Crisis Line Evaluation: Cheshire & Wirral Partnership, Mersey Care and Mid-Mersey.

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Acknowledgements

This report is the work of members of staff from the School of Psychology, Liverpool John Moores University, in collaboration with Cheshire & Wirral Partnership (CWP) and Mersey Care NHS Trust. The aim was to examine caller characteristics, referral pathways and data collection procedures for the three separate Crisis Lines for the Trusts: CWP, Mersey Care Local Line and Mid-Mersey Crisis Line.

We would like to thank Dr Claire Foster and Dr Louise Thomas for their help and support with the project as well as the staff at CWP, Mersey Care and Mid-Mersey Crisis Line.

Executive Summary

Introduction

Launched in March 2020 as a key Crisis Response Service, Cheshire and Wirral Partnership, Mersey Care and Mid-Mersey NHS Foundation Trust introduced a Mental Health Crisis Line, which is a free NHS telephone service providing urgent mental health support to individuals in self-defined crisis. The service is accessible to all, whether the person in need is the caller themselves or someone phoning on behalf of a person in need, such as a partner, parent, friend or colleague. Proactively supporting suicide and self-harm prevention across the region is a key objective of the crisis line service.

Aims of the Study

The North West of England has one of the highest proportions of people experiencing common mental disorders. Merseyside and Cheshire suicide rates fall around the national average of 10.4 deaths per 100,000; although, this rate varies considerably across different areas of the country. While anecdotal evidence indicates an increase in demand for crisis team services since the COVID-19 pandemic, no formal analysis has been conducted into the CWP, Mersey Care and Mid-Mersey NHS Foundation Trust Crisis Lines. To address this, we aimed to compile quantitative and qualitative data pertaining to call volume, demographic characteristics of those using the lines and the resultant care pathways they followed. Working collaboratively with CWP, Mersey Care and Mid-Mersey NHS Foundation Trust's we evaluated: 1) the nature of crisis line calls (service user characteristics, clinical concerns, caller journey); 2) the impact of the crisis line on serious incidents and wider services, and 3) data collection procedures within each Trust.

Crisis Line Data

Crisis line data was available for CWP from August 2020 to August 2021; Mersey Care from May 2020 to January 2022; and Mid-Mersey from April 2020 September 2021. Data received were anonymised. Descriptive analyses were conducted to produce a clinical, demographic, and care pathway profile of the callers using the crisis line.

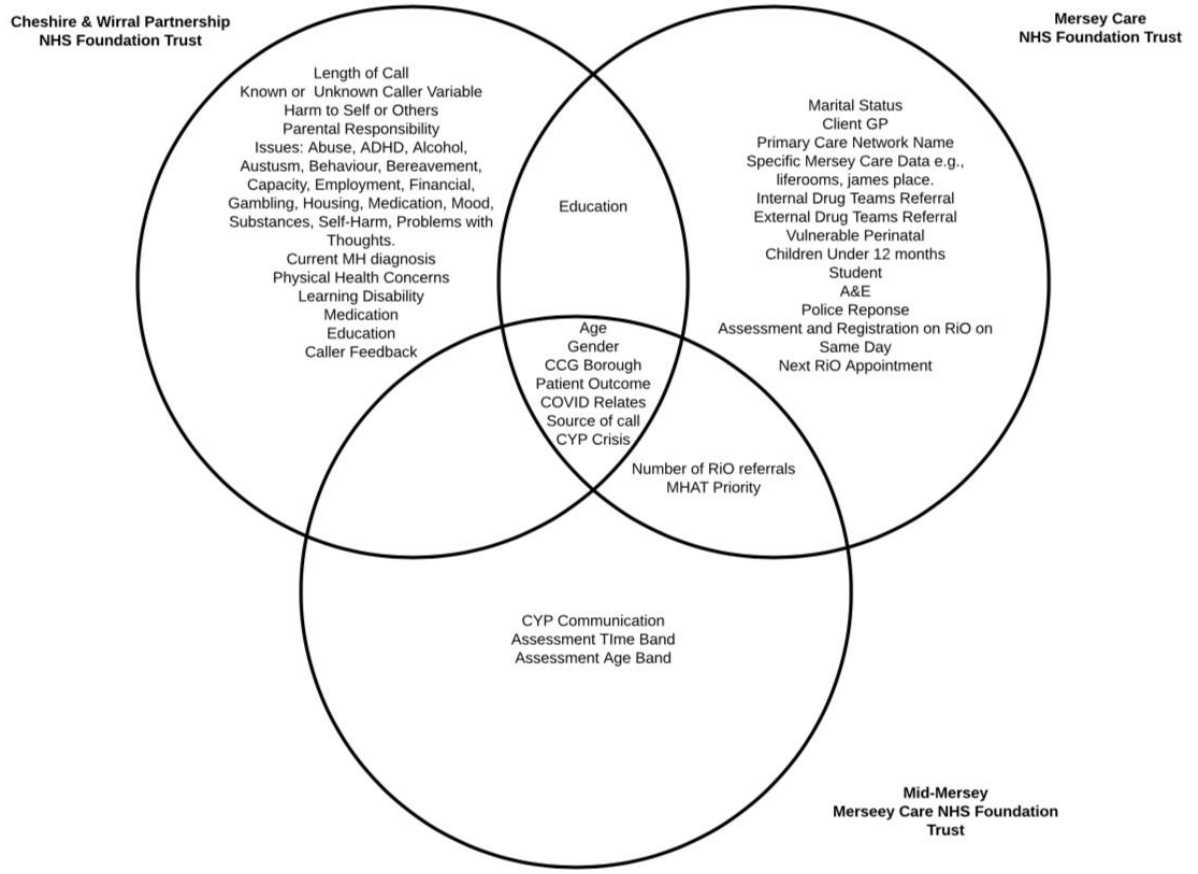
Call Volumes

Over the examined time for each trust, all three crisis lines received 60,432 calls in total. CWP received the most calls with 25,106 calls handled from August 2020 to August 2021. Out of these calls, 15.9% (3,987) were supporting children and young people (CYP). Mersey Care supported 19,107 calls from May 2020 to January 2022 and the Mid-Mersey line supported 16,219 calls from April 2020 to September 2021. Two-hundred and twenty-seven (1.1%) calls to the Mersey Care line were related to CYP and 800 (4.9%) CYP were supported by the Mid-Mersey Crisis Line.

Conclusions

Crisis lines are being utilised across all three trusts and this new service is an important addition to crisis pathways within the NHS. There were similarities and differences between data collection (see Figure 1). Data capture needs to be more consistent across the trusts for comparisons to be made about people using crisis lines across the region and more widely. There were clear patterns in caller profiles related to factors such as age, gender, and ethnicity that will be important to consider in future service implementation and marketing. Where caller feedback was available, there was evidence that the vast majority of callers found the service beneficial.

Figure 1: Similarities and Differences Between Data Collection



Recommendations

- A standardised screening tool for all crisis lines across services nationally to enable comparable and comprehensive data analysis.
- More explicit questions on suicide and self-harm as suicide and self-harm prevention is a key aspect of the service.
- Improve coding practices to reduce levels of missing data and have individual codes for each separate question asked.
- More data capture on the context of advice given for people contacting the crisis line who are signposted to other resources, and further longitudinal data capture to follow-up users of the crisis line.
- More specific codes for where individuals are signposted.
- Training for staff to ensure consistency when filling out biopsychosocial forms.
- Increased campaigns to raise awareness of the crisis line services within ethnic minority groups.
- Improve questions on gender identity to be more inclusive.

Future Directions

1) Continuation of the use of crisis lines as standard care across all mental health Trusts.
2) Standardisation of data collection across all sites, regionally and nationally.
3) Use of assistant psychologists or equivalent as first response call handlers and access to advanced practitioners for people who may be at risk of suicide/self-harm.

1. Background

Launched in March 2020 as a key part of the Trust's Crisis Response Service, Cheshire and Wirral Partnership NHS Foundation Trust, Mersey Care NHS Foundation Trust and Mid-Mersey NHS Foundation Trust (previously North West Boroughs) introduced a Mental Health Crisis Line, which is a free NHS telephone service providing urgent mental health support to individuals in self-defined crisis. The service is accessible to all, whether the person in need is the caller themselves, or someone ringing on behalf of a person in need, such as a partner, parent, friend or colleague. Proactively supporting suicide prevention across the region is a key motive of the crisis line service.

The Crisis Lines at each Trust are staffed by different mental health professionals. CWP Crisis Line management structure is comprised of Registered Mental Health Nurses (RMN's), Allied Health Professional (Occupational Therapist). The first response operatives are not qualified. Mersey Care's Crisis Line is operated by Band 5/6/7 qualified mental health nurses and Mid-Mersey's Line employs a Team Manager (Band 7) and Clinical Leads (Band 7) who support Assistant Psychologists (Band 4). Currently, Mersey Care are reviewing the urgent care model with the intention to mirror Mid-Mersey's staffing of the line. Call handlers listen to the caller's concerns, proactively explore risk, and seek to collaboratively develop a plan to support the person in need, triaging them for accessible and appropriate support in line with the person's disclosed needs. Call handlers utilise an online biopsychosocial screening form to document each call. Each call is unique in its own right and its length will be contextual to the individual call content and its associated outcomes. People contacting the Crisis Lines can be of all ages, may have a self-defined crisis, no prerequisite service engagement needed and may have a current open referral in the service.

