AVON AND SOMERSET CONSTABULARY MENTAL HEALTH ASSURANCE REPORT (OCTOBER 2020)

1. Purpose of report

- To provide thematic assurance around the vulnerability area of Mental Health.
- To provide information about assurance and ongoing and planned improvement activity
- To make recommendations for improvements in this thematic area.

2. Background / Summary

"There will be no vaccine for the population mental health impacts of the COVID-19 pandemic"[1]

This assurance report highlights the large increase in complex mental health demand, mainly exacerbated by the COVID-19 pandemic. The increasing pressures on Mental Health services have implications for police. Collaborative working to problem solve the demand challenges are more critical now than ever.

The aim of the Constabulary's mental health theme is to ensure that the correct policing purpose in any mental health related incident is identified and understood; to ensure the response is proportionate and that people who present to police while experiencing a mental health crisis will be supported and managed in the most appropriate way by the most appropriate service.

The Independent Commission on Mental Health and Policing Report[2] describes mental health as "core business" of policing. Local research suggests that officers and staff are not confident and may even be fearful of decision-making where mental health is an issue. This affects their ability to accurately assess risk and take appropriate measures. The interface between policing and mental health is complicated but must recognised as "business as usual" rather than a "medical matter". The policing purpose relating to calls involving mental health can be overlooked.

Many of the challenges discussed in this report are not unique to Avon and Somerset but are being reported nationally; however the Constabulary is one of the leading forces in this field. The Constabulary has put significant resource into understanding Mental Health related demand, working with the College of Policing, and is one of only three forces leading in this project. It is also one of the only force to have successfully rolled out Mental Health Tactical Advisors (TacAds). The Constabulary is also actively tackling the issue of diagnostic overshadowing (discussed later in this paper. The Constabulary's Mental Health Coordinator is well connected locally, regionally and nationally and has been able to influence development in this policy area.

3. Current demand position

3.1 Data

The first national mental health data snapshot, in November 2019, estimated mental health demand at 5.3%; although this is contested as too low. This figure was contested by some forces who claimed that it under-counted. Desktop analysis by the Constabulary estimates that 6.5% of all demand is related to mental health. These figures pre-date the outbreak of the COVID pandemic and should be treated with caution.

The method of counting the number of mental health related calls, however, does not reflect the entire picture. The snapshot revealed that most mental health related calls are attended. Most are graded as Immediate or Priority and the calls often take longer to resolve and require more officers. This explains why mental health related calls feel like they are taking so much of front-line officers' time. It is also recognised that mental health calls are not always accurately tagged and this too has an impact on the reliability of the findings.

In 2018, the Constabulary produced their first Problem Profile for mental health demand and this helped provide focus in this area. When this paper was discussed at the Constabulary Management Board (CMB) in October it was agreed a new Problem Profile will be produced; this is especially important given that Public Health England are predicting a 30% increase in mental health related demand of due to the pandemic. It was also agreed at the meeting that a Qlik App would be developed in order to be able to have better oversight of mental health related data in real time.

[1] Kousoulis; Van Bortel; Hernandez; John 'The long term mental health impact of COVID-19 must not be ignored', BMJ (2020)
[2] Adebowale et al, Independent Commission on Mental Health and Policing Report (2013)

3.2 Demand; levels, flow and mitigation actions

A significant area of mental health related demand for the force is the use of powers under S136 of the Mental Health Act. Use of S136 for the year 2019-2020 shows an increase of 33%, continuing a rising trend seen in previous years. The figure for the last year stands at over 1700 uses. This will be discussed later in the report.

Whilst the volume of calls has been described as “stable” the complexity of and follow-up resourcing required for these calls is increasing. Officers are being called to support the Places of Safety more frequently due to the labile presentations of patients; there have been issues gaining access to the Places of Safety and Emergency Departments; people already known to services have been calling emergency services more frequently.

There is significant internal demand on the central team for tactical advice, attendance at case conferences in complex cases and service recovery on a case by case basis.

