APCC briefing

APCC Briefing:

Mental Health & Covid19: Phase Two Report

Foreword by APCC Mental Health Lead, Matthew Scott

Phase One of this inquiry into the impact of Covid19 on mental health demand was launched before a single vaccine had been given.

Now, just 10 months later and with more than 67million doses of vaccine delivered in England and Wales it is remarkable to see how far we have come in response to the virus.

To recap, as an elected Police and Crime Commissioner (PCC) and the Association of Police and Crime Commissioner's (APCC) national Mental Health lead, I had been alerted to anecdotal reports of growing mental health demand placed on police forces as lockdown took effect.

In response, I wanted to establish an evidence base to confirm whether the common mental health demand police forces experienced pre pandemic – use of section 136 powers, missing from home, suicides, prolonged waiting times to transfer patients to qualified mental health practitioners, or calls to police control rooms - had changed because of the pandemic.

An initial call for evidence was issued in September 2020 seeking feedback from elected PCCs, police forces, health practitioners, and mental health support services working admirably to deliver vital support to vulnerable people despite the limitations brought on by the first wave of Covid19.

Analysis of submissions provided several encouraging and, in some cases, startling findings including changes to the type of demand, reports of a new cohort of people who previously had no mental health related issues and limited capacity in mental health settings due to the need to social distance. I must clarify that some areas reported little or no change in demand and additional analysis failed to identify links between demand and geography e.g. rural vs urban police forces.

The phase one report was extremely well received by PCC colleagues, stakeholders, including the Minister for Mental Health, the Home Office and Department for Health and Social Care.

To establish further evidence, and best practice, a second phase was commissioned with a series of virtual roundtables convened by the APCC in February 2021. Invitations were sent to frontline officers with experience of policing during the pandemic, mental health professionals, PCC colleagues and importantly to those with lived experience.

The result is a report which I hope provides readers with a unique insight into the efforts of those who contributed to the inquiry during a time of crisis like no other. Included within the pages below are broad recommendations for the Government and the sector to develop and

improve the response to mental health, simply put - things that need to change regardless of the pandemic but may have come to the fore during the lockdown periods.

The second thematic group of recommendations are based on valuable learning from the pandemic. These recommendations relate to potential future lockdowns and identify various steps agencies can take to prepare and respond to these situations, business continuity for want of a better description.

As an elected PCC, we can play a significant role addressing the needs of our communities and ensuring vulnerable people receive the right support at the right time. I urge my fellow PCCs to take these recommendations forward locally and use your democratic mandate and convening powers to stimulate local activity.

I would like to acknowledge the amazing work of our emergency services and dedicated mental health support workers for their response to mental health demands during this pandemic.

Finally, I want to thank all those who took the time to inform and shape this work. If we can encourage just one person to access vital mental health support, prevent a suicide or bring together organisations and individuals from across the sector to discuss mental health, then these recommendations will have made a difference.

I hope you find this a useful resource.

APCC Mental Health Lead and Kent PCC, Matthew Scott

Executive Summary

In Autumn 2020, as the effects of the Covid19 pandemic took hold, the APCC's Mental Health and Custody portfolio became aware of anecdotal reports of increased mental health demand for police forces in England and Wales. As such, the APCC launched an inquiry seeking to develop greater understanding and evidence on whether mental health demand had changed because of the pandemic.

Findings from the initial inquiry were published in January 2021. Key findings included:

- Changes in the type and number of **mental health demand** police forces were experiencing, including the emergence in some areas of a new cohort of people, with no previously known mental ill health.
- Reduced service – some policing areas reported how **reduced access to or capacity in mental health support services** had impacted on police resources, meaning officers spent longer time with people in distress awaiting medical support.
- Concerns for those people previously known to policing as suffering with mental ill health, with some forces taking a **proactive approach toward vulnerability**.

To delve further into these findings and to develop understanding and examples of notable practice, the APCC's Mental Health lead commissioned a second phase of research. A series of virtual roundtables were held, with policing, PCCs, health, and people with valuable lived experience invited to attend and share their views on:

I. **What themes or trends you have observed since the first lockdown period, with regards to demand on service provision (impact of recent lockdowns)? What has changed?**
II. **Are there new examples of good practice developed since or during the most recent lockdown periods?**
III. **Recommendations you would like to make to inform this inquiry and to share with stakeholders in policing/PCCs and mental health partners?**

This report captures examples of the work police and partners delivered during the pandemic in response to mental health demand. Additionally, a series of recommendations are provided. The first proposals relate to **'Broad Recommendations for the Sector'** – things that need to change regardless of the pandemic but may have come to the fore during the lockdown periods.