In response to the COVID-19 pandemic, the national mandate to expedite the development and launch of these lines 12 months ahead of planned schedule, in order to support and address the anticipated impact upon mental health, ensure parity to the physical health response to the pandemic and essentially to divert service users requiring mental health support away from emergency departments (EDs). Currently, four lines are in operation:

- Alder Hey for children and young people (CYP) only,
- Cheshire and Wirral Partnership for all ages,
- Mersey Care for adults only,
- North West Boroughs (now Mid-Mersey, Mersey Care) for all ages.

Crisis phonelines/hotlines have played a vital role in suicide prevention strategies since the 1950s in the United States (e.g., Lithman et al. 1965) and the United Kingdom (Day, 1974). Studies examining crisis phonelines suggest positive effects for callers (Mishara et al., 2007; Hoffberg et al. 2020). Gould et al., (2007) reported significant decreases in suicidality of callers during the course of the telephone conversation and continued decreases in hopelessness and psychological pain in the following weeks. A recent systematic review conducted by Hoffberg and colleagues (2020) examined the effectiveness of crisis line services across 33 studies. Most studies demonstrated impact on measured proximal outcomes. However, the study concluded that high quality evidence demonstrating the effectiveness of crisis lines is lacking.

The COVID-19 pandemic appears to have increased the use of crisis phonelines, with the charity 'Mind' indicating that the number of calls to their service doubled (Mind, 2020). A report from the Samaritans (2020) also shows an increase in the number of contacts from people who were concerned about COVID-19 and other related issues such as, finances, social wellbeing and mental health during lockdown in March 2020. Research suggests crisis phonelines are well used by adults, CYP experiencing crisis and are effective in reducing hopelessness and suicidality in the immediate and short-term (Gould et al. 2007).

However, differences in usage between various crisis services is unknown. The COVID-19 pandemic saw an increase in substantial negative mental health consequences, including the increase in suicidal thoughts (O'Connor et al., 2021; Winkler et al., 2020). Nationwide survey data from the first few months of the pandemic showed increased mental distress, anxiety, substance use, and suicidal thoughts in adults (Twenge & Joiner, 2020). Despite this, rates of outpatient and hospital presentations for self-harm decreased in many regions during the early phase of the pandemic, suggesting a lower prevalence of serious suicidal behaviour; though this may reflect the overall reduced use of healthcare services (Carr et al., 2021; Jollant et al., 2021). However, these findings should be viewed cautiously as they only pertain to the earliest months of the pandemic; it is unclear whether the observed trends will persist (Sinyor et al., 2021). Evaluation of crisis data is imperative to better understand the impact of the COVID-19 pandemic on mental health and allow for a clearer depiction of the number of individuals experiencing crisis.

What is a Crisis?

A crisis is often defined as a "situation in which a person's behaviour puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively" (Brister, 2018; Hogan & Goldman, 2021). Being in crisis may mean no longer feeling able to cope in conjunction with a perceived loss of control over day-to-day life. The consequences are profound: distress for individual and their families, increased isolation, difficulties exploring alternative options, thoughts to end their life or hurting themselves in some way. The increase in prevalence of crises also impact wider services and presentations to hospital EDs (McCarthy et al. 2021). Accessible and effective care is imperative to individuals experiencing crisis, yet no organised system for crisis care exists in the United Kingdom (Hogan & Goldman, 2021; Saini et al 2020).

Suicidal crisis is a significant risk factor for future suicide attempts and death by suicide (Rossom et al. 2017). Risk of self-harm is often heightened during a crisis, and people deemed at 'high' risk need rapid care to minimise potential harm (Kienhorst, 1995). Although it is vital to ask directly about suicide, research has shown that many crisis line workers do not ask about suicidal thoughts and/or behaviour during the call (Mishaea et al., 2007). This reluctance to ask about suicide has been shown across mental health professionals in fear that asking about suicide will create the idea of suicide or increase distress (Roush et al. 2019); despite this not being the case (Deeley & Love, 2010; Cukrowicz et al., 2010).

Aims of Current Report:

The North West of England is among one of the highest regions of people experiencing common mental disorders (UK Parliament, 2021). Merseyside and Cheshire suicide rates fall around the national average of 10.4 deaths per 100,000; although this rate varies considerably across different areas of the country (ONS, 2019). No formal analysis has been conducted into the CWP, Mersey Care and Mid-Mersey NHS Foundation Trust Crisis Lines. While anecdotal evidence indicates an increase in demand for crisis team services since the COVID-19 pandemic, use of Crisis Lines has not been explored. To address this, we aimed to examine: 1) the nature of crisis line calls (i.e., service user characteristics, clinical concerns, caller journey); 2) the impact of the crisis line on serious incidents and wider services, and 3) data collection procedures within each Trust.

Working collaboratively with CWP, Mersey Care and Mid-Mersey NHS Foundation Trust's, this study will evaluate:

1. Crisis Line Calls for each Trust (Volume, Demographics, Reasons for Call, Caller Journey).
2. Call Handler Feedback – Mid-Mersey.
3. Case Studies – CWP.

2. Methodology

Participants

Individuals who have used the crisis lines across CWP, Mersey Care and Mid-Mersey NHS Trust were included in this evaluation. As Mid-Mersey (previously North West Boroughs prior to June 2021) has a separate line to Mersey Care, both lines were examined separately in this evaluation. Known, unknown and frequent callers were examined. Callers included children, young people and adults.

Procedure

Crisis Line data was sought from each Trust. Data was available for CWP Crisis Line from August 2020 to August 2021; Mersey Care from May 2020 to January 2022 and Mid-Mersey from April 2020 September 2021. Data received were anonymised and non-identifiable. Information was extracted on:

a) Call volume, call source and call time.
b) Demographic characteristics – age, gender, CCG borough, ethnicity.
c) Service user characteristics – known, unknown and frequent callers.
d) Clinical concerns – nature of calls, key themes, COVID related calls.
e) Caller journey – destination following contact, repeat presentation to crisis line or other crisis service, single presentations/resolution of concerns.
f) Serious incidents – incidents of self-harm following contact with crisis, death by suicide following contact (CWP only).
g) Impact on wider services – liaison mental health services, police, ambulance, third sector (CWP only).

The data set only captured entries made in clinical records; unrecorded clinical activity of missing data from crisis line documents were unavailable. This required the calls to have been answered and a biopsychosocial screening form to have been filled out by the call handler. Across the different crisis lines varied data was available (see results for further discussion).

Data Analysis Plan

Quantitative data analysis was conducted for each crisis line using Statistical Package for Social Sciences (SPSS) software V27. Descriptive analysis was conducted to produce a clinical and demographic profile of the callers using the crisis line.

Approval

Approval for the evaluation was sought from the participating Trusts and the NHS Health Research Authority and Research Ethics Committee: Integrated Research Application System (IRAS) and Confidentiality Advisory Group (CAG) (IRAS ID: 298407).

3. Results

This section of the report contains findings from each NHS Trust Crisis Line. The findings are separated into different sections for CWP, Mersey Care and Mid-Mersey Crisis Lines. Differences and similarities between the data will then be discussed.

Over the examined time for each trust, all three crisis lines received 60,432 calls in total. CWP received the most calls with 25,106 calls handled from August 2020 to August 2021. Out of these calls, 15.9% (3,987) were supporting CYP. Mersey Care supported 19,107 calls from May 2020 to January 2022 and the Mid-Mersey line supported 16,219 calls from April 2020 to September 2021. Two-hundred and twenty-seven (1.1%) calls to the Mersey Care line were related to CYP and 800 (4.9%) CYP were supported by Mid-Mersey Crisis Line.

3.1. Cheshire & Wirral Partnership

Data for the CWP Crisis Line was available from August 2020 to August 2021. There were 25,106 calls recorded between August 2020 to August 2021. No earlier data was available as the electronic patient record (EPR) solution for the CWP Crisis Line did not come online until August 2020. The CWP Crisis Line was shown to have a higher rate of calls than reported in this report. A large percentage of calls were found to be for routine reasons, for example asking about an upcoming mental health appointment. A manual count of calls where an EPR record was not generated was conducted separate to this investigation to understand why the telephony database had higher numbers than the EPR data. For the purpose of this report, EPR sourced data, not the telephony sourced data was analysed. The calls for routine reasons are not counted in this dataset.

a) Gender

The majority of calls handled by CWP Crisis Line were from women (57.0%), whilst very few callers reported being non-binary (0.1%).