The COVID situation has aggravated and magnified issues that existed before the pandemic began. The NHS experienced a drop in demand during lock-down, but all agencies have been actively monitoring trends. A number of factors appear to be consistent across all providers:

- demand has rebounded and is beyond previous levels
- the level of psychosis in patients is higher than previously
- the level of violence is higher than previously
- more people are requiring admission to hospital under section following S136 than previously (a reported increase of about 10%)
- more of these people require placements in Psychiatric Intensive Care Units than previously and the local and national provision for this is inadequate. Sometimes there are no PICU beds available anywhere in the UK.
- in addition to people currently known to mental health services – there has been an increase in the number of people who were thought to have previously recovered and an increase in the number of people who were not previously known to mental health services.

In addition to extra demand the impact of coronavirus, and the measures to manage it, has caused the system to slow down; assessments are taking longer and it is taking longer before patients can leave the Place of Safety for a ward.

Usually officers with a S136 detainee, who cannot go to a Place of Safety would go to Accident and Emergency (A&E) as an alternative. The pandemic has also caused delays in A&E and this has led to situations where paramedics and police officers (with people suffering from both physical and mental illnesses) have been queued outside in vehicles for hours. While this is far from ideal, the multi-agency response has been quick in relation to general contingency planning and new and emerging issues.

A positive development in this area was the opening of the Bristol Sanctuary in October. This is commissioned by Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG) and will provide options for police, ambulance and acute trusts five days a week, late into the night, which have not historically existed. Where these agencies encounter people who appear to be in crisis but who do not meet the threshold for S136 (or require treatment in A&E for a physical ailment) the sanctuary can be used to take these people to. The sanctuary will help the person in their moment of crisis, make any necessary referrals or signpost them to other services and arrange for them to be taken home afterwards. Each person gets an allotted two hours at the sanctuary and it is estimated they can accommodate nine people per night. On the two nights it is not actually open to receive clients – a telephone service will be offered instead.

It is hoped that the provision of this service will reduce the number of people being taken to A&E with pure mental health presentations and also reduce the use of S136 as an unnecessary protective measure thereby reducing pressure on the Places of Safety and allowing police and paramedics to safely hand someone over and continue with other duties.

3.3 Predictions of future demand

The initial drop in mental health related demand that occurred across the whole system can be defined a COVID suppressed demand where the true level of need was artificially hidden by people not calling or lack of referrals etc.

There is also COVID generated demand which is mental illness, distress, anxiety, suicidality etc. caused by the effects of lock-down, fear and the economic fall-out.

As mentioned above there is a national prediction of a 30% increase in demand. Local mental health services had started to experience this surge in demand but it is unknown how the second lockdown will effect this.

3.4 THRIVE

The Constabulary are part of the strategic umbrella group at THRIVE and contributed to the development of their report *Mental Health and Wellbeing COVID-19 Response*. The report talks about the expected impact of COVID-19 and but also over 40 recommendations to mitigate this impact. The recommendations have been agreed by the THRIVE Gold Group and are now exploring financing options.

The Constabulary will remain involved in the work and the Office of the PCC will also be represented going forward.

This report is focused in the BNSSG area but the Bath, Swindon, and Wiltshire CCG are now recommencing their own version.

4. **The Constabulary response to mental health on a day to day basis**

4.1 The "13/22 bulge".

The "13/22 bulge" is a term used to describe the visible patterns in mental health demand at both a local and national level: there is a clear pattern that mental health related demand starts to pick up at 13:00 hours and then starts to come down again at 22:00 hours. It is believed that similar patterns are evident in demand on the ambulance service and A&E departments. Locally it has also been noted that the hour preceding midnight is also busy and close to levels at 09:00 hours.

This illustrates the need for wider and longer provision of actual mental health services beyond 17:00 hours. Police data, like this, is currently being used to inform CCG level meetings examining demand and provision.

