerable but currently without a diagnosis.

Improved awareness and provision of services for priority people

4.50 While some argued that more prevention and targeted intervention is needed with the groups known to be at greater risk of suicide and self-harm, others felt that the strategy has helped make progress towards achieving this outcome. For example, it was said to have helped promote a greater focus on men's mental health and suicide risk.

> '… In the first round of funding of small projects, there were lots of projects working with men because they're such a high-risk group. The strategy gave the focus…'
>
> Stakeholder – 10

4.51 There was some feeling that there has been insufficient focus on prevention and early intervention work with young people over the lifetime of the strategy.

> '… There should be more around people who work with children and young people and early intervention and prevention in the first place. Sometimes I feel the weighting here is a little bit too much into the postvention…'
>
> Stakeholder – 30

4.52 One stakeholder disagreed though, suggesting that with specific regard to suicide, while excellent work has been done with children and young people, not enough has been evident with those in middle age, who represent most suicides.

> 'Not that I think we shouldn't see children and young people's mental health as vital and critical, but I think there's a lot that's gone on in that space and is going

on… In the meantime, we've got middle aged people dying. I'm seeing very little evidence of what we're doing about that'

Stakeholder – 13

4.53 These differing views suggest a need to continue with an all-age approach to suicide and self-harm prevention within any successor strategy, while being mindful of the need to identify and focus on the most affected groups.

Improved sharing of effective practice in suicide and self-harm prevention

4.54 It was largely agreed that there is better internal and external sharing of research and effective practice in suicide and self-harm prevention, as well as the trends emerging from inquiries into suicide, so that lessons can be learned to inform prevention activity. This was considered essential.

'… It's good to have that external view [around], "What are the learning outcomes?" It highlights the importance of what the contributing factors were, was there anything that could have been done differently and sharing any investigation results. It's about … seeing if anything can be changed'

Practitioner – 52

4.55 Furthermore, sharing information and learning across county boundaries was also said to have improved.

'… If it happened in Blaenau Gwent then the Blaenau Gwent team had the outcomes and no-one else, whereas now we're a lot more proactive and we share it with every borough'

Practitioner – 45

Shorter waiting times for services

4.56 The general sense was that waiting times are still a significant issue, especially for those not in crisis. This was largely because of both COVID-19 and resources not keeping pace with demand, which in itself has risen due to the aforementioned greater awareness of mental health and well-being issues.

‘… as you get increased awareness, you get increased demand. And that goes back [to] not being resourced to deal with it, so I don’t know if we’ve made a lot of headway... We’ve got what we’ve got…’

Practitioner – 45

4.57 More creativity was recommended in tackling waiting lists, particularly in terms of determining what support people need, expect and are waiting for and looking more widely to determine who might be best placed to offer this.

‘… We need to be looking at… services where we’ve got more staffing that could cater to the needs of more people as opposed to funnelling people down to specialist routes where… they’ve got to wait forever… There’s far too much emphasis on psychological therapies without enough emphasis on other professions that could contribute’

Practitioner – 46

4.58 Service accessibility via GP appointments was also considered poor in many areas (more so during the COVID-19 pandemic, but also to some degree since), though this was thought to have been counterbalanced to some extent by the push to provide suicide and self-harm support via online- and telephone-based systems.

4.59 On a related note, it was said that while NICE does not want to encourage self-help for fear of this stopping people asking for help.

‘A lot of people that ask for help don’t get help anyway. So self-help is a really important back-stop position that we need to have in the critical factors’

Stakeholder – 56

Improved data and evidence on suicide and self-harm to inform policy, practice, and research

4.60 At the time the primary research was undertaken, the real-time suicide surveillance system was launched and considered potentially transformative in overcoming data inequalities and providing a more comprehensive dataset. The NAG argued that this could not have happened but for the capacity and connections made through the

Advisory Group, which itself would not have been set up if not for the T2M2 strategy.

4.61 One service user suggested that more needs to be done to engage with those who have survived suicide attempts in order to establish what could be done better in terms of prevention and early intervention.

More consultation of service users / priority people and incorporating their voices into policy and practice

4.62 Improvements were said to have been seen in consultation and engagement with service users and priority people over recent years. Several interviewees said there is generally more service user involvement than ever before and that:

> 'It tends to be one of the first things you think about, engaging service users, and that's new because we never used to do that'
>
> Practitioner – 45

4.63 However, a service user highlighted that the involvement of service users in the T2M2 work at local and regional levels varies considerably. They also felt that there should be more opportunities for service users to influence the NAG and strategy, policy, and services around suicide and self-harm prevention more widely, and for service users who are involved with the NAG to feed back to their peers about their work more regularly and in detail.

Positive, proactive use of media and reporting of suicide and self-harm

4.64 As aforementioned, the greater awareness of suicide and self-harm throughout society was thought to be due in no small part to the openness with which these issues are now discussed in the media. By and large, the media was thought to have improved the way it reports suicide especially, and many outlets were said to act proactively and responsibly in signposting those who have been affected by the issues concerned to organisations like Samaritans. This is important in a wider context, and also because one of the T2M2 objectives is 'supporting the media in the responsible reporting and portrayal of suicide and suicidal behaviour.'

4.65 However, in some cases, there is apparently still a tendency to sensationalise suicide clusters and a lack of service provision for example, the latter of which can have serious consequences in deterring people from accessing what is available.

> '… Sometimes the media can portray things in a way that isn't very positive and proactive when it comes to suicide and self-harm... You've got that sensationalised part of media which tells people that services are crap and there's no point going to them because people don't listen to you, and all these people have died because they weren't listened to…'
>
> Practitioner – 45

4.66 To combat this, Samaritans has produced helpful media guidance which (thanks to the NAG) have been adopted in Wales and translated into Welsh. These were considered an essential part of suicide prevention, and the NAG continues to work to ensure they are followed.

> '… If something contravenes media guidance and it's brought to our attention, then we write to the journalists involved... We wrote cluster guidance, how to respond to suspected clusters… If you think about the way things are reported, including ONS statistics, it can make vulnerable people more vulnerable. So being briefed and being able to talk sensibly about that stuff is a form of suicide prevention... The risk is that if it's reported in a way that people identify with, it then becomes psychologically available to them as an option. So, it's really important to do that training with journalists…'
>
> Stakeholder – 10

4.67 More action was also thought to be needed against social media groups that encourage harmful behaviours with sometimes fatal consequences and meet the strategy objective to 'reduce access to the means of suicide'. However, harnessing the positive potential of social media was also recommended, particularly in light of the increase (especially during the pandemic) in the number of organisations offering online counselling support and opportunities to discuss ways to prevent suicide and self-harm.

Long-term outcomes

4.68 No-one we spoke to felt able to comment on how well the strategy is helping to reduce the social, cultural, and structural inequalities underpinning suicide and self-harm or to ensure better longer-term/follow-up response to suicide and self-harm to maximise service users' perceptions of safety. However, some views were expressed around the aim to reduce suicides, and overall and repeat self-harm and suicide attempts.

Reduction in suicides, and in overall and repeat self-harm and suicide attempts

4.69 Office for National Statistics (ONS) data shows that the number and rates of suicide have both decreased year on year since 2017. The number of suicides recorded fell from 360 in 2017 to 285 in 2020, whereas the age standardised rate fell from 13.2 per 100,000 population in 2017 to 10.3 in 2020[18].

4.70 COVID-19 was thought to have hampered progress in reducing suicides and suicide attempts though, with stakeholders and practitioners in all areas perceiving an increase during the pandemic. This was thought to be in no small part due to a lack of access to support services during that time. It should be noted, though, that this perception is not borne out by official ONS data, which shows no increase in the number of suicides during the pandemic.

4.71 Instances of self-harm were also said to be increasing rather than decreasing. However, there are prevention initiatives in the pipeline using online apps for example, which were thought to be more in tune with the needs and culture of young people. Despite this, as self-harm is the way some people show their distress, it can evidently be difficult to reduce as, to do so, people must change the way they have learned to cope. Taking a long-term view was thus recommended.

[18] Suicides in England and Wales - Office for National Statistics (ons.gov.uk)

Where are the main gaps in the data needed to evidence outcomes?

4.72 During the data review, we were unable to source any 'hard' data around the following outcomes:

- Further improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come in to contact with people at risk of suicide and self-harm and professionals in Wales
- Information and support for those bereaved or affected by suicide and self-harm
- Support the media in responsible reporting and portrayal of suicide and suicidal behaviour
- Reduce access to the means of suicide
- Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action.

4.73 In the focus groups and interviews, the main data and evidence gaps were thought to relate to self-harm: so much of it is hidden that it is very difficult to monitor and quantify.

> 'A real gap at the moment in terms of data is around self-harm… We're much better at understanding what we need to do and there are some processes that are happening locally to understand suspected suicide, but in terms of self-harm I feel like those figures are really unknown…'
>
> Stakeholder – 33

4.74 There is some data available, however, which shows that the number of children and young people receiving counselling and recorded with self-harm as the main presenting issue increased from 804 in 2017-18 to 975 in 2020-21; and the number recorded with suicide as the main presenting issue increased from 291 in 2016-17 to 420 in 2020-21. These could be positive or negative results, of course. If they are due to greater awareness and a more appropriate response, that is positive, while a simple increase in the numbers would be negative.

4.75 More generally, a lack of consistency in data collection and recording across organisations was thought to compromise evidence gathering in terms of suicide and self-harm, as was a reluctance to share often sensitive data between agencies.

4.76 Moving forward, effective data sharing agreements were thought to be needed to ensure essential data can be shared, without compromising UK GDPR requirements. Indeed, a more partnership approach to data collection generally was strongly urged to ensure a more accurate and nuanced picture of suicide and self-harm across Wales. The example of Powys was given, where it is currently difficult for local primary care health services to gather data around A&E attendances for self-harm and attempted suicide given it does not have a district general hospital and all presentations will be in neighbouring counties. Moreover, data linkages between the statutory and voluntary sectors were also thought to need improving.

> '… [Thinking about] external organisations… the link through with suicide and / or drug-related deaths in terms of substance misuse. Getting all of that together and aligned and the processes and systems to gather that data in one way from a partnership perspective is missing… And the same would go with self-harm'
>
> Stakeholder – 28

4.77 Again, the real-time surveillance suicide system was praised as potentially transformative in improving the consistency of data collection, enabling all agencies working to prevent suicide to identify trends and potential solutions without having to wait for lengthy coroners' reports, and meeting the strategy objective to 'continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action'.