Gender (N = 25,106)	Number of people (%)
Men	10,525 (41.9)
Women	14,534 (57.0)
Non-binary	33 (0.1)
Not reported	14 (0.1)

b) Age

The highest proportion of calls were from people aged 50 – 59 years (23.3%), followed by people aged 0 – 18 years (15.9%).

Age band (N = 25,106)	Number of people (%)
0 – 18 yrs	3,987 (15.9)
19 – 25 yrs	2,179 (8.7)
26 – 29 yrs	2,490 (9.9)
30 – 39 yrs	3,584 (14.3)
40 – 49 yrs	3,194 (12.7)
50 – 59 yrs	5,844 (23.3)
60 – 69 yrs	2,606 (10.4)
70 – 79 yrs	826 (3.3)
80 – 89 yrs	331 (1.3)
90 – 99 yrs	34 (0.1)
Not known	31 (0.1)

c) Age and gender

The highest proportion of calls were from people aged 50 – 59 years (23.3%), followed by people aged 0 – 18 years (15.9%). For most age groups, women were more frequent callers than men. However, this gender gap narrowed around middle-age and there were more men than women callers in the 60 – 69 years age band (1629; 62.5%).

Age band (N = 25,106)	No. of women (%)	No. of men (%)	No. of Non-binary (%)	No. not reported (%)	Total (%)
0 – 18 yrs	2462 (61.8)	1489 (37.3)	30 (0.8)	6 (0.2)	3,987 (15.9)
19 – 25 yrs	1137 (52.2)	1038 (47.6)	2 (0.1)	2 (0.1)	2,179 (8.7)
26 – 29 yrs	1931 (77.6)	558 (22.4)	0 (0.)	1 (0.0)	2,490 (9.9)
30 – 39 yrs	2229 (62.2)	1353 (37.8)	0 (0.0)	2 (0.1)	3,584 (14.3)
40 – 49 yrs	1905 (59.6)	1287 (40.3)	1 (0.0)	1 (0.0)	3,194 (12.7)
50 – 59 yrs	2975 (50.9)	2867 (49.1)	0 (0.0)	2 (0.0)	5,844 (23.3)
60 – 69 yrs	977 (37.5)	1629 (62.5)	0 (0.0)	0 (0.0)	2,606 (10.4)
70 – 79 yrs	609 (73.7)	217 (26.3)	0 (0.0)	0 (0.0)	826 (3.3)
80 – 89 yrs	268 (81.0)	63 (19.0)	0 (0.0)	0 (0.0)	331 (1.3)
90 – 99 yrs	23 (67.6)	11 (32.4)	0 (0.0)	0 (0.0)	34 (0.1)
Not known	18 (58.1)	13 (41.9)	0 (0.0)	0 (0.0)	31 (0.1)
Total	14,534 (57.0)	10,525 (41.9)	33 (0.1)	14 (0.1)	25,106 (100.0)

d) Ethnicity

The overwhelming majority of calls were from people who indicated they were from white British ethnic backgrounds (74%). Of the 25,106 calls made to the crisis line, only 392 (0.2%) were from people from ethnic minority backgrounds. There was a very high level of missing data for the ethnicity variable (20.0%)

Ethnicity (N = 25,106)	Number of people (%)
Asian/Asian British (Bangladeshi)	3(<0.1)
Asian/Asian British (Indian)	24 (0.1)
Asian/Asian British (other)	60 (0.2)
Asian/Asian British (Pakistani)	11 (<0.1)
Black or Black British (African)	7 (<0.1)
Black or Black British (Caribbean)	3 (<0.1)
Black or Black British (Other)	68 (.3)
Mixed (Other)	51 (0.2)
Mixed (White and Asian)	29 (0.1)
Mixed (White and Black African)	14 (0.1)
Mixed (White and Black Caribbean)	58 (0.2)
Other ethnic groups (Chinese)	44 (0.2)
Other ethnic groups (not specified)	20 (0.1)
White (British)	18,574 (74.0)
White (Irish)	43 (0.2)
White (other)	154 (0.6)
Not stated	923 (3.7)
Unknown	5,020 (20.0)

e) Employment and education

Very few callers (1.7%) were recently unemployed. However, there is no data on current employment or long-term unemployment, which may be highly relevant to mental health management. The majority of callers (92.3%) were not in current education.

Question	Yes	No
Are you recently unemployed?	426 (1.7)	24,680 (98.3)
Are you currently in education?	1,935 (7.7)	23,171 (92.3)

f) Reason for call

The most common issues identified during calls were problems with thoughts (33.6%, including thoughts about suicide or self-harm or harm to others) and problems with mood (33.6%). Risk to self (10.2%) and self-harm (7.9%) were also commonly noted, as were social (14.9%) and relationship (7.0%) issues.

Reason for call (N = 25,106)	Number of people (%)
Abuse from others	351 (1.4)
Abuse to others	251 (1.0)
ADHD	339 (1.4)
Alcohol	1,321 (5.3)
Autism	578 (2.3)
Behaviour	1,358 (5.4)
Bereavement	469 (1.9)
Capacity (mental health)	91 (0.4)
Covid-related	329 (1.3)
Children and young people (CYP)	1,577 (6.3)
Employment	142 (0.6)
Financial	224 (0.9)
Gambling	34 (0.1)
Housing	464 (1.8)
Learning Disability	172 (0.7)
MAPPA	7 (<0.1)
Medication	1,235 (4.9)
Mood	8,433 (33.6)
Other social factors	1,383 (5.5)
Substances	305 (1.2)
Overdose	435 (1.7)
Physical health	1,409 (5.6)
Relationships	1,758 (7.0)
Risk to self	2,561 (10.2)
Self-harm	1,983 (7.9)
Self-neglect	314 (1.3)
Social	2,368 (9.4)
Problems with thought	6,609 (26.3)
Unemployment	103 (0.4)
Wandering	105 (0.4)

g) Information about caller

A high proportion (77.7%) of callers have had previous contact with the trust and the majority of people contacted the line themselves (75.6%).

Known to service (N = 25,106)	
Known to service	19,507 (77.7)
Not known to service	5,599 (22.3)
Identity of caller (N = 25,106)	
Self-referral	18.972 (75.6)
Third party	5,964 (23.8)
Not known	170 (0.7)

h) Safety and Emergency response

1,100 (4.4%) callers indicated that they required an emergency response and/or they or someone nearby was hurt. The safety level of participants is difficult to determine from this variable as the first question includes three sub-questions where a “yes” response would indicate safety for some sub-questions, but lack of safety for other sub-questions.

Question (N = 25,106)	**Yes**	**No**	**Null**
Are you safe? Have you harmed yourself, has anyone come to harm?	12,733 (50.7)	6,619 (26.4)	5754 (22.9)
Do you require an emergency response?	808 (3.2)	18,433 (73.4)	5,865 (23.4)
Has someone hurt you or is hurting you right now?	292 (1.2)	18.921 (75.4)	5,893 (23.5)
Have you consumed something that may be harmful (excess substances, alcohol, or medication)	1,758 (7.0)	16.953 (67.5)	6,395 (25.5)

i) Risk level of callers

The majority (18,707; 74.5%) of callers received advice or information from the call handler, while 2,042 (8.1%) callers were classes as moderate or higher risk of harming themselves or others. 453 (1.8%) calls required an emergency response and there were high levels of missing data for risk level of callers (12.0%).

Risk (N = 25,106)	**Number of people (%)**
Emergency	453 (1.8)
Very high risk (imminent harm to self or others)	244 (1.0)
High risk of harm to self or others, especially in absence of capable supports	445 (1.8)
Moderate risk of harm and/or significant distress	900 (3.6)
Low risk of harm in short term or moderate risk with good supporting factors	972 (3.9)
Referral not requiring face-to-face response from mental health	358 (1.4)
Advice/consultation/information	18,707 (74.5)
No data	3,027 (12.0)

j) Type of assistance provided by call handler

The majority of callers (63.5%) were provided with advice and/or guidance and one in eleven callers were handed over to a practitioner. There were high levels of missing data for type of assistance provided (12.0%).

Assistance (N = 25,106)	Number of people (%)
Advice/guidance only	15,934 (63.5)
No data	3,016 (12.0)
Handed over to practitioner	2,196 (8.7)
Advised to contact GP	807 (3.2)
Known patient handed over to current team	555 (2.2)
999 called	503 (2.0)
Signposted to A&E	417 (1.7)
Advised to call 999	397 (1.6)
Signposted to third sector organisation	239 (1.0)
Advised to call 111	220 (0.9)
Referred to Home Treatment Teams (HTT)	219 (0.9)
Referred to Children and Young People's service (CYP)	147 (0.6)
Signposted to Children and Young People's service (CYP)	144 (0.6)
Referred to Single Point of Access	93 (0.4)
Referred to Adult Mental Health Team	86 (0.3)
Signposted to Single Point of Access	69 (0.3)
Referred to Improving Access to Psychological Therapies (IAPT) services as new referral	49 (0.2)
Referred to Older Adult Mental Health Team	15 (0.1)

k) Current health concerns and diagnoses

The Mental Health Triage screening tool used prior to the new implemented SystmOne (previously Care Notes) had a number of pre-requisite questions relating to learning disability, safeguarding, medication, known to mental health services. For clarity, the current data set is all prior to SystmOne which is our new EPR that was introduced in November 2021.This analysis showed that 1/3 of callers had a current mental health diagnosis and one in ten had physical health concerns. The majority of callers on medication were taking their medication as prescribed (91.3%).