4.2 Diagnostic overshadowing

Diagnostic overshadowing is where somebody allows a mental health issue to overshadow situational decision-making. It means that the genuine policing purpose is missed with crimes being overlooked and safeguarding not undertaken. Diagnostic overshadowing can be found in cases subject to statutory case reviews, Professional Standards Department reviews and Independent Office for Police Conduct reviews.

Diagnostic Overshadowing is recognised as a key area for improvement and features across Constabulary mental health training discussed below.

4.3 High Intensity Users and Response Plans for individuals with mental health problems.

There is a small but significant cohort of people within the force area, with a usual diagnosis of personality disorder, who very frequently come to the attention of police and other emergency services.

Treatment for personality disorders is complex, intense and is not readily available. From a policing perspective it manifests itself in high numbers of missing person episodes, threats of suicide or self-harm. Faced with this – many officers resort to the use of S136 as a means to immediately keep the person safe. They are assessed and then discharged because a personality disorder cannot be treated with medication or in hospital.

This is ultimately a commissioning issue and it has featured in the plans discussed elsewhere in the report as an urgent and ongoing need. In the meantime, the Constabulary work with clinicians to develop appropriate Response Plans. These are based around the National Decision Model and contain all known relevant information to assist officers when they come into contact with a named person. The plans are embedded on Niche and officers are able access, read and act upon them in real time. These plans are complex and time consuming to prepare are there are only a few people in the Constabulary who can write them.

In recent months, the situation with some of these people has reached the point where taking a criminal justice pathway has been the only viable option. This is only recommended after a great deal of consideration and discussion – where possible but not always – with the agreement of clinicians. But such has become the effect of the behaviour that it has led to considerable use of resources or a significant impact on the public. This is never the preferred option and it is rarely the first but in the cases where this approach has been taken it has been entirely justified, necessary and supported by the finding of the court.

4.4 Supporting the mental health theme internally

When this report was discussed at CMB it was agreed to increase the support to the Mental Health Coordinator with an additional secondment of a Mental Health TacAd. This means the TacAds can focus on tactical and operational work allowing the Coordinator to focus on training, strategic planning and multi-agency liaison.

The Mental Health Board (see below) has also been developed so that broader organisational support can be leveraged to address some of the issues faced.

5. Section 136

The use of S136 has been rising year on year for many years. In the year 2019-2020, there were over 1700 uses which represents a rise of 33% on the previous year. Given the reporting period this increase cannot be attributed in any way to the pandemic. Base on initial data it appears that the pandemic did not cause S136 use to decrease.

5.1 "Conversion rates"

It has been suggested that the police use S136 powers too frequently. One reason that health partners believe this is because of the low "conversion rate". The "conversion rate" is the number of people who are formally admitted to hospital – under Section after a full Mental Health Act Assessment – compared to all those detained by the police using S136. This figure, has for a long time, been about 20-25%; during the pandemic it has some time risen to 30-35%.

However just using this rate does not present the full picture. It does not include the number of people who are discharged, following a S136 assessment, but who receive some kind of follow up or referral with mental health services in the days after. These people account for an additional 40-45 percent. So in total between 60-70% of people who are detained by the police under S136 receive some kind of follow up by mental health services after the event.

It is also important to consider that how someone presents during a Mental Health Act assessment – which usually takes place 12-16 hours after the crisis – will be very different from how they were presenting to the police at the time of contact with officers. That assessment will take place in a calm and safe environment, hours later and after rapport and support has been offered by nursing staff. It is a very different scenario from that faced by officers with a person in full crisis but who appears to need immediate care and control.

What these figures actually suggest is that, in the main, officers are getting the decision right. There may be other options and police powers may be used over-cautiously (see below) but police decision making is made in the heat of the moment and often when there do not appear to be other alternatives that can keep someone safe.

