

The impact of the Covid-19 pandemic on Approved Mental Health Professional (AMHP) services in England

December 2020



Commissioned by British Association of Social Workers (BASW) England
and the Department of Health and Social Care



Department
of Health &
Social Care

BASW
England

The professional association for
social work and social workers

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Foreword

BASW England and the office of the Chief Social Worker in DHSC are pleased to have been able to jointly commission and support this important piece of research. It was undertaken by BASW ENGLAND and the AMHP Leads Network.

We have been very aware of the effort and commitment by AMHP teams and Emergency Duty Services across the country to fulfil their duties under the MHA 1983 during the Covid 19 pandemic. Individual AMHPs have continued to undertake face to face support for people in mental health crisis and AMHP services have worked hard to adapt their response to meet the challenges of these very difficult working conditions.

This report provides us with the research, information and specific examples from across AMHP services. We now have the detailed information we need to understand the role of the AMHP during the pandemic, the changing pressures on the service and how AMHPs have responded.

The office of the Chief Social Worker in DHSC will study the report and the conclusions carefully. We would like to thank all of the approved mental health professionals working across the country. Your hard work and commitment is very much appreciated and valued. BASW England and the office of the Chief Social Worker in DHSC are pleased to have been able to jointly commission and support this important piece of research. It was undertaken by BASW ENGLAND and the AMHP Leads Network.

Commissioned by BASW England and the Department of Health & Social Care

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Executive summary

This report is based on responses to a survey from 100 AMHP services across England, which account for 75% of the local authorities across the country. The survey asked a variety of questions regarding the impact of the Covid-19 pandemic on AMHPs and AMHP services across England. The questions focused on changes in demand for Mental Health Act (MHA) assessments both during the first lockdown and following the easing of restrictions, the possible reasons for the changes and the impact of the pandemic and the resulting restrictions on staff.

While most respondents reported an increase in assessments overall, many reported an initial decrease at the start of the lockdown. However, there is widespread reporting of an increase during the lockdown period and into the post-lockdown period in summer. This amounts to a higher level of demand than prior to the pandemic. Many services identified a significant increase in 'first-time presentations' of people who had not been previously known to mental health services. There are variations in the different client groups with some reporting increased referrals of older adults, possibly due to shielding leading to isolation and lack of contact before deterioration to crisis point. Many services reported an increase in the incidence of s136 detentions, particularly when the lockdown started to ease. There is no information regarding the demographics behind these increases, which is particularly relevant in relation to the overrepresentation of black people, particularly those with African and Caribbean heritage amongst those detained under the Act.

There was widespread reporting of an increase in referrals for MHA assessments which did not result in a full assessment. Concern was expressed from many respondents that withdrawal of face-to-face visits and monitoring by community services, and reduction of contact to telephone only, led to requests for MHA assessments which would not otherwise have been made and which did not warrant consideration of detention in hospital. The view was expressed by a significant number of people that the AMHP services were fulfilling a function that had previously been undertaken by community teams.

The lockdown forced many services to restructure their AMHP workforce and the location of the professionals. Many moved to working from home. This raised a number of issues in relation to support, supervision and management, particularly in the context of MHA assessment referrals, which by definition entail high risk with a need for rapid information gathering and assessment. It also creates additional complexities due to the requirement for close and timely inter-agency working with the NHS, police and ambulance services. Many respondents reported a rapid development of effective virtual communication platforms, to keep contact with the AMHPs on duty and also the other agencies. Some of these will continue to be used post-pandemic.

Most services were able to access PPE but the amount and type varied considerably. There also appeared to be variation between services which had a close relationship with the NHS trust and those which relied on supplies from their local authority. The variations in use of PPE is notable and it would be helpful to gain a greater consistency of expectation in a future lockdown.

Following increased discussion regarding the legality and ethics of MHA assessments undertaken via video link, NHS England and DHSC issued a briefing note in May which included guidance on the use of digital technology for such assessments. However, despite this guidance the survey showed considerable ambivalence amongst AMHPs and AMHP services to use such platforms. The concerns were legal, professional and ethical. Some respondents reported having undertaken video assessments, but very few stated they had been used for assessments considering detention in hospital. Most used them for CTOs or guardianship.

MHA assessments pose particular challenges for health and safety in the context of the pandemic. Three professionals and a patient are (normally) required to sit together in a room as part of the process. The patient will often be in mental health crisis which may include significant distress or agitation, so distancing can be problematical. Careful consideration needs to be given to the issues which arise during MHA assessments in the context of infection control.

Difficulties in finding 'a bed' for a person needing psychiatric admission, and the problems of patients being admitted to far-flung hospitals are well-established and long predate the pandemic. Equally the challenges posed for the police and ambulance services to respond to requests for assistance, in the context of the other demands on their resources. Perhaps not surprisingly, the pandemic threw up further issues in relation to these chronic difficulties. These difficulties were reported both during the first lockdown and when the restrictions were eased.

Many respondents reported greater difficulty in accessing admission beds, possibly due to the need to isolate patients who were COVID-positive or at risk of being. Many areas found section 12 approved doctors less available, due to shielding, isolation or redeployment to COVID duties. Some ambulance services reduced or stopped providing transportation for mental health patients, leading to some services starting or increasing their use of private ambulance services.

The pandemic has brought into sharp relief a number of issues which were already problematic in the context of AMHP services. The availability of section 12 approved doctors, the timely availability of an admission bed and also of the emergency services are mentioned above. The particular problems caused by patients being admitted to distant hospitals, sometimes over 100 miles from their home, is always traumatic and distressing to the patient, and also causes significant additional difficulties for assessments.

Some of the actions taken in response to these additional challenges have raised interesting and potentially hopeful developments, and it is important that the lessons learned in the lockdown and as the restrictions were lifted in summer need to be carefully considered, both to respond to further controls which may be imposed, and to identify examples of good practice for the future.

Introduction

The British Association of Social Workers (BASW) England and Department for Health and Social Care commissioned a survey of AMHP leads to consider the impact of the Covid-19 pandemic on AMHP services across England. The survey was undertaken during September 2020 and elicited 106 valid responses.

Method/approach

A number of local authorities submitted multiple responses. The author liaised with each authority and in most cases the additional submissions were deleted, leaving a single submission. After consultation with the respective leads in six authorities, both responses were retained due to the nature of the AMHP service and the value of the individual responses.

Respondents were asked to specify their name and local authority, but this was not a mandatory field. All but one anonymous response were deleted. The one retained response contained significant information and comments.

In total, therefore, 100 different local authorities responded to the survey with a response rate of 67%.

The author felt that it was important to incorporate a number of pertinent comments from the survey, and they have been included in this report. All identifiable information from these comments has been removed.

The questions covered a variety of topics within the overall subject of Mental Health Act statutory activity during the Covid-19 pandemic. There were a mixture of multiple choice answers with most questions allowing for respondents to add their own comments, giving reasons for their answers or allowing them to expand further on the issue.

The full list of questions is provided at the annex at the back of this report, but they are divided broadly into these topics:

- The impact of the Covid-19 first wave and lockdown on MHA assessments
- The number of referrals against the number of actual assessments undertaken
- Service changes and improvements during the first wave
- Staffing issues, such as numbers of available AMHPs and the impact on staff well-being
- Support to AMHPs and PPE issues
- Changes to support to service users
- Use of remote technology for assessments
- AMHP training
- Other resource issues during the first wave.

The author, BASW England and DHSC would like to thank all those people who responded to the survey and administration support from BASW England. Respondents spent significant periods of time answering the questions and making pertinent and powerful comments thus ensuring providing the survey with valuable additional detail.

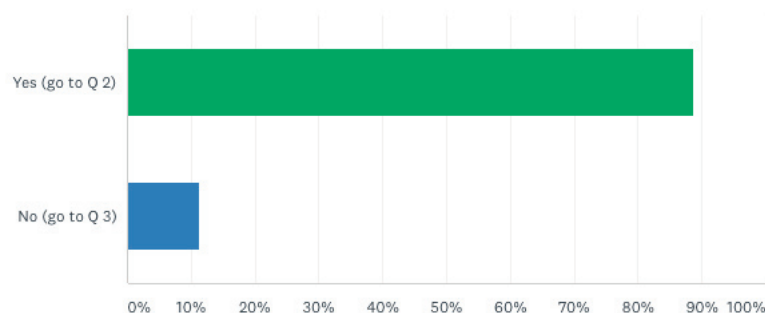
Steve Chamberlain
Chair of AMHP Leads Network and BASW England member

The impact of the lockdown (March-June) on Mental Health Act (MHA), assessments and the impact of the reduction of the restrictions (July-September)

A large majority of respondents reported a change in the pattern of MHA assessments during the lockdown period in spring. Approximately twice as many services reported an increase in assessments against a decrease.

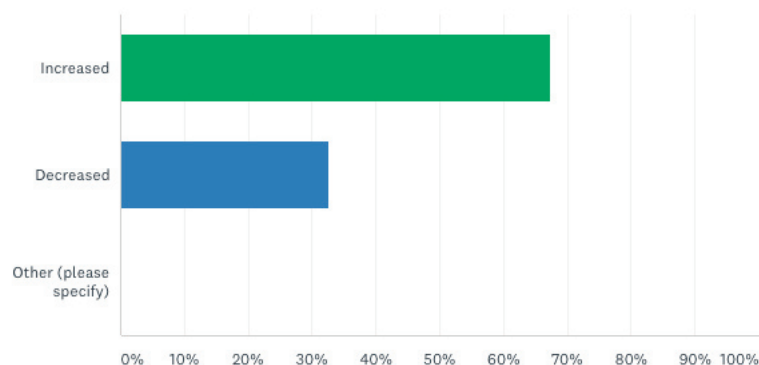
Q1. Have you identified a change in pattern or number of MHA assessments undertaken in your area during the Covid-19 lockdown (April - June)?

Answered: 106 Skipped: 0



Q2. Please indicate the change to the number of assessments

Answered: 92 Skipped: 14



Various reasons were given for the changes. Several respondents spoke of an initial reduction in assessments at the start of the lockdown, possibly due to people keeping off the street, not coming to the notice of the police, not attending hospital, not being seen by their support professional or family and therefore any deterioration in their mental health not being noticed.

Other comments included an increase in assessments for older adults, maybe due to people deteriorating to crisis point after attempting to shield and therefore staying away from services.

A striking feature was the increase in first-time presentations. 75 people reported it in response to question 12 (75% of all respondents). This was raised by several people in the comments as a relevant factor in the change to the overall number of assessments.

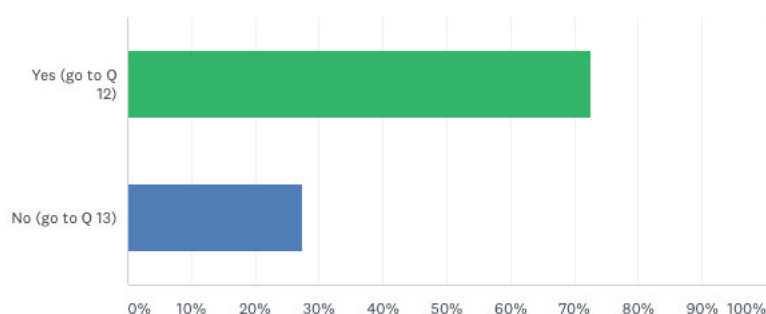
“New presentations due to increased anxiety and isolation”

“... a lot of people who had not been known to services and had a first presentation of poor MH.”

“In the early part of the pandemic ... there was an increase in ... requests linked to people with no known history of mental illness slipping into a highly anxious state”

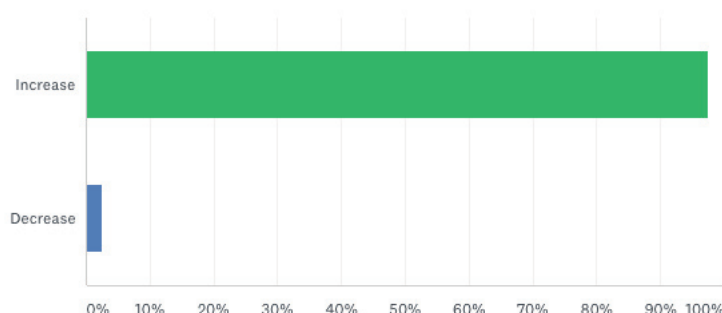
Q11. Since the start of lockdown (March), have you noticed a change in the proportion of first-time presentations? (i.e. person previously unknown to mental health services)?