> 'When we're looking to dive into some of the data, we don't have a lot of the information readily available because it can be pulled together on different systems… This real-time surveillance is meant to try and override most of that and pull it together in a consistent format and then it should give us an idea of particular trends in particular areas… We're hoping to use that as a baseline framework once its fully live and operational and then we can start measuring the impacts that we're looking to have in particular moments…'

Stakeholder – 25

4.78 The importance of effective data gathering, collation and analysis is demonstrated by the experience, once more, of Powys, where Welsh Government funded the employment of a local suicide and self-harm prevention co-ordinator. Their first remit was to gather and undertake a five-year analysis of coroners' data to understand trends and themes, and then work and understand the outcomes and experiences of the families. This, it was said, has been enormously helpful in developing future services.

4.79 Furthermore, data collection and analysis during COVID-19 was thought to have been an impetus to target specific groups. In one area for example, the data showed that males in their thirties were at greater risk of suicide, and so prevention work was targeted towards that group.

5. How has COVID-19 impacted on the strategies' delivery and ways of working?

5.1 COVID-19 was said to have had several impacts on the two strategies' implementation and ways of working. Although most impacts were negative, there were also said to have been positive opportunities for future service development.

The impact of COVID-19 on the public's mental health and service demand

5.2 It was widely felt that the pandemic has had a negative impact on the general public's mental health (which is corroborated by wider studies such as the UCL Covid-19 Social Study[19] and the ONS Opinions and Lifestyle Survey[20] on the social impacts of the Covid-19 pandemic). Children and young people were said to have suffered from increased anxiety, and older people from increased loneliness. In response to this, demand for mental health services was said to have increased substantially during the pandemic.

> 'Some of those services like specialist CAMHS saw referrals double [and] eating disorders had really, really increased. We've gone back to normal now, but there was a real increase in the pandemic'
>
> Practitioner – 12

5.3 Alternatively, some participants worried that many people had not sought the help they needed during the pandemic. Such people were said to have developed self-stigma towards their mental health, believing it to be less important than the pandemic.

> 'People who had been struggling with their mental health have felt reluctant to acknowledge how they're feeling… and therefore bottling up and making things worse for themselves in the longer term'
>
> Stakeholder – 26

[19] UCL Covid-19 Social Study
[20] ONS Coronavirus and the Social Impacts on Great Britain

5.4 Some participants voiced concerns over how the socioeconomic consequences of the pandemic could impact the public's mental health in the long-term. Housing, job security, and the cost-of-living crisis were all said to be of particular concern.

> 'If people are not in the financial position to enjoy the things they used to… that's going to create a sense of hopelessness… As they're coming out of the lockdowns, we're going into what looks like is going to be quite a dire economic situation'
>
> Practitioner – 49
>
> 'We've seen the immediate impact of increased anxiety… we know the cost of living is going up... So that's the big worry going into the next phase'
>
> Practitioner – 12

5.5 In this context it was suggested that service providers need to remind the public of what mental health and well-being services are available to them and assure them that they are still operating after the pandemic.

> 'I just think making people aware of contact phone numbers… and let them know there are still things they can do if they need to reach out and talk'
>
> Service user – 4

A reduced focus on mental health services

5.6 Despite mental health services being deemed essential services to be continued throughout the pandemic, some participants felt that the restrictions placed upon them (particularly the move from face-to-face to online provision and the need to have Personal Protective Equipment [PPE] in place) had negatively impacted on their accessibility and effectiveness for service users.

> 'We had just got our physical health care support worker with all the equipment we needed… and then we were told it wasn't a priority and that we couldn't run clinics until we had safety measures in place, as we had no PPE'
>
> Practitioner – 40

5.7 This is corroborated in the Welsh Government's *Review of the Together for Mental Health Delivery Plan 2019-2022 in response to Covid 19,* which states that the pandemic has not only impacted directly on individuals' mental health, but it has also affected routes into accessing mental health support. This review also suggests that the T4MH and T2M2 strategies may not have adapted to the pandemic flexibly enough to provide sufficient preventative mental health support, despite prevention and early intervention being main components of them. Online mental health support networks were developed, primarily by the third sector, but these need more attention and support from the public sector (Welsh Government 2020).

5.8 Concern was also raised over the potential for service users to become less visible to providers post-pandemic, with service users and practitioners both suggesting that many vulnerable people are likely still not getting the services they need.

> 'I think it's played havoc with mental health services… because people who need help, vulnerable people, we're not quite sure what happened to them... I think some people were just left to their own devices'
>
> Service user - 4

5.9 Outcomes for inpatients were said to have been negatively impacted by the pandemic, with restrictions on discharges and visits having been detrimental to patients' mental health and well-being.

> 'People couldn't have visitors… People weren't allowed to go home on leave on Christmas Day... That's a massive impact'
>
> Practitioner – 43
>
> 'When it was bad, we had to stay in our rooms, and we weren't allowed our phones… it wasn't handled very well'
>
> Service user – 5

5.10 It was also said that the pandemic made integrated working difficult or even impossible for social services.

> ‘Some social services pulled that completely out of services. They all went to work from home... That caused divides that had an impact on joint working and integration within teams’
>
> Practitioner – 45

Widening existing inequalities

5.11 Some practitioners and stakeholders felt that existing inequalities in service access had been widened by the pandemic. Ethnic minority communities were said to have particularly suffered, being less likely to access the services they needed.

> ‘I think there’s lots of inequalities because of COVID, because services didn’t know how to adapt soon enough’
>
> Practitioner – 44

Staff burn-out and demoralisation

5.12 Stakeholders and practitioners expressed concern over the impact of the pandemic on staff within mental health services. The pressures of working under such difficult circumstances were said to have led to staff feeling stressed and burned out. In numerous cases, this was said to have made the recruitment and retention of staff more difficult.

> ‘People are tired, people are exhausted, and we have a really tired, tired workforce… It’s had really significant impacts…’
>
> Stakeholder – 6

Increased responsibilities for carers

5.13 Carers were said to have taken on more responsibility than previously through COVID-19, being expected to book more appointments themselves and receiving less assistance from services. Participants were concerned that this would become normalised and continue post-pandemic, impacting carers’ mental well-being.

‘Carers are being expected to do more and I think that’s going to continue… There needs to be a big improvement in the level of support that carers get for their own mental health and well-being’

Service user – 10

The potential for service redesign

5.14 Due to the impacts already outlined, participants said that service provision and transformation had been slowed by the pandemic, since staff have had to focus on meeting demand rather than on service development.

‘COVID has thrown a massive spanner in the works as far as the progress of the strategy is concerned. Waiting times in particular are outrageously bad, we’re losing clinicians, we’re struggling to get consistency of clinicians in the area’

Practitioner – 31

5.15 However, the pandemic was also said to have provided an opportunity to rethink how services operate post-COVID.

‘[COVID-19] in some respects, has had a positive impact in regards to bringing together several health board leads, supported by some of the national support services, to work in a much more supportive way, and I think it creates a real opportunity to build on that going forward’

Stakeholder – 21

5.16 The increase in video conferencing and joint training sessions between departments were said to have been beneficial, having provided opportunities for more interaction and joint learning.

‘We’ve had much more opportunity for joint training, which is good. So, it’s brought more people together form more diverse sectors because people haven’t had to travel’

Practitioner – 46

5.17 The pandemic was also said to have forced practitioners to think more creatively about the services they provide, with new roles being created in some scenarios.

> ‘COVID has pushed us on to different, more creative ways of working and has forced healthcare professionals to provide… what it has done is made us think differently about how we deliver and be more creative’
>
> Practitioner – 50

The impact of remote provision

5.18 Stakeholders, practitioners, and service users were all positive about the use of remote provision (videoconferencing) for healthcare providers to communicate with service users. Videoconferencing and telephone calls were said to have made services more accessible for those whose ability to travel is limited, and for those who otherwise struggle to attend appointments and assessments. Attendance at appointments was said to have improved during the pandemic as a result.

> ‘Digitally, we’ve become far more integrated and accessible… I think there needs to be a specific clause that goes into the revised document that reflects this and looks at the opportunities we could have from that…’
>
> Stakeholder – 31

5.19 There were concerns, however, that many service users will prefer to have their meetings in person, and that some do not have access to the necessary equipment or have the skills to use digital media. Moreover, it was felt that certain appointments and assessments are only appropriate or effective when undertaken in person.

> ‘It’s an advantage to the people who don’t feel comfortable…but it’s also not going to be as good as a face-to-face service, and I think a lot of people lost out because they couldn’t get the face-to-face service that they needed’
>
> Practitioner – 39

5.20 It was thus generally agreed that service users should be given a choice over the format of their appointments, and that certain assessments should remain face-to-face.

‘… For some people, it’s worked brilliantly, and it’s really been effective. For others, not so much…. what I would hope would come out of it is a mixed model’

Stakeholder – 6

5.21 In addition, it was suggested that those without internet access should be given the option to receive the equipment that they need so that they are not disadvantaged.

‘If the children or the patients don’t have the technology, then give it to them. Give them a laptop so they can at least access services’

Service user – 5

6. How have the strategies improved outcomes for diverse groups?

6.1 The *Together for Mental Health Delivery Plan 2019-2022, Welsh Government Integrated Impact Assessment Summary* suggests that stronger focus needs to be given to supporting vulnerable groups and those with protected characteristics. Specific actions need to be developed to target this support, as people with protected characteristics are notably less likely to reach out for help. Services also need to be improved for people with additional learning needs to ensure that there is equal access for everyone. This is true also for promoting equity of access for Welsh speakers, not least via the active offer which is discussed further in a subsequent chapter (Welsh Government, 2019).

6.2 Many participants, though, said that the strategies had improved services' focus on and awareness of people from diverse groups and those with protected and other characteristics. As a result, services were said to have increased their efforts to consider the needs of these groups and to improve staff diversity.

> 'Raising that awareness has been really important and I think that's been quite successful over the past few years'
>
> Stakeholder – 34
>
> 'We're trying to diversify our volunteer base and create a more welcoming environment for people… Understanding how we reduce our barriers'
>
> Stakeholder – 54

6.3 However, most participants agreed that further effort is required to improve outcomes for people from the following groups, as they still tend to be poorer than for the wider public.

- People from black and other ethnic or cultural backgrounds
- Members of the LGBTQ+ community
- Women
- Refugees and asylum seekers
- Gypsy and Traveller communities
- Children and young people

- Older people
- Rough sleepers (the data review showed that the number of rough sleepers remains high: the number counted on one designated night each year was 188 in 2017-18, 158 in 2018-19 and 176 in 2019-20[21])
- People who prefer to speak languages other than English
- People in the criminal justice system
- People living in rural areas
- People from socioeconomically deprived areas
- People with hearing impairments
- People who are neurodivergent.