It will be beneficial to try and understand the circumstances of the people who are discharged with no follow up as this suggests that there was not an underlying mental health condition. Academic research indicates that the most likely reason for a S136 detention is suicidal ideation. It is likely that a large proportion of these people will have made suicidal comments. S136 is then used by police to prevent the person from killing themselves, when that is their stated intention, and in the absence of other viable options. S136 is effectively being used as a "suicide prevention tool"[3]

During the lock-down period, despite a notable drop in mental health related demand seen on STORM and across the whole mental health system, the one countable figure which did not go down was the use of S136. Its use remained consistent with numbers from previous months and years. Places of Safety reported as many admissions as the same time the previous year.

Much work has gone on to understand the reasons behind this continual rise as well as reviewing why the existence of triage has not reduced it. This research has been conducted by the Constabulary, the Office of the Police and Crime Commissioner and draft research completed by a university Masters student.[4]

The combined summary of this research outlines the following issues:

1. Officers are calling for advice from a mental health professional more often than not. The law states that this conversation must happen where it is practicable. Reasons why it might not be practicable include the need to

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[3] Menkes and Bendelow: "Diagnosing Vulnerability and Dangerousness": Police use of Section 136 in England and Wales (2014) 13 Journal of Public Mental Health

[4] Moulds K: Keeping the Peace in times of uncertainty: An examination into police and their interactions with people facing mental health crisis during the COVID-19 pandemic. (DRAFT) (2020)

take immediate action with no time to safely make calls or inability to contact a mental health professional. Research shows that officers not calling for such advice when they could or should in approximately 15% of cases. In the other 85% of cases they are either calling, it is not safe to do so or there is no reply.

2. The advice is very often to "use S136". Instances which can truly be claimed as diversions from S136 following such a conversation are very small.
3. The most likely scenario in which a "diversion" occurs takes place when a nurse actually deploys to the scene (the Street Triage Model.)
4. Officers lack confidence in decision making and there is a fear of adverse outcomes.
5. Officers feel they have no alternative option to keep people safe and not wanting to leave them.

Although the samples used for this evidence has been small there are common themes found in this Avon and Somerset based research.

5.2 Potential actions that could help improve the situation

The key, therefore, appears to be training and giving officers the confidence to make better decisions; training is discussed elsewhere in this report.

Having a mental health professional at the scene also appears to be important in what action is subsequently taken. Street Triage is currently limited to the BNSSG area and is financed by that CCG; two nurses provide cover from 10:00-22:00 hours. More needs to be done to understand how well this is used and how effective it is.

The Constabulary and OPCC continue to work closely together with BNSSG CCG and the service provider (AWP) to monitor performance, understand how effective the triage service is and ultimately aim to improve it.

6. Places of Safety (PoS) and Transport

Based on figures in Avon and Somerset, in August and September 2020, around 60% of persons subject to S136 powers are conveyed to a PoS by ambulance. This figure represents an increase on previous years, and reflects national figures.

Because of the pandemic, and increased demand on Ambulances, contingency plans have been agreed, through the Local Resilience Forum, that recognise that the police may have to operate outside of the code of practice and more frequently transport people themselves.

The current practice is that officers should still request an ambulance on every occasion but if it appears that they cannot attend or there is going to be a significant delay – in the best interests of the person concerned – police should transport directly to the PoS rather than wait indefinitely at the roadside.

6.1 Places of Safety

The pandemic has highlighted the lack of PoS capacity within the BNSSG area. Theoretically the PoS should, on most days, be able to accept and accommodate the number of people detained under S136 by police. However the situation is compounded by the speed in which they are assessed once inside. AWP estimate that it takes, on average, 16 hours to assess and then discharge or admit someone. Considering that the period of detention allowed for S136 is 24 hours it is easy to see how a backlog is created. The reasons for this delay are the availability of assessment teams, particularly the availability of suitably qualified doctors and these have been compounded by the bottlenecks described elsewhere in this report. All of these issues are being discussed at the most strategic clinical and commissioning levels with plans being developed to improve the situation.

