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# **Evaluation of the Scarborough, Whitby and Ryedale Street Triage Service**

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## Executive summary

The Scarborough, Whitby and Ryedale (SWR) Street Triage service was funded for 12 months by the Department of Health as one of nine pilots in England. Street triage was introduced to bridge a gap between police and NHS mental health services, and to help reduce the number of detentions under s.136 Mental Health Act 1983.

This evaluation used both qualitative and quantitative methods within a co-production framework involving the University of York (UoY), North Yorkshire Police (NYP) and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). While UoY researchers led the evaluation, key stakeholders from NYP and TEWV co-designed the study; helped to shape the research questions; suggested key informants to interview; and provided access to respondents. Additionally, a senior data analyst from TEWV extracted data from the TEWV PARIS database and supported the data analysis processes. Evaluation methods used were individual and focus group interviews with key informants from NYP, TEWV and other local agencies in the SWR region, and analysis of routinely collected data by the Street Triage service for the pilot and data held in the TEWV PARIS database.

46 key informants were interviewed in individual and group interviews. They provided a very positive account of the SWR Street Triage service from the perspective of both the police and NHS mental health services. This was corroborated by other local agencies. They described the service as a bridge between the police and NHS mental health services, providing support to the police in their work with people with mental health problems. The involvement of the SWR Street Triage service helped to de-escalate crisis situations and find non-custodial options for people experiencing mental distress. It freed up police officers to attend other incidents and signposted people towards other more appropriate services which could provide suitable help. Over the course of the pilot, the relationship between police officers and Street Triage practitioners strengthened so that information was shared about people coming to the attention of the police before crises occurred and preventive interventions were undertaken. Interviewees were unable to find any reasons why the service should not continue beyond its initial pilot funding period.

The introduction of the Street Triage service was not associated with a reduction in the number of s.136 detentions in the SWR region, though the rates were already low. Analysis of 524 referrals to the service during the pilot found that over 80% of referrals were of people known to mental health services but only 41% had an active care plan. Many did not reach the threshold for secondary mental health services and were referred to other appropriate services after Street Triage involvement. Referral data supported perspectives offered during the qualitative interviews that it was a misnomer to name the service 'Street' Triage as 75% of contacts occurred in individual's homes rather than public places. For the first 308 street triage users there was a reduction in the use of TEWV community services after the first contact with the Street Triage service, but an increase in inpatient admissions.

This suggests that the team were successfully diverting people away from NHS mental health services who did not need it, but it was on the pathway to admission for others who did.

This evaluation was small in scale, it lacked control groups for comparison and it did not include the experiences of service users and carers. The analysis of routinely recorded data was hampered by missing data and the lack of prospective data collection limited the availability of outcome data. However, this evaluation provides a very positive account of the pilot year of operation of the SWR Street Triage service and recommends that it receives additional funding to ensure it can provide a full and consistent service in the locality.

## Acknowledgements

We would like to express our sincere thanks to the numerous people who have supported the conduct of this evaluation. These include the core project steering group, in particular Inspector Bill Scott and PC Bob Thompson of North Yorkshire Police (NYP) and Wendy Jephcott of Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV), who gave substantial amounts of their time to join in with regular project meetings, and occasional members of the project steering group including Nicky Scott and Martin Dale (TEWV), Harriet Raine (Office of the Police and Crime Commissioner) and Helen Reed (North Yorkshire Police).

We would also like to thank other members of the Street Triage team who contributed to focus groups and individual interviews, and the numerous police officers who participated reflectively and enthusiastically in group discussions. Additionally, we are very grateful to the representatives of other agencies who gave up their time and provided valuable broader insights on the Street Triage service.

We would also like to acknowledge the individuals who have used the Street Triage service during the pilot year. Although this project was not able to involve them directly in the research, many of their circumstances and experiences were described by other research participants, adding to our understanding of the service and its impact. We hope that this study will help to improve the service and enhance the support that people receive.

Finally, we wish to thank the N8 ESRC-funded project '*Realising the Potential of Co-production*' and Josine Opmeer (University of York) for providing funding for this evaluation.

It would not have been possible without your support. Thank you.

## Authors' roles

**Annie Irvine** conducted the individual and focus group interviews; transcribed and analysed the qualitative data; and drafted the final report.

**Lyndsey Allen** extracted data from the TEWV PARIS database for the quantitative analysis and undertook descriptive analysis of this data.

**Martin Webber** led the evaluation, chaired project meetings and analysed the quantitative data.

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# 1 Introduction

This report presents the findings of an evaluation of a Street Triage pilot in Scarborough, Whitby and Ryedale (SWR). The SWR Street Triage service was one of nine Department of Health funded pilots announced in 2013 by Home Secretary Teresa May and Minister for Care and Support Norman Lamb. The SWR pilot ran from 24<sup>th</sup> March 2014 to 23<sup>rd</sup> March 2015 and was delivered in partnership by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and North Yorkshire Police (NYP).

## 1.1 Origins of Street Triage and UK context

Street Triage refers to schemes where mental health professionals are available to advise and support police officers on incidents where an individual appears to be in mental health crisis. Street Triage has its origin in the United States. In 1988 in Memphis Tennessee, the fatal shooting of a young male who was in the midst of mental health crisis led to the development of the Crisis Intervention Team (CIT) approach. CIT is primarily a police training programme, “designed to educate and prepare law enforcement officers to recognise the signs and symptoms of mental illness and to respond effectively and appropriately to the individual in crisis” (Ralph, 2010). The programme – known as the ‘Memphis Model’ – comprises 40 hours of police officer training, with officers usually participating on a voluntary basis (i.e. it is not part of core officer training). CIT has spread across the USA, with recent estimates of over 400 programmes now in operation. A core set of ‘essential elements’ underpin CIT, but the model has been adapted to meet local contexts and resources (Watson *et al*, 2008).

Street Triage has come to the fore in the UK in response to concerns that the powers under Section 136 of the Mental Health Act (MHA) 1983 were being over-used. Section 136 grants police officers powers to remove to a ‘place of safety’ an individual found in a public place who appears to be in mental health crisis and at risk of harming themselves or others:

If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above (Mental Health Act 1983, Section 136)

The purpose of removing the individual to a place of safety is expressly in order that they can be assessed by an Approved Mental Health Professional and a section 12 approved medical practitioner so that appropriate care and treatment can be arranged. Significantly, persons detained under s.136 have not necessarily committed any crime – yet the use of s.136 is, in effect, an arrest of the individual, temporarily depriving them of their liberty.

A place of safety in this context may include a hospital or other healthcare setting, local social services accommodation, the home of a relative or friend who is willing to temporarily



receive the individual, or a police station. The MHA Code of Practice states that a police station should be used as a place of safety 'only on an exceptional basis'. However, concerns have been raised that police stations were being used on an inappropriate and far too frequent basis to detain individuals detained under s.136, and there have been several calls to significantly reduce this practice (e.g. HMIC, HMIP, CQC and HIW, 2013; Department of Health and Home Office, 2014; HM Government, 2014; House of Commons Home Affairs Committee, 2015). Police stations are seen as inappropriate settings in which to accommodate people in mental health crisis both in terms of the (mis)use of police resources – where no crime has been committed – and in terms of the additional distress brought upon the individual by inappropriate accommodation and the implication of criminality. The opening of 'health-based places of safety' (sometimes referred to as *s.136 Suites*) has accompanied a reduction in use of police cells to detain people in mental health crisis. However, rates of s.136 detention in police custody are still considered unacceptably high.

In May 2013, Home Secretary Theresa May announced four Street Triage pilots, funded by Department of Health and backed by the Home Office. Four months later, five further DH-funded pilots were announced by the then Care and Support Minister Norman Lamb<sup>1</sup>. At the time of writing, there are several additional pilots being run across the UK funded through local resources.

The primary aims of Street Triage in the UK context can be seen as threefold:

- To reduce the use of s.136 of the Mental Health Act
- To reduce the amount of police resources devoted to dealing with mental health incidents
- To improve the speed and appropriateness of assessment, care and treatment provided to individuals in mental health crisis – including referral into other services and follow-up care

The Department of Health has conducted an evaluation covering all nine of the DH-funded pilots, with results expected to be published in autumn 2015.

## **1.2 Models of Street Triage**

Different models of street triage exist. As a police training programme, the foundational CIT programme (outlined above) differs from the model that has been more commonly implemented in the UK, whereby mental health nurses bring their professional expertise into a partnership working arrangement alongside police officers. Deane *et al* (1999)

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<sup>1</sup> The nine police forces involved in the DH-funded pilots are: North Yorkshire, Devon and Cornwall, Sussex, Derbyshire followed by the Metropolitan Police, British Transport Police, West Yorkshire, West Midlands and Thames Valley

distinguish three strategies by which police may approach the handling of mental health issues:

1. Police-based police response: specialist officers who have received specific training in mental health
2. Police-based mental health response: mental health professionals employed by and based within police departments
3. Mental health-based mental health response: community mental health services that have formed a specific relationship with the police department to respond at the site of an incident (mobile crisis teams)

Schemes currently operating in the UK appear predominantly to have adopted the third approach, whereby mental health nurses are 'on call' to police officers and available to provide either at-the-scene or over the telephone advice and assistance in assessing an individual in distress. There are also some UK Street Triage services which resemble the second model, or a slightly amended version, for example, mental health professionals co-located with but not necessarily *employed by* the police. In some localities, a 'triage car' operates, with the mental health and police personnel located together in a mobile unit for the duration of a given shift. Some schemes also include a paramedic within the core triage team.

### **1.3 The Scarborough, Whitby, Ryedale Pilot**

The DH-funded pilot was the first time any type of Street Triage service had been implemented in the SWR area. In designing the operating model for the pilot, there was some consultation with the team that had established a Street Triage pilot in Cleveland in August 2012. That partnership had also involved Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) – in this instance the Teesside locality working with Cleveland Police. TEWV's established involvement in the Cleveland pilot was one factor in selecting the Scarborough, Whitby, Ryedale area for the DH pilot, as a model for the partnership was already in place. Although within the North Yorkshire Police Force region, the City of York had the highest level of demand in terms of mental health, there were seen to be practical advantages in running the DH pilot in an area of the Force where working links with the NHS Mental Health Trust were already established.

Box 1.1 below gives a summary of the initial Street Triage operating model in the SWR locality. Each aspect of the model is discussed in more detail in Chapter 3 including changes to the original model which were made in the course of the pilot year.

To a large extent, the operating model in SWR mirrored that of the Cleveland pilot. However, there were some important differences. Firstly, whereas dedicated operational or strategic managers had been appointed in Cleveland, the SWR pilot did not have the resources to support such posts. As such, these roles were unfunded add-ons to the roles of

existing service managers within TEWV. The Cleveland team also had more established links with local police and already delivered services around offender health. Finally, there operational differences were anticipated, given the more rural and dispersed geography of the SWR area in comparison to the more urban and centralised Teesside locality.

**Box 1.1 Street Triage Initial Operating Model in Scarborough, Whitby and Ryedale**

Staffing	Two Band 6 mental health nurses Two Band 3 Community Support Workers (One Band 6 and one Band 3 staffing any given shift)
Hours of operation	3.00pm to 1.00am, 7 days per week
Base location	Dedicated office at Cross Lane Hospital (Scarborough)
Deployment processes and transportation	Police request Street Triage via Force Control Room Triage team travel from hospital base to incident in unmarked vehicle Vehicle equipped for hands-free use of police radio
Communication and information sharing	Use of police radios linked into police airwave Mobile phones Direct access to PARIS patient information system No direct access to police NICHE records system, but police clearance for NICHE information to be shared with Triage team
Eligibility criteria	No exclusions – all ages, all circumstances

Research participants noted some characteristics of the population particular to the SWR locality. This included the high number of people who would come to seaside towns when contemplating suicide and transient populations such as people who had left prison in neighbouring cities and were rehoused in the Scarborough region. These features could mean that clients seen by Street Triage were from outside the Health Trust area. The SWR locality also experienced high levels of alcohol and drug related mental health issues, including growing and problematic use of ‘legal highs’. Scarborough was the 83<sup>rd</sup> most deprived area in the UK in the 2010 Indices of Deprivation and has higher than average levels of unemployment.

## Chapter 2 Method

This chapter describes the method that was used to design and conduct the evaluation, explaining the 'co-production' approach and detailing the qualitative and quantitative strands of the project.

### 2.1 Co-production

A co-production approach was taken to both the design and conduct of the evaluation. The term 'co-production' originated in public service delivery and refers to an equal and reciprocal relationship between service providers and service users. It is difficult to achieve in practice and is uncommon in research, particularly evaluative research. However, it was used here as it mirrored the relationship between the police and NHS Mental Health Trust in the delivery of the SWR Street Triage pilot and because the evaluation was funded by an ESRC project examining co-production in research. Co-production in research is considered to be the equal involvement of non-academic partners in the research.

This evaluation was initially requested at the inception of the SWR Street Triage pilot by the management of North Yorkshire Police (NYP) and TEWV, to address their need for robust information about the implementation and impact of the service. Although funding was not obtained until the pilot was nearing its completion, at the most fundamental level the research questions originated from the concerns of non-academic partners.

These broad research aims were refined into a set of specific research questions through a number of stages of consultation both with service managers and operational staff. At the first meeting of the full project team (which included the university academics, management-level and senior operational staff of both services) participants were invited to put forward their key aspirations as to what the evaluation would accomplish. On-the-ground operational staff contributed to the development of research questions through a focus group, which led to both a broadening and refining of the research questions. We used a 'card sort' approach, whereby each participant in the focus group was asked to write down three or four questions that they would like the evaluation to address. Each was written on a separate piece of card, and these cards were then organised into thematic groups (figure 2.1).