Answered: 106 Skipped: 0



Q12. Please indicate the change in the number of first-time presentations. Any views on the reasons for this change are welcome in the 'other' box

Answered: 77 Skipped: 29



Many who reported an initial reduction also reported a “bounce-back” increase, either towards the end of the lockdown or during the summer period when the restrictions were eased. The thoughts regarding this focused on the lack of contact from services for people who were receiving mental health care. Home visits were suspended, people were not attending clinics and much monitoring was taking place by telephone.

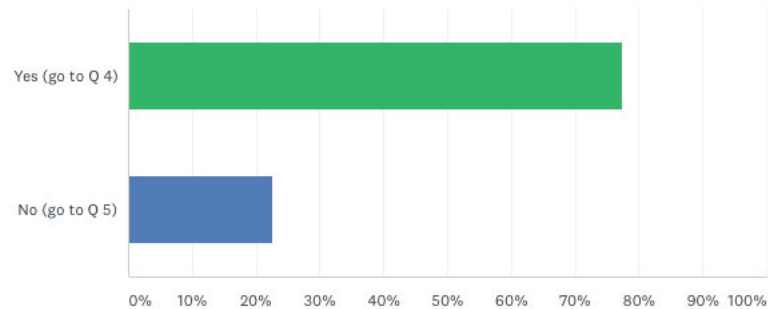
“Service users not willing/able to access community mental health services resulting in destabilisation of mental ill health”

“Lack of community-based support of face to face contact with service users”

“...a lack of services within the community due to home visits being reduced or taken away. There was a lack of lesser restrictive options due to Covid restrictions.”

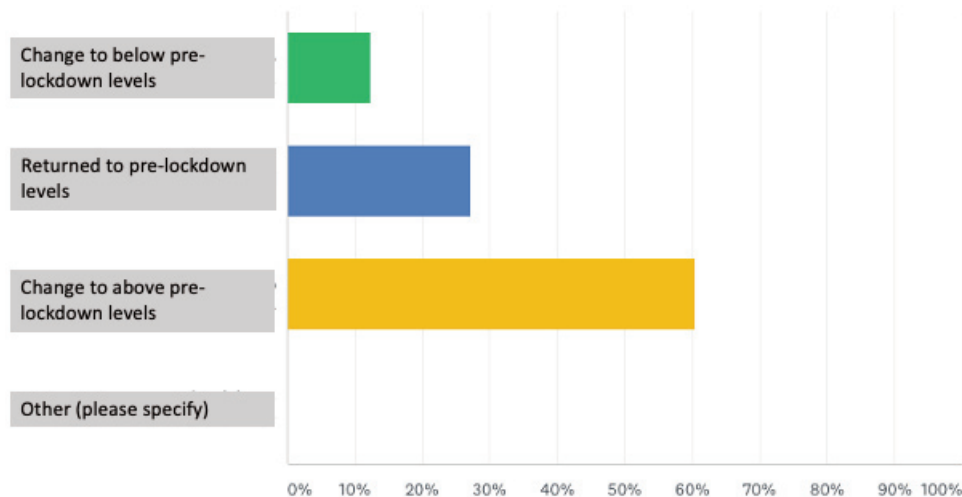
Q3. Since the lockdown started to ease, (since the beginning of July) have you noticed a further change in the pattern (or a new change if no change previously)?

Answered: 106 Skipped: 0



Q4. Please indicate the change to the number of assessments

Answered: 81 Skipped: 25



There is a mixed picture of the activity during summer when the lockdown started to ease. Some services reported a spike which settled down towards mid-summer, while the majority reported a continued increase in demand.

"Since the end of lock down we have seen a sharp rise in assessment requests – around 42% increase on same time last year"

"Many known service users relapsed as they were not followed up by CMHT's and also increase in isolation."

The pattern of presentations of people not previously known to the service continued to be mentioned by a number of people.

The impact of the lockdown (March-June) on s136 detentions, and the impact of the reduction of the restrictions (July-September)

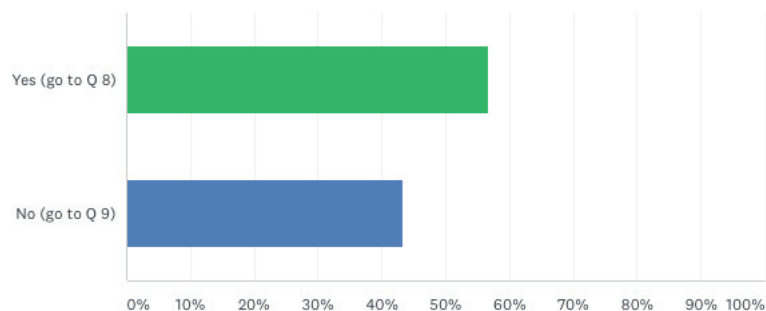
There is a mixed picture regarding the use of s136 during the lockdown period. Approximately 60% of respondents identified a change, but almost 40% of those reported a reduction, with the rest identifying an increase. Those reporting a decrease provided unsurprising reasons, such as ***“people weren’t going out and thus did not come to the attention of services”***.

For those reporting a higher incidence, there were comments regarding de-arrests at police stations leading to s136 and police using A&E more frequently.

There is a more consistent picture during the period when restrictions were eased. A significant number of services reported an increase in the use of s136 post-lockdown, and the reasons may be reasonably predictable with people returning to the streets.

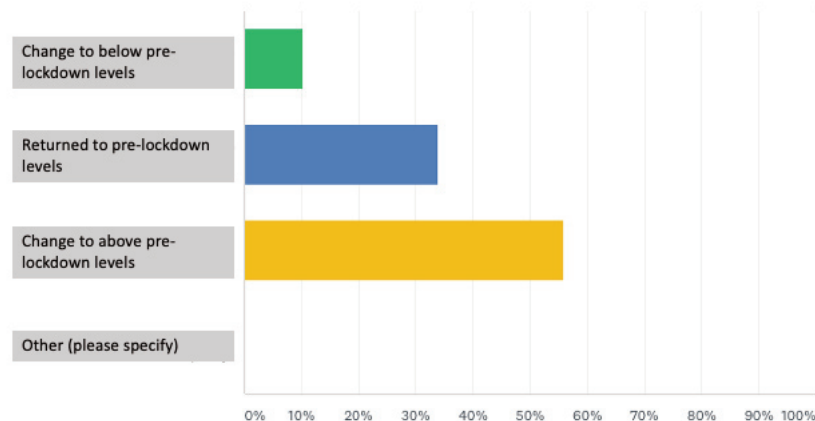
Q7. Since the lockdown started to ease, (since the beginning of July) have you noticed a further change in the pattern of s136 use (or a new change if no change previously)

Answered: 106 Skipped: 0



Q8. Please indicate the change to the number of s136 detentions

Answered: 59 Skipped: 47



"The long term impact of people's mental health due to the pandemic is now being seen with people being more visible and coming into contact with others."

"People are presenting as increasingly distressed possibly due to isolation, severe anxiety, poor compliance with medication, unable to contain their symptoms."

"28% increase in s136 use. Ongoing issue with people not being seen and supported directly. New presentations due to pandemic-related stress"

For some services, changes in the provision of Health-Based Place of Safety (HBPoS) made it difficult to make comparisons with previous years. Some HBPoSs have been closed or amalgamated, taking detainees from multiple boroughs.

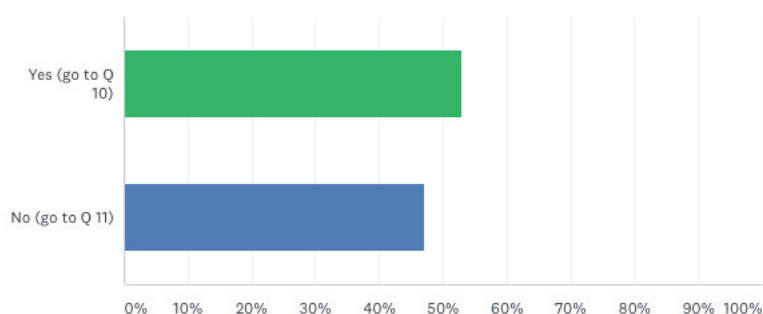
Numbers of referrals which did not result in a full MHA assessment *and* Evidence of requests for MHA assessments as an alternative due to services being unwilling/unable to visit

These were posed as separate questions, but the answers contain significant overlap in the themes that they raise, so they are being considered together in this part of the report.

While only approximately half of respondents reported a change in the number of referrals which did not result in a full assessment, of those who reported a change, approximately 90% reported an increase. Many spoke of the reduction in availability of other support services and believed that a referral to the AMHP service was being used as a method of ensuring contact with a service user who was not easily contactable. Others spoke of concerns for service users whose mental health appeared to be deteriorating, but a failure to explore less restrictive responses and a precipitate move to MHA assessment due to the anxieties and difficulties posed in gaining face-to-face access to the service user.

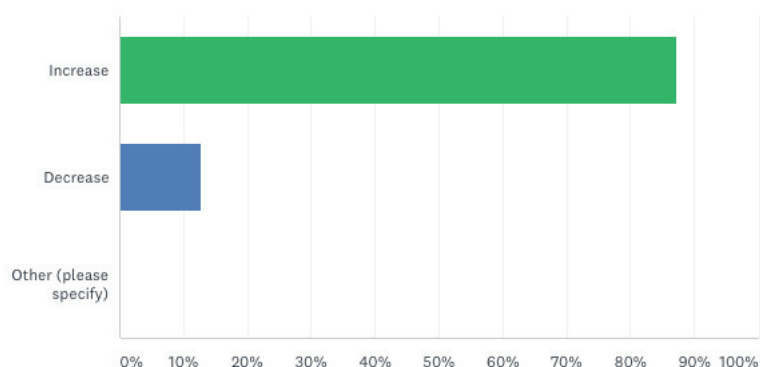
Q9. Since the start of the lockdown (March), have you noticed a change in the number of referrals to the AMHP service which did not result in a full MHA assessment?

Answered: 106 Skipped: 0



Q10. Please indicate the change in the number of referrals to the AMHP service which did not result in a full MHA assessment

Answered: 55 Skipped: 51



Several quotes are included here to indicate the responses from a range of services.

"NHS mental health services were unable to respond in their usual way and it seemed as though there were some cases where the MHA was being used to triage their new referrals."

"Primary reason is mental health teams receiving concerns from family, neighbours, informal supports and not being prepared (or feel able) to go out themselves – in effect defaulting to MHA requests."

"Due to lack of services available people saw the Mental Health (MH) route as a way of intervening which was not always appropriate but in some circumstances did lead to admissions."

"It is thought that lesser restrictive services/GP's were not willing to follow people up or visit. It was often the case that if someone would not engage by not answering the phone that a referral was made to the AMHP service, meaning that the MHA was used inappropriately and the AMHP service was bridging a gap."

"Referrals mainly from the MH Trust were MHA [assessment] was being requested as care coordinators were stating they cannot visit due to lockdown restrictions."

"Because Crisis and the AMHP's were the only two services seeing people face to face, if crisis did not know what to do, they immediately referred to us, the community referred to the AMHP's without seeing the person, as did the elderly teams, all most all these referrals were inappropriate as the least restrictive option had not been considered."

"...a lack of involvement from both social care and health services resulted in more referrals for MHAs which were not appropriate as were asked for as 'we are not going out so your team needs to'."

As mentioned in some of the quotes, policy decisions in some services that staff should not undertake home visits during the lockdown period led to some referrals being made to AMHP services without the normal assessment from the community team and consideration of a less restrictive response.

Another point raised by a number of respondents was the increase in "nearest relative requests"¹. These requests are relatively uncommon, though far from unheard of. The duty placed on the AMHP is not to set up a full MHA assessment, but to formally consider whether compulsory admission is necessary, and if that is not the outcome, the nearest relative must be informed of the reasons in writing. This statutory duty raises important issues of confidentiality, particularly if the service user is not in close contact with their relative or does not want information shared.

Several respondents commented on the increase in numbers of "nearest relative requests".