Services for children and young people

6.4 With particular regard to children and young people, The *Together for Mental Health Delivery Plan 2019-2022* stresses that activities planned around children and young people have had the greatest impact overall as this improves the lives of children – benefiting their families and looking to the future to reduce demand on services in later life. As such, maintaining a focus on this would be prudent (Welsh Government, 2019).

6.5 Moreover, evaluation participants agreed that the mental health and well-being of many children and young people has improved because of the emphasis on their needs within the strategies, and several agreed that the continuation of an all-age approach that encompasses them is essential. Indeed, the Children Receiving Care and Support Census for 2017 to 2021 is available from StatsWales and shows that the number and percentage of children receiving care and support for mental health issues compared to all children receiving care and support rose from 13% to 17% between 2017 and 2021 (though the figure fell temporarily in 2020, probably due to the pandemic). This could be a positive or negative sign: more children being recognised as in need of support for mental health issues is positive, while more children experiencing mental health issues is negative.

[21] National rough sleeper count

6.6 Others still viewed children and young people as a disadvantaged group though, with waiting times for assessments and services said to be worse than for adults. Data on Specialist Child and Adolescent Mental Health Services (sCAMHS) waiting times (available on StatsWales) shows considerable inconsistency: the percentage of first appointments meeting the 4-week target fluctuated from just over 80% in January and February 2020, to just over 22% in December 2021, to just under 45% in June 2022. As such, while no-one expressly said that a specific strategy for children and young people is needed, a strengthened focus within an all-age one was strongly urged to encourage improvements.

Cultural competency and engagement with diverse groups

6.7 It was agreed that providers have made efforts to improve the cultural competency of their services and to increase the visibility and diversity of decision-makers.

> ‘We’ve been doing work around cultural competence and unconscious bias... I think certainly now it’s very much towards the forefront’
>
> Stakeholder – 6

6.8 However, they noted that cultural competency within mental health services needs further improvement to foster engagement with people from diverse groups, different ethnic and cultural backgrounds, and those from the LGBTQ+ community.

> ‘[Services must] make decisions that include diverse communities and intersectionality. Diverse workforces and boards…’
>
> Stakeholder – 56

6.9 In addition, participants agreed that it would be useful to have a cross-government, multi-agency approach whereby mental health services, the police, and support workers actively engage with these communities and groups. This, it was felt, would lead service providers to better understand and meet the needs of diverse groups; enable them to feel more involved in decisions around the services they receive; and foster trust in services, which was said to be a barrier currently.

‘It comes back to involving service users in their own experiences but also communities to support service users to have the services that they need. And I think there’s a lot to be said about that’

Practitioner – 44

Barriers to providing services in languages other than English

6.10 As discussed further elsewhere in this report, participants said that it is often difficult for services to be provided in languages other than English. This was said to be due to a lack of staff that can speak Welsh, British Sign Language, or any of the more common international languages, such as Polish.

‘If you look at talking therapies, there aren’t any counsellors in Wales that do sign language. This means a lot of people with mental health and hearing loss are locked out of systems’

Stakeholder – 32

6.11 Whilst participants suggested that services would need to be more multi-lingual to improve outcomes, concerns were raised about difficulties in recruiting staff with the appropriate language skills. These issues are discussed in more detail in the section on the active offer.

‘To try and find the staff that are either Welsh speaking or can use sign language, it’s really, really challenging’

Stakeholder – 12

Services for those with neurodivergence

6.12 A few service users felt that they had experienced poorer outcomes due to their neurodivergence. In particular, they said that the services they were offered were not tailored toward their condition(s) and that staff knowledge of neurodivergence was poor.

‘I think the help from CAMHS is tailored more for people who are not Autistic… they were not really suitable’

Service user – 7

6.13 Similarly, it was said that practitioners can be reluctant to engage with people whose conditions do not fit within their speciality, often having a negative impact on outcomes for neurodivergent people.

> ‘People come into professions, and you’ve got preferred areas of speciality. I think again with neurodiversity… I think it’s another specific speciality’
>
> Practitioner – 50

6.14 It was therefore suggested that healthcare practitioners (including GPs) should be trained in neurodivergence and that services should have measures in place to tailor their offer towards neurodivergent patients.

> ‘Everyone needs to have more training and understanding of how neurodivergence affects us…’
>
> Service user – 5

Reviewing the needs of diverse groups

6.15 Participants suggested that further research into the needs of people from diverse groups and with certain characteristics should be undertaken (it was not specified by who) so that they can be better understood. It was believed that by doing this, more prescriptive instructions on how to improve outcomes for these people could be given to service providers, making services more targeted and effective.

> ‘They need to review all the groups… to be more prescriptive… there should be clear outcomes to measure people’s quality of life and well-being to ensure what we’re doing is appropriate’
>
> Stakeholder – 16

6.16 Participants also said that when health boards work toward outcomes for certain demographics, they should share their experiences so that other areas can learn from them. This, it was felt, could help create a national steer for health boards in approaching services for people from diverse groups and with certain characteristics more consistently and effectively.

‘It could be that one health board looks at ethnic backgrounds, for example, one health board looks at neurodevelopmental pathways, and then we just share that work… It would be really helpful, I think’

Practitioner – 48

Additional influences on poorer outcomes for diverse groups and those with certain characteristics

6.17 Finally, in addition to the more widely discussed issues above, some other factors were said to have negative impacts on certain groups. Firstly, people in more deprived areas were said to have poorer mental health and well-being because of the impact of lower-paid and insecure work. They should not, then, be forgotten in any successor strategies.

6.18 Women were also said to have worse outcomes from services, due to being more likely to have caring responsibilities, and to present with mental health issues, suicidal ideation, and self-harm later in life relative to men. Homeless people were considered particularly difficult to access, and at particularly high-risk of self-harm. There was also said to be a gap in the mental health services available to people suffering from substance misuse.

6.19 People living in rural areas were also said to be disadvantaged, with some participants suggesting that the current strategies do not appropriately consider the impact of poor transport links, lack of digital connectivity, and rural poverty on mental health service provision.

6.20 Finally, it was said that while appropriate for the wider population on inpatient wards, anti-ligature legislation could often work against anti-falls legislation aimed at older patients. This was said to be because the removal of handrails and other ligature risks often leaves older and more frail patients without means of supporting themselves when walking in corridors. It was suggested that a means of addressing this would be useful in protecting older people from falls.

7. To what extent has a cross-governmental response been developed in implementing the strategies?

7.1 All of the documents explored in the initial documentation review stressed the importance of cross-governmental and cross-sectoral collaboration and responses, having national frameworks, multi-agency standards, common definitions, and whole system measures and indicators. The T4MH and T2M2 strategies were recognised as a productive step towards establishing and achieving these, as they involve many sectors, from primary care, to workplaces, schools, universities, third sector and charitable organisations, and training networks.

7.2 Most focus group/workshop and interview participants also felt that a cross-governmental response had been developed to some extent in implementing T4MH and T2M2. Where cross-governmental responses had been implemented, they had helped to acknowledge the diversity of mental health needs across Wales and to ensure a holistic, needs-led approach to service provision, it was said.

7.3 The introduction of the dedicated ministerial profile, cross-government committees (e.g., for children and young people, and for suicide and self-harm prevention), and ministerial oversight and partnership boards for T4MH, was seen to have strengthened the links between the strategy and the delivery plans, and to have increased local autonomy in decision-making.

7.4 For T2M2, appointing the national and regional co-ordinators and the NAG was generally seen to have increased accountability in suicide and self-harm prevention services in Wales.

> ‘In terms of governance structures, I think that was an issue because there were no clear reporting structures…I think systems work where government structures and funding go hand in hand in lots of ways. It’s really noticeable: I think all of the governance structures are going to be sorted now that the national and regional co-ordinators are in place’
>
> Stakeholder – 10

Effective practice in cross-governmental working

7.5 Participants shared the following examples of where they felt T4MH and T2M2 had helped achieve effective practice in cross-governmental working.

- More awareness of and less stigma associated with mental health issues and neurodiversity in schools
- Improved collaboration between mental health and substance misuse service
- More focus on cross-cutting issues, such as alcohol-related brain damage, and prison mental health
- Greater awareness among partner agencies such as housing regarding how they can contribute to improving mental health outcomes
- Specifically in relation to T2M2, greater collaboration between suicide and self-harm prevention services and the department of transport
- Including the third sector in the strategies. This was said to have ensured that third sector organisations are better listened to and are given greater recognition for their contribution to mental health services; and to have allowed them to access more resources and make links with partner agencies to enhance service delivery.

‘Probably what’s changed most, and I think coronavirus accelerated what was happening anyway in that sort of space, is third sector partnership delivery…the acknowledgement [was that] there was no way everybody was going to be able to deliver the support that was required, and there were lots of organisations out there that were fully equipped, [and] with just a little bit more money, they could get on and do that’

Stakeholder – 20

Aspects for improvement in cross-governmental working

7.6 Some participants felt that existing governance structures are not fit for purpose because they were not originally set up for strategic decision-making around mental health services. Despite this, regional ownership of the strategies’ delivery was said to be essential.

‘Regional partnerships in Wales need a rebound is my view. They were set up at a time and a purpose for what they were…People are talking about them in governance being the oversight, being the decision maker around finance... Well, they’ve not been set up to do those things…But then, it’s the place to park the ownership for this because if mental health isn’t a regional priority, led regionally, I don’t know what should be really’

Stakeholder – 8

7.7 There was some feeling that these issues have now been resolved, but others were unconvinced. They felt that the strategies’ governance remains fragmented, leading to duplication and confusion. Some also noted that health boards all have their own ways of working, which has led to uneven service delivery across Wales.

7.8 In addition, it was again reiterated that some local health boards’ mental health strategies conflict rather than align with T4MH in particular, which reportedly takes local agencies’ attention away from delivering its outcomes. There was also said to be too much reliance on mental health services to deliver the strategies’ outcomes, and not enough accountability from other agencies. For instance, some partner agencies were said to always consider how they can link into mental health services, when instead they should be considering how they can resolve issues that underpin mental health problems within their own remit.

‘…Being homeless is a risk factor for mental health. So, resolve the housing issue… It’s not about linking to services. It’s about resolving the housing issue, giving that person stability…We’ve got the links, but it’s more about do all of those policy areas understand the areas for what they can do to improve mental health? ...it’s about embedding and integrating, really’

Stakeholder – 12

7.9 The complexity of and gaps in local monitoring and reporting processes was also seen to have weakened governance and accountability. To improve this, reporting processes, expectations, and structures were said to need streamlining and clarifying; and the availability of data to measure outcomes needed improving (as discussed in detail earlier in this report).