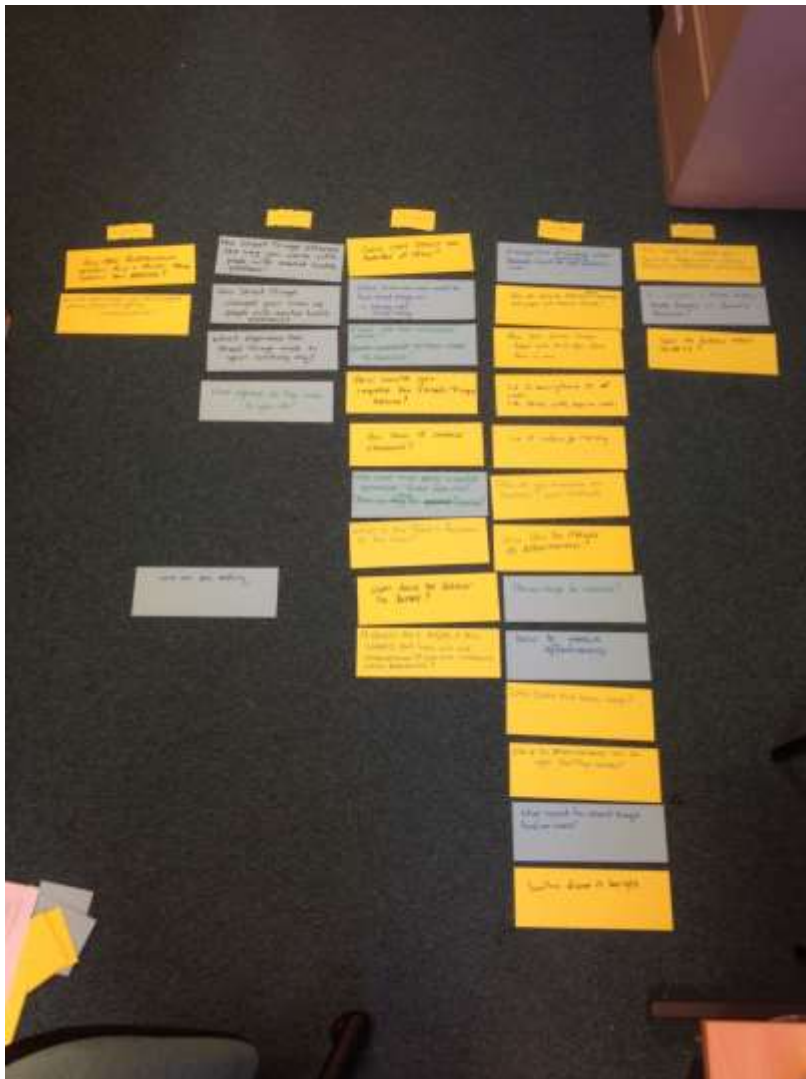
Within the scope and resources of the study, not all of the questions and concerns put forward by the non-academic partners could be addressed. A key omission, recognised by all as important but beyond current resources, included gathering the direct perspective of service users themselves (i.e. patients)<sup>2</sup>. Similarly, it was not possible to include the

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<sup>2</sup> The main obstacle here was the timescale of the project, which was carried out over only six months from the point of commission to the point of reporting. This was not felt to be enough time to adequately work through ethical requirements - both in terms of research governance processes and 'in-practice' ethics of ensuring well-managed and sensitive recruitment approaches.

perspectives of carers of service users. The desire of senior police personnel for a 'return on investment' analysis was also beyond the scope of the study, although some measures of service use were calculated to permit a rough assessment of cost/benefit. The question of whether the NYP/TEWV 'model' of street triage was the most effective way of delivering the service was also a question that could only be answered in a rather speculative sense, given the lack of specific comparators until the publication of evaluation findings from the other pilots.

**Figure 2.1 Card sort from first focus group**



A co-production approach was also taken to establish who to interview in the qualitative research. The two core groups previously identified were police personnel and the NHS team delivering the Street Triage service. However, it was on the suggestion of a police officer that we conduct focus group interviews with police personnel. This was hugely beneficial in that it significantly increased the numbers of operational police officers who were able to contribute. Additionally, several other services or organisations were suggested as relevant to interview given their interactions with, or interests in, Street

Triage. Project resources did not allow for all suggestions to be followed, but from the initial 'longlist', a smaller number of interviews were prioritised as being of most relevance (see section 2.2).

## 2.2 Qualitative research

A total of 46 individuals participated in the qualitative research, as detailed in Table 2.1 below. Police officers taking part included both Response and Safer Neighbourhoods personnel.

**Table 2.1 Qualitative research participants**

<b>Police (n = 37)</b>	<b>N = 46</b>
Inspector	5
Sergeant	6
Constable	10
Police Community Support Officer (PCSO)	12
Deployment manager	1
Dispatcher	2
Police Crime Commissioner	1
<b>Street Triage (n = 5)</b>	
Band 6 Registered Mental Health Nurse	2
Band 3 Community Support Worker	1
Health Trust Manager	2
<b>Other services (n = 4)</b>	
Ambulance service	1
Emergency Duty Team Approved Mental Health Professional (AMHP)	1
Third sector support organisation	1
County Council Community Support Team	1

Other key services which we had hoped to include within the qualitative research interviews, but project resources, timescales or participant availability did not allow were:

- Clinical Commissioning Groups
- A&E Department at Scarborough General Hospital
- Vulnerable Adults Team at NYP
- Mental Health Liaison team at Scarborough General Hospital

Services which were suggested in initial discussion but did not make the shortlist of participants to pursue (within project resources) included:

- Custody sergeants
- British Transport Police

- Fire service
- MedAx (police medical provider)
- GPs and primary care
- Social landlords
- Housing Associations
- Social Services

Qualitative data collection included a combination of individual interviews, paired interviews and focus groups. Focus groups and paired interviews were conducted face to face. Individual interviews included some conducted face-to-face and others by telephone, according to participant availability and practicality.

Interviews were audio recorded with participants' permission and were transcribed by the researcher who had conducted the interviews. Focus group discussions were transcribed verbatim and individual/paired interviews were summarised in detail, including extensive verbatim extracts.

Data were imported to the qualitative data management package MaxQDA2 and subjected to thematic analysis (Braun & Clark, 2006). Preliminary thematic categories were based on the study's research questions, but the analytic approach also allowed for additional themes to emerge from the data.

In the chapters that follow, several extracts from the interview transcripts are included. To preserve anonymity, quotes are attributed either to *police officer*, *PCSO*, *triage team* or *multiagency respondent* rather than to a more specific rank, role or organisation.

## **2.3 Quantitative analysis**

There were three forms of quantitative analysis in this evaluation:

### **2.3.1 Section 136 detentions**

Accurate recording of s.136 detentions is problematic with records being kept separately by police forces (of detentions in custody) and NHS Trusts (of detentions in health-based places of safety). In order to obtain reliable data, it is necessary to obtain both sets of records, cross-match and delete duplicates.

To evaluate the extent to which the SWR Street Triage pilot impacted on the total number of s.136 detentions, we obtained records during the period of the 12 month Street Triage pilot (24 March 2014 to 23 March 2015) and, for comparison, the preceding 12 month period. We used records of detentions to custody (from NYP), detentions to the Health Based Place of Safety (HBPoS) (from TEWV) and detentions where there was a transfer from custody to the HBPoS (or vice versa) (from TEWV). We were unable to obtain data from A&E, so these figures could be an under-estimate of the use of s.136 in the SWR area.

Data were analysed using descriptive statistics.

### **2.3.2 Street triage activity data**

This analysis is based on data collected by the Street Triage team and submitted to the Department of Health. Data were recorded by the Street Triage team on manual proformas and subsequently inputted into an electronic database, where it was cleansed by a data analyst.

In the early months of the pilot (March-July 2014) this data set included a line of data entered for every individual 'contact' made by the Triage team – in other words every single activity they were involved in regarding a Street Triage client. It was later understood that the Department of Health only wished to receive information about the initial activity – known as a 'referral' – in the data returns. Hence the data set contains a mixture of activities (initial referrals and subsequent contacts) for the first months of the pilot but from the end of July onwards, only initial referrals were recorded.

To reconcile this in the present analysis, repeat patient identifiers were examined alongside dates of recorded activities and (with reference to a separate data extraction provided by the TEWV analytical team) the closure dates of referrals. From this, a judgement was made on where to collapse activities with repeat clients into one 'referral'. It should be acknowledged that while this exercise was done systematically, there was an element of estimation involved where specific information about referral closure dates could not be found.

With the above manipulation of data, the final data set showed 524 distinct referrals to the Street Triage team, involving 379 different individuals (several people had two or more referrals to Triage). This data were analysed using descriptive statistics.

### **2.3.3 Service user outcomes**

To explore the impact of contact with the SWR Street Triage on individuals who use the service, we conducted secondary analysis of data held in TEWV records. Data were extracted from the TEWV PARIS patient information system for 308 individuals who had a first contact with the SWR Street Triage team between 24<sup>th</sup> March and 24<sup>th</sup> December 2014. Demographic characteristics (age, gender and ethnicity), whether or not they were currently receiving care on the Care Programme Approach in TEWV and length of first contact with the SWR Street Triage team were extracted for each individual. Additionally, the following were extracted from PARIS for the six months before and after their first contact with the team to evaluate changes in service use after the Street Triage intervention:

- Number of TEWV contacts
- Total length of TEWV contacts (mins)
- Number of episodes with crisis team



- Number of days with crisis team
- Number of episodes with liaison team
- Number of days with liaison team
- Number of episodes with other community team
- Number of days with other community team
- Number of episodes with street triage (other team pre, SWR post)
- Number of days with street triage (other team pre, SWR post)
- Number of episodes with primary care mental health team
- Number of days with primary care mental health team
- Number of inpatient admissions
- Number of inpatient days
- Number of inpatient days on section

Data were analysed using non-parametric descriptive statistics, as the variables were all positively skewed. To explore differences in TEWV service use before and after the first contact with the SWR Street Triage team, we conducted related-samples Wilcoxon signed rank tests for continuous variables and related-samples McNemar tests for categorical variables. All tests were at the 0.05 level of significance.

## Chapter 3      Operating model

This chapter considers in detail the Street Triage operating model in Scarborough Whitby Ryedale (SWR). Building on the summary overview of the operating model given in Chapter 1, we discuss here in more depth the following elements of the model:

- Staffing
- Operating hours and availability
- Base location
- Deployment processes and transportation
- Communication and information sharing
- Eligibility criteria

Each subsection describes: the model as initially implemented; any changes that were made during the pilot; and key strengths and challenges of the model. The chapter concludes with a brief discussion of how the size and geography of the locality influenced the operation of the service.

### 3.1 Staffing

#### 3.1.1 Staffing levels

The pilot funding allowed for 2.26 staff at Band 6 (Registered Mental Health Nurse) and 2.26 staff at Band 3 (Community Support Worker). Once enhanced hours payments were taken into account, this amounted in effect to four full-time members of staff. Due to the enhanced level of security clearance required for the roles, there were delays in some staff taking up post. For the first few months, the pilot operated with two Band 6s but only one Band 3. A second Band 3 then took up post and the team operated at full staffing for around four or five months of the 12-month pilot, with some further staff turnover. However, the team subsequently lost one Band 3 worker and later one Band 6 nurse, who were not replaced due to the short-term nature of the pilot and uncertainty about future funding at that stage.

The Triage team noted that even when operating with the initial staffing levels of two Band 6s and two Band 3s, it had still been a challenge to provide a full, uninterrupted service, given that there was no cover for staff illness, training or annual leave. A change in hours of operation made towards the end of the pilot (described further below) entailed an increase from 10-hour shifts to 12-hour shifts; this increase in hours combined with the loss of staff made providing a full service effectively impossible. Mirroring the positive impacts of Street Triage when available (discussed in Chapter 5), the perceived impacts of reduced service availability were that demand then reverted to the ambulance service, the A&E department, the Crisis Team and greater use of s.136.

There was a unanimous message from police that they would like to see more staff and hence more hours of availability of the Street Triage service, with a seven day service resumed. Optimal staffing levels, from the perspective of the Triage team, were to have two Band 6s and one Band 3 working on any given shift i.e. an increase of one Band 6 from the initial operating model. To cover the desired number of hours of operation (see below), this would mean up to three teams – totalling nine staff in all.

The pilot funding level did not allow for a dedicated manager for the Street Triage team. Although the team felt an excellent job had been done by the manager who had taken on this role alongside existing responsibilities, capacity to focus on and develop the service was inevitably limited. It was felt that a dedicated manager would have been beneficial, particularly given that this was a new and high-profile team. Administrative support would also have been helpful, to carry out data inputting and to support liaison work with other services during standard working hours (i.e. 9am-5pm Monday to Friday).

### **3.1.2 Skills and expertise**

The Triage team members had backgrounds in Crisis teams, in-patient wards and secure mental health units. Their qualifications and skills were felt to be well matched to the roles and the team members felt that their professional backgrounds prepared them appropriately. The team had not undertaken any specific training in relation to the Street Triage pilot, but had undertaken refresher Safeguarding training shortly before the pilot launched. This was felt to be particularly useful, given that a much broader range of social issues were involved in the types of scenario that Triage attended, in comparison to standard Crisis team work. The assessments carried out in Triage situations were felt to be very similar to Crisis team assessments. However, one member of the team noted that in the Street Triage context, clients could be more in the midst of crisis than might be the case in Crisis team work, where issues had sometimes calmed down somewhat by the time of the assessment. As such, skills of engagement were all the more essential in the Triage role. There was also more liaison and follow-up work involved in Street Triage, in comparison to the more discrete shift work involved in a Crisis team role.

Band 3 staff were not able to carry out clinical assessments and as such did not attend incidents unless accompanied by a Band 6 nurse. However, Band 3 staff were able to provide advice and background information by telephone or radio, carry out liaison work with the Crisis team, care coordinators and others, offer signposting and could also conduct follow-up appointments alone. As will be discussed further in Chapter 4, during the course of the pilot the role of the Band 3 staff expanded into work with Police Community Support Officers (PCSOs) around non-crisis, early intervention and multiagency work.

Notwithstanding problems of availability, police officers felt that an excellent service was provided by the Triage team. An officer from North Yorkshire Police had sat on the interview panel, and this had been beneficial in ensuring that the individuals appointed also had

attributes and approaches which would work well in a policing context.

Skills of engagement and rapport building were highlighted as important both by the Triage team and police officers who had observed the team in their work. Police officers admired the Triage team's manner of interacting with individuals, highlighting the 'softer' way they spoke with them, their patience and their willingness to remain with an individual for as long as it took to be satisfied they were safe and that a suitable plan was in place. This was contrasted with the police's feeling of being constantly pressured to conclude an incident and get on to the next job. The team's positivity and enthusiasm for their work was also complimented, one officer highlighting that there was never any sense of reluctance about attending incidents. This was also reflected in the team's readiness to work beyond the end of their shift if circumstances required.

That the Triage team members were often already familiar with some clients was viewed as a further advantage, in terms of engagement, rapport and establishing background information. Where there was already knowledge of history and risk factors, this also meant that officers could be released sooner, Triage remaining with the client without police assistance. One member of the Triage team linked this familiarity with the client base to their having worked in the locality for very many years.

In discussing possibilities for providing occasional staff cover to the Triage team, it was felt that members of the Crisis team would have the necessary skills to carry out assessments in the Street Triage context – although this could not be entirely *ad hoc* as the required levels of police clearance would need to be obtained in advance.

### **3.2 Operating hours and availability**

The SWR Street Triage service initially operated from 3.00pm to 1.00am seven days a week. Based on an analysis of demand for the service carried out by the Triage team, these hours were changed in early January 2015 to operate from 10.30am to 10.30pm, again seven days a week.