The second group of recommendations is based on learning from the pandemic and relate to potential **'Future Lockdowns'** - what agencies can do to prepare for future lockdowns if they happen, ensuring continuity of vital support services.

Key recommendations include:

- **Greater investment** in Early Intervention and Prevention – Roundtable attendees universally identified the long-term benefits of early intervention.

- **Recognising the potential for Covid19 / lockdown to be an adverse childhood experience** – parallels were drawn by subject matter experts between the impact of adverse childhood experiences, which can lead to a life of crime, and lockdown. As with the Government's serious violence and gang agenda, subject matter experts shifting focus to early intervention could help reduce this risk.
- **Make every contact count** - encouraging early access to mental health support through public sector agencies.
- **Improve Capacity** – concerns for the long-term impact of the pandemic, which could have a lasting effect on the nation's mental health. If this becomes a reality, there is a need for sustainable funding to provide and deliver services that will keep pace with demand.
- **Embrace and Explore Digital Opportunities** – although digital should not be the default, the pandemic has provided examples of how digital offers of support can help. There is a potential to be explored.
- **Partnership Working** – what does good partnership working look like and what role elected PCCs can play within this.

Additional recommendations, based on learning from lockdowns that can inform activities if further lockdown measures are required, included:

- **Effective Promotion and Awareness Raising** – During lockdowns, PCCs played an important role in raising awareness of vital mental health support services. This should be maintained.
- **Postcode Flexibility** – As capacity was severely limited in some areas during lockdown, others were able to accept patients across the postcode border, ensuring those in need of support were able to access it swiftly. This approach could serve emergency services well in the future during times of peak demand.
- **Go Digital** – Many support services were forced to be agile to ensure continuity of service. Although digital offers of support are not for everyone, they can provide a lifeline for some, particularly if housebound due to isolation requirements. This approach could form part of contingency plans if further lockdowns are required.

Readers are invited to consider what learning from this report you can take forward to implement in your organisation, be it locally, regionally or nationally. We also ask that if you work in the mental health sector, that you kindly share the report with your colleagues to help stimulate discussion on the significant opportunity for mental health arising from the pandemic.

All agency and individual contributions to the phase one and two reports are appreciated and valued. We look forward to working with you on the recommendations going forwards.

Recap of Phase One Research Methods & Findings

On 6th October 2020, the APCC launched a call for evidence on the impact of Covid19 on mental health demand, with several open questions shared directly with policing and mental health stakeholders in England and Wales.

Respondents provided a range of information, including statistical data and anecdotal evidence. A total of 49 responses were received and coding analysis applied which identified the following common themes:

DEMAND: Demand evolved in several geographical areas. Analysis demonstrated no correlation between demand and location e.g. rural vs urban. Some responders recorded unprecedented levels of demand, others reported typical or reduced demand. Respondents described how frequent mental health contacts 'dropped off' during the first lockdown; other areas experienced a new cohort of people with no previous mental health interactions. In some cases, this cohort demonstrated acute mental illness resulting in longer police time spent with these individuals. PCCs reported increased demand for mental health support from their commissioned victims' services.

IMPACT ON SERVICE PROVISION: Responses from policing highlighted the consequences and impact of reduced access to mental health support. Forces spent longer with patients for assessment and transfer, as well as responding to an increase in calls from people suffering from mental ill health. The NHS 111 number was identified as a useful mechanism for forces to divert calls to appropriate mental health support.

PREVENTION: PCCs and forces developed partnership approaches to prevent mental health demand from escalating. Examples included:

- Work with Clinical Commissioning Groups to oversee delivery of NHS Long-Term Plan.
- Work with Public Health England to share suicide data informing preventative actions.
- Work with the third sector to deliver Crisis Cafes and other opportunities.
- Co-location of police and health teams, providing rapid response to mental health calls.
- Proactive police approach to known vulnerable individuals in the community during lockdown to check on their welfare.

ADDITIONAL CONCERNS AND REFLECTIONS:

- Court backlog causing victims of crime distress and emotional uncertainty.
- Domestic abuse – areas made links between increased mental health issues and increased risk of domestic abuse during the pandemic.
- Horizon scanning suggests a rise in mental health demand as a result of likely economic difficulties e.g. unemployment. Local level public surveys show concern for children's mental health.
- Short / long-term impacts on police officer and staff wellbeing should be acknowledged.
- Concerns shared for whether there is sufficient investment in mental health support, diagnosis and care, particularly if demand increases.

