Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad i iechyd meddwl yng nghyd-destun plismona a dalfa'r heddlu
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Ymateb gan Gymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Mental health in Policing and Police Custody

Evidence from Association of Directors of Social Services

National Assembly's Health, Social Care and Sport Committee

Mental health in policing and police custody

Written Evidence by ADSS Cymru

The Association of Directors of Social Services (ADSS Cymru) is the professional and strategic leadership organisation for social services in Wales and is composed of statutory Directors of Social Services and the Heads of Service who support them in delivering social services responsibilities and accountabilities; a group of more than 80 social services leaders across the 22 local authorities in Wales.

As the national leadership organisation for social services in Wales, the role of ADSS Cymru is to represent the collective, authoritative voice of Directors of Social Services, Heads of Adult Services, Children's Services and Business Services, together with professionals who support vulnerable children and adults, their families and communities, on a range of national and regional issues of social care policy, practice and resourcing. It is the only national body that can articulate the view of those professionals who lead our social care services.

As a member-led organisation, it is uniquely placed as the professional and strategic leadership organisation for social services in Wales, to lead on national service development initiatives to ensure a consistent efficient and high standard of delivery for people who access care services across Wales.

ADSS Cymru is committed to using the wealth of its members' experience and expertise, working in partnership with other agencies, to influence important decisions around social care to the benefit of the people it supports and the people who work within care services.

This report outlines some of the difficulties that we are experiencing concerning Mental Health Act assessments, particularly in relation to conveyancing but also regarding bed availability. The implications of this are far reaching as we are increasingly seeing a decline in the number of Social Workers to operate as AMHPS. This is an issue across the UK at the moment.

In terms of the Welsh Ambulance Service Trust (WAST), the code of practice is clear however, the perception of AMHPs is that WAST do not consider a psychiatric emergency to have the same gravitas as a physical health issue even though the consequences can be very serious for the individual, the family and the AMHP.

Community assessments where the police are not involved are more problematic for AMHP's because they can be left alone for hours waiting for transport. There are also concerns regarding the suitability of some designated places of safety. The following examples from across Wales illustrate the extent of the problems we are facing:

- Carmarthenshire has an increase in delays following MHA assessments due to lack of admission beds resulting in individuals being sent out of county or to private hospitals in England where transport has had to be arranged. There have been a number of incidents where WAST have been unable to provide an ETA. This has resulted in using Health Board vehicles to convey, with detained patients being escorted by the AMHP and health staff (at least ten recent occasions). When WAST have conveyed, the average waiting time has been between 4 and 6 hours.
- Case example for Carmarthen: arrangements were made for ambulance to arrive at a certain time. Following several hours and three further calls to WAST (including a blue light request) the police conveyed the individual with the assistance from the fire brigade.
- Case example for Carmarthen: AMHP carried out two community assessments in Ammanford. Police assisted and ambulance was booked ahead. The ambulance did not arrive despite further calls also from the police; the police conveyed the individuals.
- Case example for Pembrokeshire : an individual was waiting for several hours and was eventually transported by a relative.
- Case example for Swansea: a recent case where the ambulance took 15hrs to arrive. The lady had been standing mute in her bathroom throughout declining food and water.
- Case example for Conwy: older person who required conveyance to hospital; ambulance was called at 16.40pm and arrived at 2am.
- Case example for Denbighshire: ambulance requested for community patient who was detained under S2 of the MHA. Ambulance requested at 3pm which didn't arrive by 10pm; so it was cancelled until the following day. The following day the person refused to get into the ambulance and the police refused to attend. After a further 3 hour delay the police attended following the intervention of senior management.

- Case example for Bangor: police requested to transport an individual due to the risk involved. North Wales Police refused to participate; an ambulance was called at 4pm but didn't arrive until 11pm.

The above are some of the examples faced by AMHPs on a daily basis. This is resulting in LAs struggling to maintain an AMHP service. This is a risk for LAs who will be unable to sustain their statutory responsibilities.

Furthermore, the above scenarios do not result in positive outcomes for the individuals concerned or their families. It is distressing for all those involved in what can be highly complex and high-risk situations.

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