"...more NR requests as CMHTs are telling NRs to request even though they do not feel the threshold is met."

"...families being advised of their NR rights to request MHA consideration without any reference to AMHP services (this probably more than anything else has led to more inappropriate referrals that still require a consideration and response from us)."

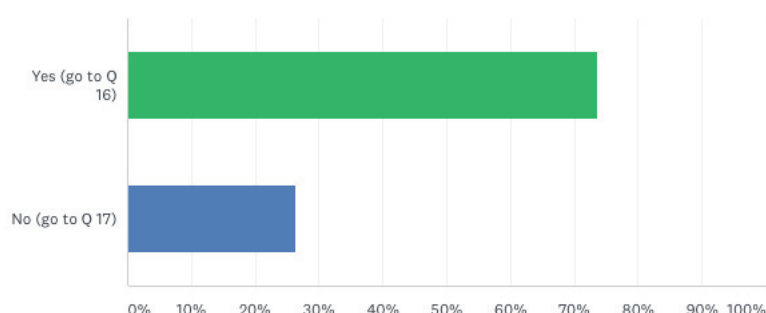
¹ MHA s13(4) places a duty on the LSSA, if requested by the patient's nearest relative to arrange for an AMHP to "consider the patient's case with a view to making an application for admission to hospital". In any case where an application has not been made, the AMHP must inform the nearest relative of the reasons in writing.

“More services were “helpfully” informing nearest relatives of their right to request assessment, when their own service were unable or unwilling to provide face to face input themselves.”

Many people who answered “yes” to question 15 (below) identified requests for MHA assessments being made by services who had not seen the person and were not undertaking face-to-face assessments as a matter of policy. Concerns about a person’s welfare were rapidly escalated to the AMHP service where it was expected that a face-to-face contact would be required.

Q15. Since the start of lockdown (March), have you identified any evidence of requests for MHA assessments to be used as an alternative due to services being unwilling/unable to visit (e.g. crisis/home treatment services)?

Answered: 106 Skipped: 0



There were a range of comments regarding which teams were continuing to see service users/patients face-to-face. A number of people commented that the Crisis Resolution and AMHP services were the only teams who continued to undertake these assessments, while a similar number stated that the Crisis team in their area had also reverted to telephone contact only.

The lack of home visiting from services such as community mental health, adult social care, GPs, primary care were mentioned. Concerns caused as a result of telephone contacts and a lack of effective screening led to requests to the AMHP service.

Several respondents spoke of an increased referral rate from police stations due to the removal of nurses from the diversion service and their availability only by telephone. This led to increase requests for MHA assessments in the absence of on-site mental health expertise or due to a reduced ability to undertake effective assessments.

“Custody [diversion] nurses were not going to police stations and instead assessed people by phone and ... made more referrals for MHAs which they knew would be face to face”

“During lockdown, the Diversion Service stopped locating themselves in Police Stations and were only willing to speak to people by telephone. This meant if a detained person had a psychiatric history, they were being referred for MHA, in order to get professionals visiting.”

“...an increase in assessments from police custody as nurses who are usually based in custody were working remotely, if the police were concerned for a persons mental state and that person refused to engage via the telephone then a request was made for a mental health act assessment.”

As a result of these concerns, a number of services reported developing a more robust triage system for MHA referrals and closer scrutiny before accepting the referral for a full assessment. This can be seen as a positive development, in that it ensures that all less restrictive options have been attempted before proceeding to a MHA assessment. However, it could also lead to increased tension between the AMHP service and community teams regarding the most appropriate response to a service user and also possible delays in the provision of appropriate support.

One quote effectively summarises the dilemma for the AMHP, who is required to follow the guiding principles of the MHA as set out in the Code of Practice, including principle one: Least Restrictive Option and Maximising Independence.

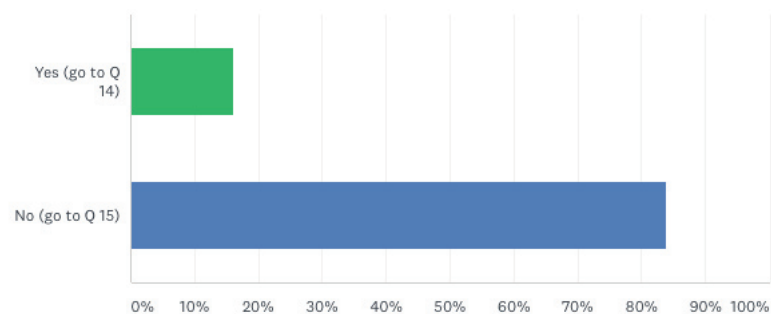
“The use of the MHA as a response in the absence of considered alternatives, continues to be an issue requiring discussion and exploration of other (statutory) alternatives.”

Change in proportion of people homeless prior to assessment

A small number of respondents identified a change in the proportion of people homeless prior to assessment, and while 60% of those who identified a change noticed an increase, this amounts to less than 10% of the total respondents.

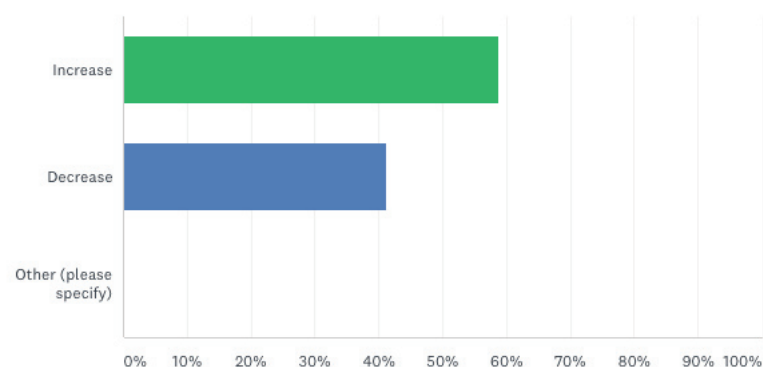
Q13. Since the start of lockdown (March), has there been a change in the proportion of people who were homeless prior to assessment?

Answered: 106 Skipped: 0



Q14. Please indicate the change in the proportion of people who were homeless prior to assessment

Answered: 17 Skipped: 89



Only 13 people added any comments to their answers. Most commented on the fact that many or most street-homeless people were temporarily housed in hotels during the lockdown period and that they seemed to be supported more effectively than in normal times.

There remained a question about how effective mental health support was provided to these people, but there is little evidence that this led to a significant increase in MHA assessments.

Staffing issues

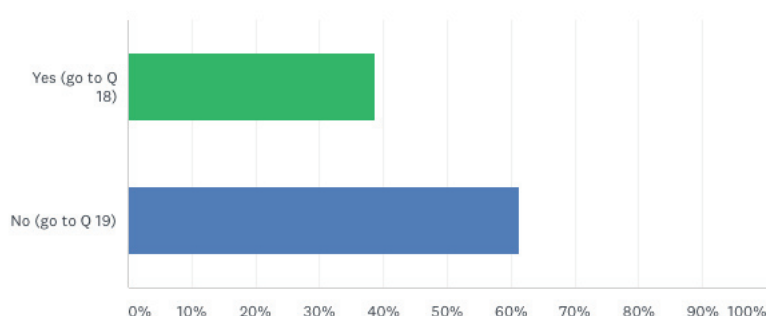
Availability of AMHPs to respond to demand and support provided to AMHPs during the pandemic

Most services reported no problems in relation to sufficiency of AMHPs during the lockdown period, although almost 40% did report issues.

A very significant proportion of those who commented mentioned staff who were shielding and therefore unable to undertake face-to-face assessments. The AMHP workforce is significantly older than the wider social workforce². It is well-established that the older age group are at considerably higher risk of serious illness from Covid-19 than younger people.

Q17. Did you experience problems during the lockdown period (March - June) with having enough AMHPs to respond to the demand for assessments?

Answered: 106 Skipped: 0



Many services rearranged their staffing to allow shielding and self-isolating staff to take on roles which could be completed remotely. These included taking and triaging referrals, follow-up discussions, setting up MHA assessments.

“... staff [unable to undertake assessments] took on other duties such as duty, screening referrals and assisting with setting up assessments. The remaining AMHP workforce pulled together to ensure we were able to fulfil our statutory duties. Community AMHPs level of contribution to the rota doubled, they made themselves available at short notice to support the rota.”

“We managed demand, but did this by seconding workers from other areas, and supporting the rota with managers and community workers.”

“We separated into 2 ‘bubbles’ very early (before Gov suggested) in order that if one was +ve did not take out the whole group. We also as a group of local AMHP Leads devised the means to authorise each other’s AMHPs if needed, this has not had to happen.”

“... other LA’s agreed for AMHP’s to act on behalf of due to our close geographical location. although not enacted, it gave a contingency.”

Self-isolation due to sickness, family exposure or concern regarding infection was unsurprisingly a common factor in staffing difficulties. Many people who reported difficulties described creative methods of ensuring the local authority’s statutory duties were fulfilled and there appears to have been considerable flexibility to keep sufficient staff available to respond to demand.

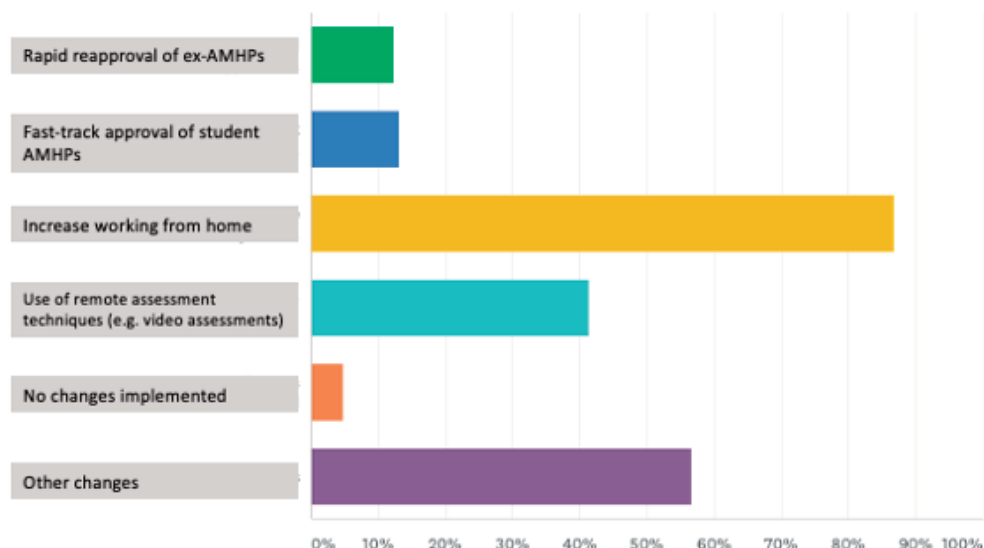
² Skills for Care survey of AMHPs in 2019 found 32% of AMHPs were at least 55 years old (up from 30% in 2018) against 22% of all social workers (21% in 2018)

Changes in service configuration

Unsurprisingly, nearly all services implemented some changes in working practices as a result of the pandemic. 87% introduced working from home and only 5% reported no changes. A little over 40% undertook remote assessments and 13% used rapid reapproval and/or fast track approval of AMHP trainees.

Q19. Did your service implement any changes in response to the Covid-19 pandemic? (please tick all that apply)

Answered: 106 Skipped: 0



Respondents had the opportunity to add other changes or comment further on their replies. Many reported increasing the frequency of meetings through remote technology: Skype, Teams, WhatsApp. This was both to share information regarding referrals and ongoing work and also to keep in contact and provide support. A small number of respondents commented on the lack of risk assessments or delays in providing them.

While many services were forced to move to remote communications due to the Covid-19 restrictions, some respondents have commented on the improvements to the service and to communications that have resulted. This has been relevant not just to internal staff but at times to the multi-agency.

***"We introduced [an] AMHP huddle meeting every morning.
Where those on duty, the manager and senior attended.
We'd talk through referrals, how people were feeling, allocate work"***

"[MS] Teams has enabled us to open up some of our supervision and reflective practice sessions to AMHPs across [county] who can login from home which would not have been accessible previously due to location of meeting and available space in meeting rooms. We have worked with partners in health and the private ambulance service to improve our communication with relation to MHA assessment work. Since Covid we have introduced a daily AMHP, AMHT, Secure ambulance daily call so we can talk about referrals for MHA's, issues such as bed availability, prioritising of assessments etc. These meeting have been really well received by all parties and which there has been discussion about continuing post Covid."