WHAT CAN PCCS DO: Phase One recommendations for PCCs included establishing partnership approaches, including the voluntary sector. PCCs are in a strong position to oversee partnerships and see the bigger picture. PCCs have the opportunity to commission particular services and raise awareness of existing mental health support.

Phase Two Research Methods

To effectively gather evidence and build upon learning from Phase One of the APCC's inquiry into mental health and Covid19, subject matter experts with a range of experience from the mental health and policing sector were invited to attend a series of roundtables. The purpose of the roundtables was to meet with these subject matter experts and discuss in greater detail their experiences of the first and more recent lockdowns, and to identify good practice and recommendations.

Roundtables, chaired by the APCC Mental Health lead, were held on 18th, 19th and 25th February 2021. Attendees included representatives from:

- Policing
- PCCs
- Mental health support services
- People with lived experience
- Approved Mental Health Professional (AMHP) Network
- Home Office
- Ambulance
- College of Policing
- British Transport Police

Attendees were asked the following questions:

IV. **What themes or trends you have observed since the first lockdown period, with regards to demand on service provision (impact of recent lockdowns)? What has changed?**
V. **Are there new examples of good practice developed since or during the most recent lockdown periods?**
VI. **Recommendations you would like to make to inform this inquiry and to share with stakeholders in policing/PCCs and mental health partners?**

Roundtables were recorded and coding analysis applied to identify findings, learning and recommendations which has been captured within this report.

Phase Two Findings

Q: What themes or trends you have observed since the first lockdown period, with regards to demand on service provision (impact of recent lockdowns)? What has changed?

Analysis of feedback received from police, health, and third sector representatives at the APCC's Mental Health and Covid19 roundtable discussions indicates demand continued to fluctuate across geographical locations during the more recent lockdowns (late 2020 and early 2021).

As captured during the initial call for evidence, the APCC identified further anecdotal examples of the impact of reduced mental health capacity, including occasions when police officers were required to seek alternative locations for assessment or beds. This was largely due to reduced capacity resulting from necessary social distancing safety measures. Such examples demonstrate how people in need of professional mental health assistance were unfortunately unable to swiftly access services during times of crisis, and how police resources were often diverted from crime to care responsibilities.

Furthermore, as identified during the call for evidence, roundtable attendees described how mental health demand changed in some areas with police and health representatives independently experiencing a cohort of people with acute mental health needs during lockdown.

Support services raised concern for the mental health related consequences of the pandemic, with already high levels of demand for support being exacerbated by it. As a result, roundtable discussions sought to identify why mental health demand had changed in some areas, with support service representatives suggesting isolation as a key driver. It was felt that the support offer from services must adapt in response to the need for emotional support caused by anxiety and isolation. There was also suggestion of moving to a digital offer of support with PCC representatives drawing parallels between mental health and victim support. During the early lockdown period there had been some reluctance from victims to take up the digital offer of support, however, more recently victim's engagement with services had increased, possibly as confidence levels, awareness, or accessibility increased.

Although positive examples were shared of how the digital offer of support had developed over the various lockdowns, roundtable attendees with lived experience were cautious on digital offers becoming the default. Instead, patient choice should be provided so as not to exclude people from accessing services. It was reported that crisis cafes and other similar arrangements had maintained a face-to-face offer during recent lockdowns which was seen as a positive option if sustainable and safe to do so.

Other areas of discussion included examples of how throughout lockdown there had been a lack of community-based support. Health representatives described inappropriate referrals

to their services and felt as if they were being asked to fill a gap due to limited availability of community support.

Health and police representatives highlighted concerns for the capacity of ambulances and conveyance. In addition, some forces described how when they were transferring contacts suffering with mental ill health to A&Es, staff were reluctant to take ownership, leading to increased waiting time for officers - "this would not happen if the person had a broken leg – there is no parity of esteem". Although there is a handover process, it is still reliant on A&E staff to take ownership.

On a positive note, both health and police representatives highlighted how during peak times of demand 'NHS borders' had dissolved in the spirit of collaboration and putting patients' needs first. It was felt this was a positive move and could be usefully deployed for future lockdowns.

Q: Are there new examples of good practice developed since or during the most recent lockdown periods?

During roundtable discussions, subject matter experts shared examples of good practice initiated during the pandemic. A snapshot of examples has been provided below to demonstrate the efforts those working in mental health and to support collaboration and sharing of notifiable practice.

Example: **Greater Manchester Police** Control Room deployed an approach whereby they could access mental health records to inform decision making, as well as provide officers with real time alternative options that meet the individual's needs.
Benefit: This has reduced the time officers spend responding to incidents and ensures people receive the right care.