Among those consulted in the evaluation, there were mixed views about how beneficial this change in hours had been for police officers. Safer Neighbourhoods police and PCSOs tended to find the earlier shift pattern beneficial, reflecting their own shift pattern and times of peak demand. On the other hand, Response officers felt they had benefitted from the later shift pattern, given that they often encountered clients in mental distress during the night. A number of Response officers called for an extension of operating hours to provide cover into the early hours of the morning.

The fifty per cent reduction in staffing (described above) led to challenges in providing desired levels of service. Initially, the team continued to work to a rota as if there was full staffing – but with certain shifts operated by either the Band 3 or the Band 6 working alone, and some shifts simply not staffed. Where the Band 3 covered shifts alone, it was not

possible to provide assessments in the community. One Safer Neighbourhoods officer noted that it was still beneficial during these times to have someone available to give advice by telephone or over the police radio. This was sometimes enough to enable Safer Neighbourhoods officers to make a decision about a situation they were encountering. In contrast, for some Response officers, this level of service was not thought to be very useful given that the types of scenario in which they would call on Street Triage would usually require an immediate at-the-scene response:

*Your heart sinks when you hear it, when they come on, on the radio and say, "Ah yeah, there's only one of us, we aren't coming out" (police officer)*

Covering a 12-hour shift alone was also not good for morale and could be lonely for members of the Triage team.

The inconsistency in service staffing led to confusion for police officers, who could not be certain as to whether the service would be operating at any given time. There was a concern that this had led to officers using Triage less, either assuming the service was not available or not bothering to check, given the lack of consistency in operating hours:

*It's just very, very unsatisfactory, running half a service. We did a lot of work in the beginning to raise our profile. We were going down to police briefings, introducing ourselves, and we did that for the first couple of months, so that police officers knew who we were and knew when we were on duty, and you know, we did a lot of work. And I just feel that we're at risk of losing that, because it's that "Are they working, aren't they working?" You get to the point where people won't bother cos they don't know whether we're there or not, so they'll just do without us. And I think that's a real kind of risk (Triage team)*

As such, a decision was taken in early April 2015<sup>3</sup> to move to a reduced but consistent set of operating hours, providing a service 10.30am-10.30pm on Thursdays, Fridays, Saturdays and Sundays, so that police could be sure of when the Triage service was available.

The reduction in total hours of service was regrettable both for the police and the Triage team. However, the unsatisfactory and confusing nature of the intermittent service cover was evident in the comments of a number of the police officers who took part in the research, and the move to reduced but more consistent hours of operation was recognised as bringing some advantages. For example, a PCSO noted that they would now know with certainty when they could schedule an appointment to visit a member of the community with the Triage team. The Triage team had the impression that referrals had indeed begun to increase now that the hours of service were more regular.

There was a universal message from police that longer hours of operation, covering seven days a week, would be very welcome. Both the Triage team and police officers highlighted

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<sup>3</sup> This was just after the end of the DH funding period, at the beginning of the three-month extension to funding provided by the Scarborough and Ryedale CCG.

the disappointment and frustration of Street Triage not being able to operate a seven day service or extended hours:

*You hear officers shout up when they're at the incident, for Street Triage. And when you hear that they're not on duty at the time, you can hear the disappointment in the officers, because they're probably thinking to themselves, "Well, what we gonna do?"... I think you've got so used to them now – knowing that help's there, there's a professional there to help, to call up, and they will come straight out to you, they'll be on the radio to you, straight away – that when they're not there, it's massively disappointing (PCSO)*

Although some officers commented that they would like to see Triage available around the clock, a 24-hour service was generally not felt to be essential by either police or the Triage team. However, extending the period of out of hours service was a common recommendation, and cover from 8am until around 2am or 3am was suggested as a beneficial period of operation. Although there was agreement that mental health crises tended to occur later in the day and into the night, it was also noted that mental health problems could affect people at any time of the day and demand for services could be unpredictable.

### **3.3 Base location**

During the pilot, the SWR Triage team were based at an office at Cross Lane Hospital in Scarborough. A key advantage to being based in NHS premises was ready access to the PARIS patient information system. The Triage team routinely referred to this information prior to attending an incident, as well as in providing background for officers in remote advice-giving situations. For the Triage team, a fundamental requirement of any relocation of the operational base would be to ensure access to the PARIS system from that new location, so that patient background information could be readily retrieved. Being based alongside the local Crisis team and the s.136 Suite (Health-Based Place of Safety) at Cross Lane was also seen as an advantage in terms of ease of mutual information sharing where there was overlap in the client base.

Maintaining a distinct identity, as separate from the police force, was seen as beneficial in terms of engagement with clients. Operating from a health service base rather than a police station (or other multiagency location) was seen by some as helpful in supporting this distinction:

*It supports our identity as health workers, being based at [NHS premises], that that's what we are, we don't work for the police, we don't work for the local social services, we are health service staff, and I think it reinforces that (Triage team).*

At the same time, other participants did not see a separate base location as critical, so long as the distinction was clear to clients when working out in the community (e.g. through the Triage team being dressed in civilian clothing). A number of suggestions were made during

research interviews about possible alternative operating bases, including police stations, the Force Control Room, and the multiagency 'hub' which was located at Scarborough Town Hall. Pros and cons were noted for each of these potential options, discussed further in Chapter 9.

### **3.4 Deployment processes and transportation**

Street Triage in SWR could only be requested by a police officer. Initially, the pilot had been designed such that only Force Control Room staff (namely Dispatchers) could request Street Triage. Police officers in the community would need to radio into Force Control to request a call to the Triage team. Over time, however, the routes in to Street Triage expanded such that Response and Safer Neighbourhoods officers of all ranks and also PCSOs could contact Street Triage directly. For Response incidents, deployment still was typically made via Force Control through the police radio, with Dispatch staff maintaining the Storm record during live incidents. For other types of concern, Safer Neighbourhoods officers and PCSOs could contact the Triage team directly to discuss and arrange planned visits in relation to non-crisis situations where there were ongoing concerns about an individual in the community.

Given that the Triage team had access to the police airwave and could be continually listening in, there were also occasions where they would hear a familiar name, hear the nature of the incident that was in progress, and offer to attend even before a request had been made by a police officer. Police officers appreciated this proactivity.

Where an outside agency wished to refer someone to Street Triage this would be done via police officers, either through Force Control, the Safer Neighbourhoods teams or via officers who were also present at the time a member of the community was encountered.

However, some participants suggested that a useful expansion to the Triage service would be for other agencies to be able to make direct referrals to Street Triage. This is discussed further in Chapter 9.

To travel to incidents, the Triage team used an unmarked car equipped with the police radio and speaker system. However, they were not able to use the 'blues and twos' warning light system that might enable quicker attendance at a scene. It was noted that in some other Street Triage pilots across the country, mental health nurses and police officers were paired for the duration of a shift and could travel together in a police vehicle that allowed for this level of 'bluelight' emergency response. Although this could have significantly reduced travel times between locations, it was felt that in the SWR region levels of demand did not justify the assignment of an officer for a complete shift in this way:

*It's a sparse population, it's a small population, small resources. So yeah, we have to kind of do the best we can, really (Triage team).*

Where staffing levels allowed, Triage typically attended as a pair, one Band 6 nurse and one Band 3 support worker. Although the Band 3 staff could not conduct formal assessments

themselves, there was felt to be benefit in having two members of staff attend:

*It's good to have two sets of eyes [because] sometimes one person will see something the other doesn't. Then you have a conversation afterwards about [it], see where you go from there (Triage team).*

Triage attending as a pair also increased the possibility that police officers could be released from an incident sooner.

On arrival at an incident, if police had not already entered the scene, it was sometimes felt useful for Triage to present themselves first as this could support better engagement with the client:

*Ideally [we] let them go in first, and then we don't make things worse' (police officer).*

In the large majority of cases, the Triage team would attend incidents alongside police officers. In a crisis response scenario, police officers would invariably be in attendance at the scene before the Triage team arrived, and would stay at the scene until Triage were happy for officers to leave (or until the situation had been moved on in some other way). Triage staff commented that they felt safe and well supported by police when carrying out assessments in the community, helped by the continual communication channel provided via the airwave radio.

On a small number of occasions, the Triage team had attended incidents unaccompanied by any police officers. This was only in situations where the client was well known to the Triage team and the assessed level of risk was low from both the mental health service and the police perspective:

*It's generally with people that they've had contact with quite a lot. The same names come up in Scarborough certainly ... and if they know and have some sort of rapport with that person, they'll go on their own (police officer)*

*We've had calls before where a job comes on and you shout a cop "Officer can you go to that" and [Triage] will come on and say, "We spoke to them, we had a chat with them yesterday, and we made an appointment to go and see them later on, so don't worry about that, we'll go and speak to them and we'll speak to them about whatever they're reporting now, and if it needs an officer we'll let you know". And more often than not they'll come back and say "Don't worry, don't worry about it". So, they are very good like that. They're worth their weight in gold (police officer)*

Although the Triage team thought that unaccompanied visits had only happened a handful of times – '*probably in single figures*' – several police officers of various roles and ranks highlighted this aspect of the service during research interviews and seemed to be of the impression that it was rather more commonplace. Regardless of the true figure, this therefore suggests that police personnel perceived it as an especially valuable aspect of the service, which they would appreciate happening even more, where possible.



Whether Triage attended the incident entirely unaccompanied, or whether they remained at the scene after officers had left, Force Control would be informed of when Triage arrived and when they left a 'live' incident and would keep the airwave channel open for the duration of the visit.

Safer Neighbourhoods officers sometimes made planned appointments for Triage to visit an individual in their home, and again where risk was low, Triage had occasionally attended alone. For follow-up visits Triage team members would more commonly attend unaccompanied by police officers.

A couple of challenges were noted in the way that Street Triage were being deployed. One was that Street Triage were occasionally requested at an incident *after* a s.136 detention had already been made. At this point, there was no functional role for the Triage team because with s.136 in place the next step was necessarily a Mental Health Act assessment by a different set of practitioners. The solution to this was seen to lie in more education for police officers about the process and implications of s.136 detentions.

Another challenge regarding deployment was when more than one incident required Triage's input simultaneously. Occasions were cited where there might be three or four jobs '*stacking*' for the Triage team. Increased staffing would go some way to addressing this problem, though it was recognised that this might be difficult to justify from a resource perspective:

*There's times when you get two or three shouts up from the police at the same time, and that would be useful, I think, if you'd got two Band 6s, so at that point you can both go off in different directions. But that might be expensive to have that around the whole time, when it would only be needed very occasionally (Triage team)*

In these situations, a kind of triaging exercise had to be carried out on the jobs themselves, to establish which was the greater priority for Triage to attend; comments from the Triage team suggested that there could be some tensions when these situations arose. One view was that it was fine for Force Control to take the lead in prioritising their deployment, though the Triage team might on occasion share relevant patient information to assist that decision. However, there had been instances where Force Control had taken the decision to prioritise a particular case for Triage's attendance where the Triage team member felt that the other concurrent incident could have benefitted more from their attendance. In this respect, it was felt that the team might benefit from somewhat more autonomy in deciding where to deploy. Interestingly, some police officers commented that in such scenarios, they were happy to let the Triage team lead on decision-making about priorities. Whilst it should be noted that these occasions were rare, and that case-by-case consideration would always be necessary, these contrasting perspectives suggest that there could be benefit in establishing a more explicit decision-making protocol for when multiple incidents were called in. Increased staffing levels would also go some way to addressing this dilemma.

### 3.5 Communication and information sharing

Three key aspects of the information and communication system used in the SWR pilot were: use of police radios, access to PARIS patient records; and use of police records systems.

The Triage team were equipped with police radios and an airwave licence had been paid for from the pilot budget. The Triage team also had unique 'collar number' identifiers. Enabling use of the police radio system was highlighted as a particular strength of the SWR operating model for several reasons, including: the ease and speed of communication both at base and in transit; the ability for Street Triage to continually listen in to incidents as they arose and proactively provide information or offer to attend; and to support the personal safety of Triage staff when attending incidents. Learning how to use the radios had taken a little while at the start of the pilot with a few mishaps (*'stuff like pressing the accidental emergency button and things!'* (Triage team)), but police officers and the mental health staff themselves noted that over time the Triage team had developed confidence in using the equipment and a greater understanding of its functionality. The Triage team also had landline and mobile numbers, which police were able to use as alternative means of contact, for example if the airwave was particularly busy.

Access to the PARIS patient records system was seen as invaluable. Before attending an incident, the Triage team always consulted PARIS records to gather history about a client, but they would also regularly provide background information over the airwave to police officers, enabling the officers to make an assessment of how to proceed with an incident, including (where relevant) establishing whether Triage were required at the scene or not. As noted above, access to PARIS was seen as essential and would need to be facilitated at any other location from which Street Triage was to operate.

In discussing response times to attend incidents, officers noted that although clearly very important, the time spent at base gathering background information could delay Triage's arrival:

*They will really research that person, which is good in one way in terms of the assessment, but also sometimes can be a negative if you're sat with someone waiting, it's a balance isn't it (police officer).*

*The research that they have to do, sometimes that can take them half an hour, 45 minutes to go through their research, so you're waiting that long for them to do some research on their computers before they come, and that's time for us, like 45 minutes, you could have however many jobs in that time that you can't go to cos you're stuck (PCSO)*

One suggestion to address this was that it might be possible to facilitate mobile access to PARIS via a Wi-Fi enabled laptop or tablet device which could be used by the Triage team en route to an incident. Subsequent to the research data collection period of this evaluation,

the Triage team had in fact been provided with wi-fi enabled laptops and could now access patient information whilst in transit.