Question (N = 25,106)	Yes (%)	No (%)
Do you have a current mental health diagnosis?	7,293 (29.0)	17,813 (71.0)
Do you have any physical health concerns?	2,760 (11.0)	22,346 (89.0)
Do you have a diagnosis of a learning disability?	576 (2.3)	24,530 (97.7)
Are you open to speaking to the Community Learning Disability Team?	336 (1.3)	24,770 (98.7)
Are you currently on prescribed medication?	7,684 (30.6)	17,422 (69.4)
Have you taken this medication?	6,928 (27.6)	18,178 (72.4)
Are you taking the medication as prescribed?	7,017 (27.9)	18,089 (72.1)

l) Caller feedback

A high proportion of people were unable to be asked about receiving text messages (68.7%), Family and Friends Test (FFT) feedback (59.7%) and whether or not they found the call beneficial (35.5%). Of the people who were able to be asked, 54% were happy to receive a text message, 44% were happy to provide FFT feedback, and 97% found the call beneficial. There were also reasonably high levels of missing data for FFT (28.7%) and call benefit (26.0%).

Question (N = 25,106)	**Yes (%)**	**No (%)**	**Unable to ask (%)**	**No data (%)**
Do we have permission to leave you a message/text?	4,268 (17.0)	3,598 (14.3)	17,240 (68.7)	0 (0%)
Are you happy to provide Family and Friends Test (FFT) feedback?	1,287 (5.1)	1624 (6.5)	14,988 (59.7)	7207 (28.7)
Have you found the call beneficial?	9,399 (37.4)	273 (1.1)	8,912 (35.5)	6522 (26.0)

3.2. Mersey Care

Data for the Mersey Care Crisis Line was accessed from May 2020 to January 2022. The Mersey Care Crisis Line has had two changes to the biopsychosocial screening form since the start-up of the line. Data on whether the caller is a student and more detailed information on Mersey Care specific services (i.e., Life Rooms) were available in the second version of the form. Both versions were analysed for this report. A total of 19,107 biopsychosocial screening forms were completed by call handlers for individuals calling the Mersey Care Crisis Line between May 2020 and January 2022.

a) Call Volume / Source of Call

A total of 17,990 calls were abandoned from April 2020 to January 2022. Due to the high numbers of abandoned calls, Mersey Care has further explored this to better understand the reasons behind calls being abandoned and the challenges the line may be facing. The reviews conducted internally within Mersey Care (with the most recent being in February 2022) found that 29% of abandoned calls were between 0-60 seconds. Of those individuals, it was identified that they were not experiencing a mental health crisis, however, would benefit from a listening/support service. Further analysis is being conducted by Mersey Care to better understand the proportion of services users, where they are open to currently to and what services they are being offered.

Call Volume per Month.				
Year	**Month**	**Calls Presented**	**Calls Handled**	**Calls Abandoned**
2020	April	1391	1371	20
	May	2811	2656	155
	June	2875	2632	243
	July	2555	2281	274
	August	2339	1675	664
	September	1910	1458	452
	October	2272	1645	627
	November	2009	1335	674
	December	2007	1439	568
2021	January	2242	1449	793
	February	2123	1284	839
	March	2284	1636	648
	April	2260	1726	534
	May	2735	1813	922
	June	2575	1729	846
	July	2861	1750	1,111
	August	2860	1597	1,263
	September	3129	1522	1,607
	October	3165	1564	1,601
	November	3247	1765	1,482
	December	2964	1671	1,293
2022	January	3218	1844	1,374

Analysis of the full dataset for the Mersey Care Crisis Line revealed a total of 19,107 calls. These 19,107 entries represented 19,107 calls supported by the Crisis Line where a biopsychosocial screening form was completed by a call handler following the call.
The majority of calls were made by the individual in crisis themselves (13,685; 71.6%). The second most common source of referral to the line was by a family member, friend, neighbour or carer, which accounted for 18.5% of calls to the line (N=3,544). Employers (25;

.01%), CMHT (39; 02%), LAES (38; 0.2%), NHS 111 (61; 0.3%) were among the least common sources of calls to the Mersey Care Crisis Line. Other sources of calls to the line were from GP (497; 2.6%), police (421; 2.2%), North West Ambulance Service (NWAS) (248; 1.3%).

Source of Call (N=19,107)	Number of People (%)
A&E	76 (0.4)
CMHT	39 (0.2)
Employer	25 (0.1)
Family / Friend / Neighbour / Carer	3,544 (18.5)
GP	497 (2.6)
IAPT	75 (0.4)
LAES	38 (0.2)
Local Authority	274 (1.4)
NHS 111	61 (0.3)
NWAS	248 (1.3)
Police	421 (2.2)
Self	13,685 (71.6)
Voluntary Sector	123 (0.6)

b) Known / Unknown Caller

Known callers were defined as individuals who had open RiO referrals in this dataset. Those who were assessed and registered on RiO on the same day were defined as unknown to the service. As shown below, 65% of callers were already known to the service (N=12,419). 9% of callers (N=1,714) were completely new to the Mersey Care Crisis Line and a new person had to be raised within the system. 35% of callers were classified as unknown to the service as they have had no contact with Mersey Care Crisis Line within 12 months. With this said, these individuals may still have open RiO referrals within the system (see Table on Number of Open RiO Referrals for further information).

Assessment and Registration on RiO the Same Day (N=19,107)	Number of People (%)
Unknown - completely new to service	1,714 (9%)
Unknown – no contact within 12 months	4,974 (35%)
Known	12,419 (65%)

The majority of callers had zero open RiO referrals (38.6%). Over 30% of individuals, however, had one open referral. As the number of open RiO referrals increased, the number of people decreased; with the lowest percentage of people (244; 1.2%) having 6+ open RiO referrals.

Number of Open RiO Referrals (N=19,107)	Number of People (%)
0	7,381 (38.6)
1	6,078 (31.8)
2	2,911 (15.2)
3	1,204 (6.3)
4	959 (5.0)
5	330 (1.7)
6+	244 (0.2)

c) CCG Borough

Analysis of the Mersey Care Crisis Line dataset over the time period revealed the majority of the calls were received from Liverpool CCG (11,492; 60.1%). 18% of calls were received from South Sefton CCG (N=3,443) and 11.9 % from Southport and Formby CCG (N=2,277). The least number of calls were received from the borough of Knowsley (1,146; 6%).

A total of 4% of calls were received from outside of Mersey Care' destined CCG borough. For example, calls were also handled from Betsi Cadwaladr University (62; 0.3%), NHS North Derbyshire CCG (65; 0.3%), NHS St Helens CCG (42; 0.2%), NHS West Lancashire CCG (45; 0.2%) and NHS Wirral CCG (86; 0.5%).

CCG Borough (N=19,107)	Number of People (%)
Knowsley	1,146 (6.0)
Liverpool	11,492 (60.1)
Southport and Formby	2,277 (11.9)
South Sefton	3,443 (18.0)

d) Age

The majority of calls handled by Mersey Care Crisis Line were received from individuals aged between 25 and 64 years. The majority of calls were by people aged 40 to 64 years (8,099; 42.4%), followed by those aged between 25 and 39 years old (6,372; 33.3%). The least number of calls were received by individuals ages 0-17 years (227; 1.1%).

Age Band (N=19,107)	Number of People (%)
0-17	227 (1.1)
18-24	3,028 (15.8)
25-39	6,372 (33.3)
40-64	8,099 (42.4)
65+	1,411 (7.4)

Age	Gender – Number of People (%)	
	Male	Female
0-17	111 (0.6)	116 (0.6)
18-24	1,114 (5.8)	1,910 (10.0)
25-39	2,783 (14.6)	3,559 (18.6)
40-64	4,026 (21.1)	4,073 (21.3)
65+	443 (2.3)	968 (5.2)

e) Gender

Females make up the majority of the calls received by Mersey Care Crisis Line (10,626; 55.6%). 44.4% of calls were received from males (8,477). Gender was not specified or unknown in less than 1% of calls (3; 1 respectively).

Gender (N=19,107)	Number of People (%)
Female	10,626 (55.6)
Male	8,477 (44.4)
Not Specified	3 (<0.1)
Unknown	1 (<0.1)

f) Marital Status

Analysis of the full dataset for the Mersey Care Crisis Line revealed that the majority of callers were single (8,888; 46.5%). For a large proportion of calls (7,415; 38.8%) information regarding marital status of callers was not known. A total of 1,265 (6.6%) of people in crisis were married or in a civil partnership, with 838 (4.4%) being divorced or had a civil partnership dissolved. 0.8% of callers were widowed (152).