Example: **Dorset's PCC** funded a project, within their MASH, to deliver return to home interviews for missing people, including those with mental ill health. During the pandemic this process was expanded to include a daily scan conducted with partners.
Benefit: So far, the project has carried out 1,000 scans of vulnerable people to identify whether they require support/services/interventions from relevant partners. Approximately, 15% of those 'scanned' have complex needs. Ultimately, this approach can reduce mental health demand through targeted early intervention.

Example: **Dorset Police** were involved in tri-service ambulance project, where an appropriate vehicle is dispatched to incidents before separate police/ambulance vehicles.
Benefit: Reduces police demand and ensures medical and police presence at mental health incidents. This is yet to be evaluated but demand is high.

Example: NHS mental health phoneline.
Benefit: This has reduced police demand providing an alternative and appropriate pathway for people in need to access support. Greater promotion required.

Example: Pre-pandemic, **South Yorkshire Police** funded a Suicide Prevention Officer and Vulnerability Officer.
Benefit: The post enables real-time surveillance of suicide 'hot spot' locations, ensuring evidence is used to inform police and partner activity e.g. patrols. The process also enables a deep dive of pathways to understand where these individuals go.

Example: In **Lincolnshire**, the PCC and partners have set up services for those with social needs e.g. crisis cafes and ensured they connect with 24/7 emotional helplines.
Benefit: Reduces police demand by diverting to appropriate source of support.

Example: **British Transport Police** have reduced section 136 arrests under the Mental Health Act by making alternative information available to officers.
Benefit: Improved decision making and reduced arrests and police time.

Example: **Essex Police** worked with partners to debrief on situations where improvements could be made e.g. section 135/136 arrests, designing five scenarios to talk through and develop knowledge. This involved 'myth busting' between agencies.
Benefit: Improved understanding between agencies, as well as better outcomes for patients and agencies.

Example: In **Hampshire** a cross border Mental Health Trust rapidly set up an arrangement to accept self-referrals offering support to people in need regardless of where they came from.
Benefit: Removes postcode barriers to accessing support and the issue of people not satisfying the necessary threshold to access support.

Example: **Lincolnshire Police** mobile devices have been linked to community (voluntary and professional) mental health teams to provide wrap around support.
Benefit: This allows officers to see immediately what help is available ensuring swift access to support.

Example: During the pandemic, PCCs proactively raised awareness of available mental health support services, including text services, encouraging people to access support early.
Benefit: Ensures those in need are aware of support and how to access, preventing their mental ill health from escalating.

Example: Some areas introduced Mental Health Emergency Department Diversion Hubs to reduce avoidable mental health attendances to Accident and Emergency Departments.
Benefit: Greater capacity for those in need.

Q: Recommendations you would like to make to inform this inquiry and to share with stakeholders in policing/PCCs and mental health partners?

The APCC roundtables provided opportunity to ask subject matter experts what recommendations they would make to partners or to Government in relation to mental health demand and the pandemic.

Recommendations

Below, recommendations have been grouped together under two thematic headings.

The first is **'Broad Recommendations for the Sector'** – things that need to change regardless of the pandemic but may have come to the fore during the lockdown periods.

The second thematic group of recommendations is based on learning from the pandemic. These recommendations relate to potential **'Future Lockdowns'** and what steps agencies can take to prepare and respond to these situations to ensure continuity of vital support and response services.

As identified in Professor Sir Simon Wessely's 2018 review of the Mental Health Act, there are '*manifest inequalities in our mental health system*.' Whilst issues relating to inequality did not present during the roundtables, it is important to acknowledge disparity when considering the recommendations and what you can do locally to prevent and remove it.

Broad Recommendations for the Sector

Greater Investment in Early Intervention and Prevention:
One of the clear recommendations to emerge from the roundtables is the need for greater focus and prioritisation of early intervention and prevention around mental health.

Roundtable attendees universally identified the long-term benefits of early intervention, such as the personal benefit of early access to support that can prevent an individual's mental health needs from escalating. Not only are there benefits to the individual, but early intervention also provides health, police and third sector agencies with benefits by reducing demand and delivering financial, resource and time savings. To deliver this, representatives suggested horizon scanning was required, and the need for a forward view of what will happen as we come out of the pandemic to prevent serious mental health problems. This should also inform the Government's funding decisions, especially if there is evidence that mental ill health will increase because of the pandemic.

Building on the horizon scanning themes, discussions identified parallels between the risk of adverse childhood experiences and gangs/serious violence with the risk of pandemic related childhood experiences leading to long term mental health problems. As with the Government's serious violence and gang agenda, subject matter experts felt recognising lockdown as an adverse childhood experience, and subsequently shifting focus to early intervention, could help reduce this risk. The Government's approach to recognise the benefit of early intervention by delivering funding that has a preventative focus, rather than reactionary, has proven beneficial. Adopting this strategy in mental health could deliver similar benefits. PCCs can play an important role in this approach given their local mandate, knowledge and ability to work across local authority areas.