Two police data recording systems were relevant to Triage activity - 'Storm' for live incidents and 'Niche' for the long-term record of closed incidents. For live incidents being monitored by Force Control, the Storm log would be continually updated with information including the input of Street Triage. At the close of an incident, the Storm record would be transferred automatically into Niche. The Triage team also provided a summary at the end of each shift detailing all activities undertaken, which was inputted by police personnel into Niche records. Having these updates in Niche was seen as useful to the police in situations where the same individual was encountered on subsequent occasions:

*It's all good intelligence for us. We'll have an update at the end of the job when [Triage] resume back to Cross Lane ... so that's the most recent intelligence we've got for the next time we deal with that person, which actually helps [officers] because when they get a missing people report, they've got concerns for poor mental health, it helps with them, certainly particularly with Street Triage, cos you've got a health professional who's given an up to date [report] (police officer)*

Emerging from the research discussion, there was some indication that (i) not all officers were aware that reports from Triage were fed back into Niche and (ii) it would be more effective if incident details were brought more quickly and directly to the attention of police personnel. This would avoid the scenario, which had sometimes arisen, where officers were called to the same scene only a few hours later and put in a request for a second attendance by Triage, unaware that a full assessment had already been carried out and that plan was in place with no further action deemed necessary:

*If you knew they've got an appointment tomorrow at nine o'clock at the Ellis Centre [CMHT], it's all fine and that's the plan, you wouldn't always need [to attend], or if you did need to attend, you could just go and say "You've got a plan, you're being seen tomorrow" and then come away (Triage team)*

Given their rather different role and ways of accessing information, Safer Neighbourhoods officers and PCSOs noted that it would be useful if they could receive a direct update or alert when a member of the community had been attended by Street Triage. If an incident had been handled via Force Control, PCSOs were sometimes unaware that a client known to them had been seen by Street Triage or that a visit was planned. An email sent to the Safer Neighbourhoods inbox to let them know that Triage had had involvement with a client was suggested as a way of ensuring information was conveyed. PCSOs also felt that more detailed written updates on the nature of Triage's engagement with clients and any next steps planned would also be useful. As one PCSO noted, this could enable them to provide more effective input, for example, in reassuring the client, reminding them of scheduled follow-up appointments, and deflecting unnecessary further calls to Triage:

*When we're dealing with people long term, if we actually knew that Triage were going out and what they've done, if we see that person the next day, we know exactly what's been said to them and things like that, so we can maybe stop them from ringing up again or presenting themselves in exactly the same way. We can say "Well we know Triage did this with you last night, do you want us to ring this person or do you want us to do that", or whatever. But we can try and sort of back them off a little bit if they're like trying to present in exactly the same way as they did the night before (PCSO)*

It was felt that having direct access to the Niche records system would be beneficial for the Triage team. This would enable the team to input their own case reports and updates, which would improve the level of detail and accuracy of information recorded about mental health incidents, which as one participant described it could sometimes be *'like Chinese Whispers, so we'll say something and then they'll document something slightly different'* (Triage team). It would also enable Triage to access police-related client background information directly.

Research participants also talked about increasing opportunities for face-to-face information sharing between police and the Triage team, away from the live incident scenario. In the early stages of the pilot, the Triage team had attended routine police briefings at different local stations. It had not been possible to sustain these visits when Triage staff numbers dropped, but both police and mental health staff had found this useful and something they would like to resume if possible. Other suggestions were a fortnightly or monthly 'drop in' at police stations, regular meetings with PCSOs to share updates on clients who were engaged with services in the long term, and attendance at the multiagency meetings that were held weekly in Safer Neighbourhoods areas, again to provide information about known clients. These types of contact and information sharing were seen as contributing to greater opportunities for crisis prevention and early intervention work. As noted earlier, some participants saw advantages in Triage being based at a police station in that this would allow more opportunities for informal face-to-face communication, information sharing and education. A police operating base would also be one of the more simple ways of facilitating direct access to Niche for the Triage team.

### **3.6 Eligibility criteria**

The Street Triage service in SWR was an 'all ages' service with no lower or upper cut off. This was noted as a distinct advantage, offering something unique among the range of mental health provision available in the region:

*One of the problems [is] the CPNs that work in the Crisis team refuse to have any involvement with juveniles. And it's a huge problem for us, out of hours and at night. But Scarborough Street Triage do, and that makes all the difference (multiagency respondent)*

Furthermore, the Triage team had agreed from the outset to operate a 'never say no' philosophy, where any referral from the police would be considered. This aspect of the service was very much appreciated by police officers and other services and was contrasted

favourably with other parts of the mental health service which imposed exclusion criteria around such things as patient intoxication, locations where assessments would be conducted out of hours and, as noted, the age of the client:

*They come out every time, don't they ... The only reason I've known them not go to you, wherever you are, is cos they're somewhere else (police officer)*

*Your never say no approach to this is just so refreshing. That has been just brilliant, and you stand that at odds with other people that we deal with who are like "Oh, we can't do that because they're children" or "We can't do that because they're drunk". Having just that approach where you'll take anybody, and speak to anybody is fantastic (police officer)*

*One of the things we'd agreed at the beginning of our service, that we wouldn't say no to anything. And we pretty much haven't (Triage team)*

### **3.7 Size of the locality and impact on response times**

The SWR pilot operated over a geographical area of approximately 900 square miles<sup>4</sup> with typical driving times of between 30 and 45 minutes between the main centres of population. The Triage team were based close to the largest population centre (Scarborough town centre) but regularly attended incidents in the more outlying areas. Hence policing teams in all areas could expect to wait at least 45 minutes to an hour for attendance by Street Triage if they were travelling from a job in a different part of the locality. The gathering of background information from PARIS systems at the Triage office base also added to the time taken to arrive at an incident.

Police in some areas of the locality seemed to be more tolerant than others of long waiting times for service. Officers based in the more rural and remote areas of the patch were more accustomed to long waits for services to attend and so found 45 to 60 minutes a fairly acceptable timeframe. In contrast, officers based in the more urban centre seemed somewhat more frustrated by having to wait for Triage to attend. As will be discussed further in Chapter 5, response officers sometimes felt the need to use s.136 powers because the level of risk at an incident was so immediate that they could not wait for Triage to arrive. Officers in more outlying locations were also more inclined to remain with the Triage team until an incident was concluded, in part because they were mindful of the length of time it would take them to travel back if they were later recalled to the scene:

*If they're out somewhere in the sticks and it's a 45 minute drive, I think the officer's rationale is, "Well if I come back to Whitby and then they kick off, I'm only going to have to drive [back]" ... But I think in Scarborough, certainly when you listen to them, they're like "Oh, Street Triage have got them and we're off", and I think a lot more of that goes on (police officer)*

A member of the Triage team did note that where travel times were particularly long,

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<sup>4</sup> Figure provided by North Yorkshire Police GIS Application Support (ICT) team

incidents had sometimes been resolved by the time they arrived at the scene.

There was felt to be no more practical single base for the Triage team than the one they currently operated from in Scarborough. Cross Lane Hospital was not the most central location on the SWR patch (it was suggested that Eastfield police station was perhaps slightly better located in terms of access to other population centres) but Scarborough was arguably the area of highest demand for service. Acknowledging the challenges of the geographical area, Scarborough was generally recognised as a sensible location for the base of operations.

Although levels of demand were typically higher in the town centre location, there was no evidence to suggest that officers were not using Triage purely because of geographical distance from the operating base. It was noted that there needed to be equitable access to the service across the locality and that priority should not be given to the areas of highest demand on that basis alone:

*We can't just say to them to sit in Scarborough, because these other people [elsewhere] need their help as well. I mean, the funding's there for that area ... it shouldn't become a postcode lottery should it. Just to say to them no, we keep them in the centre of Scarborough because that's where the bulk of the customers are. I mean if somebody out in the sticks- they all pay council tax don't they, at the end of the day ... So they're still entitled to service aren't they, certainly as far as the National Health Service is concerned (police officer)*

One possibility suggested for reducing travel times was to have multiple bases located in local police stations. However, this had associated staffing and resource implications and clearly could not be facilitated under current staffing levels.

Another potential solution to lengthy response times, which was being investigated by North Yorkshire Police around the time of the research, was the possibility of using video streaming to deliver remote triage from a mental health nurse in the control room to officers at an incident. However, research participants raised both practical and ethical concerns about this. In rural areas, the technological capacity to deliver high quality web-based video feed was questioned. More importantly, mental health nurses and police officers voiced concerns about the appropriateness of conducting mental health assessment with clients in distress over a video interface. There was substantial agreement that this kind of service needed to be delivered in a personal, face-to-face manner both for the engagement with the client and also because of the importance of observing and assessing their physical appearance and (where relevant) living environment.

## 4 Street Triage in Practice

This chapter looks at the type of work the Street Triage team engaged in. Section 4.1 gives an overview of the kinds of scenario in which Street Triage were offering input, drawing on both qualitative and quantitative data. Section 4.2 looks in more detail at the kinds of input provided by the Triage team. Section 4.3 considers the ‘triaging’ function of Street Triage, describing the ways in which the team was directing individuals towards various different pathways, as relevant. Section 4.4 discusses perceptions of the extent and appropriateness of use of Street Triage.

### 4.1 Types of scenario addressed by Street Triage

The SWR Street Triage service operated a ‘no exclusions’ philosophy and this was reflected in the wide range of incidents they had attended over the pilot year. Users spanned a wide age range from adolescents to people in their late 80s. A spectrum of mental health conditions had been encountered including severe mental illnesses through to milder forms of mental distress triggered by personal and social circumstances. Several incidents involved alcohol use as a primary or contributory factor.

Situations described in the qualitative interviews involved the following range of circumstances:

- Suicide attempts or expressions of intent
- Self-harm or expressions of intent
- A range of mental health problems including:
  - Personality disorder
  - Attachment disorder
  - Dementia
  - Psychosis
  - Depression
- Learning disabilities
- Neighbour disputes
- Domestic conflicts - including disputes between couples and conflicts between young people and their families
- Intoxication/substance use - drugs, alcohol, legal highs
- People ‘behaving oddly’ or showing signs of cognitive confusion
- Missing persons
- Welfare checks and concerns for safety

Based on data provided by TEWV, Table 4.1 below gives an overview of the types of mental health problems triggering involvement of Street Triage.

**Table 4.1 Mental health problems triggering Triage involvement**

	n	%
Harm to self	247	47
Unusual behaviour/any other mental health problem <sup>5</sup>	209	40
Intoxication	36	7
Harm to others	21	4
Other aggression	8	2
Physical violence	1	0
Not recorded	2	0
Total	524	100

As has been recognised in several pilots across the country, the term ‘street’ in Street Triage was something of a misnomer as a substantial proportion of the service’s work took place in private home settings. Quantitative data provided by TEWV indicated that over the pilot year, just 25 per cent of referrals were initiated with the client in a public place, with 75 percent occurring in private settings. For the police, knowing that Triage were on their way to assist gave them more confidence to stay with an individual in their home or, if encountered in a public place, to bring the person back to their home (on a voluntary basis) rather than transport to a place of safety:

*That’s another huge culture change. We’d have never done that before the triage team, because we’ve instantly lost our 136 power when they go into the house, and taken away what was previously our one and only option. We’d have never taken someone home. Yet that’s probably the best place for them, most of the time (police officer)*

Notably, the SWR Triage team provided input both to immediate crisis situations but also to non-crisis situations where police officers had more longstanding concerns about a member of the community. This latter type of input was something that developed as the pilot progressed, forming an increasing part of the Band 3 community support worker role, and is discussed further below.

## **4.2 Types of input provided by Street Triage**

The Street Triage team provided a number of forms of input, including:

- Face-to-face client assessments in crisis scenarios
- Remote advice and information provision
- Liaison, referral, signposting and follow up
- Non-crisis assessments and multiagency interventions

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<sup>5</sup> Incidents recorded in the category ‘unusual behaviour/any other mental health issue’ included: dementia, psychosis, autism, paranoia, delusions, hallucinations, rough sleeping, domestic disturbances, depression, wandering, confusion, expressing unusual or concerning beliefs, hearing voices, mania, domestic disturbances, agitation.



Based on quantitative data provided by TEWV, Table 4.2 below shows the distribution of the three main types of Triage engagement. Note that this data relates to the *initial* contact in any given referral. Where referrals involved one or more follow up contacts, these included a mixture of telephone and face to face.

Type of triage engagement	n	%
Face to face	328	63
Nurse to police telephone advice	156	29
Nurse to client telephone advice	40	8
Total	524	100

#### 4.2.1 Face-to-face crisis assessments

As indicated by Table 4.1, the majority of incidents involving Triage related to individuals in crisis such as engaging in or expressing intent to self-harm, or behaving in an unusual or concerning manner.

##### Case example

Triage attended an elderly male in a residential care home, who was open to the elderly mental health team. The individual had dementia and had attempted to strangle another resident and was being very aggressive towards staff. The staff had called the police, who had attended and then called for triage.

Triage arrived at around 9.00pm, engaged with and assessed the individual and established that a Mental Health Act (MHA) assessment was required. Triage stayed with him, managing the situation, until around 3.00am. Meanwhile, a large fight had broken out elsewhere in the town and police officers were able to leave triage at the care home and attend that incident.

Following the MHA assessment, the individual was admitted to the elderly ward at the mental health hospital. Had triage not been available, the police would have been at a loss what to do, as they could not use s.136 within the residential care home and the individual was unwilling to go to A&E:

*The police wouldn't have thought about calling the crisis team. They would have just basically stood there and scratched their head at that point, I think. I really don't think they knew what else to do. And they officers did say, actually, "If you weren't here, I don't know what we'd have done". And it also freed them up cos there was a big fight that went off in town just shortly afterwards, so they shot off and left us with him (Triage team)*

One of the triage team who had attended then encountered the individual on the ward some time later and noted a significant improvement, which was rewarding to see.

In the large majority of cases, Triage assessments did not lead to detentions or admissions under the Mental Health Act. It was far more common for incidents to be de-escalated at

the scene and for a plan to be put in place for liaison, referral, signposting and/or follow up by the Triage team (discussed further below).

Containment and de-escalation were particularly useful in situations involving alcohol or drugs, and where other crisis services may have refused to engage. Although the Triage team agreed that it was very difficult to assess an individual who was heavily intoxicated, they would nevertheless attend the individual and assess as best as possible rather than turn down the police's request for assistance.

There were infrequent occasions where the outcome of an intervention would be a request for a full assessment under the Mental Health Act, and in a small minority of cases the Triage team had advised that under the circumstances use of a s.136 detention was appropriate. Instances were also noted where an individual had subsequently been arrested for a criminal offence such as breach of the peace, where they were under the influence of alcohol.

#### **4.2.2 Remote advice and information provision**

As well as attending incidents in person, the Triage team provided background information to police officers over the radio airwave or telephone. At the request of an officer or PCSO, Triage would run a name through their patient records system and provide officers at or en route to the scene with some background information which could give helpful context and guide officers in how to proceed with a situation:

*I've been in touch with them before, over the phone and they've given me quite a lot of history on one particular individual that I can think of off the top of my head, which was helpful in how we then moved forward with him (police officer)*

*I've rung them quite a lot when they've been on duty and just asked them about somebody and somebody's history to see sort of whether they've got any support or anything like that (PCSO)*

As will be discussed in Chapter 5, providing access to patient information was seen as a key benefit of Street Triage, overcoming the blockages that had previously been encountered between police and health services. Useful information provided by Triage might include, for example, whether the individual was currently open to mental health services, whether they were receiving treatment, whether they had substance misuse issues, whether there were relevant family members to liaise with and any alternative address or contact details to those held by the police. Two instances were also noted of the Triage providing background information about deceased individuals where unexplained deaths were being investigated.

