Needs of adults in a mental health crisis in contact with mental health or community services, during the COVID-19 crisis

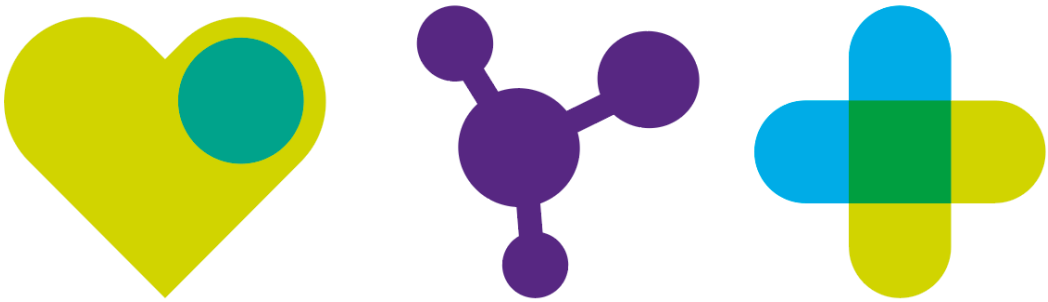
April 2020

Health Innovation Network South London

About

The Health Innovation Network is the Academic Health Science Network (AHSN) for south London, one of 15 AHSNs across England. As the only bodies that connect NHS and academic organisations, local authorities, the third sector and industry, we are catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients.

This means we are uniquely placed to identify and spread health innovation at pace and scale; driving the adoption and spread of innovative ideas and technologies across large populations.



The Challenge

NHSX wants to understand the needs of adults during a mental health crisis in contact with mental health or community services. NHSX is keen to understand the pressing needs of this cohort during the COVID-19 crisis and how the changes enforced by the virus are affecting their needs.
NHSX is interested in investigating the needs, particularly of vulnerable groups (adults with protected characteristics such as black and minority ethnic as well as LGBTQ+, those in contact with social care and justice systems, and those who are especially vulnerable to the virus and are 'shielding').

Responses

Two hundred organisations /clinical leads were contacted directly throughout England during the period 26 to 29 April 2020. This report focuses on the needs of this cohort. A further 500 organisations were contacted through the Zero Suicide Alliance membership data base.

The following 15 organisations/respondents replied within the three-day time frame given by NHSX for this request. Many represent large geographies and/or several organisations.

- South West London St George's NHS Mental Health Trust
- South London and Maudsley NHS Foundation Trust
- Thrive London Suicide Prevention Multi Agency Group
- S12 Solutions
- Health Education England
- West Yorkshire and Harrogate Health and Care Partnership
- Cumbria Partnership NHS Foundation Trust
- Mental Health Innovations UK – Shout
- Bristol Health Partners
- Wessex AHSN
- Hampshire Liaison and Diversion Team
- Southern Health Partners
- Dr Phil Moore – GP /Mental Health Clinical Commissioners NHSE
- Coventry and Warwickshire Partnership NHS Trust
- Barnet, Enfield and Haringey Mental Health NHS Trust

The following three organisations also responded, however were not able to contribute due to the short time frame for responses.

- Oxleas NHS Foundation Trust
- Leeds City Council
- Big White Wall

No response was received from the remaining organisations contacted.

Experts by Experience

Health Innovation Network (HIN) gathered responses from some experts by experience, people with a mental health diagnosis who were either offering peer support or coping with their own mental health issues, or both.

The themes that emerged were as follows:

- A feeling of isolation and anxiety due to COVID-19, particularly when you live alone
- Having to take each day as it comes - some days being quite difficult to manage and heightened by having no end in sight to the lockdown
- People reporting that their mental health has been affected hugely at this time
- Needing to offer peer support to a lot more people since COVID-19 and lockdown came into effect
- Personal helplines / video calls are helpful currently – offering evening and weekend support
- All face to face appointments have stopped some mental health trusts
- Group therapy and 1-2-1 therapy running via a video call, and patients reporting that this is very helpful as a second best to face to face. However, the patient did cut off and not answer the phone for weeks before 15 April because it was so easy to do so. The patient could 'hide' and not be interrupted in plans for suicide at the time. Because there wasn't that face to face, it was so easy to isolate, which is the worst thing for their mental health
- Patients stopped answering the phone to their support workers too, who they would normally see six hours a week. There were two home visits unannounced, which the patient believes led to having a safety plan and getting back in touch, rather than taking their own life
- Patients think digital platforms really help to sign post people
- Digital apps and tools can offer support to people in Mental Health Crisis – DistrACT app mentioned specifically to manage self -harm.