Marital Status (N=19,107)	**Number of People (%)**
Divorced / Civil Partnership Dissolved	838 (4.4)
Married / Civil Partnership	1,265 (6.6)
Not Applicable	6 (<0.1)
Not Disclosed	285 (1.5)
Not Known	7,415 (38.8)
Separated	258 (1.4)
Single	8,888 (46.5)
Widowed / Surviving Civil Partner	152 (0.8)

g) Ethnicity

The majority of callers using the Mersey Care Crisis line were white (16,624; 87%). Other ethnicities represented a smaller percentage of callers, with 342 (1.8%) being Mixed, 288 (1.5%) Black and 161 (0.8%) Asian. Missing data represented 7.9% of callers (N=1,488), with 3.3% of caller's ethnicity not known and 3.1% not know due to the call handler not being able to request this information.

A caveat to the ethnicity data reported for Mersey Care's Crisis Line is the lack of information on whether English is the callers first language and whether translation services are available for individuals with English as a second language.

Ethnicity (N=19,107)	**Number of People (%)**
Asian or Asian British	161 (0.8)
Black or Black British	288 (1.5)
Mixed	342 (1.8)
Not Known	624 (3.3)
Not Known (Unable to Request)	591 (3.1)
Not Stated (Client Refused)	128 (0.7)
Not Stated (Not Requested)	145 (0.8)
Other Ethnic Groups	204 (1.1)
White	16.624 (87.0)

h) Caller Journey / Outcome

Analysis of the Mersey Care Crisis Line dataset from May 2020 to January 2022 revealed the most common outcomes for callers was signposted online (N=18,302), signposted to local IAPT (N=17,596) and signposted to GP (N=15,522). The least likely outcome reported was mental health follow-up (N=5,625).

Outcome (N=19,107)	Number of People (%)		
	Yes (%)	No (%)	Missing (%)
Signpost to Third Sector	7,686 (40.2)	375 (2.0)	11,046 (57.8)
Signpost Online	18,302 (95.8)	779 (4.1)	26 (0.1)
Mental Health Follow Up	5,625 (29.4)	2,437 (12.8)	11,045 (57.8)
Signpost to Local IAPT	17,596 (92.1)	1,489 (7.8)	22 (0.1)
Signpost GP	15,522 (81.2)	3.563 (18.6)	22 (0.1)
Response 999	7,599 (39.8)	462 (2.4)	11,046 (57.8)

1.4% of individuals calling the Mersey Care Crisis Line were assessed as priority 4 which means a mental health assessment is needed within 72 hours. 0.5% of callers were indicated as priority 1 in which an assessment was required within 4 hours.

Mental Health Assessment Team Priority (MHAT) (N=19,107)	Number of People (%)
1 – within 4 hours	95 (0.5)
2 – within 24 hours	100 (0.5)
3 – within 48 hours	94 (0.5)
4 – within 72 hours	267 (1.4)
Missing	18,551 (97.1)

When the second version of the Mersey Care biopsychosocial screening form was introduced to the Crisis Line in September 2020 more options for caller outcomes were included. One of which related to internal and external drug teams. 1.3% of callers were referred to drug teams internal to Mersey Care (N=147). The majority of callers (10,877; 98.7%) were not referred to internal drug teams.

Internal Drug Teams (N=11,024)	Number of People (%)
Yes	147 (1.3)
No	10,877 (98.7)

A small percentage of callers (92; 0.8%) were signposted to drug services external to Mersey Care. The majority of callers were not signposted to these services (10,932; 99.2%).

External Drug Teams (N=11,024)	Number of People (%)
Yes	92 (0.8)
No	10,932 (99.2)

Life Rooms is a free NHS service specific to Mersey Care which provides a safe space, access to opportunities and community resources. The majority of callers utilising the Mersey Care Crisis Line were not referred to Life Rooms (10,808; 98%). 2% of callers were referred into the service (N=216).

Life Rooms (N=11,024)	Number of People (%)
Yes	216 (2.0)
No	10,808 (98)

Referral to SPA assessment relates to the call handler indicating the individual in crisis is in need of a further nonurgent assessment. This can take place from 72 hours to 6 weeks following the call to Mersey Care Crisis Line. 96.4% of callers did not need further assessment following their call to the Crisis Line (N=10,632). 3.5% of callers were indicated as needing a further nonurgent assessment (N=391).

Referral to SPA Assessment (N=11,024)	Number of People (%)
Yes	391 (3.5)
No	10,632 (96.4)

i) Additional Data

Analysis of the Mersey Care Crisis Line dataset revealed that the majority of calls handled were not related to COVID (18,365; 96.2%). Only 3.8% of calls were identified by call handlers as being related to COVID (N=721).

COVID Related (N=19,107)	Number of People (%)
Yes	721 (3.8)
No	18,365 (96.2)

Additional variables added into the second version of the biopsychosocial screening form also included information on whether the individual in crisis is experiencing perinatal vulnerabilities. 64.6% of callers were not experiencing this (N=7,449), however, 122 individuals calling the line expressed these concerns (1.1.%). Similarly, 64.4% of callers to the Mersey Care Crisis Line did not have a child under 12 months of age (N=7,428). 59.3% of callers were not currently a student (N=6,844). See tables below:

Vulnerable Perinatal (N=11,536)	Number of People (%)
Yes	122 (1.1)
No	7,449 (64.6)

Children Under 12 Months (N=11,536)	Number of People (%)
Yes	128 (1.1)
No	7,428 (64.4)

Student (N=11,536)	Number of People (%)
Yes	296 (2.6)
No	6,844 (59.3)

3.3. Mid-Mersey

The findings in this section of the report pertain to the Mid-Mersey Crisis Line dataset from April 2020 to September 2021. This dataset is a centralised call log that automatically gains a new entry each time a Crisis Line call handler completed a biopsychosocial screening form on the RiO system. This required a call to have been answered, and for a call handler to support the mental health crisis.

The centralised call log pulled data from two sources: (1) the persons RiO profile., i.e., age, gender, CCG borough, and (2) the biopsychosocial screening form created and completed by the call handler, i.e., the source of the call, actioned outcomes. Whilst this centralised call log captures relevant statistics including date, time, source of the call, and actioned outcomes, it did not capture nor contain details relating to the free text answers regarding biopsychosocial factors, reasons for calling, nor the cultural background or ethnicity of the person calling.

a) Call Volume

The full dataset from Mid-Mersey contained 16,220 entries between April 2020 and September 2021. The Crisis Line saw a month on month increase in calls handled from April 2020 to August 2020. A total of 15,418 calls from adults were handled by the Mid-Mersey Crisis Line over the time period examined and 800 calls were received by CYP. The month with the highest number of calls in 2020 was October with 871 adult and 71 CYP callers. 2021 saw a higher number of calls per month compared to 2020. May 2021 received 1,417 adult and 117 CYP callers. Over the time period examined, there were more adult callers on a monthly basis. March 2021 had the highest number of CYP callers (108) from April 2020 to September 2021.

A total of 2,536 calls were abandoned from April 2020 to September 2021: 759 in 2020, 1,777 in 2021. Abandoned calls were defined as occurring when a caller disconnected the call, *after* selecting a call option *but* before speaking to a call handler. Reasons for calls being abandoned may include a decision to end the call and dial 999 where an immediate threat to safety, the caller dialling the wrong number or choosing not to engage with the Crisis Line at that moment. It is also possible call wait times may have influenced attrition rates on occasion.

	Call Volume per Month.				
Year	**Month**	**Adult/CYP**	**Calls Presented**	**Calls Handled**	**Calls Abandoned**
2020	April	Adult	337	313	22
		CYP	29	27	2
	May	Adult	667	642	25
		CYP	54	47	7
	June	Adult	771	704	67
		CYP	72	62	10
	July	Adult	870	808	62
		CYP	73	67	6
	August	Adult	1,001	880	118
		CYP	75	66	9
	September	Adult	888	789	97
		CYP	62	55	7
	October	Adult	1,000	874	124
		CYP	82	71	11
	November	Adult	967	858	101
		CYP	90	73	17

	December	Adult	923	851	72
		CYP	67	59	8
2021	January	Adult	1,078	982	96
		CYP	45	37	8
	February	Adult	1,039	963	76
		CYP	66	60	6
	March	Adult	1,135	1,037	98
		CYP	114	108	6
	April	Adult	1,255	1,135	120
		CYP	89	76	13
	May	Adult	1,653	1,417	236
		CYP	141	117	24
	June	Adult	1,662	1,399	263
		CYP	121	99	22
	July	Adult	1,416	1,253	208
		CYP	85	74	19
	August	Adult	1,373	1,139	277
		CYP	127	68	17
	September	Adult	1,416	1,087	286
		CYP	178	98	29

Analysis of the full dataset revealed that the majority of the calls supported by Crisis Line from April 2020 to September 2021 were placed by the person in crisis themselves (11,415; 70.4%). The second most common source of calls came from a family member, friend, neighbour or carer (3,802; 23.4%). The least number of calls were sourced from education services (24; 0.1%).