Remote communication of this type sometimes avoided the need for Triage to attend in person. Advice given to officers over the radio or telephone could sometimes provide sufficient context for the police to proceed without further assistance:

*They wouldn't necessarily have to come out. It's just sometimes that extra bit of information that they've got can dictate which way you may sort of go with this person that you're dealing with (police officer)*

A number of officers commented positively on how Street Triage would also proactively 'shout up' over the police radio if they heard a name that was familiar to them or if they overheard an incident unfolding where they felt it might be useful for them to intervene. The Triage team noted that this was something that they had begun to do more as the pilot progressed, as they became more confident and accustomed to using the police radios:

*They're always listening. If they pick up on the name being said, they will call up and say, "Street Triage. Can I come in, I actually know that person". They're not just waiting to be sent to stuff. They are sort of actively engaging in what's going on (police officer)*

*What I like with it is that if you say somebody over the air that you're dealing with, if they know about them, they'll check their own systems and give you some background information if they've dealt with them before. Sometimes that can be all that we need, a little bit of information that they have been under sort of mental health treatment before, or something like that. So it's useful (police officer)*

#### **Case example**

A PCSO encountered an individual in the community who was displaying signs of mental distress. The gentleman was not willing to engage with the officer but did give his name. The PCSO 'shouted up' the name over the police airwave. The Triage team proactively responded, explaining that they were familiar with the individual and had in fact seen him the previous day. They went on to explain that the individual's pet had recently passed away and this had caused a decline in his mental health. This was information that the PCSO felt she would not have managed to gain from the individual, given his reluctance to engage. Triage attended the scene accompanied the gentleman home and arranged for a follow up visit to be made the next day to check on his wellbeing. The PCSO felt that, had Triage not been listening over the radio airwave, the individual would not have received this level of support: *'We wouldn't have got sort of that level of support if they hadn't been on the radios ... He didn't really want to talk to me very much ... If I'd got his address, I could have taken him home, but more often than not, in that situation, if they don't want to engage then there's very little that we can do'.*

In some cases, the Triage team would speak to a client directly over the telephone providing a form of remote guidance and support. This tended to be in cases where the individual was known to services and had perhaps had recent contact with the team or had an appointment pending with community mental health services. In these cases, Triage were able to offer verbal support and reassurance to the individual, reminding them of the plan that was in place or prompting them to contact a known keyworker:

*If they've got an appointment with the care coordinator the following day and there's not*

*any risk identified, then it might be “Do they need to be seen tonight? What’s the risk if they don’t? Well they’ve got the appointment; remind them they’ve got their appointment with the care coordinator”. And we’d let the care coordinator know that the person had had contact with the police. So it’s just that kind of information sharing (Triage team)*

It should be noted that full initial assessments of individuals in crisis were not conducted by telephone in the SWR pilot. Face-to-face engagement was viewed as very important to being able to make a well-informed assessment and the ability to observe the individual’s wider context was also noted as beneficial.

#### **4.2.3 Liaison, referral, signposting and follow up**

The short term outcome of a Street Triage intervention varied according to individual circumstances, but would always conclude with a plan in place for follow up or next steps. This included liaison with other services (including GPs, care coordinators in community mental health teams and social services teams), referral or signposting to statutory or non-statutory services, and follow up appointments with the individual either face-to-face or by telephone. The service model was designed to include up to three follow ups per incident, but this was applied flexibly according to individual need:

*We do try and follow people up with a quick phone call, even if we’re not going to see them again, just from a “How are you feeling?” kind of thing, “Has it settled down? Is it just the same?” ... Sometimes when you take the heat out, once the crisis has abated, you can actually often get a different view of it. So we try and sort of do a phone call just to check that up (Triage team)*

The Triage team were able to refer into primary and secondary mental health services (including the IAPT service) and could liaise and arrange appointments for patients who were resident in other Health Trust areas. An example was given of an individual from Leeds who presented in Scarborough stating suicidal intent. The Triage team liaised with the Leeds and York Partnership NHS Foundation Trust and arranged for an assessment to take place as soon as the individual arrived at her local hospital, meaning that she was not unduly detained away from home.

In addition to referrals into statutory services, the Triage team also collected and maintained information on a range of non-statutory services to which they could refer or signpost individuals as relevant:

*We’ve got as many of the leaflets as we can find, really, as we’ve been going, picking them up from here, there and everywhere, so that we’ve got them if they need them. And we send them out by post, or if we’ve got them in the car we give them by hand (Triage team)*

Examples of charitable and third sector organisations mentioned in research interviews included:

- Hopes service for survivors of sexual abuse

- Relate
- Scarborough, Whitby & Ryedale Mind
- St Catherine’s Hospice bereavement support service
- Befriending services
- Horizons drug and alcohol service
- Citizen’s Advice Bureau
- Debt advice services

Speaking about liaison around young people with mental health problems, a multiagency respondent noted that through the working partnership between the police and the Triage team, useful links could be made between different sectors such as Youth Justice, targeted youth work, education and Child and Adolescent Mental Health Services (CAMHS).

Another respondent highlighted the effective work Triage had done around linking people into substance misuse services:

*I think that we have done remarkable work in terms of the alcohol and drugs problem in Scarborough, so we’ve referred them into the correct service, whereas before, historically, these people were becoming a problem for the police [and] emergency services (Triage team).*

Liaison took up a substantial amount of the Triage team’s time and more than had originally been anticipated. As such, the value of administrative support to carry out some of this work was noted, should it be possible to expand staffing.

#### **4.2.4 Non-crisis assessments and multiagency interventions**

Involvement in non-crisis situations and greater involvement in multiagency approaches was an aspect of Triage which evolved during the course of the pilot. These types of input were particularly valued by Safer Neighbourhoods officers and PCSOs, whose role involved longer-term engagement with community issues. Officers could arrange a ‘planned’ joint visit where the Triage team could be briefed in advance and have time to gather together information from other services as relevant:

*Rather than being on call straight away saying “We need some assistance”, when you’ve got an ongoing issue, get to the point where I need some assistance, make arrangements, meet, do a joint visit, and then they take over (PCSO)*

#### **Case example**

An individual who was known to the police as a ‘frequent flyer’ and would go through periods of regularly presenting at the police station (sometimes several times a day) reporting various highly implausible crimes. This would be a drain on police resources. In between these periods, however, the individual was apparently functioning in the community. Arrangements were made for Triage to carry out a planned assessment of the

individual at his home. It was established that the gentleman had been very unwell for a number of years, experiencing psychosis and paranoid delusions.

Given that the individual was apparently functioning in the community in between episodes, the triage team suspected he may never have come to the attention of mental health services. However, on encountering the individual, it was quickly clear to the team that he was very unwell: *'Suddenly, once you've got mental health services in there, it's suddenly "My God!" sort of thing, you know, it's "The man's really unwell!" And he would have never come, I don't suppose, to the attention of mental health services, had Street Triage not been around'*.

There was a keenness to expand this side of the service, to offer a more preventive, early intervention function, which could respond to the concerns of community-based officers who might become aware of early signs of decline in an individual's mental wellbeing.

Street Triage had also been involved in multiagency professionals meetings convened by the Community Safety Partnership, where the needs of a particular individual were being discussed, and police-led meetings where Acceptable Behaviour Contracts were being drafted. Street Triage were able to bring information on individuals' mental health backgrounds (including any recent intervention by Triage themselves) and offer an expert perspective on potential ways forward. This input was noted as extremely helpful by the other agencies involved, and again something which there was a keenness to see expanded.

### **4.3 The triaging role of Street Triage**

It emerged from the qualitative research data that the Street Triage team were providing a true triaging function resulting in a wide variety of outcomes. Importantly, the triage role extended beyond simply establishing whether a scenario warranted the use of s.136 detention or not. The various possible outcomes of the Triage assessment process noted in research interviews included establishment of:

- severe mental health problems requiring urgent secondary mental health input (and in a small number cases appropriate use of a s.136 detention)
- lower level mental illness requiring referral to primary or secondary mental health services
- personal, social or emotional issues (e.g. bereavement, relationship breakdown) requiring referral or signposting to statutory or third sector support
- mental health problems which were causing behaviours that might otherwise have been inappropriately dealt with as criminal cases
- mental health problems but with capacity to understand actions and consequences hence a valid case to pursue criminal or civil proceedings
- no presence of mental illness but diagnosis of physical illness underlying distressed or confused behaviour

- primary problems of intoxication or addiction which could then be addressed with referral and signposting

#### **Case example**

Police were called to attend a shoplifting incident. The accused female was evidently in some mental distress, speaking about various difficulties in her life and becoming very emotional. The fact that she had stolen a very low value item when she had plenty of money in her purse further alerted the police that there could be a mental health issue.

The female was taken to the police station where she was seen by Street Triage. As a result of the assessment, the female was admitted to hospital. The individual had had problems in the community before, but these had been '*misunderstood*' without police having the full picture on her mental health. The shop owner had been seeking prosecution for the individual, which the police officer involved felt may have been the outcome were it not for Triage's intervention: '*Rather than deal with her as a criminal, we dealt with her as an individual with mental health issues [but] if the Triage team weren't there, that's what would have happened. She would basically have been criminalised because of it*'.

#### **Case example**

Police were called to a female who was staying at a caravan park. The individual's partner had called the police because she was exhibiting concerning behaviour (repeating numbers, calling people by the wrong names). The individual was not violent but was evidently not in control of her actions.

The police contacted Triage, who were able to do some preliminary background checks before attending, established that the individual was from another area of the country, contacted the relevant mental health team and learned that she had recently been admitted to (general) hospital in the past, with a urinary tract infection. An ambulance was called and the individual was taken to the hospital, where she was diagnosed as having a recurrence of severe urinary tract infection, which was the cause of the unusual behaviour.

In the absence of access to a triage service, the police would have considered s.136 immediately: '*We'd have gone "Oh right, 136", into custody, she'd have been there for 24 hours, and just for the- she had just a really bad urine infection*'. An officer who had been present at this incident commented:

*That shows that they're giving value for money are Street Triage, because that lady didn't need to be put into a cell. It's the most horrific experience for somebody that's never been there, and just because of a medical condition she could have been put there. But they actually got that information, and it doesn't happen then ... They got the information about the lady's previous health ... and because of that, the right place*

*with her was at the hospital A&E. And it's quite a simple thing to deal with once they get the right medication in.*

An important role of Street Triage, especially in relation to reducing the use of s.136 detentions was assessing the degree of risk where individuals were expressing suicidal intent. Not having professional mental health expertise, police officers described how they had always had to 'err on the side of caution' in such situations, treating all expressions of intent as genuine. With Triage on hand to make a professional assessment, there were several occasions where the risk of suicide was in fact deemed to be low, and after de-escalation and other follow-up support had been put in place, the individual could be allowed to remain at home:

*Very often Street Triage don't spend a long time with [people]. We'll turn up, they'll tell us what they wanna tell us, you know, "My life's shit, this, this and this, I'm gonna kill myself". We know they're not. Street Triage will come out and speak to them very quickly and establish that they'd not going to. And then they'll be gone sort of ten, fifteen minutes after we are. I mean they see the same people again and again and again and again. So certainly as a quick fix, they've been fabulous, have Street Triage, really, really useful (police officer)*

Police officers were extremely grateful where Street Triage had been able to bring appropriate support to an individual experiencing a mental health crisis and in some cases avoid criminalising someone who was very unwell. However, there were occasions where they were also appreciative of Triage assessing an individual as not having a mental illness, allowing the police to pursue a different approach with that person. This was particularly useful in the case of what police referred to as 'frequent flyers' – people who made repeated inappropriate use of the police service, through regular calls for unwarranted assistance, spurious reports of crime or insincere threats to self-harm. This was viewed by some officers as 'attention seeking' and linked to personality disorder or substance use, but where Triage could advise that the person had capacity to understand the consequences of their actions, the police could then take punitive action or at least not devote further resources to inappropriate calls for service:

*I've sat through an assessment with one of our most prolific callers of that nature, and they [Triage] basically told her that she's been assessed that many times that they know that there's nothing that they can do to help her further than what she'd already got, and that that was it, and that nobody was going to entertain it any more because they couldn't do any more. And then they just told her to – because she was at the police station at that point – just told her to leave. And she did. And she's fine! (PCSO)*

This type of input was also of benefit to the Community Safety Team, who had the dual role of protection of the individual but also the interests of the community. Triage had been able to provide a steer as to whether individuals needed to be dealt with primarily on the basis of mental illness, or whether there was a justification for pursuing antisocial behaviour measures:



*There's something about that for me, for then being able to act on the person's best interests, so what support does that look like, if we were to give support, is it mental health or is it lower level? Is it something we can deal with as a team? But also there's something about being able to protect the wider community. So actually, if that person has got capacity, then we can start to take appropriate action, and sometimes unfortunately that is enforcement action, to protect the wider community (multiagency respondent)*

The Triage team were also not averse to supporting such outcomes. It was important to their professional practice that where an individual had capacity, they were helped to take responsibility for their actions and the consequences:

*I would absolutely defend to my last breath somebody with command hallucinations that had committed a crime. But somebody with a personality disorder that's been shoplifting, and they had the capacity, they knew the consequences, they absolutely should face the same consequence as anybody else. Cos if they don't then they're not able to learn by their mistakes, if they don't face consequences. So I would equally fight with my last breath that they absolutely should face the consequences (Triage team)*

#### **Case example**

A female who was well known to the police and frequently came into contact with officers had been accused of stealing a handbag. The case had been going on for a long time and when it reached court was dismissed as not in the public interest due to the individual's mental health. The victim of the crime complained and so the police officer contacted Street Triage to establish whether there was any history of service use. The individual was known to have alcohol misuse issues and had been in contact with a local support organisation, but other than one occasion where the individual had contacted mental health services saying she wished to take her own life, the Triage team did not find any other record of mental health service involvement. Having Street Triage as a bridge between police and mental health services meant that this information could be shared much more readily than might otherwise have been the case:

*Without being able to pick up the phone, speak to them [Triage] and saying, "Just out of curiosity, do you have any background on her?" we would have had to try and go down the lines of getting in contact via the NHS or whatever. They'd have just turned round and say "Ooh, data protection. Can't do that".*

The case went back to court and the individual was prosecuted for theft. The police officer noted: *'We still don't know exactly why the court just threw it out [initially], but it was wrongfully done and their information actually just overruled their decision essentially.*

The individual was nevertheless in need of support and the police officer arranged for a PCSO to make a follow up visit. During this visit, the individual again expressed intent to end her life. The PCSO was able to request Street Triage, who attended and assessed the

individual. On arrival, it took only around five minutes for Triage to establish that the individual was not a suicide risk. The PCSO was then able to leave the scene, while Triage remained with the individual for around two hours. As far as officers were aware, Triage had had no further involvement with the individual following this.