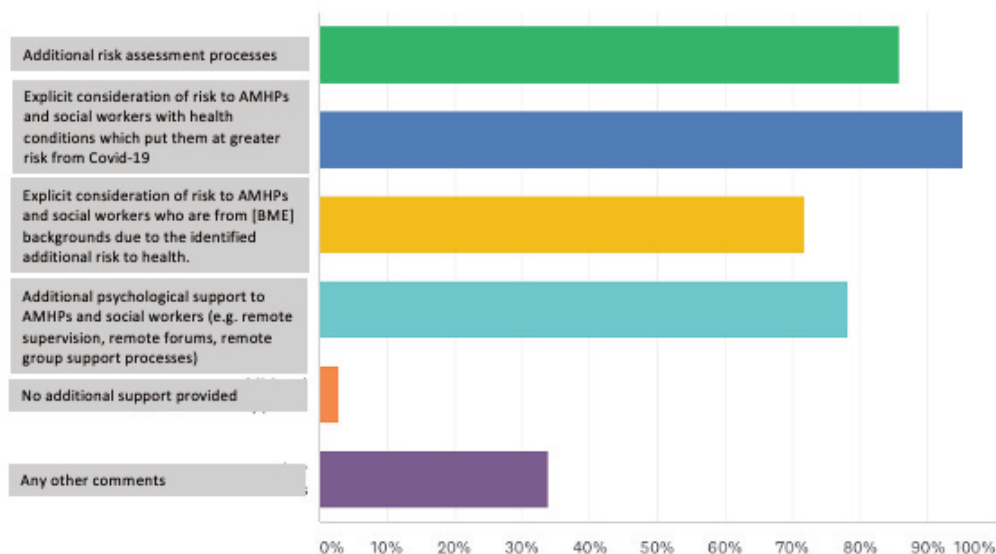
Some services made agreements with neighbouring councils to authorise their staff to work on behalf of each other's authority, as a contingency for severe staff shortages, but of those who mentioned this, they commented that it had not been necessary.

Action by managers to support AMHPs

A large majority of respondents reported a variety of actions to support AMHPs since the start of the pandemic. 95% gave additional consideration to AMHPs with health conditions placing them at greater risk of the disease and 86% increased their risk assessment processes. 78% referenced explicit consideration of risk to AMHPs from black and minority ethnic backgrounds. Although this suggests that 22% did not make such considerations, some commented that they did not need to consider this as they did not have any AMHPs from these backgrounds in their workforce.

Q20. What specific action has been taken by managers to support AMHPs since the start of the pandemic? (please tick all that apply)

Answered: 106 Skipped: 0



Many services increased contact within teams, including daily meetings of AMHPs on duty, or multiple 'catch-up' meetings during the day. Some increased the frequency of team meetings to weekly to ensure contact was maintained with all staff. Several people commented on the use of social media platforms such as Skype, WhatsApp, MS Teams, etc. to keep contact with and between staff members.

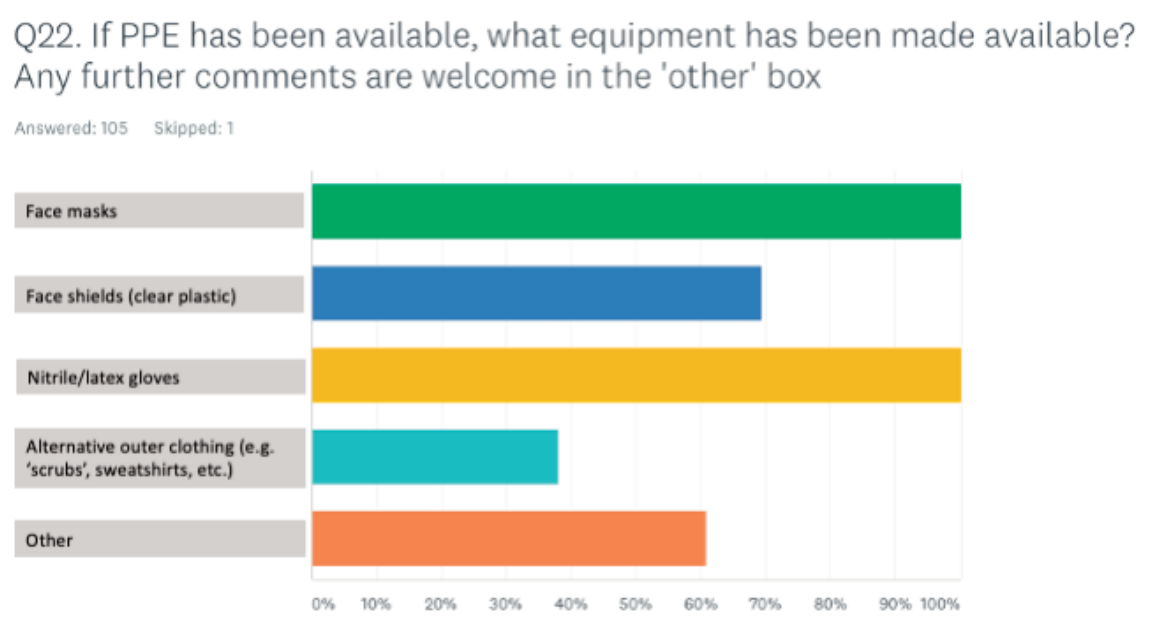
One organisation (not just the AMHP service) developed a 24/7 helpline for staff, while another had a "staff welfare cell". An issue raised by a number of respondents was concern about possible isolation of team members. This is mentioned further below in the section on well-being of the workforce.

"[A regular morning meeting] has been received well and continues as most of us are still working from home. I feel strongly AMHP's should not work in isolation. It's still not quite the same as being in the office on duty together but the team feedback is that they continue to feel supported."

Availability and use of PPE

84% of respondents stated that PPE was available throughout the lockdown period. Of the remaining replies, half reported availability towards the end, and half had intermittent availability. No one reported that it had been unavailable or that staff had been expected to use their own.

All respondents reported the availability of face masks and gloves, 70% reported the availability of face shields and 38% alternative outer clothing, including scrubs.



There was a very common theme of PPE being difficult to obtain in the early stages of the lockdown. This was a significant cause of stress for AMHPs at that time. Some AMHPs started by purchasing and using their own cleaning and sanitising materials. A small number of respondents reported positive experiences from the start.

"Despite our AMHP Service not being part of our s75 agreement, [our] local MH Trust...provided us with all the PPE our AMHP required and our s12 doctors. They were outstanding!"

One local authority trained three of their AMHPs to use specialist PPE for use in very high-risk situations.

Respondents were asked to state what equipment had been made available. The word cloud indicates the most commonly used terms. Aprons and hand sanitiser/gel were the most common items, with goggles, face shields and face coverings also featuring regularly.

There were a variety of supply arrangements between trusts and local authorities. This may reflect the different partnership arrangements. Three respondents mentioned the availability of 'scrubs', with one restricted to hospital assessments only.

One organisation provided lockable bins to dispose of used PPE when out in the community.

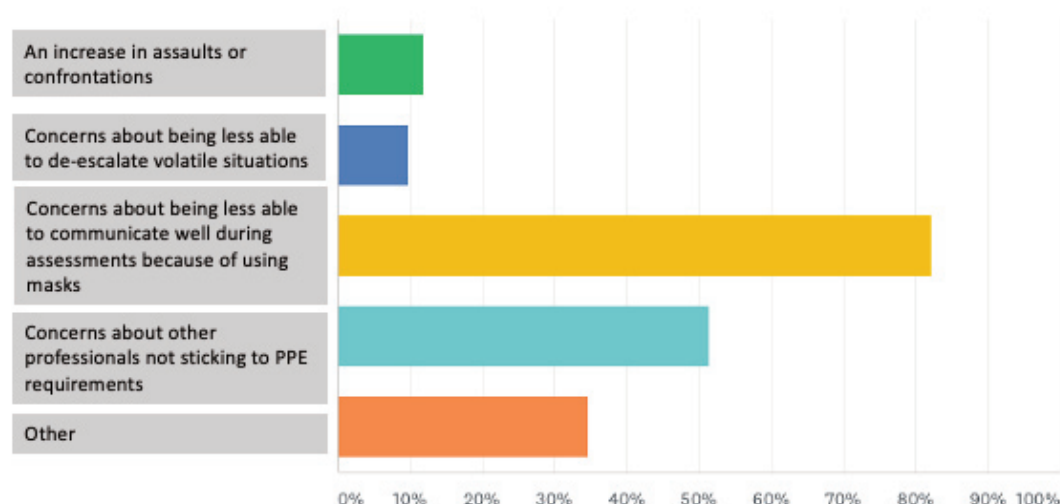


Concerns from AMHPs in relation to undertaking MHA assessments

The main concern from AMHPs was about the difficulties communicating well during a MHA assessment when wearing PPE. Over 80% of respondents reported this. Approximately half reported concerns about other professionals not complying with PPE requirements.

Q23. Since the start of the lockdown, have your AMHPs experienced any of the following? Any other comments are welcome in the 'other' box

Answered: 101 Skipped: 5



A smaller number (around 10%) had experienced an increase in assaults or confrontations, and also had concerns about being less able to escalate violent situations.

One respondent raised the possibility of using clear masks to improve communication and visibility of the AMHP's face, but at the time of the survey was still awaiting a response from their organisation. There was a positive comment on the use of face shields (visors), although there is a debate about whether face masks should also be used even when shields are worn³. The use of face shields could address a variety of issues, such as service users being unable to see the AMHP's face; inability to lip read and problems for people with impaired hearing; and production of excess waste (if reusable shields are used).

Some respondents reported pressure on AMHPs not to wear PPE, with other professionals stating that the PPE would cause fear to patients in a hospital. There were several instances where other professionals were not wearing PPE or practicing effective distancing, which could also impact on the ability to work as a team during the assessment. These examples were not widespread.

Some incidents were reported where the PPE fed into the service user's delusional thought processes or exacerbated mistrust in people who were already reluctant to engage. However, more respondents stated that the need for PPE tended to be acknowledged, while some AMHP services developed a standard procedure of commenting at the start of the assessment on the unfortunate but necessary requirement to wear the PPE.

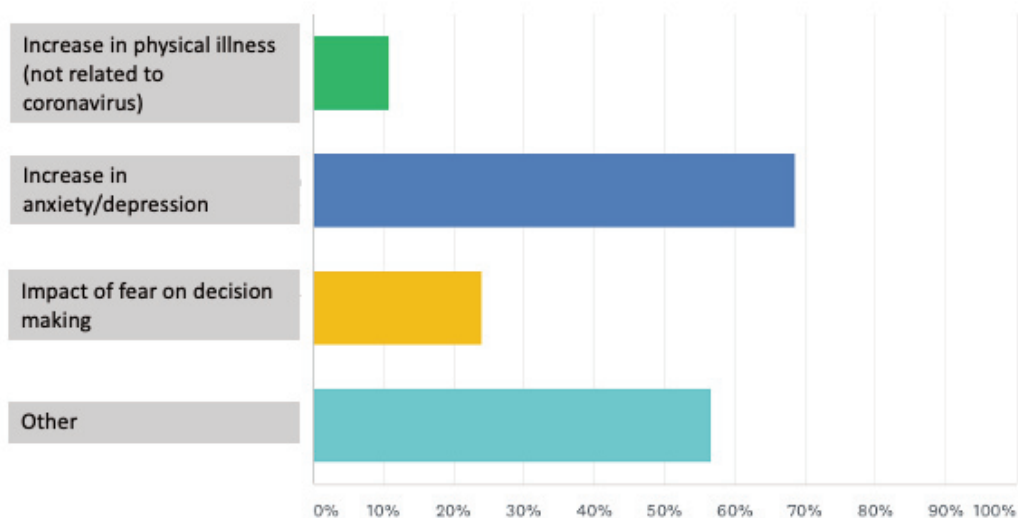
³ There is conflicting advice within the UK countries about the use of face shields. The US Centre for Disease Control advises if someone uses a face shield rather than a face covering, it "should wrap around the sides of the wearer's face and extend below the chin".