Source of Call (N=16,219)	**Number of People (%)**
A&E	75 (0.5)
Education Service	24 (0.1)
EM	27 (0.2)
Family / Friend / Neighbour / Carer	3,802 (23.4)
GP	222 (1.4)
IAPT	24 (0.1)
Local Authority	197 (1.2)
NHS 111	70 (0.4)
NULL	3 (<.1)
NWAS	113 (0.7)
Police	131 (0.8)
Self	11,415 (70.4)
Voluntary Sector	116 (0.7)

b) Known / Unknown Caller

From April 2020 to September 2021, 40% of callers had an open referral to another already mental health team. This data, however, does not necessarily mean the caller is classed as known to the Crisis Line. The variable indicates the caller may have a history with another mental health team but may not be currently open and known to the service.

Open to Another Mental Health Team (N=16,219)	Number of People (%)
Yes	6,422 (39.6)
No	9,797 (60.4)

c) CCG Borough

The CCG borough with the highest number of calls from April 2020 to September 2021 was St Helens (3,429; 21.1%). The least number of calls were received from the borough of Knowsley (2,350; 14.5%).

Analysis of the dataset, however, revealed 24% of calls were located from CCG boroughs external to the Mid-Mersey area. Calls were also received from NHS Cheshire CCG (N=54), NHS East Lancashire CCG (N=25), NHS Salford CCG (N=42), NHS South Sefton CCG (N=30), NHS Trafford CCG (N=22) and NHS West Lancashire CCG (N=24).

CCG Borough (N=16,219)	Number of People (%)
Halton	3,203 (19.7)
Knowsley	2,350 (14.5)
St Helens	3,429 (21.1)
Warrington	3,365 (20.7)

d) Age

Between April 2020 and September 2021 individuals aged between 25 and 39 years were supported by the Mid-Mersey Crisis Line the most (5,713; 35.2%), closely followed by those aged between 40-64 years who made up 34.8% of those calling the Crisis Line (N=5,641). These figures sit alongside The National Confidential Inquiry into Suicide and Mental Health (NCISH) findings that UK rates of suicide were highest in those aged between 25 and 64 years (NCISH, 2021). The smallest proportion of calls supported by the Mid-Mersey Crisis Line related to individuals aged 0-17 years (800; 4.9%); the low number of calls from this age group may be explained by the alternative Crisis Lines available in the area specifically for CYP (Alder Hey).

Age Band (N=16,219)	Number of People (%)
0-17	800 (4.9)
18-24	2,841 (17.5)
25-39	5,713 (35.2)
40-64	5,641 (34.8)
65+	1,223 (7.5)

Age	Gender – Number of People (%)	
	Male	**Female**
0-17	264 (1.6)	536 (3.3)
18-24	1,183 (7.3)	1,657 (10.2)
25-39	2,669 (16.5)	3,041 (18.7)
40-64	2,694 (16.6)	2,945 (18.2)
65+	408 (2.5)	815 (5.0)

e) Gender

Analysis of the full Mid-Mersey dataset from April 2020 to September 2021 revealed that more females (8,994; 55.5%) were supported by the Crisis Line over the time period. 7,218 (44.5%) males and 7 individuals with gender not specified (<0.1%) also called the line over the examined time period.

The Mid-Mersey full dataset findings are reported with the caveat that the current system operationally limits call handlers to a binary approach of recording someone's gender as male or female. The current system is not able to record someone's sexual orientation leading to a lack of richness in the data for people who may not identify with their assigned gender at birth, and/or any awareness of how those accessing the service self-identified their sexual orientation. Research indicates a higher prevalence of stigma, discrimination, mental health needs and suicidal distress among the wider LGBTQ+ community (Kaniuka et al. 2019; Almeida et al., 2020).

Gender (N=16,219)	Number of People (%)
Female	8,994 (55.5)
Male	7,218 (44.5)
Not Specified	7 (<0.1)

f) Time of call

Analysis revealed that the majority of calls supported by Mid-Mersey Crisis Line from April 2020 to September 2021 were received between 12pm and 6pm (6,795; 41.9%). 24.4% of calls were also supported between the hours of 6pm and midnight (N=3,965). Calls between midnight and 8am were least likely to be received by Mid-Mersey Crisis Line (1,997; 12.3%).

Time Band (N=16,219)	Number of People (%)
Midnight to 8am	1,997 (12.3)
8am to 12pm	3,462 (21.3)
12pm to 6pm	6,795 (41.9)
6pm to Midnight	3,965 (24.4)

g) Caller Journey / Outcomes

This section of the report pertains to actioned outcome. A call handler can record more than one outcome per call; this reflects the reality that a call can encompass multiple outcomes. These fields are non-mandatory and can also be left blank as appropriate.

Directing people in need to their current mental health team for follow up was the most frequently actioned outcome by call handlers representing 26.3% of calls (N=4,268). 20.9% of calls were signposted to their GP and 14.1% were signposted to third sector services. CYP crisis referral was the least actioned outcome by call handlers, representing 1.2% of calls (N=195).

Caller Outcome (N=16,219)	Number of People (%)
Signpost to Third Sector	2,285 (14.1)
Signpost Online	1,330 (8.2)
Mental Health Follow Up	4,268 (26.3)
Signpost to Local IAPT	2,207 (13.6)
Signpost GP	3,395 (20.9)
Response 999	812 (5.0)
Referral to Local MHAT	1,986 (12.2)
CYP Crisis Referral	195 (1.2)
CYP Community Referral	1,080 (6.7)

5.2% of callers were identified as MHAT priority 3, in which an assessment is needed within 48 hours (N=847). 245 individuals (2.1%) were identified as priority 4 (assessment within 72 hours). Missing (NULL) data represented 87.8% of callers; however, this may refer to individuals being signposted out of the system rather than being referred for further assessment. A MHAT Priority will only be assigned if a referral to a mental health assessment team has been made.

MHAT Priority (N=16,219)	Number of People (%)
1 – within 4 hours	415 (2.6)
2 – within 24 hours	379 (2.3)
3 – within 48 hours	847 (5.2)
4 – within 72 hours	345 (2.1)
NULL	14,233 (87.8)

h) Additional Data

Key findings regarding calls flagged by call handlers as reporting biopsychosocial difficulties that had arisen or been aggravated as a result of the COVID-19 pandemic. These figures are reported with the caveat that flagging a call as reporting difficulties due to the COVID-19 pandemic was reliant upon call handlers selecting a non-mandatory field within the screening form. Analysis revealed that 6.7% (1,080) calls supported by the Mid-Mersey Crisis Line between April 2020 and September 2021 were flagged as reporting difficulties due to COVID. Relevant examples may include loss of reduced employment, increased social isolation, increased financial difficulties and delays in accessing relevant NHS/third sector support systems.

The majority of calls supported by Mid-Mersey Crisis Line (15,139; 93.3%) reported no biopsychosocial difficulties related to the COVID-19 pandemic. However, this statistic may be reflective of call handlers refraining from completing this field in the screening form.