Further recommendations linked to early intervention included encouraging public sector agencies to embrace a '*make every contact count'* approach towards mental health. Mirroring the criminal justice system's approach in how it considers domestic abuse was offered as a useful approach to encouraging early access to mental health support. Linked to this approach was the suggestion of how the pandemic has provided opportunity to better identify mental health needs in offenders as they come through custody with a view to diverting to support – agencies were interested in how effective Liaison and Diversion teams are currently at delivering this. Additionally, roundtable discussions focussed on what opportunities there were for those under probation to access mental health support.

Improve Capacity:
Sustainable funding was a further key area of discussion during the roundtables. Representatives were concerned if the pandemic does have a lasting impact on the nation's mental health, then there is a need for sustainable funding to provide and deliver services that will prevent and respond to mental health issues.

One recommendation to address this concern is to increase the number of available community interventions, with some agencies eager to stress how availability was already struggling to keep pace with demand before the pandemic. From a policing and health perspective, having sufficient capacity for people to access mental health support at a community level, should reduce police demand and inappropriate referrals. Community support should also act as early intervention to prevent mental health from escalating and to support those people who do not meet medical thresholds in need of accessing support. Investment in community interventions could also reduce demand on safe places and help with capacity issues experienced before and during lockdown. Roundtable attendees felt a cultural change was required to deliver this recommendation, with the need to accept that safe places are a reaction to mental health symptoms and there is a missed step on this journey relating to earlier intervention.

Discussions also focussed on the need to form a clear pathway for police to refer into community services, this includes Liaison and Diversion activities. This approach should be data driven to inform where demand is. The existing landscape provides an adverse situation, where people who fall below the threshold are denied support. Given how those people below the threshold are at risk of seeing their mental health needs increase if they do not have access to support, this approach does not make sense. Any changes in response to these recommendations should also acknowledge the lack of services in rural areas.

The need for realism was highlighted during discussions on embedding early intervention and community interventions, which will not happen immediately. Agencies raised the need for greater capacity in Psychiatric Intensive Care Unit beds nationally as the journey towards a more community-based system advances, asking how do we manage that 'handover' in the interim?

There was also a call for rural areas to receive greater investment and consideration. Often rural areas can suffer from reduced mental health support capacity, meaning access to

essential services is extremely limited. It was recommended there is need to ensure this is considered and to improve police access to data to effectively identify what is happening in rural locations.

Other recommendations linked to capacity included a need for better and more appropriate vehicles to deliver appropriate and effective conveyance, with concerns that Government funding for this is not currently ringfenced and at risk of being swallowed up for other needs.

Embrace and Explore Digital Opportunities:
The pandemic has seen numerous services, mental health and beyond, forced to embrace video technology. The roundtable provided a clear view to avoid digital from becoming the default offer. However, the benefits and opportunities digital support has offered are clear and the need to include a digital offer could improve access and take up. There was a recommendation to explore how this approach could be encouraged, with incentivisation and grip nationally suggested. There was also some discussion that digital offers of support may help overcome issues in rural or remote locations, but participants were eager to stress this should not be the only option.

Partnership Working – what does good look like:
The pandemic created a necessity for partners to work together. It was recommended that this progress is used as a foundation to identify and promote what a good strategic mental health partnership looks like and to ask the question - should it be on a statutory basis with sufficient responsibilities?

Dual diagnosis and treatment:
The roundtables touched upon other emerging problems linked to the pandemic, including excessive drinking and drug use. In recognition of evidence that suggests alcohol consumption at home had increased during the first lockdown, worryingly amongst those already classed as vulnerable or having a drinking problem, roundtable attendees stressed there is greater need for dual diagnosis. Discussions suggested dual diagnosis and treatment have been 'wicked' issues for some time now with vulnerable people often having to seek support from multiple agencies instead of one accessible service. It was recommended that services are incentivised to tackle multiple complex issues through funding.

Measures of success:
Broader roundtable recommendations related to how agencies, pre and post pandemic, have been guilty of measuring how well they are processing people suffering with mental ill health by the time spent with person or waiting times etc, instead of focussing on the person themselves. Such data sets only provide information on how well the organisation is doing (or not) and does not measure outcome of impact on person's wellbeing. A change in focus to the person being treated is required.