7.10 Other issues with cross-governmental working to deliver the strategies included the reported lack of medical involvement with them; insufficient integrated working between health and social care; and conflicting messages between central and local government; between the deputy minister for mental health and well-being and local government ministers for example.

> '… I do think there are still conflicting challenges. I think we're fortunate in health, in that all of it comes under the health minister so whether that's primary care, mental health service, all of that is under the minister. Whereas, with local government you've got their aspect of the mental health services which is part of local government but it's driven by health and social care. So that presents some challenges'
>
> Stakeholder – 14

7.11 Participants made the following suggestions for improving cross-government working to implement T4MH, T2M2, and their successor strategies.

- Develop detailed, aligned plans at local and national level – with clear governance structures - to improve clarity and understanding around decision-making, and ensure all partners are working together and delivering against agreed targets
- Share effective practice in cross-governmental service delivery across Wales
- Improve integrated planning around funding
- Ensure that Regional Partnership Boards have ownership of the T4MH successor strategy so that all relevant services share responsibility for delivery
- To maximise quality in service delivery, Welsh Government should be open to commissioning services from new service providers, including those within the private sector. Welsh Government was said to use providers with which it has existing relationships because it is easier, rather than considering new ones. It was also said to be reluctant to use private sector services, despite them having a valuable contribution to make
- Improve communication between management and clinical staff at all levels to ensure the latter understand the operational and strategic activity being

undertaken to deliver the strategies. Inter-agency communication also needs to improve to ensure everyone is following the same processes and working towards shared goals

- Adopt a national collaborative approach to implementing the successor strategies to T4MH and T2M2, to resemble the implementation of A Healthier Wales[22]. Key elements of this approach include encouraging organisations to bid collaboratively to deliver services; and reviewing their success and incorporating lessons learned on a rolling basis

'I was really heartened by the Healthier Wales approach and the parliamentary review that took place… the approach and principles outlined in that Welsh Government document and policy. There is some re-learning that we could take from that for mental health. I think it didn't go as far as it could have gone, and I think it also fell short in its implementation. For me, let's learn from that…don't just give us another year of funding…but encourage each of those pilots to go and budget with one or two areas so you are starting to build up that scalability'

Stakeholder – 21

- Increase clarity around the roles of third sector agencies in delivering the strategies (an issue also raised in some of the documentation reviewed). Sometimes, it was said to be unclear whether partner agencies deliver services or just advocate for service users, despite being full members of partnership boards and receiving funding for service delivery

'Third sector…[are] talking to government about what we're not doing, or where the NHS is not doing particularly well. Whereas… the third sector gets quite a substantial amount to provide some of these services… how do we separate that role? Because third sector likely have a role where they scrutinise and lobby government, and that's absolutely right. But they're also receiving funding to deliver services, so in regard there should be a bit of scrutiny the other way…'

Stakeholder – 12

[22] 'A Healthier Wales' (2021) is Welsh Government's plan for health and social care.

- Specifically in relation to T2M2, appoint a national lead for suicide and self-harm prevention based in Welsh Government to make decisions and set priorities
- Also in relation to T2M2, to strengthen the public health approach to suicide and self-harm prevention, Public Health Wales should have a formal role in delivering suicide and self-harm prevention strategies, it was said.

8. How has the workforce in terms of numbers and skills impacted on implementing the strategies?

8.1 Several participants stated that, in general, the mental health workforce has improved in terms of both numbers and skills since the strategies' introduction. One stakeholder noted that opportunities for nurses to train in psychological therapies and Autism Spectrum Disorders (ASD) had increased, which they valued; and most of the service users who participated in interviews praised the CBT practitioners they had worked with. They welcomed their 'human' approach, willingness to listen, and ability to put them at ease.

8.2 However, there was quite strong feeling that more staff members are needed across the board to ensure the strategies' full implementation. The COVID-19 pandemic has shifted priorities away from staff training and development to frontline service delivery, it was noted (as highlighted elsewhere), which should be recalibrated in the COVID-19 recovery phase. In addition, many staff's workloads were said to be too high to allow them to meet service users' needs fully.

8.3 Service users also acknowledged frontline staff shortages, especially in more rural areas. One described how high staff turnover required her to repeat her story numerous times to different professionals, which 'takes up the bulk of the appointment'. Another highlighted the need for services to 'look after' staff to ensure that they are able to deliver quality services.

> 'There are not enough frontline staff in the NHS…I think more nurses, more professionals, hopefully equals better care… I think that you need to invest in people, and take time with people, and build relationships with people to sustain better health. And that's not happening very much because everybody is stretched to extremes. So, there's loads of vacancies now and they have a problem with recruiting'
>
> Service user – 4

8.4 Staff workload and stress was said to be affecting retention within mental health services, with staff also said to be retiring early due to this. It has apparently led to the workforce being dominated by newly qualified professionals. Consequently, the

need to train and nurture new staff to encourage them to stay within the profession was also raised, along with the need to provide them with mental health support.

8.5 One stakeholder felt that, to improve staff morale and retention, all mental health staff should be trained on the principles of prudent healthcare to ensure they prioritise those in greatest need rather than dealing with inappropriate referrals. Offering greater flexibility around working hours and more opportunities for progression would also help, it was said.

8.6 A workforce skills audit was thought to be needed to understand the existing skills mix and where skills gaps lie across all agencies responsible for contributing to both strategies' implementation, according to several stakeholders. This, they felt, would establish what training and resource is needed to respond effectively to those with mental health issues and needs related to suicide and self-harm in Welsh and in English. This exercise should then inform the development of a Wales-wide training and competency framework to ensure consistency in staff training and skills. The recommended skills audit should dovetail with the competency framework which is currently being developed by Health Education and Improvement Wales (HEIW) to ensure consistency and avoid duplication across Wales, it was said.

8.7 The need to upskill and boost the confidence of the workforce at all levels was also highlighted to ensure that everyone understands the strategies' aims and priorities.

> 'From a leadership perspective, we've probably got people who really understand…what implementing these strategies looks like, but I'm not sure how well we filter that to the ground. I think that there should be opportunities for all staff on the coal face to have inputs around the strategies so that they really understand what these mean and how this can apply in their job from the very little things that are around attitude and environment, through to particular interventions'
>
> Stakeholder – 33

8.8 Some participants advocated broader systemic change over and above workforce numbers and skills to ensure that the mental health workforce is fit for purpose. For example, one interviewee recommended refocusing the workforce to ensure that it

truly adds value for service users, rather than simply continuing to provide services in the same way.

> ‘For me, this is really about the way we worked rather than about who’s in post. I think there’s such an awful lot of waste in terms of failure in the system…that the system itself is creaking, and we keep bolting things onto a broken system. So, I think if we refocused things in such a way as to really look at what is of value to the population and the service users and patients we have, rather than trying to continue the things we’ve always done just because that’s the way we do it’
>
> Stakeholder – 28

8.9 Participant’s reflections on the numbers and skills of specific parts of the mental health workforce are summarised below.

GPs

8.10 Some stakeholders said that introducing GP clusters to co-locate mental health services across Wales had helped make them more accessible to service users. For example, someone with anxiety could visit their GP and speak to a mental health practitioner with specialist skills to support them. This, in turn, has helped embed mental health services within primary care, and instil a wider recognition of the importance of mental health and well-being.

8.11 GP clusters could be further extended through including occupational health professionals such as recovery and peer support workers to help address mild to moderate mental health issues and social isolation, it was said. This would help prevent these issues, and the need for services to address them, from escalating.

8.12 Conversely, capacity issues were raised in relation to GPs providing or signposting to mental health support. There was also some feeling that GPs need more specialist mental health training.

> ‘GPs… only have three years specialist training [which] often…doesn’t include mental health…women [or] children. They open the door, and the…clinic is full of mental health, children, and women. In my mind, it’s a completely unsatisfactory training route for the job you’ve got to do, and I know that’s being considered’
>
> Stakeholder - 18

8.13 This was said to have contributed to over-prescribing for mental health issues, according to stakeholders and service users. One service user reported that their GP did not listen and talked over her when she was trying to discuss her mental health issues, which she attributed to workload pressure and a lack of training. Another noted that their GP immediately prescribed medication without fully assessing their symptoms.

8.14 Stress and workload issues among GPs were also cited as barriers to implementing the strategies, as was the reportedly high use of locums, which has reduced continuity of care.

Education

8.15 Participants largely welcomed the increased emphasis placed on mental health and well-being within the new curriculum for Wales and the greater opportunity it affords to introduce related topics. They did, though, acknowledge that schools will need support to implement this to full effect.

> ‘The new curriculum provides a huge opportunity for all children and young people… to sidestep the situation where the mental health aspect just becomes PSE plus… [For example] if you’re talking about Winston Churchill… a big part of his character was depression…How did that character in history deal with that situation? What would that have meant for him? How would he have felt? Rather than just teaching it as the bare facts…It’s a creative way of weaving that in, and I think teachers will need support to do that’
>
> Stakeholder - 15

8.16 Continuing and extending teacher access to specialist support for mental health and for suicide and self-harm prevention was also said to be essential in continuing to implement the strategies, whilst acknowledging the resource implications of this. Several participants also cautioned that teachers must not be seen as specialists and must be trained and supported to identify where their responsibilities start and end.

8.17 Improved partnership working between schools and mental health services was cited as a benefit of the T4MH and T2M2 strategies. The CAMHS in-reach service

was cited as an example of effective practice, where CAMHS staff upskill school staff to better support learners' mental health, although the need to appoint Welsh speaking CAMHS in-reach advisors was highlighted.

The police

8.18 Partnership working between mental health nurses and the police was cited as an example of effective practice in implementing the strategies which should be expanded to ensure 24-hour coverage going forward, according to some participants.

> 'A huge positive has been those mental health nurses in support[ing] members of the community via police… triage nurses in control rooms [have] specialist knowledge that police officers don't have…having somebody with medical training really gives you a real degree of confidence that you're making the right decisions'
>
> Stakeholder – 27

Psychology and psychiatry

8.19 Shortages of psychiatrists and psychologists were mentioned by several participants, especially in CAMHS. This was linked to insufficient funding; an increasing demand for services; and the limited clinical psychologist training available in Wales. The current need to temporarily remove psychologists from clinical practice to gain certain therapeutic qualifications was also cited as a barrier to ensuring that staff with the right skill sets are in place to deliver the strategies. Alternative pathways to qualifications in psychiatry and psychology were said to be under consideration to address this issue.