Impact of the pandemic on AMHP well-being and sickness

70% of respondents reported an increase in anxiety/depression⁴ during the lockdown period, and this remained high (62%) since the lockdown eased. Many comments were made differentiating the two 'diagnoses' and commenting that anxiety has been featured, rather than depression. Some commented on low mood and low morale, in the context of the duration of the restrictions and the ongoing additional stress while undertaking the AMHP role.

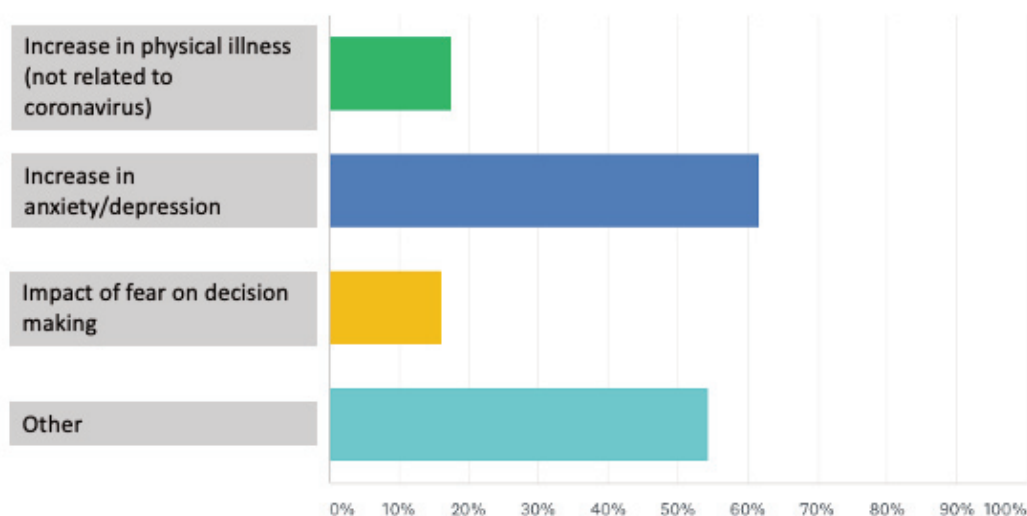
Q27. Have you noticed any of the following withing your AMHP workforce during the lockdown period? (April - June). Any further comments are welcome in the 'other' box (please tick all that apply)

Answered: 83 Skipped: 23



Q28. Have you noticed any of the following within your AMHP workforce since the lockdown has eased?

Answered: 68 Skipped: 38



⁴ Please note that these terms are used in the 'lay' sense and do not indicate formal diagnoses of these common mental disorders.

A common message spoke of emotional and physical fatigue developing over the course of the lockdown period and beyond. Despite the lifting of the harshest restrictions, risks of infection have remained, requiring additional risk assessments and adaptations to assessment processes. It must be noted that the current resurgence of the virus across wide areas of the country is likely to exacerbate the issues raised in this survey.

"I sense that as time has gone on, it is becoming tougher and tougher on most AMHPs due to the cumulative effects of such substantial changes in working practices. AMHPS and managers have less face to face time with each other, other professionals and also clients."

"They have worked hard, adjusted their working hours, undertaken increased numbers of assessments and often working over hours due to limited resources. This does not appear to be coming to an end anytime soon."

The nature of MHA statutory work has also been raised. In contrast to many of their professional colleagues, the expectation has been that AMHPs continue to visit people in their own homes or in hospitals, including 'hot zones' within A&E departments or wards in order to undertake their statutory duties. It is suggested that while AMHPs are aware of this requirement and have not attempted to avoid it (see below on the limited use of remote assessments), this has also had an impact on their well-being.

"There was lots of talk about protecting other professionals and them not doing face to face visits and I feel AMHPs have been just expected to get on with it.....which to be fair, they have."

"Resentment that AMHPs always have to make themselves [available] to assess when others won't necessarily."

A number of respondents commented on the resilience of the AMHP workforce and how they have managed to maintain their level of functioning during this period. There are also numerous examples of work done to support staff who will frequently be working remotely and without regular face-to-face access to colleagues and managers.

"The staff group have been very resilient and adaptable to change."

"AMHPs have demonstrated unusual levels of resilience."

"...bizarrely resilient and stoical."

The issue of home-working leading to isolation from colleagues has been raised by a number of people. This is particularly relevant for AMHPs who are routinely working with situations of high risk and mental health crisis. Notwithstanding the ability for telephone consultation, working from home considerably reduces the availability of peer support as well as immediate managerial advice and assistance.

"The impact of lone working and isolation at home has been a significant factor."

"Working in isolation has been particularly challenging for newly [qualified] staff who have often been left with distressing telephone experiences."

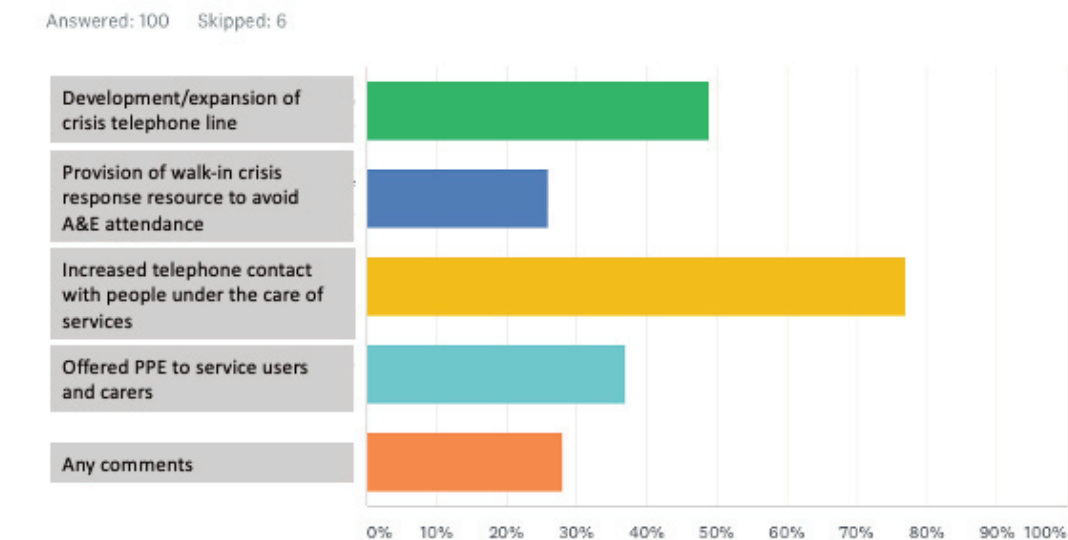
"Remote working causing emotional isolation"

Impact on service users and changes to delivery

Unsurprisingly, the most common change to the provision of support services has been the increased telephone contact with service users, with 77% of respondents reporting this development. This is closely linked to the next highest change (49%), which is the provision of a crisis telephone line. This must of course be balanced with the reason for this change, mentioned by several people, which has almost entirely been due to the reduction in face-to-face contact during the lockdown period.

37% reported making PPE available to service users and carers while a quarter mentioned the provision of a walk-in crisis response service to avoid A&E attendance. Some of these crisis services appear to have been already in preparation prior to the pandemic but were brought forward at this time.

Q24. Has your local service made specific changes to support people who use services? Any further comments are welcome in the 'other' box



Many respondents talked about limited knowledge of trust changes as the mental health service was now located within the local authority. One spoke of continuing to provide face-to-face contact, based on the assessed need of the individual.

“We have kept a MH Social Work Team and during this whole period we have never stopped face to face visits, if we have felt these have been required. We have taken an individual/person centred approach, meaning the people we know will not manage/cope with telephone calls we have continued to see them.”

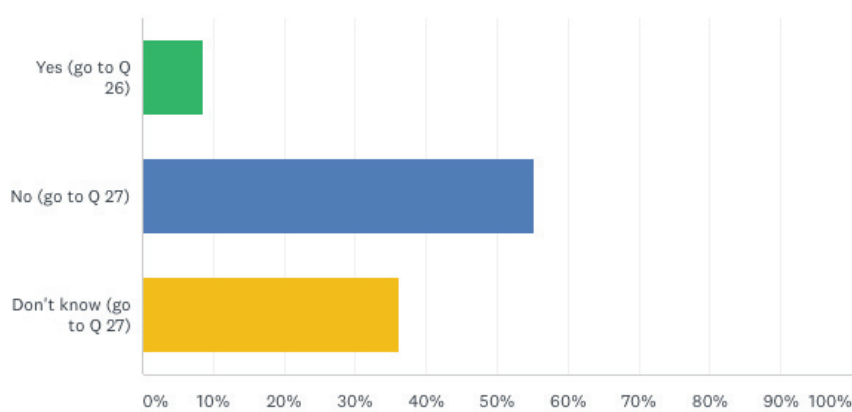
Changes to s117 aftercare support

A question was asked whether there had been any changes to the provision of s117 services during the emergency. Over one third of respondents could not answer this question and over a half reported no changes.

9% answered that there had been changes. Most comments reported on the changes to funding arrangements between the local authority and the CCG. One person reported the suspending of panel approval for s117 accommodation requests to fast-track the provision of service. The reasons for these changes tended to be related to enable early and speedy discharge from hospital.

Q25. Has there been any change to the provision of s117 services during this emergency?

Answered: 105 Skipped: 1

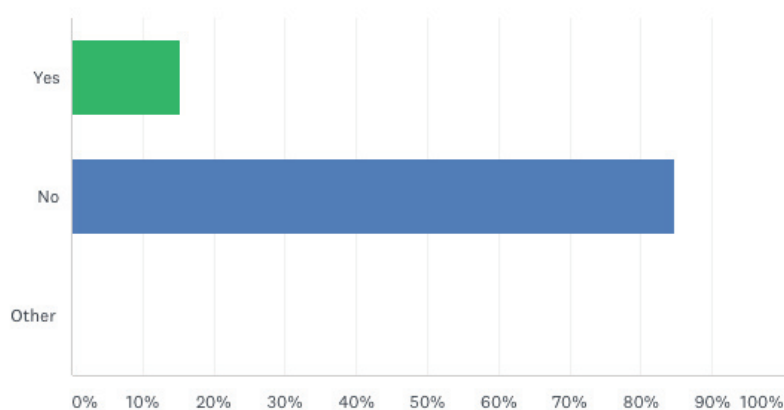


Serious incidents as a result of Covid-19

A small but significant minority of respondents (15%) stated that serious incidents had occurred as a result of Covid-19. Only 19 comments were recorded for this question and many spoke of difficulties in bed availability, staffing or handing over unfinished work, rather than specific incidents.

Q29. Has your service experienced any serious incidents as a result of Covid-19?

Answered: 105 Skipped: 1



One reported four serious incidents during MHA assessments but did not provide any further details. Another person told of an assault on the assessing AMHP, which the AMHP felt may have been related to their PPE.

“An AMHP was physically assaulted while undertaking a [MHA] assessment. The AMHP felt that by wearing a face mask they were less effective with their communication.”

“We have had individuals who have stated that they were COVID positive attempting to spit at AMHP’s and other health colleagues.”

Three people spoke of increased incidents of self-harm and/or suicide, with concerns that these events were directly linked to the Covid-19 pandemic.

“...increased number of females who had been assessed and detained despite having no previous MH issues who were very anxious and experiencing psychosis due to Co-Vid 19 then soon on arriving on the ward seriously self harmed and unfortunately a death resulted.”

Use of digital technology during MHA assessments

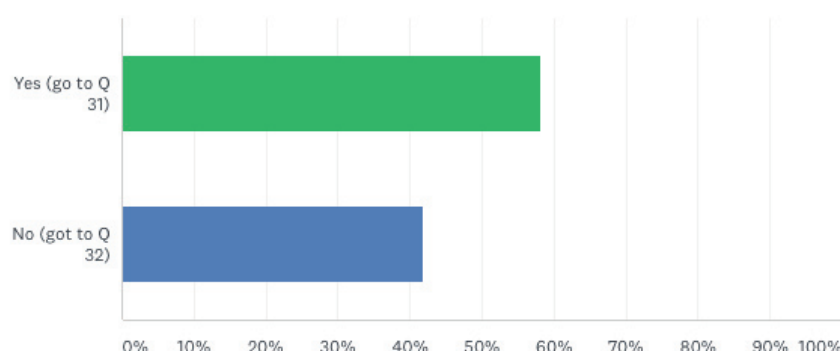
There has been significant debate and discussion regarding the use of digital technology during MHA assessments, and the legality of this method of assessment, given the wording in the Act and the Code of Practice. The author of this report contributed to that debate in the early stages of the lockdown⁵.