Themes Emerging from all Responses

People in Mental Health Crisis – contributing factors

- When people reach crisis point it's difficult to unpick how they reached that point
- Poor medication adherence seems to be a factor.
- Significant psychotic relapses.
- Reduced Mental Health Community Team contact.
- Patients with high risk enduring mental health issues who normally have frequent face to face contact by specialist teams are being absorbed into community mental health teams, their contact has been reduced to one or two telephone calls a week. Patients are simply not coping with that reduction.
- The confusion around which teams have priority for PPE has led to lack of face to face contact for patients in the community.
- No mental health community team contact.
- Alcohol misuse is more prominent than ever
- Self- harm has increased.
- Peoples usual routines have been massively disrupted and for that group of patients who just about cope, their lives are unravelling under COVID-19 restrictions.
- Access to medication, especially liquid meds, is an issue and therefore, we have had an increase of patients who have not collected their medication or who cannot access their prescription.
- In recent days, increase of anxiety management of patients now anxious about going out due to COVID-19.

- Activity seems to come in waves of a surge every 10-12 days in lockdown.

Digitally excluded/challenged populations – key questions and problems

- How do we make remote consultation available to patients that don't have internet and/or mobile phones?
- How do we provide 'private' remote consultations to those who are in vulnerable/abusive relationships?
- Can we create remote hubs to enable private access to these populations who experience mental health crisis in GP surgeries or libraries?
- Providing mobile phone devices has its own challenges. We have tried this before and they were all sold shortly after being handed out.
- Mental Health Act assessments are up in some areas and down in others.
- It is difficult to comment on what can be offered digitally to support this cohort of patients because what it clearly evidenced (anecdotally from our team) is that there is a clear correlation in reduction in face-to-face, human contact with an increase in symptoms or distress.
- Interventions offering information regarding voluntary sector food delivery appears to have been the best received
- There is a constituent theme that some of these patients that may not be able to read or write, access WiFi at home or have a smart phone
- Patients who are being discharged from inpatient units, back to the community, do not necessarily have the right 'set up' to engage with virtual support. Many of the digital innovations rely on patients having:
    - An e-mail address
    - Access to a suitable device (a phone or laptop) to be able to engage with remote services
    - Sufficient data or Wi-Fi to download applications
    - Means to regularly charge the device
- These patients may have previously relied on access to libraries or communal spaces to access the internet to complete online forms, or to charge their phones – this is now not an option under the current COVID-19 regulations.

LGBTQ+

- Shout UK see a higher absolute number of LGBTQ+ texters vs a ratio of those who identify as such in society. Thirty five per cent of texters who respond to their optional anonymous survey at the end of the conversation identify as LGBTQ+ as compared to about four per cent in UK society as a whole.
- Of those (and this is over time with about 7,000 individual surveys recorded. This is all data and not just since lockdown. The per cent not in brackets is LGBTQ+ and in brackets is the whole of the platform:
    - 39 per cent (34 per cent) exhibit suicidal ideation
    - 22 per cent (31 per cent) suffer from anxiety
    - 32 per cent (33.5 per cent) suffer from depression
    - 23 per cent (26 per cent) mention relationship issues
    - 22 per cent (14.50 per cent) self-harm
    - 17 per cent (17.7 per cent) suffer from loneliness
- Shout UK have seen increasing numbers of conversations with LGBTQ+ texters about COVID-19 (17 per cent of conversations since 23 March).
- Conversations about COVID-19 are also particularly likely to have anxiety as an issue (52 per cent, which is almost twice the level we usually see). Other common issues continue to include suicide, depression/sadness, relationships, loneliness, and self-harm.

Reduction in Mental Health Crisis Presentations

- We have found that there has been a reduction in the referrals we have typically received for new presentations to A&E in crisis presenting with issues surrounding adjustment disorders, emerging disordered personality traits, self-harm or mild to moderate depression: typically not meeting the threshold for on-going intervention from secondary mental health services once a crisis has passed. This cohort has, for the most part, been isolating with friends or family or have an established support network, and whilst interpersonal issues arising from increased proximity to relatives may be a contributory factor in any crisis, there has been less concern about the amount of support they are receiving. When we have received these referrals, patients have typically been amenable to telephone support and open to engaging with digital means of communication.

Justice / Liaison and Diversion (LiDi)

- We are monitoring and collecting data throughout the period to look at potential changes in needs, we are seeing a reduction in referral numbers and those that are being referred are presenting with potentially different needs – including more complex presentations, there has also been an increase in domestic violence too
- The other factor is the change in the way the external systems we work within are changing. For example, use of virtual courts and the delays in court hearings and a likely surge as we move out of this phase, which could potentially lead to a higher number of cases with needs which weren't identified earlier in the process
- There has been an increase in activity in the cells and these mirror the Crisis Resolution and Home Treatment Team (CRHTT) as in more psychosis and mentally disordered individuals. We are only operating in the custody suites as no courts are open
- Reports from LiDi is also that more people are in custody due to spitting offences, which has increased the pressures on personal protective equipment for this group
- We have seen an increase in activity in the Psychiatric Clinical Decisions Unit who are flexing the service to try and support Crisis and Arden Mental Health Acute Team (AMHAT)
- For section 136 we have observed an increase of just under 50 per cent compared to this time last year
- Suicidal behaviour often with police and ambulance involvement has increased.