The third sector

8.20 The third sector was considered a very valuable provider of needs-led mental health services (especially early intervention) by several of those interviewed. However, third sector workers are sometimes seen as less qualified than the professional workforce, which should not be the case, given the value of their contribution to mental health services, it was said.

8.21 The need to promote the mental well-being of the third sector workforce to ensure that they can continue to provide their valuable contribution to mental health services was cited as a priority going forward.

Suicide and self-harm prevention services

8.22 As mentioned earlier in this report, participants widely considered the appointment of the national and regional co-ordinators for suicide and self-harm as a valuable addition to the workforce and emphasised that these roles should be sustained in future. There was also some feeling among participants that, although the numbers of skilled staff working to implement the T2M2 strategy has increased, more staff will be needed to deliver dedicated suicide and self-ham prevention services in Wales. This could include a suicide and self-harm prevention lead in each health board to drive the strategy going forward, it was suggested.

8.23 Improving early intervention through peer support models and more innovative ways of working, and prioritising clinicians' time for those most in need was also mentioned as priorities for ensuring the strategies' full implementation.

> 'I think the shift really is into that prevention and early help or early assistance, and that being done by people who are not specialists, and it's about reworking things so our clinicians are further back in the system, and they're pulled in when they're needed, but that real sense of innovating models at the edge of care so that we leverage all that's available'
>
> Stakeholder – 28

8.24 Several participants highlighted a wider need to train all public sector staff in suicide and self-harm prevention. Although training has been delivered in health boards, currently, levels of knowledge and understanding among staff were said to be inconsistent. This calls for tailored, in-depth training, as well as support for staff working with those who self-harm or die by suicide and their families.

Staff shortages and skills gaps

8.25 Participants highlighted the following training needs and skills gaps among the workforce.

- Implementing a trauma-informed approach
- De-escalating situations in inpatient settings to reduce the use of restraint (according to a stakeholder) and ensure a more compassionate approach (according to a service user).

‘A lot of them don’t know how to deal with it when you get [agitated]. A lot of them just tackle you to the ground, but de-escalation [training] and just talking and asking why and just listening, definitely’

Service user - 6

- Welsh speaking staff across the mental health sector[23]
- Training for using technology effectively when delivering mental health services
- Cognitive Behavioural Therapy (CBT) training for staff in primary care and education
- Early intervention in emotional well-being (e.g., social prescribing) to prevent that escalation of mental health issues that require more specialist care, for children, young people, and adults
- Further training for managers in the NHS to support them to think strategically about service development
- Educating children and young people on the possible effects of recreational drug use on mental health, such as psychosis
- Detecting neurodiversity among girls and women. There was some feeling that symptoms are often dismissed as hormonal or ‘moodiness’, leading to missed diagnoses, worsening symptoms, and distress
- Adopting a no-blame approach towards servicer users who have relapsed

[23] This is discussed in more detail in the section relating to the active offer.

- Deepening awareness of equality and diversity, and sensitivity towards the support needs of service users with protected characteristics. One service user recounted how they were asked directly about their sexuality in an intrusive and inappropriate way.

'One of the nurses... she asked, "Are you gay?", and it was really an intrusive question to ask…It's, "if you don't want to tell, them, don't push it". In the end, I did feel comfortable with some of the nurses, and I did tell them, but for that nurse to ask me straight out and not give me an option to be able to say, "I don't want to talk about this" [was inappropriate]'

Service user - 6

8.26 To ensure that staff have the right blend of values, attitudes, and skills, service users would also welcome the opportunity to design, co-deliver, and evaluate initial and ongoing training for staff, especially on suicide and self-harm prevention. Opportunities to do this had been very limited to date, it was said.

8.27 Participants noted staff shortages in several specific areas which are affecting the implementation of T4MH. These included:

- Crisis care staff in A&E departments
- Screening and assessment for autism, especially in north Wales
- Occupational therapists to support people to develop coping skills and prevent mental health issues from escalating, and to link in with wider communities
- Art therapists
- Inpatient teams
- Community mental health teams
- Entry-level nurses
- Staff with lived experience of mental health issues, ideally as employees rather than just volunteers, as is currently the case.

8.28 Participants also noted that staff shortages and / or areas for upskilling in several specific areas are affecting the implementation of T2M2. These included:

- A need for more staff, more thorough training for all public sector staff, and better communication of relevant policy and what their role is in implementation
- Supporting all public sector staff at all levels to talk about suicide and self-harm prevention with those who may need support
- Supporting staff working with parents of children and young people who are affected by suicide and self-harm and
- Educating service users who have been sectioned on their rights.

9. What progress has been made with embedding the 'active offer' in mental health services in Wales?

9.1 Overall, views were mixed about the extent to which the active offer is embedded in mental health services in Wales. Some participants felt that it had been implemented effectively. However, those who expressed this opinion tended to stress that bilingual letters, leaflets, signage, email signatures were consistently provided, and that staff were encouraged to take up Welsh language skills training through work, possibly reflecting that they misunderstood the requirements of the active offer.

9.2 Other examples given by participants to reflect the embedding of the active offer were more salient, including having Welsh-speaking police to handle suicides (mainly in north Wales); and offering Welsh language services from the first point of contact with services.

> 'So, the conversation happens at the first contact with a person…Not just at the first point where we are ticking the boxes for the written material and ensuring that we are asking that question from the offers to which language would you prefer your assessments and support to be in, but we also have that consideration that if Welsh is someone's first language, we can't really progress an assessment without considering that because we get false information particularly around memory services'
>
> Practitioner – 42

9.3 However, most participants expressed that the active offer had some way to go before it became fully embedded; and the extent to which Welsh language services are proactively offered rather than being available on request was said to be variable. Embedding the active offer was also said by some to have become less of a priority during the pandemic, as staff had to focus on service delivery.

9.4 Several of those who were less positive about the active offer's embedding said that it varies in line with the proportions of Welsh speakers in each area. As noted elsewhere, in areas where less Welsh is spoken, health services were said to struggle to recruit Welsh speaking staff. It was also noted that some services in

Welsh are only available part-time, such as the Samaritans helpline. The cost and availability of translation services in some health boards has also caused problems.

9.5 Court-based capability assessments in Welsh are not widely available, which was said to be a particular issue for first language Welsh speakers with dementia, who may have less ability to converse in English. Data on the numbers of Welsh speaking staff who can do capability assessments apparently does not exist; this was said to be needed to be able to identify where gaps in this provision lie.

9.6 A few participants emphasised that implementing the active offer should not be at the cost of reducing the availability of services in languages other than Welsh and English, especially in areas where few service users speak Welsh and/or where other languages, such as Polish, are prevalent.

How can the active offer be fulfilled throughout Wales?

9.7 As already noted, several participants suggested that a skills audit should be conducted across the mental health workforce in Wales to identify skills gaps and training needs. This should also establish staff's ability and capacity to provide Welsh language services, some felt.

9.8 Overall, more Welsh speaking staff were said to be needed to embed the active offer. To achieve this, staff should be encouraged and incentivised to learn Welsh, it was suggested. One interviewee felt that incentivised Welsh language courses should be offered alongside initial training for mental health professionals.

9.9 Introducing Welsh mentors or 'champions' to promote Welsh and support staff to learn the language was also proposed.

> 'It would be about continual promotion of the Welsh language and utilising the existing staff whose first language [sic.] or have learned through the medium of Welsh, making sure they're onboard and supportive of the attempts to promote the Welsh language'
>
> Practitioner – 49

9.10 Raising awareness among staff of the importance of offering services in Welsh was said to be important in embedding the active offer going forward. This could be

achieved through sharing the experiences of those who prefer to access services in Welsh.

> ‘I think we need more understanding of why it’s important if we can’t pronounce somebody’s name correctly, because I don’t think staff would ever do something knowingly, if they realised how it made someone feel… It’s maybe about being able to share some service user experience to really help people understand in a positive and supportive way and why it’s important’
>
> Practitioner – 39

9.11 Some noted that more funding is needed to achieve full implementation, especially for third sector organisations who were said to need extra funding to provide a bilingual service.

9.12 Services should also consistently transfer information about language preference between themselves to ensure that service users’ language preference is accommodated, others said. This would also help to ensure that English-only information is sent to service users where preferred, as sending them the same information in Welsh and in English when this is not required could be overwhelming or confusing.

9.13 Several participants suggested that Welsh Government should develop a detailed strategy which sets out in detail how health boards can meet demand for and create change in relation to Welsh language mental health services and support them to achieve this. At present, they felt that guidance and support at this level is lacking, and that the approach is too ‘broad brush’.

9.14 Measuring the implementation of the active offer could also be better, it was said. Rather than recording and reporting the numbers of service users who requested Welsh language services, one interviewee suggested that success should be measured through the numbers who were proactively offered services in Welsh at the first point of contact.

10. Successor Strategies

10.1 The T4MH and T2M2 strategies are seen generally to be making important improvements to mental health services and their scope in Wales, covering and considering a wide variety of risk factors for poor mental health, such as homelessness, poverty, debt, and contact with the criminal justice system – but it has been emphasised by many that the pace and progress set by the T4MH and T2M2 strategies must be sustained in the long-term (Welsh Parliament, 2020). Successor strategies will be important in ensuring this.

What should the successor strategy to T4MH focus on?

10.2 Participants and service users made a range of suggestions for the T4MH successor strategy.

Data, evidence, and outcome use and measurement

10.3 As noted elsewhere, there was strong feeling that more, and more specific, data should be made available to provide clear evidence of both strategies' achievement of their outcomes. The need to establish a baseline at the end of the current T4MH and T2M2 strategies' lives was also highlighted to accurately inform the successor strategies' priorities, as was the need for clearer and fewer specific outcomes than T4MH.

10.4 Related to this, it was noted that agreements should be reached that enable the sharing of data between all relevant agencies. This was said to be essential to enable timely action which meets service users' needs across Wales.

> '[We need] a national agreement for information sharing. It's critical [but] the evidence is it's not there, so let's really get that going so that we can legitimately share information about people in the right way…so that we're not scrambling around and doing things that really is not together for the mental health of that individual but is making it worse, actually'
>
> Stakeholder – 28

10.5 According to one interviewee, the outcomes from T4MH and T2M2 that have not yet been achieved should be transferred into the successor strategies. However, another highlighted the need to 'think outside the box' when developing the strategies to consider what mental health services in Wales should really look like.