Had Street Triage not been available, the PCSO would have had to remain at the incident and call for the assistance of a police officer in light of what the individual was saying about harming herself. It would not have been possible to use s.136 in the private home environment and so the officers' options would have been limited to calling out an ambulance or the Crisis team, which '*would have turned into an hours and hours and hours situation*'.

#### **Case example**

A young female was well known to the police as one of the highest repeat callers, sometimes making up to 30 calls per month. She experienced extreme Obsessive Compulsive Disorder but also had antisocial behaviour issues. Without expert knowledge, police were not able to effectively address this situation: '*We didn't understand her [and] we didn't get anywhere with her. She was literally playing with the organisation*'.

Following intervention by Street Triage, multiagency liaison between the police and the individual's mental health worker had led to a better understanding of the individual's presentation and allowed the police to pursue a line of harassment warnings with regard to the antisocial behaviour (ASB): '*We understand now that her OCD is one part of her and ASB is another, so we can now address it with confidence and deal with the ASB side ... knowing that she has capacity*' (police officer)

Since this intervention, calls to the police from the individual had significantly reduced, to only around six calls in the past four months.

#### **4.4 Extent and appropriateness of service use**

Despite the universally positive views on Street Triage expressed by police officers (see Chapter 5), there was a feeling among some respondents that the service was not being utilised enough. Incidents were still being recorded where mental health was a factor but Street Triage had not been requested, and in some cases these had led to a s.136 detention. Differential use among different officers was noted:

*I think there's pockets of police officers that have an interest in mental health, or are frustrated cos they don't know what to do with mental health patients, and that group of people are using Triage, and requesting it. I still think there is a large portion of people the police aren't even thinking about Triage. They're either arresting them and taking them to*

*custody, they're walking away and hoping that it doesn't reoccur, or taking them to A&E (Triage team)*

Around the time of the research evaluation the police force had implemented some new actions and directives aimed at increasing awareness and use of the Triage service, including:

- daily alerts to Force Control staff via the 'scratchpad' electronic memo system, giving reminders of when Triage came on shift and emphasising the need to use the service whenever mental health was a factor
- a detailed email circulated to Force Control outlining the role, remit and operating procedures of Street Triage and again encouraging regular use
- an instruction to frontline officers to always contact Street Triage in any mental health incident before using a s.136 detention<sup>6</sup>
- The introduction of mental health 'Champions' in the Force Control Room, whose role included monitoring the Storm log and prompting officers to utilise Street Triage whenever a mental health flag was raised.

The importance of the Triage team establishing and maintaining a profile among police officers emerged as a theme in the research. In the early days of operation, the Triage team had occasionally attended the briefing sessions held daily at each police station. This was seen as useful in building relationships, establishing an identity, and also gaining information about clients who might come to the attention of Street Triage during a shift. However, it had not been possible to continue this activity as staffing numbers dropped. During the research interviews, it was noted that it would be beneficial if, resources permitting, attendance at briefings could be resumed.

Approximately half way through the pilot year, the Triage team had also delivered a briefing session for one of the Safer Neighbourhoods teams, in which they explained their role, remit and the input they could offer. This session had had the key benefit of raising awareness among PCSOs that they could also call upon the service:

*A lot of the PCs knew what Street Triage were, and were using them. But not all the PCSOs were aware what Triage can offer, so they actually came out for an hour and actually explained what they do, what they can help with, and since then, I think there's been a bigger take-up then, once you knew what they could do for you and that they would come out [to PCSOs] as well (police officer)*

It was suggested that more awareness raising sessions of this type could further enhance service use across the SWR region. There was some indication that officers had not initially been aware of the full range of inputs that Street Triage could offer and the varied circumstances in which they might provide assistance. To some extent, this knowledge had

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<sup>6</sup> NB: This was implemented on April 9<sup>th</sup> and was an internal instruction to attempt to reduce the risk of inappropriate detentions

developed organically as the service had bedded in and word had spread about specific instances in which it had been used. It was recognised among police officers that their use of Triage had both increased and been refined as they got to know the service better, including an increased awareness that the service could be called upon for background checks and information provision as well as attendance in person at incidents:

*As times gone on and we've got to know them and what they can do, we've sort of learned how to use them better as well. Cos maybe we've not known initially how best to use them, and I think it has got better ... I think it's more confidence in using them, from my perspective. Knowing that they're there, knowing that there is a point of contact. Whereas until you've used it, you don't sort of get used to what's there (police officer)*

*Officers are getting more educated on asking for Street Triage as well, cos if they go there- I mean [dispatch] staff are at the end of a phone. When officers go and meet them face-to-face, it could be different to what we've been told on the phone. And they are shouting up now, and saying "Can we have Street Triage" (police officer)*

Being physically co-located with officers at police stations or in the Force Control Room was suggested as another way of maintaining a profile among officers and hence increasing use of the service. The potential benefits of co-location are discussed further in Chapter 8.

Regarding whether police officers were using the service appropriately, the Triage team's perspective was that they would rather be overused than underused. If the police had any genuine concern that an individual was experiencing a mental health problem, the Triage would rather be called out and perhaps reach an assessment of no mental health problem, than not be called when they perhaps could have offered useful support:

*There's obviously times when we go out there and there is no identifiable mental disorder. But from the police's point of view, you know, they need that confirmation. So that's as important and as valuable, I think, as if the person has a mental illness (Triage team)*

On the whole, the Triage team felt that officers were using the service appropriately and if anything they wanted to see usage increased.

In line with their 'no exclusions' approach, the team had rarely turned down a request to attend an incident. A small number of exceptions were noted, mainly occurring in the early days of the pilot, where an individual's circumstances suggested to the team that what they were experiencing was a '*normal reactive expression of emotion*' in relation to an upsetting life event. There was felt to be a need to dispel perceptions of Street Triage as just '*somebody to talk to*' or a '*shoulder to cry on*' as this was not the role of the service. Moreover, the Triage team had a duty to conduct a thorough mental health assessment whenever attending an incident and in the case of normal emotional responses, this could be disproportionate and '*not fair*' on the individual.

The other type of circumstance noted where Triage may decide not to attend was where an

individual known to services had only very recently been assessed under the Mental Health Act and it would not have been appropriate to put them immediately through another full assessment unless it was evidently required.

## 5 Impact of Street Triage on services and service users

This chapter considers the impact of Street Triage on a range of services and individuals, drawing on perspectives shared in the qualitative interviews. Subsections discuss the impacts on:

- Police
- Health services
- Other services
- Multiagency working relationships
- Clients and carers

While the discussion has been organised into subsections, it should be noted that many of the positive impacts described below spanned multiple groups. For instance, an improved experience for service users was seen as a benefit to both the police and health services looking to support these individuals. To give another example, speedier and more accurate assessment of mental health problems through having a qualified health professional at the scene was a benefit to individual service users and other allied health services, saving time and resources.

### 5.1 Street Triage: a highly valued service

Before discussing the specific impacts on different groups, it is important to highlight that across all of the different organisations and services who contributed to the research, views on Street Triage were universally positive. Other than the disappointment of reduced hours due to loss of staff (see Chapter 3), it was striking that nobody had anything negative to say about the service that was being provided. Moreover, officers taking part in the research felt that these uniformly positive views would be echoed by their colleagues across the SWR region:

*I don't think I've ever heard anything negative about them, in any way, shape or form (police officer)*

*Everybody sings their praises ... From a police perspective I have never heard anything negative said about them. Everything is extremely positive (police officer)*

*I don't think anyone will have a bad word to say about it (police officer)*

*[1] These people, I think, are pretty much universally being seen as a benefit to us. [2] I think you'll struggle to find anyone with a different opinion within the local police (police officers)*

*Generally as police, we always find fault with something, and I think this is one of the few things that nobody can find fault with, you know, it's a brilliant service (police officer)*

Street Triage was described as ‘fantastic’, as being a ‘genuine help’, ‘worth their weight in gold’, a ‘godsend’ and even as ‘a lifeline’ for officers. Several participants, from the police and from other services, emphasised that the service would be greatly missed if discontinued, talking emotively about the ‘huge loss’ that this would be:

*We really wouldn't want to lose them. It's one of the few things that has ever been introduced that has genuinely helped us (police officer)*

*When there was rumours that they're going, it was like a black cloud up at that police station ... They've made it so positive for us, and if you were gonna keep a resource, it would definitely be the Street Triage, definitely (police officer)*

*Please don't let them take them away because, you know, I just think they're fantastic (police officer)*

*The dread of them taking it away from us altogether is the main thing (police officer)*

*I do think it will be an absolute disaster if Street Triage were to be pulled (multiagency respondent)*

*They've filled so well that huge – it wasn't a gap; it was a chasm [in mental health services]. They've filled that hole so well and without them, we'll be poorer (multiagency respondent)*

*It's a positive thing and it will be a great shame if it's lost (police officer)*

In summary, the Street Triage service was extremely highly valued by police officers across the SWR region, and its benefits were also recognised by public and third sector agencies beyond the police force.

## **5.2 Impacts on police**

Positive impacts from the police perspective fell into four main themes:

- Saving time and resources
- Improved decision making through expertise and information sharing
- Moving situations forward through liaison and multiagency working
- Knowledge and attitudes towards mental health

Note that impact on use of s.136 detentions is discussed separately in Chapter 6.

### **5.2.1 Saving time and resources**

Time savings for the police came about in several ways: releasing officers from an incident sooner; concluding incidents more quickly overall; avoiding the need for officers to attend an incident; and reducing police time spent on problematic recurrent callers.

Where Triage attended a live incident, it was sometimes possible for police officers or PCSOs to leave the scene earlier than they might otherwise have done. Once it was established

that there was a low level of risk and no other requirement for a police presence, officers could resume to other duties, leaving the Triage team with the client. This was perceived as a significant advantage by officers of all roles and ranks and the Triage team were also comfortable working in this way:

*They come out, and nine times out of ten, they'll just take over and do what they need to do, which releases us to go back. That's one of the biggest benefits of their situation is the time it saves us, to go out and move onto the next job (police officer)*

*It's made our life so much easier ... We get all these jobs on and we just need to resource them. So it's a lot less stressful for us because we have more officers available. The officers can go on and deal with other things, rather than sitting with someone for hours when they've not really got the qualification to do so (police officer)*

*The police will stay and while ever there's a risk there's never been any hassle at all with the police, they're more than happy to stay if we need them to. But quite often if it's people that we know, or if it's people where there's no risk presentation, or the risk is low and they've got a carer around ... then we do release the police as soon as is appropriate, as soon as we can, to get back out on the beat (Triage team)*

*It takes a considerable amount of demand and a considerable amount of pressure off our frontline resources (police officer)*

One officer described how they would sometimes bring an individual in to the police station (on a voluntary basis), to be met there by Street Triage. Triage would then take over, enabling the officer to attend to other duties within the station (e.g. catching up on paperwork) whilst the assessment continued elsewhere in the building. This had the advantage of making the most of the officer's time whilst also remaining in close proximity should help be required:

*It frees us up in the sense that I can finish writing that statement, or whatever ... You're within ten seconds if anything goes wrong, but you're not having to physically be sat with them like you would be in someone's house (police officer)*

The ability to release officers more quickly was seen as effective both in scenarios of 'genuine' mental health problems but also in those cases where antisocial behaviour, substance use or personality issues were believed to underpin the call for police service. Without the professional expertise of the Triage team, police officers felt duty-bound to remain with an individual, even if they felt there was no genuine risk to their wellbeing, because they did not have the professional skills to make this judgement call. But with Triage's assistance, police officers could be assured that an accurate assessment had been made:

*We have an awful lot of people who ring up with shall we say 'pretend' mental illness, or personality issues. When we get one of those, Street Triage are fabulous for interjecting and allowing us to leave, because previously we've been stuck with them for hours ... Street*



*Triage, they have the training to say “This is a personality issue, you’re feeling these symptoms because you’re drunk, stop drinking”, and then people can go ... Because we know they’re not going to harm themselves, we’ve met them hundreds of times in exactly the same situation; they’re not. We know that, they know that, everybody knows that. But we aren’t mentally health trained, so we can’t say “You’re not gonna. We’re off” (police officer)*

Even where officers remained at an incident to its conclusion, some felt that with Triage’s input, situations were concluded more quickly overall. In contrast to the alternative of taking a client to A&E, it was noted that as soon as Triage arrived at the scene, time was being spent productively. Avoiding the need to take clients to A&E brought further time saving benefits for police officers and clients who were not sitting waiting in the emergency department for what was typically described as four or five hours before being seen. This was in addition to any time spent awaiting an ambulance. An incident attended by Street Triage could be concluded in half this amount of time or less (the median length of contact with street triage was 70 minutes – see chapter 7):

*So many times now, these guys turn up, and have that rapport, quite often will already know the people, can turn up, speak to them, and 15-20 minutes of their time saves four hours of our time. Because they’re able to say “Well, you’re not gonna kill yourself” or “You’re not gonna take a load of pills. Let’s book you an appointment” ... And that kind of ability to save a huge amount of time and resources for us, and similarly for the service user as well, they’re not sat in a police van, a police cell, A&E, for that amount of time (police officer)*

*I’ve sat with [a colleague] in A&E before, with somebody who we’ve had detained under 136 and we’ve been in Accident and Emergency for hours on end, waiting to be seen, and then for them to say “Well actually, they’re ok to go”, which could have been done three hours prior to that, if we had Street Triage at that time, to sort of make that assessment on the street (police officer)*

*We don’t have the professional expertise ... so always having to err on the side of caution, which means a trip to A&E and Crisis team, then sit there for four or five hours. And on a Friday evening, to have two officers sat in A&E when there’s so much public order stuff going on in the town, it’s almost criminal really (police officer)*

Officers noted that A&E was not the appropriate setting for a person in mental health crisis and individuals themselves often did not appreciate being there, meaning that continued police presence was required to ensure that people did not ‘*get fed up and wander off*’, then becoming a high risk missing person requiring further police resource to relocate them.