Organisational responses to prevent mental health crisis /suicide

- In our organisation we actively promote the Zero Suicide Alliance Suicide prevention training, alongside the Health Education England's 'We need to talk about suicide'
- Preventing Suicide and Mental Crisis is complex and requires action at every level, including voluntary, community, primary, secondary and specialist services
- Cumbria Partnership NHS Foundation trust has developed a COVID-19 response plan base on their suicide prevention plan and launched the www.stopsuicidenenc.org
- A booklet has been developed and delivered to all homes in Cumbria, and working towards all homes in the north east
- Expanded use of video calling, Total Mobile RiO solution/ working from home solution, use of iPad to support staff and patients
- Use of WhatsApp to communicate with patients.

Good Practice to prevent Crisis/Suicide /Self Harm – Thrive London Suicide Prevention Group

- A single three-digit access to crisis support nationally is needed – in all areas, NHS 111 must be able to hot transfer the person (without a call back) to qualified and trained workers on a Mental Health crisis line that can fully deal with their circumstance

- The crisis line needs immediate access to **both** mobile crisis teams **and** shorter stay crisis facility services (such as crisis stabilisation, temporary observation, living room models and crisis houses) . During COVID-19 alternatives to A&E attendance have been implemented in a matter of days and should not be lost post-COVID-19
- One of the things that people report back positively in crises is when they have been shown genuine kindness by those dealing with them – quoting a voluntary sector worker, 'people want services that are simple, kind and human. People in crisis need a safe place, a sanctuary where hope and connection can be rebuilt'
- Resolution is the goal of crisis care, taking the person from agitation to comfort and supporting the individual in creating hope – one person with lived experience said that out of two crisis experiences, the first provider kept him alive, the second helped him become well
- What people want is a common-sense approach to wellness. This process commences with the individual in crisis being fully engaged and informing their own treatment
- Trained peer support is a huge enhancement during a crisis
- There should be active enquiry about suicidal ideation and proactive safety planning jointly with the individual (e.g. https://www.stayingsafe.net/about , https://stayingsafe.net/ST/ , https://papyrus-uk.org/wp-content/uploads/2018/09/Suicide-Safety-Plan-Leaflet.pdf and many others
- Family and friends must be engaged if possible and not excluded under the cover of confidentiality
- Isolation is the instinctive recourse for someone in mental health crisis, hence the major danger in social distancing – needs to have publicity on a par with physical health to encourage people to come forward despite social distancing
- All services should be trauma-aware when dealing with people in mental health crisis
- The patient and carer/s to be provided with phone numbers to a responsive, round the clock crisis service at hand
- Good capacity of services so that people who need admission to hospital are not denied that place due to a shortage of beds
- Compassionate, well trained medical and nursing staff
- Not being made to feel like an inconvenience, a waste of time or a burden. Validating their feelings.
- Being listened to without judgement. Feeling understood
- All GPs can recognise patients in crises and make timely and appropriate referrals to psychiatry, without having to worry about how long they might have to wait on the phone for someone to answer or how long the patient might have to wait to be seen by a specialist
- All GP surgeries have staff trained in mental health and suicide prevention, who can devote the time that a patient in crisis needs
- That the families/partners/friends who accompany the patient are treated with respect, kept informed and offered support, resources and psycho-education
- Information leaflets on suicide prevention should be available in all emergency departments like we have for stroke and diabetes.
- That the physical spaces that these patients come into are welcoming and calm, unlike an A&E
- Meaningful and safe handovers between different teams as the patient moves from one team to another. For example, liaison psychiatry to GPs, home treatment team to GPs. Recognising that the level of expertise falls when a patient's care is being downgraded and hence, furnishing the new team with adequate information of warning signs and symptoms to actively look out for in a patient.
- Staff, capable of drawing up individual safety plans in collaboration with each patient at every opportunity (Brown and Stanley: https://www.sprc.org/resources-programs/patient-safety-plan-template)
- An aftercare service that follows up patients after the crisis is over, helps them make sense of their experience and find connections and hope in the community

- Peer support from trained peer support workers
- Like CPR, everyone should receive a standardised suicide prevention training, so that they have a common language for exchanging information about patients in suicidal crisis, for example https://www.4mentalhealth.com/org/healthcare
- Electronic patient records should be readily available so that the patient does not have to repeat their story
- Community resources (such as Charities) should be actively liaised with to help with rehabilitation and on-going wellbeing
- Actively identifying gaps in the safety nets that should keep the patient safe and plugging them
- Trusts and individuals learning and sharing lessons from previous deaths and near misses
- A national survey aimed at frontline mental health professionals should be released to gauge the impact of COVID 19 on this mental health population.

Acknowledgements

The HIN would like to thank the Healthy London Partnerships (Thrive London Suicide Prevention Group) and the Zero Suicide Alliance for requesting support from their members on our behalf for this request.