Following consultation with service users and a number of organisations, the NHS issued a legal guidance document on supporting people with mental health, learning disabilities and autism through the pandemic, the second version of which included a section on the “application of digital technology to Mental Health Act assessments”⁶. This document suggested that remote MHA assessments using video technology could be legally robust, provided certain conditions were met. Specific guidance was issued on the different environments in which such assessments can take place.

This survey asked AMHP leads whether they had used such ‘flexibilities’, the advantages and disadvantages of using them and if they had not been used, why not.

Q30. The DHSC issued guidance in May on the use of digital technology for MHA Assessments. Have you used these flexibilities?

Answered: 105 Skipped: 1



61 respondents (58%) reported having used digital technology, but it is important to consider the comments that were provided in conjunction with this question. Of those who answered ‘yes’, 20 specified that they were **only** used in relation to Community Treatment Orders (CTOs). Some restricted them to CTO renewals, some stated they would only be used if the AMHP knew the service user, while others included initial CTOs and revocation decisions. These 20 all specified that MHA assessments for detention in hospital continued to be undertaken face-to-face. A further 8 commented on them being used mainly or primarily for CTOs. Taking into account those people who spoke of guardianship, tribunals and reviews, it would appear to be a relatively small number of services which have used digital technology to undertake MHA assessments for the purpose of considering detention in hospital.

⁵ www.communitycare.co.uk/2020/04/21/carrying-mental-health-act-assessments-video-ethical-considerations-amhps/

⁶ www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0454-mhlda-spec-comm-legal-guidance-v2-19-may.pdf

Advantages have included:

- Reducing risk of Covid-19 infection to all individuals (professionals and service users)
- Undertaking out-of-area assessments: Some people spoke of the use of video link to undertake assessments in hospitals which may be over 100 miles away. This was particularly pertinent during the full lockdown period.
- The ability to use shielding AMHPs (and doctors) and a number of respondents reported that shielding AMHPs have been allocated CTO work to undertake to reduce the burden on the rest of the AMHP workforce
- The ability for the Responsible Clinician (RC) to be involved in the assessment, as they will know the patient best. This mainly refers to CTO assessments.
- Some service users preferred a video assessment in relation to their CTO to reduce the infection risk to them.
- Assessing (as one responded stated) *“sensitive young people who may be freaked out by an assessment team in person”*
- Assessing people in care homes which are not permitting visitors

Disadvantages include:

- The technology: either poor connectivity or an unsuitable digital platform
- Difficulties in using electronic forms which frequently follow a remote assessment⁷
- Concern that some professionals will want to use it *“for convenience rather than necessity”*, or they will want this to become the norm.
- It hampers effective communication, including the observation and assessment on non-verbal cues and behaviour.

Only a small number of respondents felt that these assessments worked well

***“Generally better than initially thought.
Have been used in as few circumstances as possible.”***

***“Feedback from staff is that it is easier with a patient who you know well,
it is more difficult with those who are not known due to the limitations on
how you can engage with the patient on a video call.”***

It is interesting to note that while only 44 people answered the question “Have you used these flexibilities” with a ‘no’ answer, 64 people answered the following question “If you didn’t use these flexibilities, why not?”. This indicates that 20 respondents answered ‘yes’ to the former question but nonetheless commented on reasons why the flexibilities had not been used. This may well indicate the considerable ambivalence about the use of digital technology which has been evident in much discussions within the AMHP leads network during the pandemic period.

The main reasons given for not using the flexibilities have been:

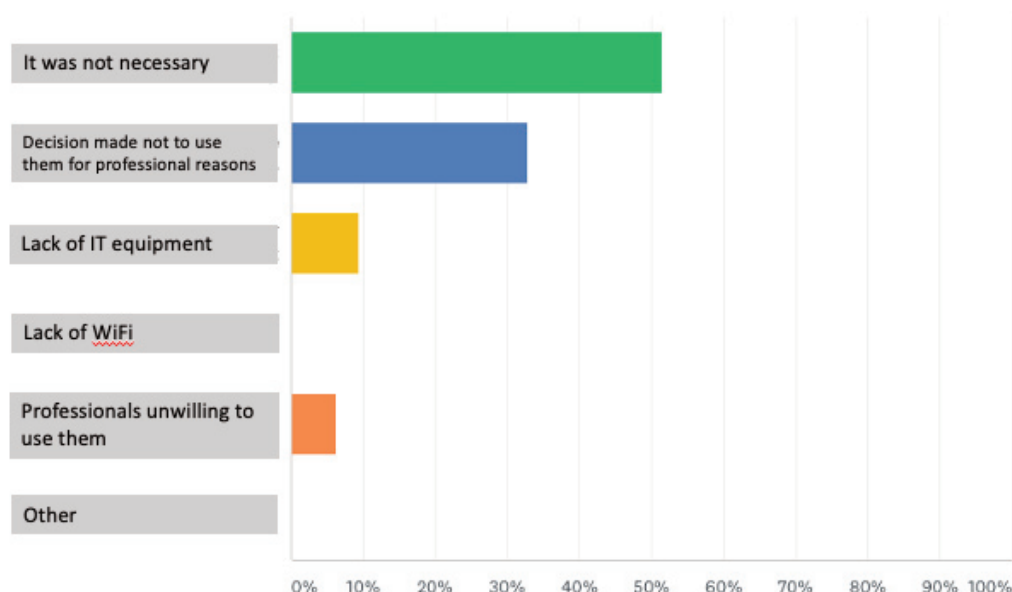
- **They were to be used as a last resort and services did not get to that stage**
- **Reluctance to use digital technology for professional, legal and ethical reasons**
- **Lack of confidence in the technology – both hardware and wi-fi connectivity.**

There was some criticism about the formatting of this question as it only allowed for one answer. Several respondents commented that they would have ticked most or all the options if they had been permitted.

⁷ New MHA regulations will be coming into force on 1 December 2020 to explicitly permit the use of electronic forms and signatures. The MHA statutory forms will be changing as a result.

Q32. If you didn't use these flexibilities, why not?

Answered: 64 Skipped: 42



Therefore, the main response, 'It was not necessary' conceals significant support for the other answers. There was powerful legal and ethical reluctance to use digital methods. Some AMHPs were unhappy about the legality of proceeding down this route despite the NHS guidance document. The quotes below provide a striking example of the strong professional ethos that many AMHPs maintain to ensure an appropriate assessment, given the enormity of the decision at stake, and to protect the service user's human rights.

"All AMHPs felt it was imperative to conduct mhaa face to face"

"The AMHPs were of the opinion that face to face assessments were more appropriate for professional reasons"

"AMHP commitment to assess in a suitable manner and to protect rights of person being assessed"

"Professionals unwilling to use video technology for such a significant decisions as depriving someone of their liberty"

"...ethical reasons. do not feel remote MHAA assessments are appropriate given the magnitude of the potential outcome."

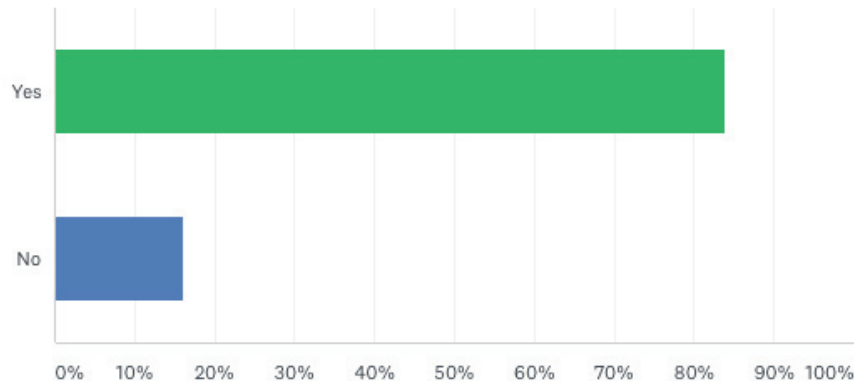
Significantly more than the 9% indicated in the chart commented on the limitations of hardware and wi-fi. It is clear that for video conferencing to become more widespread in this field of practice, significant improvements need to be made in the provision of technology, which will provide reliable and good quality communication.

AMHP training

A large majority of services (83%) are intending to send people on AMHP training courses this autumn.

Q33. Are you hoping to send staff on AMHP training this autumn?

Answered: 105 Skipped: 1



It will not be surprising that most courses have changed as a result of the pandemic, with many moving to remote teaching.

Several people reported that courses which were mid-way through were suspended when the pandemic struck and most appear to have restarted. A number of respondents reported that the courses scheduled to start in autumn have been delayed until the beginning, or spring 2021. This will have an impact on the throughput of new AMHPs.

“... placement dates and coursework hand-in dates changed, the remaining taught sessions moved online, shadowing assessments is more difficult when people...are working from home, with the result that the trainees are not going to qualify till well into next year.”

Some people spoke of refresher (update) training, although the question did not specifically ask about that. Most of this appears to have moved to virtual platforms, with some people reporting reduced availability, while others stated that the quality remained high.

One university is exempting students from completing their pre-AMHP course, which is often a pre-requisite for the course. Another has arranged for a *“fast track course...to strengthen our team”*. It is not clear how this will work, but the university must be satisfied that the academic requirements continue to be met, in order to make the award.

One respondent made an important point about the importance of practice placements for AMHP trainees, and the view that experience of face-to-face assessments is a vital part of the training experience and competence gathering. Most comments about practice placements have indicated continuing face-to-face experience, some also reference remote shadowing.

“predominantly online teaching, however decision made that placements must support trainees being able to undertake face to face MHAA ”

“The placement will be done as a combination of remote working-liaison and face to face work depending on the situation at the time and the assessment being carried out.”

“there has been a reduction in the opportunity to shadow AMHPs because of reductions in contact with the community, hospitals and care homes.”

“...we’ve had to adjust placements to incorporate remote shadowing.”

Resource issues for AMHPs during MHA assessments

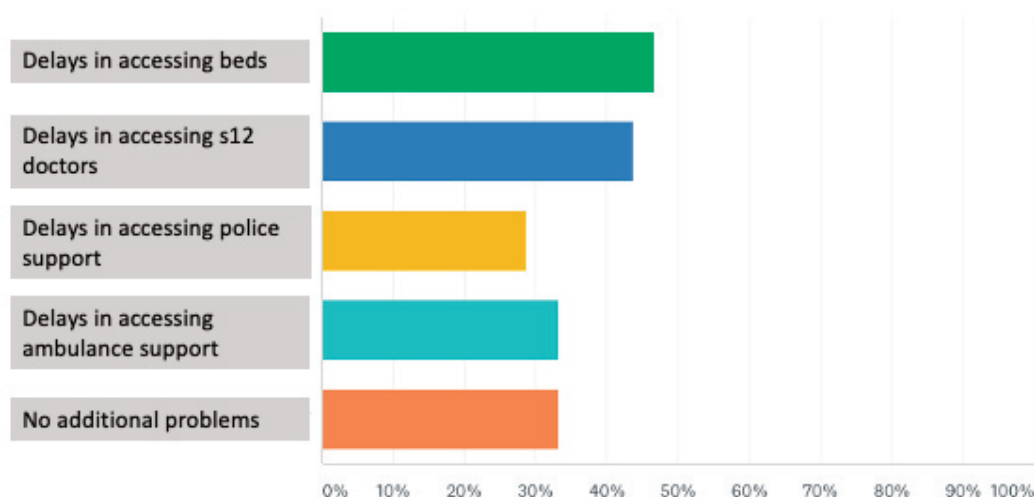
The survey asked respondents whether their service experienced additional problems with resources both during the lockdown period (March-June) and following the easing of restrictions (July – September). People were also asked to comment on the worst resource issues they had encountered during each of these periods.