As will be discussed in Chapter 6, perceived time savings further came about through the perceived reduced use of s.136 detentions. Describing the typical scenario when Street Triage was *not* available, one officer noted:

*[You’d] take them to custody and then have the issues with custody. You’ve taken someone in for 136, and custody aren’t equipped to deal with it but we’d spend hours and you’d have*

*to stay with that detained person and watch them in a cell, whilst something was sorted out, and it could take 5-6 hours (police officer)*

PCSOs mentioned that by having access to Street Triage, there were occasions where they did not need to call upon a police officer to join them at an incident, again reducing the use of resources:

*As PCSOs, we don't use the 136, but if we've got somebody that we think is perhaps on the borderline we can't assess them and we wouldn't be able to act on that ourselves, and it would take time up of the police officers coming to do it. Calling Triage instead alleviates us from having to call an officer off other duties to come and do that assessment (PCSO)*

*It's support for us, because sometimes if we get Street Triage out cos we're not quite sure how to deal with them, it frees up an officer from having to come. Cos obviously if we're not sure whether it's gonna be a s.136 or not, if we can get Triage out and they can deal with them it frees up an officer (PCSO)*

*It's very rare that I've used them, but when I have it's been a positive thing cos I don't have to involve the response cops then, unless obviously there's an immediate necessity to. And it frees them up to do what they need to do and then Street Triage just come and take people off our hands (PCSO)*

As described in chapter 3, there were also a small number of occasions where Triage had been able to attend an incident unaccompanied, avoiding the need for any police resource to be deployed. This included response incidents and also planned appointments made through Safer Neighbourhoods officers. This type of unaccompanied visit would only take place where there was a low level of risk and typically where the individual was already known to services:

*We've had calls before where a job comes on and you shout a cop "Officer can you go to that" and they [Triage] will come on and say, "We spoke to them, we had a chat with them yesterday, and we made an appointment to go and see them later on, so don't worry about that, we'll go and speak to them about whatever they're reporting now, and if it needs an officer we'll let you know". And more often than not they'll come back and say "Don't worry, don't worry about it". So, they are very good like that (police officer)*

In the longer term, officers also felt that recurrent calls from certain problematic members of the community had reduced following contact with the Triage team. This included people who regularly called the police under the influence of alcohol or drugs, or who had 'personality issues' and who took up a substantial amount of police time. Because these individuals would now be assessed quickly by Triage as requiring no further intervention, their attention seeking behaviours (as it was perceived by those officers commenting) were no longer proving effective and so calls to the police had reduced:

*It's really helpful when Street Triage will come and say, "Well no, they haven't got a mental health problem". Whereas these people we've probably been bringing in 136 ... now we sort*

*of have a little bit more sort of faith in being able to sort of say “Well, no, actually, you know, we’re not gonna deal with you in this way”. And they don’t like it, because they’re a bit miffed, the fact that they’re not getting this attention. But for some of them, it does mean that they stop calling us (police officer)*

More positively, signposting and referrals made by Triage meant that some of these individuals were now connected with and receiving support from the appropriate support services, rather than placing demands inappropriately on the police. There was also a view that hearing the assessment of no mental illness from a qualified mental health nurse perhaps held more validity for the individual, who was then more accepting of the outcome.

### **5.2.2 Improved decision making through expertise and information sharing**

Improved decision making came about through the information and expertise that Street Triage were able to bring to situations. Police personnel were very conscious that they were not experts in mental health. Officers wanted to do the best they could for clients in distress, but it could be ‘*draining*’ and demoralising to feel that they were unable to help or that their intervention was making things worse. The professional knowledge and patient background information provided by the Triage team helped police to feel confident that accurate assessments of the situation were being made and that mental health incidents would be well handled:

*We’re not the experts basically. We’re Jack-of-all-trades and previously we’ve gone and put a plaster over it and done our best, whereas now we can call those guys out, if they’re on duty, to come and assist us and give us some actual expert assessment and advice (police officer)*

*It’s getting help first and having somebody there with an understanding who can assess and assist right from the beginning ... As much as we want to give these people time, you know, we’re talking to them but we don’t know if we’re saying the right things (police officer)*

*It makes the incident more easy to deal with. If you know that they’re en route, you just have to keep an eye on the person, talk to them, find out what’s going on, but then someone that actually knows what they’re talking about turns up to deal with it (police officer)*

*When you compare to the decisions we were making about people with none of that information; We’d have access to only police information, and we’re making decisions to put people in police cells, when we don’t- we’re not medical experts. I mean, it’s got to be better (police officer)*

Triage assessments led to quicker and more accurate assessment of the presence, nature and extent of mental illness. Examples were given where Triage’s intervention had revealed that an underlying physical health problem (for example, a urinary tract infection) was the cause of unusual behaviour, and as such detaining somebody as a mental health risk would have been wholly inappropriate. There were also examples where behaviours that may otherwise have been treated by the police as criminal or nuisance were identified by Triage as being related to serious mental ill health (see case examples given in Chapter 4).

A third type of scenario was where the individual was assessed as not having a mental illness, but was in genuine distress due to personal circumstances. Here Triage could provide signposting or referral to appropriate non-mental health services. This was equally useful to police officers who felt they would not have had the knowledge to provide help in these circumstances.

Police officers appreciated the way that having input from mental health professionals shared or removed the '*burden*' of decision making around clients experiencing mental health issues. This sharing or transferring of decision making was linked to perceived reductions in the use of s.136. In the absence of a professional opinion, s.136 could be used as a '*catch all*' or '*back covering exercise*' because officers felt the need to err on the side of caution (see Chapter 6 for further discussion). If Triage had attended and provided an expert assessment of mental health risk, police officers felt more confident to leave a client in their home. This benefit was also noted by participants from the Triage team and other agencies:

*I think there's an overriding fear, if we don't [use s.136] and this person then goes and kills themselves, it's going to be us, isn't it. So the safest option is always to use 136, but not maybe the most appropriate, but it's better than that person losing their life. So for me they [Street Triage] take the whole burden of that away from us (police officer)*

*I think it's nice for the police to be able to hand it over to somebody that knows what they're doing, rather than doing the best that they can, and then not feeling very confident in dealing with people with mental illness' (Triage team)*

*You're sharing that responsibility aren't you. So you're sharing the risk ... Thresholds change all the time, capacity changes all the time, and then what we've got is a situation where we're holding it here where people are saying "I'm worried this person's gonna die, I'm worried this person's gonna do something", and we sit holding that. Now if you were sharing that risk with the right people, including mental health, then surely that risk is managed better for everybody (multiagency respondent)*

The background patient information provided remotely by Street Triage, over radio airwaves or by telephone, was also useful to officers in instances where the Triage team did not necessarily need to attend. This information could provide context for officers and guide their decisions as to how to approach or move forward with a situation:

*'With the information side of it, that they can give us, we act on a lot of information and it sometimes determines how we deal with something and the best way for us to deal with it for the individual (police officer).*

As well as providing information about local service users, police benefitted from Triage's ability to access out-of-area patient information somewhat more easily than the police could themselves.

As noted in chapter 4, the triaging function of Street Triage worked both to identify cases of 'genuine' mental illness but also in some cases to determine that individuals had capacity to

understand and moderate their behaviours and so could be treated under criminal processes. This had led to situations where the police's approach to an individual had been altered, Triage's assessment giving officers the confidence to proceed along punitive lines:

*Some of the most challenging people in Scarborough, we've actually changed our plans completely on the grounds of the only [thing] we can do with this is prosecute them, either bring them in for wasting police time or call for an ASBO on them. And we'd never of had the confidence to do that beforehand. But if somebody professional says "They are just wasting your time", the officers will quite happily do it. But they would never do it off their own back, ever (police officer)*

Triage's assessment also provided reassurance and boosted officers' confidence where their own instincts about how to approach a situation were confirmed:

*I think you kind of feel reassured, if you've got somebody from the health perspective confirming what you already think, and if you've got people from different angles coming in saying the same thing, it kind of helps you to get it right first time (PCSO)*

*Sometimes we'll have a sort of gut feeling about where we wanna go with it, and quite often we're supported by Street Triage who put that into a plan and a rationale and basically take the problem away from us (police officer)*

Triage's NHS affiliation meant that there was now easier access to information and liaison with other parts of the health service, overcoming longstanding challenges of information sharing between the police and health services:

*Information sharing from the medical services generally is poor. They're really nervous around sharing medical information and that's a real blockage. Even though they've got lawful reasons they can do it, it's a real blockage for us ... So that's really a massive plus isn't it (police officer)*

Triage were seen as a 'bridge' or a 'link' to both primary and secondary mental health care and were able to 'get the ball rolling' more quickly, for example, in getting responses from out of hours GPs. Triage's involvement had been helpful in opening up information sharing and thus facilitating better support for individuals well known to the police. Speaking about a particular regular client, one officer noted:

*We're now getting more information being shared back ... There's information being shared back to all partners about her condition. Where before it was often hard to get the information between Cross Lane, the hospital, the doctors, now it's shared, because it's coming from the right organisation at the right time (police officer)*

There had been instances where police were not aware that an individual with whom they had regular contact was also open to mental health services and, vice versa, where the mental health team was unaware that a patient was using police services inappropriately.

Through multiagency liaison, Triage was able to put agencies together to begin a dialogue around individuals who were accessing both services:

*Some people have already been under CMHT and the police weren't aware that they're under CMHT, so there's been a number of successful outcomes just actually connecting the care coordinator with the police ... Before, the care coordinator didn't know that they were using the police inappropriately, being a bit of a nuisance for the police really, and the police didn't know they had a care coordinator, so just that simply connecting people together has been really positive (Triage team)*

A knock-on effect of this information sharing in the Triage context was that Force Control personnel and individual police officers were now sometimes contacting the Crisis team outside of Triage operating hours to request background client information. The Crisis team were willing to provide this information and this was seen as a very positive step forward in partnership working. Likewise, there was a perception that police were now more willing than in the past to share client information around risk with mental health service personnel. Better information sharing was recognised as being in everybody's best interests, but it was also acknowledged that this was a significant cultural change for organisations which would take time to embed.

### **5.2.3 Moving situations forward through liaison and multiagency working**

Police officers felt that Triage intervention led to situations being moved forward quickly and constructively, in a way that they had not been able to achieve as a sole organisation:

*We always were aware of the people in our community that had the mental health problems, but we didn't know how to deal with it. We were never trained in it, and so you just constantly dealt with them as being a problem that, "Oh, I've got to go back again", and you never advanced the situation, you never got to a point of progressing it to a stage where it would be resolved. And I think the bringing in of the Street Triage now has actually given us that tool to be able to move it forward, so that they're not just a constant call on our service (police officer)*

*Prior to Street Triage, things tended to be passed around in circles. Something would come in and then they'd discuss it, "Oh we'll pass that to so-and-so, whoever it is", and then even though it was maybe a mental health issue, it would end up with housing, and it would go all the way round the houses and then come back to us, and we felt like nothing had moved forward. Whereas this is hitting it head on, straight away ... Some things you've got to wait such a long time to get the processes in place, where this just happens (PCSO)*

This ability to progress situations was linked to Triage's easier access to health services, through its NHS affiliation and through the team's liaison, signposting and multiagency activity. In turn, this was also a further contributor to time savings for the police:

*If there is a shortfall in one of the other agencies, if they're not sort of pulling their weight with this person's mental health and the support that they're supposed to be getting, and*

*Street Triage come and they say, "Well, you're supposed to have this support" and they sort of say, "Well I'm not getting that," they would then chase it up and know how best to chase it up. Whereas if we did, we'd probably just end up getting cross with [services], and not really understanding it (PCSO)*

#### **Case example**

A PCSO had been dealing with an ongoing neighbour dispute where there was '*clearly something wrong*' but the officer had been at a loss as to how to move the situation forward. The gentleman who was exhibiting problematic behaviour had recently lost his mother and was hearing voices and banging his furniture, causing difficulties for his neighbour.

The officer arranged a joint visit with Street Triage who came out and did an assessment of the individual's mental health. Following this, they looked further into the individual's history and liaised with his GP. The ultimate outcome was Triage signposting the gentleman to befriending services as it was felt that his problematic behaviour was a result of loneliness. Since Triage's intervention, the problems had so far ceased. The PCSO commented that had it not been for Street Triage, '*I wouldn't have known which path to go down, to be fair*'.

#### **Case example**

A woman who had a history of serious mental illness combined with alcohol misuse and had been sectioned in the past was now living in the community and had been doing well for a period of time. However, a neighbour began to report frequent problems with the individual coming home very late at night, showing signs of deteriorating and concerning behaviour and hoarding items in communal areas of the property causing access difficulties. The individual was at risk of eviction by the housing association and was also exhibiting problematic behaviours in relation to her child, who was in social services foster care. This was causing concerns to the school, which was reporting that the mother had been '*hanging round the daughter ... hanging round the peripheries, sending bizarre letters to her*'. Several agencies had attempted to engage but the individual was refusing entry to the property.

Following some informal and incidental communications between agencies about this individual's deteriorating mental health, a multiagency professional meeting was convened, involving Street Triage, the police, the individual's care coordinator, social services and the council's community safety officer. Agencies shared what they knew of the individual and exchanged ideas about what would be the most appropriate way to deal with the situation. A plan was made that the police and Street Triage would attend the property together with the individual's care coordinator and attempt to gain entry to the property, on a volunteered basis if possible, but using the power of a s.135 warrant if necessary. This was described as '*a planned approach*' with the aim of causing the individual the '*least distress*'.

*possible*'.

The result of the intervention was that the individual was admitted to hospital under the Mental Health Act, with access gained to the property using a s.135 warrant, and was currently spending time as an in-patient. A PCSO who had been part of this intervention felt that Street Triage's input had expedited the arrangement of the warrant, due to the information they were able to share across agencies.

Whilst distressing for the individual, it was felt that this outcome was in her best long-term interests: *'My expectation would be that she'd be quite angry about it still at the moment. But she gets quite psychotic and was clearly relapsing, once all the evidence was together on the table it was very clear'* (Triage team). There was also the beneficial outcome that the problematic behaviours in relation to her child and the school had ceased as a result of the in-patient admission.

#### **Case example**

A PCSO was called to an incident at a care home, where a young male with learning disabilities and personality disorder was presenting challenging and concerning behaviour, including going missing from the home. The care home was struggling to address the situation. The PCSO requested Street Triage, who were already occupied on another incident at that time, but were able to attend the following day to carry out an assessment of the young man, accompanied by police officers.

Following Triage's assessment, a Deprivation of Liberty Safeguard (DoLS)<sup>7</sup> was put in place. This order set a number of conditions and constraints on the individual's freedom to leave the premises. It was felt that Triage's assessment was more thorough than those conducted by DoLS assessors and so expedited the process of obtaining the order, which may have been more difficult for the care home to achieve otherwise.

As noted earlier, forward progress typically involved linking clients into relevant mental health or other social support services, but alternatively could be about establishing capacity and responsibility and thus enabling police officers to pursue punitive lines where appropriate.

#### **5.2.4 Knowledge and attitudes towards mental health**

On the whole, police did not feel that their attitudes towards working with individuals with mental health problems had changed since the introduction of Street Triage, in that their

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<sup>7</sup> The aim of the safeguards is to provide legal protection for those who lack capacity to consent to care or treatment but are not detained under the Mental Health Act 1983. Introduced by an amendment to the Mental Capacity Act 2005, DoLS aim to make sure that people in care homes, hospital or supported living arrangements are looked after in a way that does not inappropriately restrict their freedom.



approach had always been one of sensitivity and a desire to provide the best possible service. Rather than changing the way they personally responded to individuals in crisis, the introduction of Street Triage was seen as giving them ‘another resource’, ‘a different option’ or ‘an extra tool in your box’ when dealing with mental health incidents.