Pressure on the PoS has also been aggravated by issues in police custody. In cases where a person has been arrested on suspicion of a criminal offence and requires an in-custody Mental Health Act assessment - the speed of assessment and, in particular, the speed in which a bed can be found for someone following an assessment in custody has slowed considerably during the pandemic. This has meant that custody staff – facing an expiring PACE clock – have had no option other than to follow national guidance to use S136 in order to ensure that continued detention is lawful. This means that the person then has to be conveyed to the PoS thus creating additional demand for them.

The general situation is slightly less problematic in Somerset but the availability of suitably qualified doctors seems to be a national issue which cannot be easily remedied.

In response to the pandemic a number of contingency plans were developed which have included temporary increased capacity and the choice of PoS being defined by the location of the detention. None have been sufficient to alleviate the issues entirely.

The wider issue of actual PoS capacity within the BNSSG area is being discussed as part of the overall system-wide response and review meetings which are underway as a result of the pandemic.

6.2 Escalation process

There are no figures for the number of times the multi-agency escalation process has been used. When it has been used the response has, on the whole, been successful. On occasions where it has not worked as well as intended the matter is normally raised with the Mental Health Coordinator who is able to liaise with a senior counterpart in the other agency and resolve the situation. Instances where it has been needed have usually revolved around access to PoS, requests for police assistance or custody related. The escalation process has been highlighted over the pandemic period and partners are working together to identify any learning to improve the processes.

7. Training of officers and staff

7.1 Communications Training

As has been discussed previously data quality is an area for improvement and this applies with mental health in terms of proper flagging and tagging on core systems. To help improve this an automation has been added into the first point of contact process. For the three call-types most commonly associated with mental health (Suicidal, Concern for Welfare and MISPER) the initial call scripts now ask whether it is believed that mental health is the cause of the incident. If this is answered “yes” it automatically populates the mental health tag and qualifier.

Internal training is currently being delivered to the Communications teams; this started in September and sessions will continue to the end of the year. The session outlines relevant mental health legislation, data and demand, case studies regarding diagnostic overshadowing, a myth-busting session and outlines what Triage and the Mental Health TacAds can offer to support staff.

7.2 Mental Health Tactical Advisors

The course delivered to the TacAds is done so by police colleagues, clinicians and a service-user. Students spend one day on placement with mental health services with one of the local Mental Health Trusts.

Separately, the Mental Health Coordinator delivers training and input to outside agencies, such as Places of Safety and approved Mental Health Practitioners on the police role and responsibilities in mental health related incidents.

Feedback on the TacAds has been positive and both the OPCC and university research also identified benefits of the training and the role. Formal evaluation is due to take place by the College of Policing but this has been delayed because of the pandemic.

Between September 2019 and January 2020, over 60 TacAds were trained, from all areas of frontline uniformed policing and from within Communications. Maintaining these levels requires regular training programmes and this has also been delayed because of the pandemic. Due to the success of the course there has been additional demand from staff wanting to take it and additional departments asking for their staff to be included in this training schedule. Consideration is being given as to how to adapt this delivery to ensure it is as effective but also sustainable going forward.

7.3 Supervisor workshops

By late 2018 almost all uniformed Sergeants and Inspectors (at the time) had taken part in one-day workshops on mental health in policing. Due to other training priorities this was not sustainable and the resource was re-deployed to focus on designing, developing and delivering the TacAd training. During this period training was also designed and delivered to Communications supervisors and Custody staff.

The Constabulary has recognised the importance of delivering suitable mental health training to supervisors and has begun to deliver training in Patrol. These are online sessions delivered by the Thematic Lead and Mental Health Coordinator together. Each session covers an update on the current situation regarding policing, mental health and COVID-19. There then follows learning on common errors, legislation and powers, use of force, appropriate use of the Mental Capacity Act and diagnostic overshadowing.

7.4 Mental health training for new officers

In recognising the importance of equipping new officers with the right skills – and to try and address the lack of confidence in decision making – all new officers on the Police Constable Degree Apprenticeship now receive an input,

within their initial weeks, about mental health in policing. Later in their training student officers also take part in mental health related role-play situations which will further test and embed their learning.