Evidence and Evaluation:
Whilst the Phase 2 research highlighted a need for more community-based support, there was recognition of the equal need for greater evaluation and understanding of what works

to inform activity and commissioning decisions. To help embed this recommendation, participants wanted to see greater focus on evaluation and evidence-led decisions, as well as better sharing of practice.

Suicide Prevention: Police and health agencies expressed concerns throughout lockdown for the risk of suicides to increase, driven by loneliness or mental health-related issues. Agencies recommended better data sharing between health and police to inform prevention activity.

Future Lockdown Recommendations

Both Phase 1 and 2 provided plenty of learning that could be applied in the event of future lockdowns in England and Wales, and perhaps for other countries.

Whist the roll out of vaccines and subsequent loosening of social distancing measures hopefully points toward a reduced risk of further lockdown situations, unfortunately as variants emerge, they are not something that can be entirely ruled out in relation to Covid19 or other pandemics. The following recommendations have been gathered with the intent of informing Government, police, PCC, health, and third sector activity during future lockdowns.

Embedding Learning to Maintain Support Services:
The pandemic has tested the capacity of mental health services. Not least as services were forced to adapt their support offer to ensure it was covid secure. Services should identify learning from the pandemic and use this intelligence to inform planning for any future lockdowns. Planning should include measures to deliver services in an agile manner. Services may also consider how best to promote their services, linking in with public sector organisations to raise awareness of available support and how to access it.

Effective Promotion and Awareness Raising:
PCCs played an active role in actively promoting mental health support during lockdowns. Working with health and voluntary sector representatives will be important for any future lockdowns. PCCs may wish to conduct local mapping exercises of available and up to date support, and to co-ordinate promotion activities during lockdown. This should include the NHS 111 non-emergency number. Police forces should do the same and utilise this information in the contact centres, where we know there have been frequent non-emergency mental health related calls during previous lockdowns (e.g. loneliness).

Postcode Flexibility:
The pandemic witnessed multiple mental health trusts sharing their capacity with areas that had reached their maximum, thereby overcoming postcode barriers that prevent people in crisis from accessing care. This approach was seen as helpful as it prevented long waiting times and a '*bottleneck'* scenario whereby police resource was taken up waiting with mental health patients outside facilities waiting to be seen. Adopting flexible approaches during times of high demand such as lockdown should be maintained and encouraged where appropriate.

Go Digital:
During the first lockdown, forces and other respondents to the APCC's call for evidence described a withdrawal of community mental health support. This improved as services adapted to the Covid19 restrictions by offering digital assistance to maintain vital support and prevent people's mental health from reaching crisis point, which can often lead to police involvement. For future lockdowns, community services should, where possible, be digital ready, but consider the need for patient choice and any barriers that a purely digital offer presents.

Conveyance:
Some police forces reported a drop in ambulance availability for conveyance of people with mental ill health. Given the impact of the pandemic on the ambulance service, effectively demonstrated by the need of fire and rescue service support, there is need to consider how capacity issues can be managed for future lockdowns. Contingency plans involving fire and rescue are one option that could be explored.

Next Steps…

At the beginning of this APCC inquiry, the objective was to hear from stakeholders about their experiences of mental health during the pandemic and to identify learning and recommendations.

By working with partners, the APCC has been able to collate valuable evidence from a broad spectrum of sources, including those with frontline and lived experience.

Findings from Phase One have previously been published and shared with the public, respondents to the call for evidence, as well as the Minister for Mental Health to help shape public policy and activity.

The intention of Phase Two is to also publish and share findings, however, this time with the view to informing both general mental health policy and Government decisions, as well as policy around any future lockdowns that may arise.

As a reader, we ask you to read the findings and recommendations within this report and consider what learning you can take forward to implement in your organisation, be it locally, regionally or nationally. We also request of those who work in the mental health sector, that you kindly share the report with your colleagues to help stimulate discussion on what is a significant opportunity for mental health arising from the pandemic.

Finally, we would like to share our appreciation and gratitude to all those who contributed to the report, we look forward to working with you on the recommendations.