> 'In-patient beds, access to psychological therapies, mental health in schools – it feels a little bit old school. Looking forward, what are the mental health services we want in Wales? What can professionals bring to the table? It feels like we need to say something about the principles underpinning mental health services – 24/7, open access, co-produced, accessible, trauma informed, culturally appropriate – all important…But if we were starting with a blank piece of paper, would we have the services as they are now? Probably not. We'd be doing some very different things and I think we need to give ourselves permission to start thinking differently about how services are configured in Wales'
>
> Practitioner - 56

10.6 Both successor strategies must be evidence-based, meaningfully co-produced with services and their users, and have clear, time-tied priorities which are not swayed by changes in political preferences. They should also be revised in line with qualitative and quantitative outcome data, including feedback and complaints from service users, participants said.

10.7 Service users echoed these sentiments, expressing that they wanted to feel much more involved in decisions around service provision, and in those around their care in future. They also felt that carers should be involved, and that the reasons and choices for decisions should be made clear to service users. When developing the successor strategy to T4MH, the need to avoid duplicating existing strategies was also highlighted.

Governance, accountability, and legislation

10.8 The strategies should, it was said, align the priorities of regional partnership boards, mental health partnership boards, other boards such as substance misuse, with the work of partner agencies to ensure joined-up services, widen accountability and ownership for mental health, avoid duplication and roll out good practice. To

achieve this, Welsh Government could fund local authorities to integrate work with health boards, one interviewee suggested.

> ‘’You’ve got all the different departments in Welsh Government, and they all need to realise mental health is everyone’s issue and everyone’s problem. Not just think there’s a mental health budget to do this and that – mental health issues don’t discriminate whatsoever…The mental health budget is used to provide various things and maybe it’s time to look at all the budgets – education, sports, whatever – and say mental health does occur and we know that mental health can be alleviated by sport – but you don’t see the sport budget paying into mental health, it’s always mental health providing sport facilities’
>
> Stakeholder - 32

> ‘It’s important that the strategy is linked to complaints processes and look at what the complaints process is like for people – for mental health problems, suicide, and self-harm. At the moment, there isn’t a process for evaluating services for people who’ve attempted suicide which can be frustrating as it feels like nothing has been learnt’
>
> Practitioner – 56

10.9 The importance of having clear accountability structures to enable measurement of impact was also highlighted by several participants.

> ‘If this is going to be a mental health strategy…we have to be clear on who is going to be held responsible and supported in these things, because that’s the only way we are going to see traction changing and then a much more national governance structure that is about responsibility and accountability and is about performance management’
>
> Stakeholder – 21

Early intervention and prevention

10.10 Several stakeholders and practitioners suggested that the successor strategy for T4MH should place greater emphasis on early intervention and prevention, which ideally separates out the two areas to ensure clarity. This would help prevent mental health issues and service need from escalating, it was said. Service users agreed,

with some emphasising that they should not have to reach crisis point to be offered help.

> ‘I think they should react quicker and instead of waiting until things get to crisis point, actually put the work in. I know they are continually talking about putting in before it gets to crisis point, but they don’t…I was dealing with some really dark thoughts, and I was really anxious, and things were going really quite badly and I was really struggling at that point and I was still told that I wasn’t bad enough’
>
> Service user – 7

10.11 One service user also advocated for an emphasis on recovery strategies as a form of prevention, as well as self-management approaches led by peers.

10.12 One stakeholder highlighted the need for ‘proportionate universalism’ within prevention, which balanced universal and targeted actions, allocating resources in line with levels of need. Others cautioned that prevention and early intervention must not be emphasised over inpatient care for those with the most acute needs to ensure that the strategies recognise the diversity of mental health needs across everyone in Wales.

> ‘We sometimes don’t focus [on] the horrible things like inpatient care and sections of the Mental Health Act because that’s not seen as nice. We focus on prevention and intervention and that needs to be matched between those two. I think we need to make sure we’re sighted in all the different aspects of mental health…. It needs to recognise the complexity of mental health…across the life span…It’s really interesting and important that we focus on that prevention, but there’s lots of adults and older adults with dementia and the dementia action plans are outside of mental health which confuses the hell out of me’
>
> Stakeholder – 7

The workforce

10.13 Regarding the workforce, participants noted that staff capacity, retention, and training, among all mental health professions needed boosting. Relating to a point made elsewhere, there was also some feeling that training for mental health

professionals should be more trauma-informed, to ensure that services themselves moved in this direction.

10.14 Employing staff with lived experience of mental health issues should also be a priority for the T4MH successor strategy. This would help change the culture of services towards one which is user focused, participants suggested.

> ‘People with lived in experiences…want to be involved, and they would make cracking good employees…we don’t really believe that mental health services will change their culture towards one that is more genuinely user-focused if they don’t do that….If you think of things like alcohol and drug work, that’s delivered and led and managed and commissioned in no small part by people who have personal experience. Not a sniff of that in mental health, so I think that is a failure if you will of the last strategy’
>
> Stakeholder – 26

10.15 T4MH should be explicit about the role of the third sector in delivering mental health services, and dedicate adequate, ring-fenced, sustainable funding for this. Local and national commissioning processes were said by some to need closer alignment to ensure that services are appropriately funded.

Funding

10.16 Participants emphasised that adequate, sustainable funding was essential to implement both successor strategies. Short-term funding was said to lead to unstable staffing and inconsistency in service delivery. The need for proper resourcing, especially for community care, was also emphasised by service users.

Tackling inequality, stigma, and discrimination

10.17 It was suggested that the successor strategy to T4MH must tackle inequality in service provision, specifically addressing how services will meet the needs of ethnic minority people, those from diverse groups, and people who do not speak English but may have significant mental health needs, such as asylum seekers, in line with the impending Welsh Government workplace race equality standards and wider equality legislation.

10.18 In general, service users perceived that stigma around mental health (and suicide and self-harm) has lessened over the last decade. They welcomed the fact that these issues are discussed more openly. However, they felt that more could be done to address it in future, especially around men's mental health, and neurodiversity, potentially through linking up with the media to encourage more appropriate reporting. Stakeholders made a related point about the need to tackle stigma around mental health issues using positive, appropriate, and accessible language and terminology.

> 'Behaviour is the elephant in the room when it comes to stigma. People are very judgemental about unusual or difficult behaviours that can be a result of psychological injury. It's the same for dementia, learning difficulties, etc, and if we're looking at reducing stigma and discrimination, it's something we really need to address'
>
> Practitioner – 56

10.19 Service users also felt that the successor strategy should take a holistic approach to addressing related inequalities such as poverty, housing, and education.

> 'I think we need to look at how we care for people and also adopt a far more holistic approach looking at issues around housing. Poverty is a huge one, because if we solved poverty then we could do a lot to alleviate the prevalence of mental health problems in our society because poverty and poor mental health go hand in hand often, so there needs to be a multi-agency strategy to look at everything and see how one thing effects something else. You can't divorce someone's mental health from the context of the environment in which they live, so you need to look at wat's going on with education, accommodation, health inequalities, nutrition, it's a big one, really'
>
> Service user – 4

The active offer

10.20 As highlighted in relation to the active offer, some participants felt that the successor strategy to T4MH should seek to ensure that services can be accessed in Welsh or English, as users prefer. It was suggested that this could be achieved

through firstly mapping the workforce's Welsh language skills; modelling how Welsh language services could be provided, considering establishing regional co-ordinators to lead on this; then strategically funding university and training courses which incorporate significant Welsh.

Mental health across the lifespan

10.21 The T4MH successor strategy should acknowledge that most service user's support needs vary throughout their lives and can change quickly, participants suggested. Interventions should therefore be holistic and flexible to meet individual needs. More broadly, it was felt that the T4MH successor strategy should acknowledge that mental health is a whole-life issue, rather than something which affects people at certain times in their lives. Services should therefore focus on imparting coping strategies for people throughout the age range. The new strategy should also have a more granular and comprehensive focus on older people's mental health needs, not just dementia, also incorporating social isolation and loneliness, it was felt.

10.22 Several suggestions were made regarding improving services for children and young people. Firstly, improving mental health support for children and young people who are in contact with youth justice services. Although participants acknowledged that this topic is covered in the Youth Justice Blueprint for Wales[24], some felt that there should be more crossover between mental health and youth justice services in Wales.

10.23 Participants also suggested that better mental health support was needed for young service users as they transition to adulthood; for those with complex needs; and for those who have experienced neglect and abuse, from perinatal stage onwards. Improved processes for sharing information between services were needed to facilitate this, according to service users, who emphasised that transitions between services were often poor.

Acute mental health conditions

10.24 Although T4MH's focus on psychosis was welcomed, several participants felt that the successor strategy should have a clearer focus on acute mental health

[24] Youth Justice Blueprint

conditions such as schizophrenia, bipolar disorder, and personality disorder and the addressing inequalities which exist around them, such as supporting those experiencing these illnesses to engage with work. It was suggested that developing national service principles around these elements could help to achieve these changes.

Secondary care

10.25 Achieving parity of esteem for 'core' secondary mental health services, such as inpatient care and community (local authority) mental health services, with primary mental health services was seen by some as an important priority for the new strategy.

Linking addiction and mental health services

10.26 Joining up addiction services with mental health services, to increase coordination and sharing of effective practice between these services, and adequate support for the many people who experience addiction and mental health issues, should be prioritised under the T4MH successor strategy, a few participants noted.

Ensuring appropriate access points and referral routes

10.27 Although, as noted elsewhere, participants welcomed the expansion of mental health services through GP clusters, they acknowledged that GPs were not experts in mental health. This had apparently meant that some people had not been referred to the right services. The successor strategy should therefore seek to address this.

10.28 This point was echoed by some service users, who felt that GPs sometimes lacked understanding of mental health issues, and/or were too busy to see people when needed, as noted already. One service user therefore recommended that it should be possible to access services through alternative routes.

> 'It would be good if you could just bypass the doctor, because the doctors are overrun, and the receptionists are crazy busy. I understand, and the receptionists are not always the most approachable, so I think a completely separate line or number or something for mental health would be much better'
>
> Service user – 5

Estates

10.29 The T4MH successor strategy should outline how estates will be made fit for purpose for delivering mental health services, one participant suggested.

Women's mental health

10.30 Service users welcomed the fact that girls' mental health is now taken more seriously, but felt that the impacts of menopause, pregnancy, and postnatal depression on women's mental health also need to be taken more seriously by professionals.

Raising awareness of mental health services

10.31 More generally, one participant suggested that communication strategies need to be improved to widen prospective user's awareness of services.

What should the successor strategy to T2M2 focus on?