7.5 Improvement activity

When this was discussed at October's CMB the Board approved a number of recommendations for improvement activity in this theme:

- to create a cohort of associate trainers from within the existing Mental Health TacAds who could then assist in the delivery of basic mental health training to a wider audience;
- to review all existing initial training for communications, PCSOs, custody and newly promoted Sergeants to establish if there is an opportunity to expand or enhance any mental health elements to include diagnostic overshadowing and other local perspectives;
- for the bespoke mental health courses to be included in the central suite of Avon and Somerset training;
- to design and develop a new basic mental health training package for patrol and neighbourhood teams which would reflect local and national learning. This would be delivered by the new TacAd Associate Trainers.

8. Governance and Partnership working

8.1 A&S Mental Health Strategic Board

The challenges faced in relation to mental health in the Constabulary effect many different parts of the organisation. In recognition of this and to strengthen the senior leadership in this theme, the Constabulary will establish a Mental Health Board. The overarching aim of the board is:

"To ensure that the correct policing purpose in any mental health related incident is identified and understood; to ensure the response is proportionate and that people who present to police while experiencing a mental health crisis will be supported and managed in the most appropriate way by the most appropriate service."

Whilst there is some partnership focus of the board, its primary focus will be internal to ensure all parts of the organisation understand the challenges and work together collaboratively to address these, particularly those relating to diagnostic overshadowing.

8.2 Avon, Wiltshire and Somerset Crisis Care Concordat

The Crisis Care Concordat had been on a long hiatus and was reconvened for the first time in 2019. A way forward being considered is for more local meetings to continue but with the ability to escalate to a regional executive level on an ad hoc basis if the need arises.

8.3 Redesign of the care pathways

The redesign of the care pathway in the North of the force has largely been interrupted and superseded by the contingency planning required to deal with the pandemic. The contingency work has led to emergency and temporary measures being introduced not previously considered as part of the redesign. Many of these local meetings are now adapting into groups examining the lessons learned and considering how things may be different once the crisis period of the pandemic has passed.

The Bristol THRIVE report (discussed above) touches on many of the themes that the care pathway redesign was considering. In many respects the work is progressing but the prioritisation of different elements has changed. Most of the people attending the various THRIVE groups and sub-streams were members of the original pathway redesign group.

There have been no meetings of an equivalent nature in the South of the force. The Constabulary are still engaged with the Somerset Foundation on both operational and strategic items. However there has been no move to "re-invent" the entire pathway in the South as, at this stage, it appears to be a less pressing issue.

8.4 Mental Health Referral pathways

There is currently no method by which the police can notify GPs or primary care of concerns following attendance at an incident whether S136 was used or not. The main reason for needing such a referral pathway is to enable earlier intervention of appropriate health services and support. Even GPs are reporting that they are not being made aware of their patients predicaments until after they have been subject to S136. This presents a significant gap in the ability to better manage mental health issues.

It was hoped that the Avon, Wiltshire and Somerset Crisis Care Concordat would drive this issue forward but, as discussed above, this group is not working effectively. Another avenue considered was how Triage could be utilised but this cannot progress currently due to information governance issues being resolved.

This continues to be a significant risk and the Constabulary are looking for opportunities through the Safeguarding work but also looking to follow up on recent movement from health partners in both the North and South of the force.

9. Conclusion

Mental health demand was increasing prior to the pandemic and this has been exacerbated by the pandemic and response to it. This demand is anticipated to continue.

Mental health is recognised as core policing business by senior leaders in the Constabulary but more needs to be done to embed this view among 'front-line' colleagues. Through leadership and training the Constabulary are trying to change the way mental health is dealt with internally in order to improve the service both to those with mental ill-health whilst also securing the best public service for the wider community.

As well as progressing the improvement agenda internally the Constabulary are working with partners locally, regionally and nationally to try to bring about the whole system changes. This broader change is needed to make a fundamental difference to those with mental ill-health and ensure they receive effective help which will prevent their repeated contact with the police.