Further Reading and Contact Details:

- **Phase One report**
- **Association of Police & Crime Commissioners**
- **Kent PCC**

For queries on this report please contact: Eddie Smithwick, APCC Senior Policy Manager
Enquiries@apccs.police.uk

Appendix

Recommendation notes from Phase 2 – Covid19 impact on Mental Health and Policing

Data

- Expansion of data sharing – numbers with NHS, Department for Health and Social Care, policing and Home Office to show NHS what police are trying to do and have impact effect.
- Improve data access to show us what is happening in rural locations (police incidents).
- Data in local areas, so that local inspectors and community mental health teams can work together. They can map activity in their area. When linking this with Integrated Care Systems (ICS) and primary care network, it enables district councillors to get involved and opens different funding pots. Allows NHS organisations to take ownership of place-based budget conversations. This way you can see the local number of suicides/service access and the activity. Identifies community needs and the resource put in to fill that gap. Spreading this regionally and nationally (data evaluation and impact)
- NHS having a national system - similar to the Police National Computer (PNC) relating to a database for mental health providers to use.
- Work across county, healthcare provider, mental health trust and policing boundaries, which amplify issues when they arise. Record sharing is an issue when a patient needs support but is from a different county but no record of the person in that county. Concur with the need for a national data sharing across UK for mental health records.
- NHS/Lincolnshire PCC's office – data formatted in the right way helps Chief Officers and PCCs challenge that health-based commissioning and the resource that sits behind the 111 is needed otherwise you cannot do anything with the demand. It is about HOW the money is allocated. Using data to lead to cohesive action with partners. How do we get capacity in NHS that stretches across to Policing consistently and uniformly across UK supported by NHS and National Police Chiefs Council (NPCC)?
- National agreement that non-identifiable personal information can be shared by Emergency Departments with Blue Light Organisations, to establish the true demand of mental health across the partnership. Allow an improved response to early intervention, recognition of cross cutting themes and any gaps/improvements in service provision.
- Her Majesty's Inspectorate of Constabulary, Fire and Rescue Services (HMICFRS) set specific baseline standards around data recording and collection for mental health demand to understand demand.

Partnership-working

- What does a good strategic partnership for mental health look like? Should it be on a statutory basis? Maybe giving the boards more powers/teeth similar to criminal justice boards.
- Digital offer and connecting mental and physical health are essential.
- Violence Reduction Units (VRU) and Adverse Childhood Experiences (ACE) approaches to mental health like we do with preventing young people joining gangs. Children's services are fragmented - education, early Child and Adolescent Mental Health Services (CAMHS) split between local authorities and mental health providers, so PCCs can navigate breadth of that relationship through partnerships, such as Community Safety Partnerships (CSPs) and Concordats etc.
- PCCs could influence Mental Health Trusts to work more closely in partnership and potentially make funding available to emergency response to crisis.

- Community Policing Volunteers with an interest in mental health supporting activity around this process area.
- Office of the Police and Crime Commissioners around peer support workers, lived experience.
- Co-located with mental health teams which incl. Street Triage, Proactive Vulnerability Engagement Team (PAVE), Liaison & Diversion (L&D), Outreach and our long-term vision is that duty Approved Mental Health Professional (AMHP) teams and Ambulance also co-locate with the team.

Education

- Student officers to receive comprehensive training developed by the College of Policing that is cognisant of the threat and risk that the subject presents to policing (rather than basic knowledge).
- Investment in training for front line officers to understand mental health from the service user's perspective.
- It is important that the public is made aware of what is happening. If the public truly knew the extent of near misses or police involvement in incidents where the NHS systems have failed, then there would be a greater drive to get change.
- Training and awareness of mental health issues need to reach ALL officers.
- Partnership-led improved training would provide officers with recognising the challenges faced by individuals in crisis.
- Awareness raising with other agencies to provide a consistent message identifying pathways and options for those wanting support. Officers could additionally be trained on the correct pathways, signs of deteriorating mental health and recognising symptoms.

Funding

- Conveyance funding promised in 2018 for dedicated mental health ambulances through long term plan, however spending review did not take that into account. 50% of conveyance still by police vehicles, so this national funding is needed.
- Increase Psychiatric Intensive Care Unit (PICU) beds nationally (although we are moving towards community-based system, how do we manage that 'handover' in interim?)
- Need a forward view of what will happen as we come out of covid to prevent serious mental health problems. Making every contact count to address mental health, similar to how Criminal Justice System look at domestic abuse through professional curiosity. Consistency across the country would be beneficial. Needs investment from Government, especially if it is a different cohort to before pandemic. This coupled with video technology needs connecting through incentivisation and grip nationally between police tech referral arm and NHS receiving arm.
- Ambulance Service called for levelling up areas with postcode lottery with mental health services. Consistency with what we deliver. Evaluating progress made as well as bad points identified. How we evaluate. Improving Access to Psychological Therapies (IAPT) is measured on making first contact. Waiting for 10-12 months for face to face follow up. Not measuring outcome of impact on their wellbeing. Organisations doing 'well' rather than patients doing well.
- 24/7 AMHP provision to get assessments done within code of practice 3 hours.
- Ringfence funding for Health-based Places of Safety beds (HBPOS).
- Demand has increased due to those not being able to access mental health services, exacerbated by covid. This demand is not seen fully yet and there is a lag of some months before people can access help, which means police get called. Improve funding and access to mental health services, conveyance and phone support to point of contact.