This question was designed to ask about resource issues caused by the pandemic and additional to the chronic difficulties that AMHPs face on a day-to-day basis. There is the risk that the answers may reflect chronic issues as well as additional issues caused by the pandemic. However, many respondents made it clear in their comments that the resource difficulties were particular to the pandemic period and in addition to the chronic issues that are widespread.

As can be seen in the charts, 80% respondents reported additional difficulties with a range of resources. Most frequent were beds and section 12 approved doctors, each with over 40%. One third mentioned ambulance support and a little under 30% referred to delays in obtaining police support.

Q36. Did your service experience additional problems during the pandemic lockdown period (March - June) with the following? (please tick all that apply)

Answered: 105 Skipped: 1



70 respondents added comments to this question, indicating the widespread desire to expand on the multiple-choice answers. Bed availability was mentioned by a considerable number of people. This is perhaps not surprising given the nature of the pandemic. However, it must be recognised that the increased pressure on hospital beds comes in addition to the long term issues regarding acute psychiatric inpatient capacity. Some trusts created quarantine wards to manage the risks of infection. Notwithstanding the extremely difficult circumstances the NHS was facing, the fact that some respondents reported delays of between one and two weeks for some people requiring admission is extremely concerning. The case of David Stacey⁸ who died following a failure to admit him to hospital in a timely manner is an illustration of the risks involved when rapid admission to hospital is not facilitated following the decision of a MHA assessment.

⁸ See Regulation 28 Report to Prevent Further Deaths www.judiciary.uk/wp-content/uploads/2020/02/David-Stacey_Redacted.pdf and report on "Inquest" website

“Bed pressures leading to use of s135(1) warrants until a bed becomes available and an application can be made.”

“We have had children in A&E under no legal authority for several days awaiting beds.”

“The Health Trust created a quarantine ward for new admissions but this then created a bottle neck for people needing to come in. It also created difficulties in arranging admission for people in the community due to priorities given to people on s136 and ED...We had some community patients waiting up to 12 days for a bed to be available...”

“Beds – due to capacity of wards reducing, we had one particular bad spell in which we had 4 patients at the same time waiting 14, 10, 8 and 8 days for beds.”

Many comments referred to the reduced availability of s12 approved doctors, who were often shielding or who had been transferred to Covid-specific duties. The Coronavirus Act 2020 included potential amendments to the MHA⁹ in the event of staffing shortages becoming critical. These amendments (“easements”) were not enacted and have now been removed from the legislation. It is the author’s understanding that a widespread view among AMHPs was that the amendments were a disproportionate reduction in patients’ rights and that at no time was the staffing situation so critical that they should be implemented. Some of the comments in the survey do, however, illustrate the significantly greater difficulties some services experienced in sourcing sufficient doctors.

“A number of doctors declined to participate in MHA assessments (due to shielding), which meant the pool of available doctors was smaller.”

“We have had situations where AMHPs have contacted 31 Doctors before being able to secure Doctors for an assessment.”

“Reduced number of S.12 doctors. However, we had a group of who stuck with us over the period and demonstrated very unusual commitment to doing MHA assessments.”

A number of areas were forced to use private ambulance services due to the unavailability of the NHS service. A number of respondents in London commented on the LAS withdrawal of availability of ambulances during the pandemic, which appeared to be without consultation or notice. Others commented on increased waiting times for ambulances. This is not a new problem but appears to have become more acute during the lockdown period. A number of commissioners and ambulance services have experimented with using non-emergency ambulances for mental health admissions, but this structure still seems to be patchy at best and not supported as a long-term alternative.

“Ambulance waiting times increased dramatically across the board. Longest waits were one of 5 hours and one of over 6 hours which was ended when police decided to convey rather than wait longer.”

“just as lockdown happened we were piloting our own transport for detained patients, so we were able to convey service users into hospital very quickly.”

“The ambulance service was the worst resource issue, we were unable to get an ambulance for around 12 hours or more.”

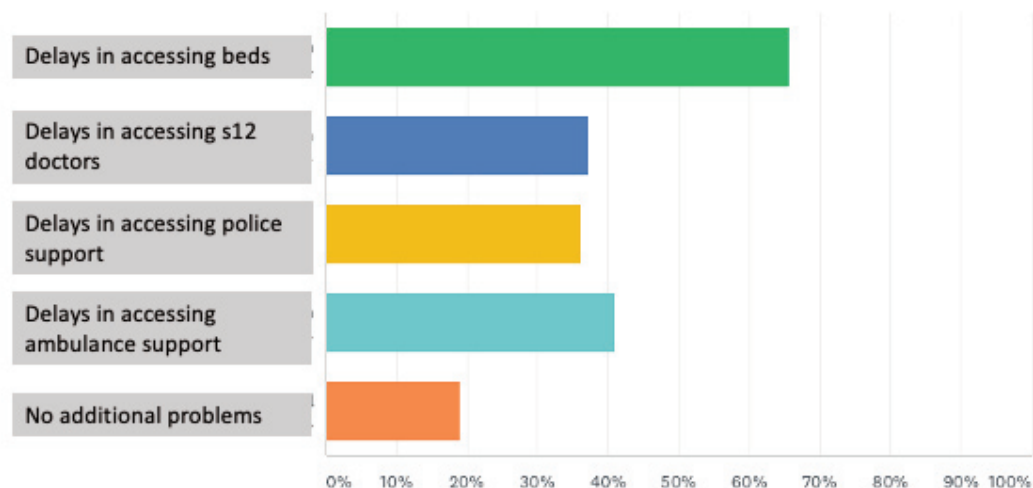
Police support was also more difficult to access, with a number of respondents commenting on delays to assessments where s135 warrants were being used.

⁹ These amendments included a provision which would have allowed for a patient to be detained on s2 or s3 by an AMHP pursuant to a single medical recommendation, rather than the usual two.

"Total lack of police support when risk assessed as needing this; told the policy is for us to go & assess & call 999 if needed. We have done so on 2 occasions & both times someone was assaulted (Dr & P's father)."

Q38. Did your service experience additional problems during the post-lockdown period (since July) with the following? (please tick all that apply)

Answered: 105 Skipped: 1



There was a broadly similar response regarding resource issues during the post-lockdown period, although it is interesting to note that fewer respondents (19%) reported no additional problems. The proportion of people reporting delays in accessing beds increased significantly, with increases also reported in the proportion of delays in police and ambulance support. Proportionately fewer people reported delays in accessing s12 approved doctors (although it must be noted that 37% still reported this issue). This is maybe understandable as lockdown eased, more doctors made themselves available or returned to their substantive roles, and the emergency services were more likely to be responding to people out and about in the community.

Many comments remain similar to those raised in the previous question. The availability of beds remains a major concern which has increased in several areas as a result of the pandemic.

"Availability of female acute beds is worse than during or before lockdown. We have had many people going to private beds all over the country and in a greater than usual number of cases not being repatriated. We have had to travel to a greater number of distant s.3 assessments for people detained under s.2. However, worst waits have been for older people's beds, one of 11 days and another of 12 days."

"Reductions of beds because of wards needing to be converted to Covid-19 'hot' & 'cold' environments."

"Because our psychiatric wards are dormitory style we lost 10 beds to make them Covid safe. This has an ongoing impact."

"Getting a bed is a major issue now, we have lots of people out of area. MHAs get delayed trying to manage the risk issues with no guaranteed [bed], also transport doing more out of area work means they are not available [till] the next day."

"At the start of the lockdown, 33 beds were closed due to restrictions and to enable social distancing on the wards. Those beds have not been re-opened so the same problems are still with us. Waiting 2-3 days for beds on some (rare) occasions."

Other issues

Respondents were given the opportunity to make free comments on any other issues at the end of the survey.

One respondent suggested that digital technology should be reinforced post-pandemic, to improve efficiency. This did not apply to 'routine' remote MHA assessments by video, but specifically mentioned three circumstances where digital technology could assist

- Applications for s135 warrants (rather than the AMHP having to attend magistrates court)
- The use of electronic applications when the assessment has been completed but a bed is not initially available. This may avoid the need for a second assessment if the AMHP cannot physically complete and deliver the forms. Otherwise the patient will need to be reassessed by another AMHP which is extremely inefficient and increases the stress and trauma for the patient
- Remote assessments for patients who are placed in distant out-of-area hospitals, avoiding the need for the AMHP to travel long distances to complete the assessment.

Some respondents took advantage of this section to make positive comments about the way the services and staff have coped.

"I have been very impressed and proud of the service – the commitment demonstrated by [local authority] AMHPs has been second to none at a time when most people would rather be home and shielding."

"I have been very proud to work in the AMHP service in [local authority] during COVID. The team has shown a high level of resilience and commitment to the role and in ensuring that all work continues to focus on the needs of the individual being assessed, especially in such challenging times."

"How fantastic, caring and committed have all AMHPs been and are during this difficult period!"

"The AMHP hub in [local authority] have ensured the least impact has been felt by the community and other professionals and have grown resilience through this pandemic."

"The AMHP workforce in [local authority] has been excellent, resilient and adapted to all the new challenges. No refusals to attend any statutory assessments have been observed. "

Some expressed concern about the perceived failure of other parts of the mental health service.

"I believe patients have been extremely let down by secondary care mental health services. The only services that continued frontline were the amhps, crisis team, home treatment team and PLT."

"The AMHP's in our area have felt that we have been left to carry the flame really along with the crisis team, and everyone has expected us to respond when everyone else has said no we are not doing that, and as AMHP's [are] so used to dealing with crisis and having the just get on with it approach they have, but have been left drained by it all, and this has not been recognised by anyone."

Key considerations for national and local responses to a further national lockdown

Again for this question, a high proportion of respondents (76) made comments. Many comments related to the chronic issues affecting mental health and AMHP work. People spoke of the need for improved availability of acute beds, more AMHPs and more s12 doctors. While these are undoubtedly needed, focus will be given to some more specific suggestions.

Face-to-face contact with patients

There is concern that a further lockdown will result in services closing down as before. The need to continue face-to-face contact with people with mental health needs was a common issue raised. This is related to the concern that failure to provide support and follow up to patients had a major impact on their mental health. A risk that concerns for physical health in lockdown overrode consideration of the risk of impact on vulnerable individuals' mental health.

PPE

Several people mentioned PPE and the need for more consistency. The use of see-through face masks or reusable face shields was mentioned in order to address the concerns over the impact of PPE on the assessment process.

"Given that AMHPs across the country were one of the few front line staff continuing to work face to face it would have been helpful if that role had been recognised in PPE guidance as none of it seemed to cover the unique sort of role AMHPs have."

Digital technology

Despite the clearly evidenced ambivalence regarding the use of digital technology in the context of MHA assessments, a number of respondents commented on the need to explore this further and to develop the potential for its use.

"A broader debate about the use of digital technology – setting good practice standards, acknowledging it should not be used arbitrarily, but can sometimes be better for service users and assessing teams."

National data set for AMHP activity

A number of respondents commented on the need for better information about national trends and data on AMHP activity. This is a general point but was made in relation to the impact of the pandemic.

"We need to have a better idea about the numbers of assessments that take place across the country and where and what those assessments. It seems amazing to me that we do not collect any kind of data nationally or regionally about the number of Mental Health Act assessments carried out by AMHPs."

Out of area assessments and the legal responsibilities of completing s2 and s3 assessments¹⁰

The issues surrounding MHA s13 and the duties on respective local social services authorities (LSSAs) to arrange assessments, sometimes at considerable distance, was raised by several individuals. This disproportionately impacts on LSSAs which have large private hospitals or regional units (e.g. CAMHS) within their catchment area. There is a call for improved guidance. While the law permits cooperation between LSSAs, MHA s13 is clear on the current statutory duties and there has been a suggestion to the MHA Review that this is considered in any change in the legislation.

¹⁰ MHA s13 places a duty on the local authority where the person is located to undertake an initial MHA assessment (the 'where the body is' rule). However in cases of assessments for s3 following s2, MHA s13(1(A/B)) places a duty on the authority which arranged the s2 assessment to undertake the assessment for s3, irrespective of where the person is currently located. These rules have created significant difficulties, particularly during lockdown when travel has been severely restricted.