10.32 More generally, there was some feeling that the T2M2 successor strategy should replicate the structure of the current strategy, i.e., setting out its priorities broadly, and incorporating a relatively small number of recommendations and an action plan. Specific suggestions made for the successor strategy to T2M2 are as follows.

Crisis care

10.33 Several suggestions were made for the successor strategy to T2M2 around crisis care. It was outlined that crisis care which meets the needs of all children and young people aged 0-18 should be prioritised which recognised that young children are likely to have very different needs to those of an older teenager. Crisis care provision within hospital A&E departments was also said to need improving.

10.34 The need to join up the actions around crisis care in the T2M2 successor strategy with the Crisis Care Concordat National Action Plan[25] was also emphasised, as was planning with crisis care service users when they are well regarding how they want to be treated when they are in crisis. In addition, extending the duration of crisis care services to support service users in dealing with the trauma of having had a

[25] Wales crisis care concordat national action plan 2019-2022

crisis, and the longer-term impacts of this on their lives, was also noted as a priority for the T2M2 successor strategy.

Tackling inequality, stigma, and discrimination

10.35 Reflecting a point made in relation to the T4MH successor strategy, participants felt that the next T2M2 strategy should raise public awareness of suicide and self-harm to reduce stigma and encourage people to talk openly about these issues. This, it was felt, would foster earlier intervention and improve support for those in need of it. More attention was also thought to be needed in tackling stigma in rural areas, where it was said to be worse.

Resilience among school-aged children and young people

10.36 Specifically in relation to the next T2M2 strategy, it was suggested that interventions which aim to boost resilience are put in place for school-aged children, especially for those who have experienced Adverse Childhood Events (ACEs).

Community input into suicide and self-harm prevention

10.37 Increasing community input into suicide and self-harm prevention was cited as a priority for the T2M2 successor strategy, such as providing appropriate training for community organisations, businesses, and volunteers. Service users also highlighted the need to provide more and better information about suicide and self-harm within communities, both virtually, and through leaflets and billboards, for example.

Decision-making structures

10.38 Service users felt that T2M2 had ‘confusing’ decision-making structures that should be re-written in the successor strategy.

> ‘Especially in Talk to Me 2, the decision-making structures there aren’t working at all. The advice that’s being given on how decision making should be done is complex and difficult to understand’
>
> Service user - 11

Equal emphasis on self-harm and suicide prevention

10.39 Ensuring that self-harm prevention has equal emphasis to suicide prevention was another priority for the successor strategy. Some suggested that this could be achieved through separating out suicide and self-harm within the T2M2 successor strategy (regardless of whether it is combined with or separate from a successor strategy to T4MH, as discussed elsewhere). Several of those who expressed this opinion noted that suicide and self-harm were distinct concepts with different support requirements. Combining them as concepts could also be stigmatising or even offensive to some service users, a few felt.

> 'I think suicide and self-harm need to have separate strategies. People find it quite offensive… people that self-harm are less likely to look at support if they're worried people will think they're suicidal as well. It's like the stigma with mental health. It's taken a long time to get where we are now and we're still a way from removing stigma completely. Having a strategy for suicide and self-harm – there is a link, but it's not as prominent as the title seems to imply'
>
> Stakeholder – 32

Trauma-informed bereavement support

10.40 The T2M2 successor strategy should prioritise trauma-informed support for those who have lost loved ones to suicide, and for other individuals and communities who have been affected by suicide. This, it was said, should aim to reduce the currently high risk of further suicides occurring among those who have been bereaved.

Consistent, pan-Wales processes and pathways

10.41 The need for consistent, pan-Wales processes and pathways for suicide and self-harm services was also highlighted as a priority for the T2M2 successor strategy.

Digital communications and access to means

10.42 Updating content on digital communications and access to means, to reflect advances in understanding which have been achieved since T2M2 was introduced.

Should there be separate or joint T4MH and T2M2 successor strategies?

10.43 Several participants discussed the need for separate mental health, and suicide and self-harm strategies. Some felt that a unified strategy would prevent 'overkill', provided the strategy was clear and comprehensive, and gave enough emphasis to mental health and to suicide and self-harm prevention. A few felt that there should only be one unified strategy for mental health and suicide and self-harm prevention, possibly with additional considerations for agencies like the police and highways, because suicide and self-harm are so closely linked to mental health. Producing separate mental health and suicide and self-harm prevention strategies was therefore unnecessary and added complexity.

> … I think suicide is best dealt with by having very good mental health services [and] by supporting services which can deal directly with people that come forward about their suicide problems. My impression is that T2M2 has had an unnecessarily complex view of this, so I'm not sure that was right'
>
> Stakeholder – 26

10.44 However, most participants who commented on this matter emphasised that there should be separate suicide and self-harm prevention, and mental health strategies. This was said to be because many people who self-harm or die by suicide are unknown to mental health services, so amalgamating the suicide and self-harm prevention, and mental health strategies, would be inappropriate, some reflected.

10.45 Others noted that having separate strategies would ensure that sufficient emphasis is placed on mental health and on suicide and self-harm prevention and their respective services, and that the strands are led effectively.

> 'The two strategies need to work together, but I think having a separate suicide and self-harm strategy is a really, really important thing for Wales because they are very different and there are different services and support requirements. I think it would be a real risk if those strategies were combined in any way because I think suicide and self-harm gets swallowed into the wider mental health remit'
>
> Stakeholder – 33

How long should the successor strategies to T4MH and T2M2 be?

10.46 There was some feeling that the successor strategy to T4MH should be delivered in under ten years. This would 'sharpen' outcomes and clarify ownership, it was said. Also, the political landscape changes a lot in ten years; implementation staff tend to move on, potentially causing disruption; and impacts tend to take around five years to start emerging. Consequently, five years was suggested by several participants as a more appropriate timescale for the successor strategy.

10.47 A minority suggested that the successor strategy should cover a ten-year period. The main reason for this was that some actions took longer to embed and impact than others.

10.48 Several aspects were said to be more important than the T4MH successor strategy's duration. These were, firstly, allowing time and providing sustainable funding for the outcomes to be fully realised. The need for the strategy to be ambitious was also said to be more important than its duration, as was embedding regular reviews and feedback; and including measurable objectives and accountability.

10.49 Varied views were also shared regarding the duration of the T2M2 successor strategy. Most of those who reflected on the strategy's duration felt that it should be under ten years to reflect changing governmental priorities and to evaluate progress made towards achieving outcomes. Others felt that the successor strategy should be longer to allow enough time for implementation. As with the T4MH successor strategy, regular reviews were also said by some to be more important than duration in relation to the T2M2 successor strategy.

11. Conclusions

General thoughts on the strategies

11.1 Positively, there was widespread support for the T4MH and T2M2 strategies. Much good was thought to have come from both, particularly with respect to having a framework of activity and common goals for all individuals, services and organisations working within mental health and well-being services, and suicide and self-harm prevention.

11.2 Of particular benefit has been the way in which the strategies have facilitated cross-sector co-ordination and partnership working, as well as a cross-governmental response. Where this has been evident, it was said to have helped acknowledge the diversity of mental health needs across Wales and ensure a rounded, needs-led approach to activity. The need for further improvement was stressed, however, to ensure consistent, holistic and person-centred service provision delivered in partnership by all relevant parties.

Evidencing outcomes

11.3 The general feeling among research participants was that at least some progress has been made in meeting most of the strategies' outcomes, but that all remain a work in progress (particularly considering the largely negative impacts of the COVID-19 pandemic and ongoing issues with staff capacity, recruitment and retention).

11.4 As for whether any success can be directly attributed to T4MH and T2M2, there was a sense that both strategies have influenced all outcomes to greater or lesser degrees. However, it was considered nigh on impossible to isolate their impacts from other activities, policies and legislation (the Well-being of Future Generations Act (Wales) 2015 for example), as well as societal and cultural changes.

11.5 Moreover, one of the strongest themes to emerge from the research was that the absence of embedded processes for data capture, measurement and reporting in relation to the strategies' outcomes has made it difficult, if not impossible, to properly measure the strategies' effectiveness and to establish direct causation between them and any successes. It was, though, acknowledged that there is now

a Mental Health Core Data Set in place, which will be beneficial in evaluating any successor strategies.

11.6 It should also be noted here that while a plethora of data was said to exist, it is currently disparate due to a lack of consistency in data collection and recording across services and organisations, and a reluctance to share it.

11.7 In light of all this, the need for much more robust means of measuring impacts and outcomes in future was stressed to establish success and aid standardised decision-making across the mental health and well-being and self-harm and suicide prevention sectors. Furthermore, establishing effective data sharing agreements will, it was felt, be crucial in ensuring a more accurate picture of mental health and well-being and suicide and self-harm issues and services across Wales, and enabling the sharing of effective practice.

Improving governance and accountability

11.8 Contributing to the issues reported above around data collection and reporting has been an alleged lack of governance and accountability to underpin both strategies, but especially T2M2. Crucially also, this lack of governance was said to have resulted in good practice in mental health and well-being support and suicide and self-harm prevention not being identified, shared and rolled-out across Wales.

11.9 Encouragingly though, recent improvements have been evident. For example, appointing the national and regional co-ordinators, the NAG and the regional forums (all of which were said to have been driven by T2M2) was generally seen to have enhanced governance and accountability in strategy delivery.

Addressing specific data gaps

11.10 In terms of addressing T2M2's gaps, the recent introduction of a real-time surveillance suicide system was thought to be potentially transformative in improving the consistency of data collection in relation to suicide. However, addressing the significant gaps that exist around self-harm may prove trickier given much of it is hidden and so very difficult to monitor and quantify.

11.11 As for T4MH, a lack of data around the number and experiences of Welsh speakers accessing mental health and well-being services was alleged, which is important in

light of embedding the active offer. Indeed, the general sense around the active offer is that the question of preferred language is not being regularly asked of service users at the point of access, which hides potential demand for Welsh language services. As such, improving understanding of the importance of the active offer was considered an essential element of any future strategies, albeit there was recognition that the lack of Welsh speaking staff in some areas will remain a barrier to its consistent implementation.

11.12 Data relating to those with protected and other diverse characteristics was also said to be lacking, making it difficult to know whether current services are appropriate and accessible to them. Indeed, while the strategies were praised for having improved services' focus on and awareness of people from diverse groups, more effort was thought to be required to improve their experiences and outcomes, which will be difficult to achieve without the required supporting data and evidence. In light of this, future strategies should maintain a focus on tackling inequality in service provision, specifically addressing how services will meet the needs of diverse groups.