- Gap between mental health pathway and emergency pathway. Need places of safety etc 24/7 otherwise officers will have to take patients to A&E, which is not the right place for them and for officers to sit with them for hours.
- 24/7 HBPOS integral to reduce demand in time. Link between missing/mental health and safe and well checks, which the College of Policing are looking at.
- 24/7 HBPOS also needs to be accessible and run by the right professionals and right organisations, not just voluntary. Needs to be right location too. Currently, only open for four hours. Other forces have experienced similar issues.
- Improved access to services pre-crisis for patients to avoid contact with the police and enhanced pathways in place should people in crisis come to police attention for diversion to the right support without delay.
- Resourcing issues mean that Crisis Teams are only able to respond in a four-hour window meaning any calls for urgent need are picked up by police. In an ideal world Crisis Services could provide a face-to-face response AND telephone service.
- Can PCCs support AMHP services which are key in prevention of crisis? A 135 Mental Health Act (MHA) warrant that only AMHPs can obtain is calm, controlled and planned out as opposed to the crisis management of a 136, but AMHPs are rare.
- Support for families and friends who are supporting individuals in crisis.

Policy/Legislation

- Open door policy needs to be reviewed in A&E and mental health hospitals.
- National consistency and better understanding in models of crisis care response with regards to conveyance. Mentioned pilot in Hull.
- Hampshire – have been challenging requests for police to deal for the last 8 years. Politely but assertively say no but asking questions to signpost why they have not phoned mental health service/111 first with regards to suicidal ideation. Sometimes a follow up call to make sure the right agency has it. Peak mental health demand was in 2013, 8 years ago. 68% reduction equating to 137,000 officer hours a year.
- National welfare check policy work.
- Proposed Mental Health Bill white paper by October (3 key areas are the concept of a holding power for clinicians in A&E; legislative changes to 136s; and clarity on use of remote interviews that are legal and will benefit people to reduce time in custody).
- The powers for clinicians to balance out where the responsibility lies.
- A need to re-launch of parity of esteem after lockdowns. Evidence base or framework for suicide to assist referrers knowing who to contact rather than just phoning police (national charities knowing to refer to local provision).
- Review and guidance about the police role in health incidents, Health need to be held to a higher standard and have more responsibility to prevent adverse outcomes.
- Statutory hand over periods from police to health so that the police are not left 'picking up the pieces'.
- All Mental Health Act paperwork including Section 136 being available electronically, so they can be completed and signed virtually.
- Consideration needs to be given to allow police officers to 'de-section' someone in the same way that they can de-arrest if new information comes to light.
- Greater scrutiny around s140 MHA and emergency access to beds – particularly Psychiatric Intensive Care Unit beds.

- More specific timescales and escalation processes for delays in finding mental health beds.

Early Intervention/Prevention

- Acknowledged two separate cohorts (those suffering mental ill-health in public or private and those who are suspected of committing crimes or investigated). Earlier intervention for those being investigated. Trauma informed practices, including in probation (pre-sentence reports)
- Back trauma-informed approach for all frontline services. Need to make it clear to Government that this is not just an acute fall out from covid but longer-term challenge of impact on mental health. Choice for people to go via online or face to face/phone. Benefits system is entirely phone service – people are losing support and some people's mental health is triggered by talking on the phone. Joined up holistic thinking of what mental health is and how it affects people.
- We should treat impact of covid as a potential adverse childhood experience.
- Better access to mental health services in rural areas
- Existing services do not cater for new cohort. Do not know where to go and preventing them from going into long term secondary services.
- Mental health trailblazers in school – focus on early intervention and building the resilience and emotional wellbeing of our children. Linking in with school's liaison officers with mental health trailblazer school nurses to do some additional training inputs to children.
- Dual diagnosis. Services want to address issues such as mental health or drug abuse individually rather than holistically. Housing (private rent, social housing etc) broad concern for quality of exempt accommodation, support and capacity of exploitation in that sector. This is stopping people from recovering.
- Pre-custody diversion schemes especially if committed a low-level crime – committed because of poverty etc. Develop partnerships in community. Community sentences post-court. Dual diagnosis label has been a problem for years to access multiple services. Need to find a solution to both – Dame Carol Black recommendations may assist.
- Not just mental health crisis but social issues such as drugs, alcohol and homelessness. If pathway was there, we can educate those that need that support to go to the right place/phone to the right organisation.