Key recommendations

Maintaining face-to-face contact between mainstream services and service users

There is a strong message about the need to avoid the shutdown of support services which happened during the first wave. Many services moved to telephone contact only and there is a significant concern that this impacted on individuals known to services, either positively due to the loss of support, or negatively due to the inability to identify deterioration in mental state. Continued face-to-face contact with service users is important for both these reasons. As knowledge develops regarding infection control and risk mitigation, it is felt that ongoing contact should be managed in a more controlled manner and not reduced in such a draconian way.

Clearer guidance on the role of AMHPs in the community and use of PPE

A particular concern raised within the survey was regarding the importance of communication with the service user during a MHAA and the impact on this of the use of PPE. In particular, face masks impacting on the ability to engage with the individual being assessed, and to be able to see facial and non-verbal cues.

During the first major lockdown, the majority of services stopped undertaking face-to-face visits, with AMHP services, alongside a number of crisis teams, continuing to see and assess people in this manner. It is suggested that clearer guidance be provided to non-clinical staff such as AMHPs, who are required to continue to see individuals face-to-face, and further consideration of alternative types of PPE such as transparent masks or face visors.

Bespoke guidance on the use of digital technology by AMHPs

As discussed in this report, the survey illustrated the ambivalence amongst AMHPs about the use of digital technology during MHA statutory work. Many AMHPs are concerned about the impact of video interviews, and the loss to the assessor of the subtle nuances of non-verbal cues and environmental factors. However, others have commented on the benefits of this method of assessment in particular circumstances. These have been discussed above and will not be repeated here.

There are lessons to be learnt for a further wave of the pandemic and beyond. Digital technology is very new to the MHA landscape and many professionals are unaccustomed to using it for this purpose. Some disquiet may be due to lack of familiarity, but it is the author's view that there are valid professional concerns about its use.

However, in the context of a second wave of the pandemic, and a likely increase in demand for MHA assessments of people with Covid-19 or showing symptoms, it is vital that health and safety issues are fully explored, including the use of video technology, for the AMHP workforce. This is particularly important for those AMHPs who are more vulnerable to the disease, due to age, health conditions or ethnic background.

This includes the importance of safe spaces in clinical settings where the assessing team and patient can meet to allow for sufficient distancing. The particular nature of a MHA assessment must be considered, where at least four individuals will be in a room, and the likelihood of one person exhibiting distressed or agitated behaviour, and who may find it particularly difficult to manage distancing guidelines.

There is no doubt that the use of digital and video technology will continue to develop beyond the pandemic and there is an important opportunity to hold further discussions with the range of professionals in mental health and users of services about the advantages and limitations of its use.

Learning lessons from inter-agency collaboration

As a continuation of the previous discussion regarding the use of digital technology, some respondents reported some interesting developments, stimulated by the restrictions imposed during the first wave, whereby digital and video conferencing has enhanced inter-agency collaboration. Links between AMHP services, crisis teams, bed management process and ambulance services have in some areas improved as a result of more structured and regular contact through digital means.

There is potential for broader learning when examining some of the developments that have taken place in relation to this area of work.

Highlight models of good practice in cross border collaboration arrangements

The question of out-of-area placements and patients requiring MHA assessments many miles from their home authority has been a live issue for AMHPs for several years. It has been exacerbated by the shortage of acute psychiatric beds in many areas, but also applies to specialist services such as CAMHS, learning disability and PICU. The real solution to this problem is the increased local availability of admission beds to individuals needing inpatient psychiatric care.

There have already been developments within DHSC to provide improved guidance to CCGs regarding MHA s140 and the duty to notify local authorities of the location of hospitals to take patients in cases of special urgency (and young people under 18). It is important that this is not lost and further developed to reduce the need to transport patients long distances due to the absence of available beds in their locality.

As discussed in the report, the law places specific responsibilities on LSSAs to arrange MHA assessments, dependent on whether the person is already detained under the Act or not, and this will not change until the MHA is amended.

However, some regions of the country have developed cross-border agreements (which do not undermine the legislation), whereby neighbouring authorities agree to cooperate with their adjoining boroughs to reduce the need for AMHPs to travel maybe over 100 miles to undertake an assessment. At other times it may be important that an AMHP who knows the person travels to assess them.

Other authorities have developed agreements whereby AMHPs are authorised to act on behalf of neighbouring authorities, either as contingency planning, or due to the structural arrangement of the mental health service.

Further investigation of these collaborative arrangements will be helpful, both for a second wave and for future service provision.

AMHP training and update training– appropriate level of exposure to practice and assessment of their competencies

The survey touched briefly on this subject, and there is evidence of significant changes in training arrangements due to the need for distancing between individuals. Social Work England (SWE) have taken over responsibility from The Health and Care Professions Council (HCPC) for regulating AMHP training courses (but not update training).

It is important that the quality and rigour of AMHP training does not suffer as a result of the pandemic and resulting changes to service delivery. Comments were made regarding the importance of face-to-face practice experience for AMHP trainees, while others spoke of arrangements to move placements to a virtual platform.

It is suggested that SWE carefully consider the impact of changes to AMHP training and to ensure that individuals undertaking AMHP training courses continue to receive the appropriate level of exposure to practice and assessment of their competencies.

Transportation of patients to hospital – development of a national strategy to provide appropriate transportation of detained patients to hospital

The pandemic has in some areas exacerbated a problem which has existed for many years. This is the difficulties in obtaining a timely transportation of detained patients from the place of assessment to hospital. In many areas, emergency ambulances continue to be used and there is a clear and evident tension between the needs of individuals in mental health crisis and those with life-threatening physical conditions requiring urgent medical attention.

The evidence of the survey is that in some areas at least, the pandemic has placed such a burden on the ambulance service that mental health admissions have dropped further down the list of priorities, leading to considerable delays in conveying patients to hospital.

Very few mental health admissions require the technology of an emergency ambulance and the medical skills of a paramedic. It is an expensive resource which should be used only for those patients who need it most. Conveying patients to psychiatric care is certainly not simply a taxi service and a secure method of transportation is required with staff skilled in the management of acutely distressed and agitated patients. Some services have experimented with using alternative methods of transport to hospital, but these are not widespread and many have not been made mainstream.

Many AMHPs have reported the need to resort to private ambulance services, which are likely to be significantly more expensive than a service commissioned by the CCG or wider NHS bodies. Further consideration needs to be made on a national strategy to provide appropriate transportation of detained patients to hospital, which does not compete with the overstretched 999 ambulance service.

Further work

In consideration of the findings of this survey, it is recommended that a conference is hosted to consider the learning and recommendation from this survey.

Further research should be considered regarding the impact of the pandemic on the mental health of people from black and minority ethnic communities, focusing particularly on the use of s136 and how the change in detentions has impacted on these communities.

Consideration of a further survey in the context of the second lockdown.

Appendix: Survey questions

1. Have you identified a change in pattern or number of MHA assessments undertaken in your area during the Covid-19 lockdown (April-June)
2. Please indicate the change to the number of assessments. Any views on the reasons for this change are welcome in the 'other' box.
3. Since the lockdown started to ease, (since the beginning of July) have you noticed a further change in the pattern (or a new change if no change previously)?
4. Please indicate the change to the number of assessments. Any views on the reasons for this change are welcome in the 'other' box.
5. During the lockdown period (April-June) have you noticed a change in the pattern of s136 use?
6. Please indicate the change to the number of s136 detentions. Any views on the reasons for this change are welcome in the 'other' box.
7. Since the lockdown started to ease, (since the beginning of July) have you noticed a further change in the pattern of s136 use (or a new change if no change previously)?
8. Please indicate the change to the number of s136 detentions. Any views on the reasons for this change are welcome in the 'other' box.
9. Since the start of the lockdown (March), have you noticed a change in the number of referrals to the AMHP service which did not result in a full MHA assessment?
10. Please indicate the change in the number of referrals to the AMHP service which did not result in a full MHA assessment. Any views on the reasons for this change are welcome in the 'other' box.
11. Since the start of the lockdown (March), have you noticed a change in the proportion of first-time presentations? (i.e. person previously unknown to mental health services)?
12. Please indicate the change in the number of first-time presentations. Any views on the reasons for this change are welcome in the 'other' box.
13. Since the start of the lockdown (March), has there been a change in the proportion of people who were homeless prior to assessment?
14. Please indicate the change in the proportion of people who were homeless prior to assessment. Any views on the reasons for this change are welcome in the 'other' box.
15. Since the start of the lockdown (March), have you identified any evidence of requests for MHA assessments to be used as an alternative due to services being unwilling/unable to visit (e.g. crisis/home treatment services)?
16. Please provide details.
17. Did you experience problems during the lockdown period (March-June) with having enough AMHPs to respond to the demand for assessments?
18. Please provide details
19. Did your service implement any changes in response to the Covid-19 pandemic? (please tick all that apply)
 - Rapid reapproval of ex-AMHPs
 - Fast-track approval of student AMHPs

- Increase working from home
 - Use of remote assessment techniques (e.g. video assessments)
 - No changes implemented
 - Other changes
20. What specific action has been taken by managers to support AMHPs since the start of the pandemic? (please tick all that apply)
- Additional risk assessment processes.
 - Explicit consideration of risk to AMHPs and social workers with health conditions which put them at greater risk from Covid-19.
 - Explicit consideration of risk to AMHPs and social workers who are from black and minority ethnic backgrounds due to the identified additional risk to health.
 - Additional psychological support to AMHPs and social workers (e.g. remote supervision, remote forums, remote group support processes)
 - No additional support provided
 - Any other comments
21. Has PPE been available throughout the Covid-19 emergency? Any further comments are welcome in the 'other' box.
22. If PPE has been available, what equipment has been made available? Any further comments are welcome in the 'other' box. (please tick all that apply)
- Face masks
 - Face shields (clear plastic)
 - Nitrile/latex gloves
 - Alternative outer clothing (e.g. 'scrubs', sweatshirts, etc.)
 - Other
23. Since the start of the lockdown, have your AMHPs experienced any of the following? Any further comments are welcome in the 'other' box. (please tick all that apply)
- An increase in assaults or confrontations
 - Concerns about being less able to de-escalate volatile situations
 - Concerns about being less able to communicate well during assessments because of using masks
 - Concerns about other professionals not sticking to PPE requirements
 - Other [for comments]
24. Has your local service made specific changes to support people who use services? Any further comments are welcome in the 'other' box. (please tick all that apply)
- Development/expansion of crisis telephone line
 - Provision of walk-in crisis response resource to avoid A&E attendance
 - Increased telephone contact with people under the care of services
 - Offered PPE to service users and carers
 - Any comments
25. Has there been any change to the provision of s117 services during the emergency?
26. Please provide details
27. Have you noticed any of the following within your AMHP workforce during the lockdown period?

(April-June). Any further comments are welcome in the 'other' box. (please tick all that apply)

- Increase in physical illness (not related to coronavirus)
- Increase in anxiety/depression
- Impact of fear on decision making
- Other

28. Have you noticed any of the following within your AMHP workforce since the lockdown has eased? (since July)

- Increase in physical illness (not related to coronavirus)
- Increase in anxiety/depression
- Impact of fear on decision making
- Other

29. Has your service experienced any serious incidents as a result of Covid-19? Any further comments are welcome in the 'other' box.

30. The DHSC issued guidance in May on the use of digital technology for MHA Assessments. Have you used these flexibilities?

31. What were the advantages & disadvantages?

32. If you didn't use these flexibilities, why not? Any further comments are welcome in the 'other' box.

33. Are you hoping to send staff on AMHP training this autumn?

34. Have AMHP training courses changed to cope with Covid-19 risks?

35. Please comment on the changes to the courses

36. Did your service experience **additional** problems during the pandemic lockdown period (March – June) with the following? (please tick all that apply)

- Delays in accessing beds
- Delays in accessing s12 doctors
- Delays in accessing police support
- Delays in accessing ambulance support
- No additional problems

37. What were your longest/worse resource issues?

38. Did your service experience **additional** problems during the post-lockdown period (since July) with the following? (please tick all that apply)

- Delays in accessing beds
- Delays in accessing s12 doctors
- Delays in accessing police support
- Delays in accessing ambulance support
- No additional problems

39. What were your longest/worse resource issues during this period?

40. Are there any other issues you wish to comment upon?

41. What suggestions do you have for responses to a further lockdown if required (local or national)? Is there further advice needed in specific areas?

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