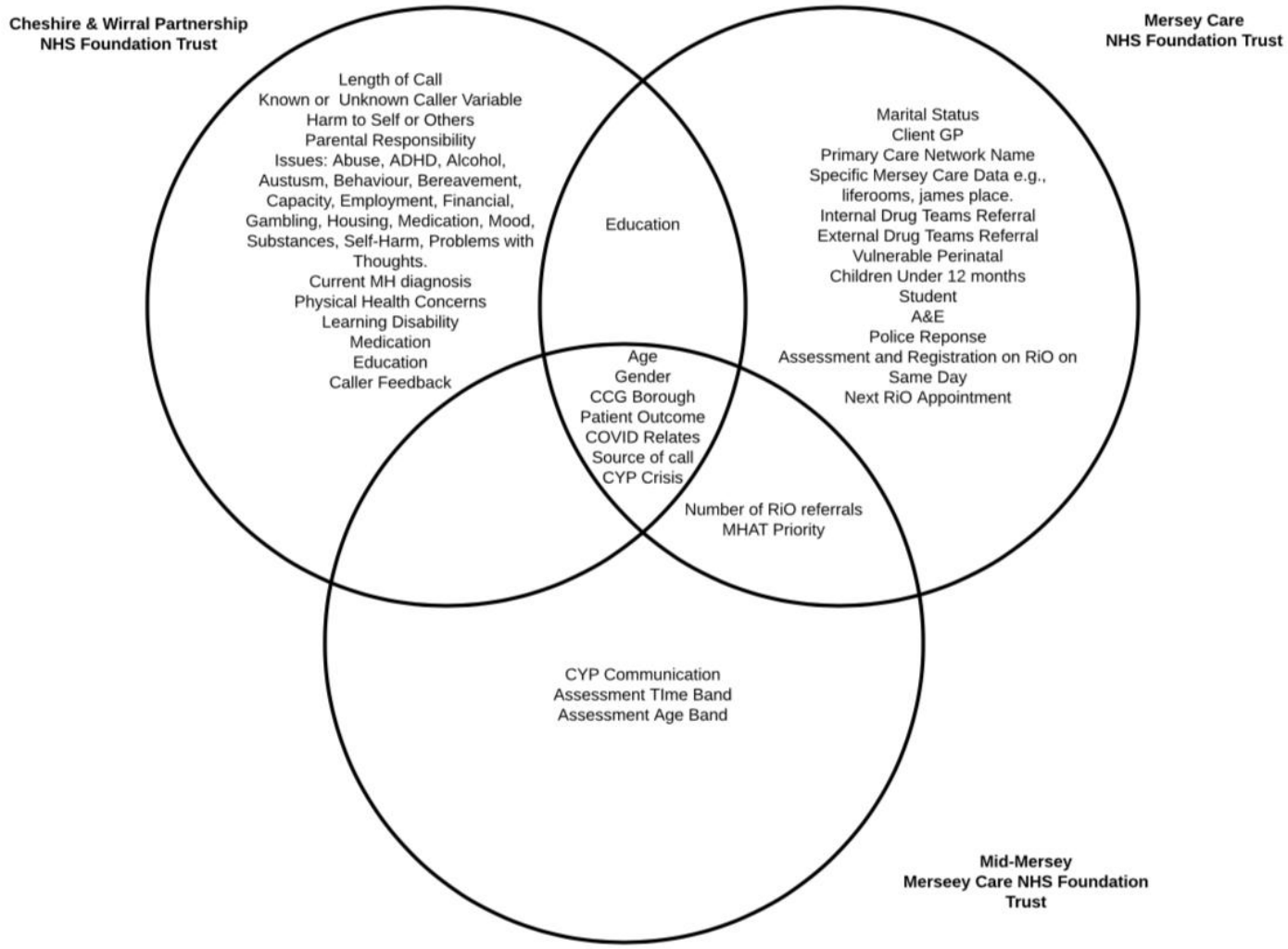
COVID Related (N=16,219)	Number of People (%)
Yes	1,080 (6.7)
No	15,139 (93.3)

Forty per cent of callers to the Mid-Mersey Crisis Line were signposted to the likes of GP, online services, IAPT or third sector. The further assessment column is used for anyone who has needed to come into contact with secondary services to receive a full assessment. 37.8% of callers were indicated as needing a further assessment following their call to the Mid-Mersey Crisis Line. There is the possibility that on some occasion's callers will have both of these outcomes ticked. For example, "we feel you need a full assessment of your mental health; however, you may also find these online resources beneficial while you wait".

Signposted (N=16,219)	**Number of People (%)**
Yes	6,422 (39.6)
No	9,797 (60.4)

Further Assessment (N=16,219)	**Number of People (%)**
Yes	6,134 (37.8)
No	10,085 (62.2)

4. Similarities and Differences Between Data Collection



5. Alder Hey Crisis Line

Alder Hey CAMHS Crisis Line offers 24-hour support to specifically to children and young people who are in mental health crisis. Between April 2020 and March 2021, Alder Hey Crisis Line received a total of 6,959 calls. The 0-16 age group across all localities had the highest number of calls in comparison to the 17+ age group. Liverpool area has the highest number of calls from the 0-16 age group with 3171 calls and 325 calls for 17+. For further details please see Ashworth et al. (2022).

Across all three Crisis Lines examined in the current report 5,014 calls were supporting CYP. The table below highlights the calls supported by each Crisis Line for CYP in crisis. CWP splits age bands from 0-18, 19-25 years, whereas Mersey Care and Mid-Mersey lines age bands are separated from 0-17, 18-25 years. Cheshire & Wirral Partnership NHS Foundation Trust supported the highest number of CYP aged 0-25 years (6,166; 24.6%). Mersey Care Crisis Line supported the least number of CYP, with a total of 3,255 (16.9%) of calls from individuals aged 0-25 years.

Crisis Line	**Call Volume**	**Total:** 0-25 years
CWP	**0-18 years:** 3,987 (15.9%)	6,166 (24.6%)
	19-25 years: 2,179 (8.7%)	
Mersey Care	**0-17 years:** 227 (1.1.%)	3,255 (16.9%)
	18-25 years: 3,028 (15.8%)	
Mid-Mersey	**0-17 years:** 800 (4.9%)	3,641 (22.4%)
	18-25 years: 2,841 (17.5%)	

6. Call Handler Feedback

"I feel this position has enabled me to continue developing my skills in risk assessment and build my confidence in approaching 'crisis' situations. Initially when I first started, I did feel the calls were slightly daunting, but the team here is so supportive which eases the anxiety around some of the calls we receive. Some of the calls and patients I have encountered during my short time in this role have brought on some emotional distress but having the space to reflect on this with clinical leads and peers has been brilliant at these times. I have been involved in a range of work within this role, from providing emotional support and advice to crisis response." (Assistant Psychologist, Mid-Mersey Crisis Line).

"My experience of being a call handler with the crisis line is generally positive. I think the crisis line is a very important service and it has taught me a lot about secondary mental health care in general. Although my interest lays within in psychology and this professional field (and my role being an assistant psychologist role), having the opportunity to fill a role that has traditionally been filled by nurses has allowed me to obtain a more holistic understanding of mental health care and skills that other AP roles wouldn't necessarily provide. Also, I think the team is generally well run/managed and that the team chemistry/comradeship is the best I have ever worked in. In my opinion the type of work involved in the crisis line can be challenging but is also rewarding and the unknowing aspect of what the content of the next call will be keeps the job feeling fresh for me personally (although I know for others this may not be the case). My experiences with patients are overall positive and most users of the crisis line tend to be very thankful for the support provided. One criticism that I do have is that is that as the crisis line role is traditionally run by band 6 nurses, I find the pay discrepancy sometimes unfair, especially considering APs on the crisis line essentially have two job roles but I understand that there's not really anything that could be done about this (apart from bumping us all up to band 5 APs !!)." (Assistant Psychologist, Mid-Mersey Crisis Line).

"As my first Assistant Psychologist post, my experience on the crisis line has been extremely positive. I have had many valuable learning experiences around dealing with risk, triaging patients, and the role of secondary mental health services. As a call handler on the crisis line, you speak to a range of service users from different backgrounds with a variety of different issues regarding their mental health. Although the role is challenging due to the fast-paced nature of triaging patients in crisis, the role can be extremely rewarding given the fact you can speak to and provide support for many different patients each shift. Working within a large team made up of other Assistant Psychologists, you work alongside lots of other like-minded colleagues with similar interests but come from different backgrounds with alternative thinking styles, making the learning experience very diverse and holistic. I have felt supported throughout my journey as an Assistant Psychologist as there are always very knowledgeable and caring clinical leads ready to offer a supporting hand. There are many opportunities for managerial, clinical and peer supervision which encourages a reflective culture and ensures you are always improving your professional practice." (Assistant Psychologist, Mid-Mersey Crisis Line).

7. Case Studies - CWP

a) 111 Referral Received at the First Response Service

Patient contacted via telephone; patient is a young male aged 23. Suicidal thoughts and not wanting to be here anymore, very flat expressing suicidal thoughts. Previous trauma, family history of mental health illnesses. Started Citalopram 10 days previously via GP telephone appointment. Patient agreed to a face-to-face assessment; due to their social anxiety we arranged a home visit. Clinical lead and a First Response Operative went to complete assessment. It was assessed that they didn't meet criteria for a referral to HTT but would benefit from support over the weekend; two further home visits. Health box referral and primary care referral completed. Email sent to GP to review on the Monday, First Response Operative spoke with GP re appointment on the Monday, GP arranged for a face-to-face to further discuss mood and medication. Patient feedback was that his support from the first response service was appreciated over the weekend, felt supported and that it had "saved his life".

b) Frequent Caller

Frequent caller, dual diagnoses with additional complexities due to past trauma. Often receiving conflicting advice and approach when calling the line, which caller found unhelpful and would trigger multiple calls overnight, disrupt sleep hygiene and evidence caller's crisis period was building. Due to this, a crisis line care plan was devised collaboratively with caller and care team. Feedback of plan was helpful and felt this prevented an admission. Prior to this, the caller's recovery programme was in jeopardy as they were phoning a lot at night and not able to participate in the plan the care team had originally devised due to being exhausted in the day. All we did diffidently was talk about sleep hygiene between midnight and 6am, and if safe to do so arranged a call back in the morning / and spoke with her carers. This validated her experiences, while promoting sleep hygiene and self-management. While caller remains a frequent user of Crisis Line, volume of calls has declined, and care team report better engagement with overall treatment plan and self-management.

