Report to the Suicide Prevention Committee (Tabled to People Scrutiny Committee at Monmouthshire County Council ~ 20th April 2026

Concerns Regarding Service User experience of the Monmouthshire Community Mental Health Team (CMHT)

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1. Purpose of Report

This report has been prepared to formally provide feedback regarding the Monmouthshire Community Mental Health Team (CMHT). The issues outlined relate predominantly to systemic service-delivery problems, rather than the actions of individual staff members. Staff encounters have been consistently courteous and staff present as being committed to providing support; however, significant barriers within the system are preventing timely and appropriate intervention for vulnerable individuals.

2. Summary of Systemic Concerns

2.1 Communication Difficulties

Across recent months, the following issues have been consistently observed:

- Telephone calls to the duty desk frequently go unanswered.
- At times, calls divert to voicemail; on other occasions, the system reports being unavailable.
- Emails raising urgent concerns about client wellbeing often receive no response.

This inability to connect and communicate has contributed to:

- Increased distress and hopelessness for clients already experiencing significant risk.
- Barriers to accessing timely intervention.
- Heightened pressure on supported accommodation staff attempting to escalate concerns.

2.2 Lack of Continuity and Cover Arrangements

Further concerns include:

- Clients not being informed when their Community Psychiatric Nurse (CPN) is absent or has left their role.
- A lack of clarity regarding temporary or alternative points of contact.
- Failures to follow through on commitments to call clients or workers with updates or safety plans. These gaps have left clients without support during periods of acute need.

3. Case Examples Illustrating Systemic Failures

The following three anonymised case studies relate to incidents occurring since December 2025, each highlighting significant risks arising from lack of communication, delayed intervention and inconsistent follow-up.

3.1 Case A: "J"

Background:

- Moved into supported living in November 2025 following a serious suicide attempt, resulting in burn injuries (approx. 10% of body).
- Diagnoses include Chronic Fatigue Syndrome, with contributing stressors of homelessness, relationship breakdown and financial hardship.
- Discontinued mental health medication over Christmas due to adverse effects, resulting in daily suicidal ideation and significant distress.

Timeline of Concern:

- Assessment took place on **13 January 2026**, with agreed actions:
    - Additional support to be implemented
    - Medication review
    - Case to go to MDT
    - Follow-up call by Friday
- No follow-up call was made.
- Over the following three weeks:
    - CMHT staff repeatedly assured that calls would be made, but none occurred.
    - Emails raising urgent concerns received **no response**.
    - A medication review was offered for **16 March 2026**—two months after assessment—despite escalating suicide risk.

Impact:

- Continued daily suicidal ideation.
- Deteriorating mental health and increased feelings of abandonment.
- Prolonged period without clinical intervention despite high-risk presentation.

3.2 Case B: "K"

Background:

- Moved into supported living April 2025.
- Diagnoses: depression, anxiety, learning difficulties; possible schizophrenia not fully assessed/ diagnosed.
- Experiences persistent visual and auditory hallucinations.
- Three acute mental health crises since moving in, two requiring hospital admission.
- No medication review since engagement with services; only one in-person CMHT appointment.

Key Events (December 2025):

- Presented with severe confusion, involuntary movements, and non-responsiveness.
- Seen by GP and hospital; discharged with diagnosis of migraine.
- Over following days, continued to present as significantly unwell.

Escalation Attempts:

- Multiple attempts by staff and family to contact the Duty Desk; responses were delayed or absent.
- CPN advised that calls had been attempted, though the family reports not receiving any.
- Email warnings regarding lack of Mind in Gwent support over Christmas due to closure received no reply.
- Support Worker again unable to reach duty desk despite high and escalating concern.

Impact:

- KF required physical prompting for basic self-care.
- Significant deterioration in mental health functioning.
- Recovery was prolonged and unsupported.
- As of this report, **no follow-up** or medication review has occurred.

3.3 Case C: "E"

Background:

- Diagnoses: traumatic brain injury, PTSD, bipolar affective disorder.
- History of five hospitalisations for manic episodes.
- Undergoing a significant life change (moving home), identified historically as a potential trigger for mania.

Key Concerns:

- During the move, EO displayed early warning signs of mania including disorganised communication, extreme sleep disruption, and erratic behaviour.
- Misplaced medication during move and requested support from CMHT.
- Advised that CPN was absent and told to contact GP rather than CMHT assisting with a replacement prescription.

Communication Breakdown:

- EO went approximately one week without medication.
- Support worker emailed CMHT raising concerns about escalating risk—**no response was received**.

Impact:

- Deterioration in mental health and increased risk of relapse into manic episode.
- Lack of continuity despite known triggers and previous hospitalisations.

4. Scale of Impact

The Mind in Gwent Tenancy, Supported Living and Welfare Rights Project currently supports just under 200 individuals in Monmouthshire experiencing mental ill-health.

We only escalate concerns to CMHT when:

- A client is at significant risk of self-harm or suicide
- A mental health crisis appears imminent
- Risk of hospitalisation is high

The cases described represent only a portion of the issues identified since December 2025; additional examples could not be included without client consent.

5. Conclusion

The concerns raised in this report **do not** reflect a lack of professionalism or care from individual CMHT staff members. Instead, they indicate underlying systemic and operational failures that are:

- Increasing risk to vulnerable individuals
- Preventing timely clinical intervention
- Causing avoidable deterioration in clients' mental health
- Reducing trust in support services
- Creating pressure on community-based organisations attempting to manage risk without clinical backing

Given the severity of risk involved—including repeated suicidal ideation, unmanaged psychosis, and risk of manic relapse—there is significant potential for serious harm if these systemic issues remain unaddressed.

6. Recommendations for Consideration

1. **Review and strengthen duty desk capacity** to ensure predictable, timely responses.
2. **Improve communication protocols**, including confirmations of receipt for risk-related emails.
3. **Introduce clear cover arrangements** when staff are absent or cases are unallocated.
4. **Implement faster triage and follow-up for high-risk individuals**.
5. **Conduct a system-wide audit** of communication failures and missed follow-ups.
6. **Establish direct liaison pathways** between CMHT and supported accommodation services.