Successor strategies

11.13 There was strong support for developing successor T4MH and T2M2 strategies, not least as much of the long-term change they are seeking to achieve is generational. Many suggestions were made as to what form these successor strategies should take, as below.

- Most participants agreed that there should be separate suicide and self-harm prevention, and mental health and well-being strategies to ensure sufficient emphasis is placed on mental health and well-being and on suicide and self-harm prevention; and that the strands can be led effectively.
- With specific reference to T2M2, there was significant concern that self-harm is becoming somewhat 'lost' due to the prominence given to suicide prevention. Moreover, some felt that as suicide and self-harm are so fundamentally different, they should not be linked in one strategy. If they are both to remain within a further iteration of the 'Talk to Me' strategy, parity of emphasis must, it was said, be ensured.

- Though there was debate around duration and some support for another 10-year period to allow time for implementation, a majority agreed that the strategies should cover a shorter timeframe (five years was the most common suggestion) to reflect changing political landscapes and enable the timelier evaluation of progress towards achieving outcomes.
- Other aspects of any successor strategies were considered more important than their duration however, such as ensuring ambition; co-production with those with lived experience; developing proper governance structures and accountability; the provision of adequate and sustainable funding to ensure outcomes can be realised; addressing workforce training, skills, capacity and support gaps; embedding regular reviews; and including measurable priorities and objectives that can be revised in line with qualitative and quantitative outcome data.

11.14 Importantly, establishing a set of baseline indicators, and embedding the means of collecting data to evidence success or otherwise against these, was considered essential in being able to evidence the success or otherwise of future strategies. This, it was said, should include a means of gathering evidence from those with lived experience via a nationally agreed ‘experience indicator’. With specific regard to T4MH, there was some sense that the volume and complexity of the strategy’s outcomes and objectives can be daunting to try and evidence, and it was suggested that its successor have a clearer, more concise set of outcome indicators.

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Appendix 1: Data analysis specification and table of results

The following table sets out the specification of outcome measurement indicators which the data analysis followed and a summary of the results of the analysis against each of the measures specified.

OUTCOME MEASURED	DATA SOURCE/S	LINKS	SUMMARY RESULTS
Warwick-Edinburgh Mental Well-being Scale (WEMWBS)	National Survey for Wales, Welsh Government	Mental well-being (National Survey for Wales): April 2016 to March 2017 | GOV.WALES Mental health and well-being (gov.wales) National Survey for Wales: May 2020 to March 2021 | GOV.WALES Well-being of Wales | GOV.WALES	The WEMWBS total scores fell from a mean score of 51.4 in 2018-19 to 48.9 in 2020-21, but the most likely reason is the COVID-19 pandemic.
Life satisfaction and mental well-being scale	As above	As above	Scores for 'Life satisfaction', 'Feeling life is worthwhile' and 'Feeling happy yesterday' all fell slightly over time while 'Feeling anxious' increased.
% of people feeling lonely	As above	As above	The percentage of people reporting sometimes feeling lonely fell to 51% by 2019-20 then rose to 71% in 2020-21. In 2021-22 it returned to the historic level of 58%.
Mental Well-being rates for boys and girls aged 14 - Wales	Millennium Cohort Study	CLS | Millennium Cohort Study (ucl.ac.uk)	Not collected - difficulty accessing data. Note this is only a single data point and will not show change over time.

% of secondary school children feeling lonely during summer holiday, 2017.	School Health Research Network / Health Behaviour in School-aged Children 2017	School Health Research Network National data	Most (69%) of secondary school pupils never felt lonely or rarely felt lonely. 15% felt lonely some of the time and 16% felt lonely often or all the time.
Number of rough sleepers	National Rough Sleeper Count, Welsh Government	National rough sleeper count	176 rough sleepers were counted in the 2019-20 counts. The number has increased over time.
Number and % of children receiving care and support with mental health issues	Census. Changed from Children in Need Census (2010 to 2016) to Children Receiving Care and Support (CRCS) Census, 2017 to 2018	Children receiving care support census 2017 Children receiving care and support census 2018-experimental-statistics StatsWales Children receiving care and support StatsWales Children-in-need	The number of children receiving care and support with a mental health issue rose from 1,000 in 2017 to 1,500 in 2021. This is 17% of the total number of children receiving care and support.
Age-standardised suicide rates	Office for National Statistics	Suicides in England and Wales - Office for National Statistics (ons.gov.uk)	The number of suicides fell from 350 in 2015 to 285 in 2020. The rate per 100,000 population fell from 13.0 per 100,000 in 2015 to 10.3 per 100,000 in 2020.
Rate of hospital admissions with any mention of intentional	Patient Episode Database for Wales (PEDW)	Annual pedw data tables *WG to confirm what dataset to use	Not collected - WG to confirm what dataset to use.

self-harm for children and young people (aged 10-24 years) per 1,000 population			
Number of referrals for a Local Primary Mental Health Support Services (LPMHSS) assessment received during the month	Mental Health (Wales) Measure data collection, Welsh Government	Part 1: Local Primary Mental Health Support Services (gov.wales)	The number of referrals increased over the long-term since 2013. But the number of referrals fell from 8,199 in October 2018 to 5,169 in April 2022, before increasing to 6,029 in September 2022.
% of LPMHSS assessments undertaken within 28 days of referral	As above	As above	The percentage of assessments undertaken within 28 days increased over time from 49% in April 2013 to 83% in October 2018 then fell over time to 64% in April 2022. However, this percentage has steadily increased since, reaching 80.6% in September 2022.
% of therapeutic interventions started within 28 days following a LPMHSS assessment	As above	As above	The percentage of interventions within 28 days increased over time from 59% in April 2013 to 87% in July 2020 but since fell over time to 60% in April 2022. The number has since risen slightly to 64.9% in September 2022.

% of patients resident in the LHB, who are in receipt of secondary mental health services, who have a valid Care and Treatment Plan (CTP)	As above	Part 2: Care and Treatment Plans (gov.wales)	The percentage with a valid CTP fell consistently from 2014 to 2022 from 91% to 85%.
% of outcome assessment reports sent less than or equal to 10 days after the assessment had taken place. Source: Mental Health (Wales) Measure data collection, Welsh Government.	As above	Part 3: Assessment of Former Users of Secondary Mental Health Services (gov.wales)	The percentage of outcome reports sent within 10 days increased slightly over time, but has fallen since April 2021 to 92.5% (September 2022), which is below the longer-term trend.
Number of children and young people attending counselling	Local Authority School Counselling Services collection, Welsh Government.	Counselling for children and young people | GOV.WALES Counselling for children and young people (gov.wales)	Apart from 2019-20 (9,666), the number of children and young people attending counselling has remained between 10,500 and 11,500 between 2013-14 and 2020-21, with most years being around 11,500.
Main presenting	As above	As above	The number of issues over the number of years demands a

issues on referral for children and young people receiving counselling			detailed analysis. Key points: Anxiety has increased over time as the main presenting issue, overtaking Family, but both remain very common predominant issues. The next two most common main presenting issues are Anger and Stress. Both have decreased considerably between around 2018 and 2020-21.
Specialist Child and Adolescent Mental Health Services (sCAMHS) waiting time	Stats Wales, Welsh Government	Specialist Children and Adolescent Mental Health Service first appointment waiting times | GOV.WALES Admissions to mental health facilities (gov.wales)	Large fluctuations in the percentage meeting the 4-week target. Overall, the percentage has fallen over time from around 80% in January 2020, standing at 45% in June 2022. Given the fluctuations, this trend could be reversed over the following few months.
Number of admissions to mental health facilities	Admissions, changes in status and detentions under the Mental Health Act 1983 data collection (KP90), Welsh Government	Admission of patients to mental health facilities | GOV.WALES Admissions to mental health facilities (gov.wales) Detentions under Section 135 and 136 of the Mental Health Act | GOV.WALES Detentions under Section 135 and 136 of the Mental Health Act (gov.wales)	The number of admissions to mental health facilities has fallen consistently over time from a total of 9,997 in 2012-13 to 7,466 in 2019-20.
Average daily NHS beds available/	QueSt1 return, NHS Wales Informatics Service (NWIS).	NHS beds | GOV.WALES	Both have decreased year on year between 2013-14 and 2020-2: average daily available beds from 1,704 to 1,304; and average

occupied for mental illness			daily occupied beds from 1,495 to 1,055.
Average duration of stay in NHS beds and % occupancy for mental illness	As above	As above	Percentage occupancy remained between 86.8% and 89.0% between 2013-14 to 2019-20 but fell to 78.7% in 2020-21, presumably due to Covid. Duration of stay not collected - average duration of stay is only available up to 2011-12.
Number of patients in mental health hospitals and units with a mental illness	Psychiatric Census, NHS Wales Informatics Service	Patients in mental health hospitals and units | GOV.WALES Patients in mental health hospitals and units in Wales with a mental illness (gov.wales)	The number of patients in Wales decreased from 1,597 to 1,291 between 2013 and 2019. The number of patients in all LHBs also decreased.
Number and % of outpatient attendances for Adult Mental Illness and Child and Adolescent Psychiatry	Outpatient activity minimum dataset, NHS Wales Informatics Services (NWIS)	Outpatient attendances by treatment function (gov.wales)	The number of adult appointments increased over time to 73,315 in 2018-19 while non-attendance fell from 18.2% in 2016-17 to 14.3% in 2018-19. Child and Adolescent Psychiatry outpatient attendances increased from 33,902 in 2013-14 to 51,285 in 2018-19. The percentage of non-attendance fell from 13.8% in 2014-15 to 11.9% in 2018-19.
Number of referrals by treatment function including Adult Mental Illness and Child and	Outpatient Referral Dataset, NHS Wales Informatics Service (NWIS)	Referrals by treatment function and month (gov.wales)	Adult Mental Health and Child and Adolescent Psychiatry referrals have increased consistently since April 2012. In June 2022 there were 4,228 Adult and 1,691 Child and Adolescent referrals.

Adolescent Psychiatry			
Number of delayed transfers of care by delay reason	Delayed transfers of care database, NHS Wales	Delayed transfers of care | GOV.WALES Delayed transfers of care (gov.wales) NHS beds by specialty (gov.wales)	Total delays for all reasons have remained static since 2012 at around 400 to 500. Of the two most common reasons for delayed transfer, All Healthcare delays decreased between July 2015 to January 2020 while All Community Care increased from 96 to 169.

Appendix 2: Topic Guides

The topic guides used for the evaluation can be accessed via the links below.

Stakeholder interviews

Regional stakeholder events

Practitioner interviews

Adult service user interviews

Young service user interviews

Service user forum workshop