c) Homeless Caller

34yr old male contacted the crisis line with thoughts and plans to end his life, he was desperate, homeless and hadn't eaten for two days. He described feelings of hopelessness, worthlessness and being burdensome to his family. The call handler engaged him on telephone and made several suggestions regarding support he could access that day. The call was handed to Practitioner, we spoke for some time and he agreed to meet practitioner at 71 (Café 71: a safe space for people struggling with emotional and psychological distress) to discuss a plan moving forward. While practitioner was talking to the man, the call handler had spoken to housing and arranged an appointment for him later on that day. The man attended 71 and was assessed by myself and a member of staff from 71, he was low in mood reactive to his social situation. He engaged with 71, was given food bank vouchers and later that day was given temporary housing. He has continued to engage with 71 and is hopeful of returning to employment. Does not report any further suicidal ideation.

d) Night-Time Caller

A patient called the crisis Line for support. Supported at present by perinatal Team. Patient was distressed, anxious, could not feel her legs. The caller disclosed the trigger for this was attending a First Aid Course. Patient already called ambulance due to this. While waiting for ambulance, patient called Crisis Line for emotional support, initially expressed she could not wait for ambulance and would attend AED via taxi. Crisis Line reassured the patient and was supportive in manner. Patient then received call form NWAS nurse on triage, offered advice and support ambulance was cancelled for more appropriate support next day. Patient re-called Crisis Line thanking for support and reassurance, advised she felt calmer and was happy she had avoided AED due to joint response from NWAS triage and Crisis Line. Patient advised this made her feel better as she did not like AED environment, and also did not like to feel a “burden” if she was to attend unnecessarily.

8. Conclusion

This report examined crisis line data for CWP, Mersey Care and Mid Mersey NHS Foundation Trusts. The report provides detailed information about a population that has been the focus of attention due to concern of a rise in suicide and self-harm during the pandemic and beyond, and the public health priority given to a reduction in the national suicide rates. Calls were examined for people of all ages who contacted the crisis line between April 2020 and January 2022, dependent on when the line was introduced in each respective Trust. Results indicated that approximately three-quarters of calls across the three trusts were made by the person who was in crisis followed by friends or family of the individual who was in crisis.

There were varied results for age and gender across the three services. More girls and women contacted the crisis line across all services; however, men showed an increase in usage of the CWP line as age increased and usage was highest for those aged 60 to 69 years where men exceeded women in call volumes. This finding should be considered in the context of research, which shows that men are more likely to die by suicide (ONS, 2019), particularly middle-aged men (ONS, 2019) and they have lower levels of help-seeking compared to women (Staiger et al, 2020ref). However, women are more likely to experience anxiety (McClean, et al 2011) and to have mental health problems in their early twenties (Hantsoo & Epperson, 2017ref), where there are high call volumes. There were also very few callers who identified as non-binary. This is unusual given non-binary people experience mental health issues at higher rates than the general population (Valentine & Shipherd, 2018) and may reflect issues of inclusivity in the way gender is discussed and coded in the different trusts.

Data was collated on different age group bandings across each service and therefore this was not easy to compare; however, one noticeable difference was the higher number of calls by CYP in CWP compared to both Mersey Care and Mid Mersey. This may be due to Alder Hey Children's Hospital Crisis Line being used instead by CYP who live in the Mersey Care and Mid-Mersey areas. For example, the borough of Knowsley is under both Mersey Care and Mid-Mersey. Examination of Alder Hey Crisis Line (see Ashworth et al. 2022 for further details) indicated 5.3% of calls in 2018-2020 and 10.7% of calls in 2020-2021 to be out of area; this may be reflective of those CYP in the Knowsley borough. A further explanation for the lower number of CYP calls to Mersey Care and Mid-Mersey Crisis Lines may reflect how the services are publicised. In the context of child healthcare, parents may prefer to use a child specific service rather than general crisis care designed for all ages.

People from ethnic minority backgrounds do not seem to be engaging with the service as much as people from White backgrounds across all three trusts, even though people from ethnic minority backgrounds are a higher risk group for mental health problems (Smith, Bhui & Cipriani, 2020). This non-engagement, however, is not disproportionate to the demographic of the area. According to 2019 figures from the Office of National Statistics, ethnic minority groups make up 14.4% of UK and16.1% England (Jones, 2021). Additionally, ethnicity data could not be collected for some callers or was not shared by the individual, thus increasing the amount of unknown or missing data. More research is needed to understand why people from ethnic minority backgrounds are not accessing the crisis lines and whether more targeted messaging is needed about this new resource available nationally.

Further demographic data varied across the services. For example, in the Mid-Mersey region, there is currently a data gap regarding the support of the LGBTQ+ community. Wider systematic change is needed to accommodate service delivery that is inclusive and acknowledges a broader spectrum of gender and sexual orientation. In terms of data capture, improvements need to be made in terms of information on employment (e.g.,

current employment status was rarely captured adequately) and safety (e.g., three questions with opposing wording on whether or not the person is safe coded in a single variable). Data capture needs to be simplified for some questions and coded separately for each part of a question rather than collectively for three different questions.

With regards to whether the caller was known to services prior to their call, there was data captured for CWP and Mersey Care; although, there were some areas identified for improvement. Within Mid-Mersey, a variable specifically related to known and unknown callers would be beneficial moving forward. For CWP only, there was useful data on the reason for the call (e.g., problems with suicidal thoughts, relationships issues, etc.), risk level, outcome of the call, and caller feedback. For Mersey Care and Mid-Mersey, there was useful data on the source of the call. This highlights that each service has different data capture strengths and weaknesses and that greater consistency between trusts would allow better data comparison and aggregation.

Data was available across all three trusts for where individuals were signposted; however, this was inconsistent across all three trusts and some of the coding was difficult to interpret. For example, it was not clear if "GP signpost" meant that individuals were informed to see their GP or whether their GPs were contacted via letter to inform them about their patient accessing the crisis line. Further training for all Crisis Line staff would ensure greater consistency when filling out biopsychosocial screening forms and ensure patient journeys and outcomes are accurately captured.

For CWP, 97% of callers found the call beneficial; however, it would be informative to capture in what way they found it beneficial – e.g., did it help them through the crisis; did they feel more positive about the future; did they know what they needed to do next? There was no data collated from Mersey Care and Mid-Mersey on caller feedback.

Interestingly, CWP Crisis Line noted a high level of calls for 'routine' reasons; for example, people calling to check when their appointment is. A possible explanation for this may be because the line was publicised as a 'helpline' rather than a 'crisis line'. Although this may result in a higher number of unrelated calls, CWP did also have the highest number of crisis calls over a shorter time period compared to Mersey Care or Mid-Mersey Crisis Line. Potentially publicising the CWP Crisis Line as a 'helpline' has been beneficial in this case to increase accessibility and ensure people feel comfortable accessing support. For example, some individuals may feel more comfortable with the terminology of 'helpline' rather than 'crisis line' (i.e., saying they need help rather than 'I am in a mental health crisis').

Data was also collected on the risk level of callers and whether the caller was identified as needing to be seen by a mental health assessment team (MHAT) within 4, 24, 48 or 72 hours. The level of missing data for this variable, however, its concerning. For example, "NULL" data accounted for 87.8% of calls to the Mid-Mersey Crisis Line. This may be due to people being put through to the line inappropriately or individuals being signposted out of the system (i.e., to other external services) rather than being referred for further assessment. The decision-making of call handlers is of future interest, and it is important to understand what factors led to the decision a MHAT was not needed and why. Moving forward it may be useful to include an option for 'signposted out of system' to better establish caller risk and ensure accurate data collection.

Finally, feedback on the delivery and use of the crisis lines from Mid-Mersey and CWP is positive and encouraging for the continuation of this new innovative, accessible service. Staff reflected on the nature of the work being challenging but equally rewarding. Staff also spoke about the support they received from their colleagues, the positive feedback from people using the crisis lines and the importance of this holistic service being available, particularly for people who may not be receiving care. Users of the crisis line reported that the availability of the service had "saved [their] life", reduced unnecessary visits to their local

emergency department, supported them with housing issues enabling a return to employment, better engagement and facilitated better engagement with treatment plans and self-management.

9. Recommendations

- A standardised screening tool for all crisis lines across services nationally to enable comparable and comprehensive data analysis.
- More explicit questions on suicide and self-harm as suicide and self-harm prevention is a key focus of the service.
- Improve coding practices to reduce levels of missing data and have individual codes for each separate question asked.
- More data capture on the context of advice given for people contacting the crisis line who are signposted to other resources, and further longitudinal data capture to follow-up users of the crisis line.
- More specific codes for where individuals are signposted.
- Training for staff to ensure consistency when filling out biopsychosocial forms.
- Increased campaigns to raise awareness of the crisis line services within ethnic minority and LGBTQ groups.
- Improve questions on gender identity to be more inclusive.

10. Future Directions

1) Continuation of the use of crisis lines as standard care across all mental health Trusts.
2) Standardisation of data collection across all sites, regionally and nationally.
3) Use of assistant psychologists or equivalent as first response call handlers and access to advanced practitioners for people who may be at risk of suicide/self-harm.

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