However, some frontline officers commented that they had picked up new knowledge or skills about how to interact with a person experiencing a mental health crisis. This had largely been through observing the Triage team in the course of their work at incidents, hearing how they spoke to clients and noting the kinds of questions they asked:

*Just listening to what they discuss with the person, if you're there, and how they interact with the person and what sort of information they try to get from the person as well ... where to go with the conversation. After being with somebody who has been trained in how to speak to somebody or how to try and get that information out of them, it's been a lot easier to be able to communicate with somebody with mental health (PCSO)*

*When you're just with them and you hear how they speak to them, and you just pick it up, it's like osmosis really (police officer)*

*I've learned quite a bit about what they ask, and sort of what they're trying to get at, which you can then just essentially use yourself ... Like when was the last time they'd seen their GP? How long have they been feeling like that? When was the last time they felt like that? And what changed? You know, just being sat in on assessments you pick up on little things that you then just end up asking them automatically (police officer)*

One officer felt that knowing more about what to ask and how to ask had improved their ability to engage with individuals and in turn have more success in encouraging people to come voluntarily to a place of safety where necessary. There were also officers who felt they gained knowledge about different diagnoses and conditions, for example the distinctions (or indeed overlaps) between mental illness, personality disorder and substance misuse. It was also noted that some police officers were now independently referring clients to local drug and alcohol support services on their own initiative, prompted by what they had observed from Street Triage.

As will be discussed further in chapter 9, the provision of more formal training to the police by the Triage team, as well as more informal opportunities to share knowledge, were felt to be very useful potential developments.

From the mental health service perspective, it was felt that the partnership working through Street Triage had contributed to broadening police understandings of mental illness and risk, and the beginnings of culture change around shared organisational responsibility for mental health, in line with the Crisis Care Concordat. Some of the longer-serving police officers who took part in the research commented on the shifting role of policing in contemporary times, noting the need for cultural change in operational policing as support

for vulnerable individuals began to take prominence over the more traditional crime fighting role. These issues are discussed further in chapter 8.

### 5.3 Impacts on health services

A key impact on health services was that, through providing an effective triaging role, the Street Triage service was diverting unnecessary demand away from other parts of the mental health care pathway. As one respondent put it, *'what Triage does is, in very crude terms, sorts the wheat from the chaff'*. This reduced pressure on other services, freeing them up to focus on their core client groups. It was acknowledged that quantitative evidence of demand reduction was inherently difficult to obtain. However, the perceptions of those working in and across the Triage team and Crisis services was that the Crisis team was receiving fewer requests to facilitate assessments at A&E or in custody, and that fewer inappropriate (i.e. sub-threshold) referrals were being received. This is borne out by the quantitative findings presented in chapter 7. Triage were picking up individuals who in the past were likely to have presented to the Crisis team (directly or via A&E) but who often did not meet Crisis service thresholds:

*I think ultimately, the people that Triage have seen haven't needed to see Crisis team. They've needed to see Street Triage. And the sole purpose of why the Department of Health set it up, which was to prevent unnecessary detentions under a 136, as well as provide a community service that didn't push people into a mental health service, that's exactly what they've done (Triage team)*

Another member of the Triage team commented that the Crisis team were *'aware that an awful lot of people that would have come to them previously now get filtered out at the Triage level, and for that they're very grateful'*.

Similar impacts were perceived in terms of diverting inappropriate demand away from community mental health services, psychology services, primary mental health care and GPs. This perception was also supported by the quantitative data (chapter 7). The phenomenon of *'scatter referrals'* was described, whereby a referral would be made to multiple services in respect of one individual, because the referring party was unsure which service was the appropriate one to target. Each service would then have a duty to conduct an assessment, often with the result that the individual was not eligible for provision by that agency. Furthermore, for services with longer target response times, immediate issues had often dissipated by the time an assessment was made and the presentation could by then be somewhat *'nondescript'*. The early, on-the-spot intervention of Street Triage was seen to have reduced the scattergun approach to referrals, reduced duplication, and enabled more rapid and timely direction to the most appropriate service, which in many cases would not be secondary mental health care:

*It's prevented an awful lot of that delay, wait, expensive reworking, and what it's done at source is nipped a lot of things in the bud, by going out to the street – or often people's*

*homes more often than we imagined – to see people, deal with things at source, signpost them correctly or offer a short bit of follow up to see things through. And those people then, on the whole, have not come into secondary mental healthcare (Triage team)*

At the same time as diverting unnecessary or inappropriate referrals away from community mental health services, it was noted that Street Triage also offered assurance to these teams in providing an additional line of support for existing clients out of hours. The ability to respond in the community out of hours and to offer a quicker response was felt to *'add a more immediate string to the Crisis bow'*.

Police officers and members of the Triage team felt that use of A&E had been substantially reduced during times when Street Triage was on duty. Calculations carried out by TEWV suggested that, based on the presenting issues, around 80 per cent of cases referred to Triage would otherwise have gone to A&E in the absence of the service. Reduced use of A&E had associated benefits for the ambulance service, in that there was less demand for transportation to hospital:

*Previously the police had nobody to turn to. If they were faced with a situation with a mental health patient, it was call for an ambulance or take them up to hospital themselves. Now they've got this Triage team to be able to go and deal with them wherever they are, I think it probably has reduced the number of A&E admissions (multiagency respondent)*

As well as diverting people away from A&E in the first place, it was felt that Triage had also reduced repeat attendances through the implementation of appropriate onward referrals and support. Furthermore, it was noted that some of the individuals who misused police services with spurious calls for assistance behaved the same way with other emergency services and, as such, Triage was also contributing to a reduction in inappropriate demand on the ambulance service.

Echoing the comments of police officers, the Triage team also felt that mental health services had benefited from improved mutual sharing of information.

Only one possible negative impact on health services was mentioned, in that under a Payment by Results funding model, a diversion of clients away from the Crisis team may have financial implications that could be of concern at a strategic level. For operational personnel, however, the reduction of service demand and associated pressures was perceived as a positive outcome.

#### **5.4 Impacts on other services**

Other services consulted in the course of the evaluation included the social services Emergency Duty Team (EDT), the Borough Council's Community Safety Partnership and a local third sector organisation offering support to clients with a wide range of personal and social needs. For all of these services, a key benefit of Street Triage was the provision of a rapid response mental health assessment service, operating in the community. Mental

health was a factor for many of the individuals who came into contact with these services, but respondents from each of the services noted challenges in gaining access to or forming productive partnerships with mental health services. Street Triage was seen to have provided an important bridge into mental health services meaning that clients were now receiving timely assessment and relevant onward referrals or signposting:

*What's been the benefit of Street Triage really for us is that we have been able to get immediate support. So whether that's been in the person's home, whether that's been on the street, we've been able to call on that service to say, ok, what is the immediate risk for that person from themselves or for others, but also looking to see whether we can get them into the service long-term (multiagency respondent)*

For some of the services consulted, it was not unusual for their clients to be arrested due to challenging or antisocial behaviours. Although a mental health assessment could be requested in custody, it was felt that these assessments were not very accurate or comprehensive:

*If they get arrested and they go into the cells, you can then ask for a mental health assessment. But then somebody comes down and they do a very quick mental health assessment and they'll say "This person is ok to go; they've got no mental health issues". And we know that's rubbish, because we work with them. We're not mental health trained, I wouldn't profess to have any idea about mental health training, but I've done the job long enough. We've done the job long enough to know that there's some issue that's concerning, that concerns us, and it's mental health issues (multiagency respondent)*

Access to the Street Triage service meant that clients who might otherwise be at risk of custody detention were now receiving a more thorough assessment and appropriate diversion and onwards support.

The timeliness of intervention was highlighted as particularly important by one respondent, who described the needs of their client group as 'immediate' and not something that could wait several weeks to be addressed. Specific crises may be over relatively quickly (and often not appropriate for Crisis team intervention), but through their liaison, referral and signposting activities, what Street Triage had brought was the potential for longer term improvement in the 'root causes' of individuals' difficulties:

*Most of the client groups we work with are immediate. It's not something that you can say to them, "Well come in again in three weeks' time and you might get seen by mental health services". Because in three weeks' time, [the crisis] has gone. But the issue hasn't gone [and] without the Street Triage, the root cause is never dealt with (multiagency respondent)*

One respondent particularly emphasised the value of Street Triage being an all age service able to meet the needs of adolescents with mental health issues or behavioural problems. Triage was seen as highly effective in intervening and de-escalating domestic situations that might otherwise lead to arrest or removal of the young person from their home:

*We have very difficult teenagers who are open to CAMHS and it's really often escalating behavioural problems, and Street Triage might be called. But what they offer is just really fantastic, because it's about nipping it in the bud before it kicks off ... It's been kicking off at home and it's been nipped in the bud before it's escalated to that point where they've needed arresting [or] where they've needed admitting to hospital (multiagency respondent)*

Echoing the perceptions of some police officers, it was noted that certain young people who were described as 'revolving door' clients were now being encountered less often, following intervention from Street Triage:

*I can think of two or three that are well known in the community that are now well known by Street Triage and they've actually stopped them coming in. Whereas we might have had them in custody every Saturday for the last, you know, six weeks, it's completely quieted down ... Certain kids that had been so dreadfully problematic, where we're stuck with them in custody at weekends, have actually settled, and I think that's largely due to the influence of Street Triage (multiagency respondent)*

Demand on the Emergency Duty Team was perceived to have reduced since the introduction of Street Triage, in that fewer Mental Health Act assessments were being requested following a s.136 detention. Where it did appear that a client might be heading towards a s.136 detention, it was also noted as helpful that the Triage team sometimes gave the EDT a certain amount of advance warning meaning that the EDT could make preparations and begin to gather necessary information. Furthermore, staff carrying out Mental Health Act assessments in the community felt safer when accompanied by police and the Triage team, particularly if working late at night:

*If we have a community assessment which is picked up through Street Triage, we've got protection there, by the police and Street Triage, cos they're there. Because many a times, we're left on our own in the middle of the night, in a situation that's not safe. So it's that liaison, working together (multiagency)*

Again reflecting the experience of police officers, there was felt to be a useful role not only in connecting individuals into mental health services but also, where appropriate, providing a professional assessment that an individual had capacity and understanding of their actions and so could be dealt with along different lines. This was important for the Community Safety Team, whose role spanned both the protection of the individual but also the safety and interests of the wider community:

*Because of the problems they're causing in society, some of these people need antisocial behaviour orders or the new criminal behaviour orders, and sometimes we're not able to do that because what is being said is that they've got mental health issues. Now that's ok, but quite often they've got the capacity to understand what they're doing is having an impact on the community. But to get that information can take a long, long time, and whilst that's happening, the community is suffering from that. So there's two ways for [Triage], there's one about protecting the individual but there's also one about being able to protect the*

*community quick time as well from these individuals that are causing issues (multiagency respondent)*

As with the police and other emergency services, it was felt that demands made on third sector organisations by certain individuals who persistently made inappropriate use of these services would have been reduced by the intervention of Street Triage.

A further benefit was that 'safeguarding alerts' put in by the police to social services teams were perceived to have reduced, now that Triage was able to provide immediate assistance and onward referral at policing incidents.

## **5.5 Impacts on multiagency working relationships**

The Street Triage pilot was felt to have had a very positive impact on working relationships between the police and mental health services. From the police perspective, the service had been so useful to officers that, as already noted, views were universally positive about the Triage team. For both services, there was a feeling of partnership and collaboration in working towards the shared goal of delivering a better service for clients. One police officer described Street Triage as '*part of the team ... part of our policing team*'. Street Triage was a positive and constructive interface between two services for whom in the past interactions had more often been strained or blocking:

*Interfaces where the relationship could grow were slim and far between, usually based around the crisis itself. The development of Triage allowed us to not only make a more efficient way of dealing with crises in the community, but also to spend more time with the police and grow the relationships (Triage team)*

*It's increased my faith in the mental health service, because of how difficult it's been to communicate with the other mental health services that we've got. So for me, working with them [Triage] has increased my confidence in them getting the right support, through getting them that quickly and getting mental health assessment that quickly (PCSO)*

The pilot had started to break down barriers that had previously existed between the police and Crisis services. Evidence of this came in the increased amount of information sharing between the two services that was now taking place *outside* of Triage operating hours (as noted in section 5.2.2).

The face-to-face model of working between police and mental health professionals was felt to have contributed to the pilot's effectiveness in strengthening working relationships. This had helped to develop mutual trust and a greater respect for each other's roles. There had been education and an increase in understanding in both directions. Mental health staff acknowledged that they had not previously realised how much mental health was involved in policing work. This realisation had contributed to the greater willingness to share information between services and understanding of the need to work in effective partnership:

*I can tell you that the nursing workforce didn't believe that the police were dealing with mental health problems as much as they were ... And I think what's happened is, having that insight, by spending time with the police and really seeing what they really are dealing with, shifted a massive culture that you never anticipated (Triage team)*

*All of this has helped us see the police in a different light, because we see the pressures (Triage team)*

Mental health staff had been impressed by police officers' attitudes and approaches to working with individuals experiencing mental distress, commenting on officers' effective communication skills and sensitivity in interactions. In focus group discussion, one Triage nurse readily contested officers' claims that they lacked competence in dealing appropriately with mental health scenarios: *'Our key tool is communication, and you're all skilled communicators, you know, don't decry your own skills that you've already got'* (Triage team)

At the strategic level, very productive working relationships had developed between senior members of TEWV and NYP, leading to further opportunities for new collaborative projects around mental health in policing.

Respondents from other agencies commented that the introduction of Street Triage seemed to have led to improvements in multiagency working. For example, in a crisis situation, the presence of Street Triage along with the police seemed to mobilise ambulance and out of hours GP services more quickly and lead to a more cooperative approach by all parties. For the Community Safety team, Street Triage brought a highly valuable perspective and set of connections when participating in multiagency planning meetings. As will be discussed in chapter 9, there was felt to be much scope to build and expand upon this positive start.

While messages about Triage's impact on working relationships were very positive, it was noted that there was still further to go in improving systems around information governance and information sharing. There was also felt to be potential to further enhance cross-agency education and understanding, for example, through co-location of operating bases.

## **5.6 Impacts on clients and carers**

This evaluation was not able to gather the views of clients and carers directly. However, the view of the police officers, mental health professionals and other services consulted, was that the majority of service users and carers were pleased with the intervention and support provided by Street Triage and that the service was leading to better outcomes for those individuals.

### **5.6.1 Quicker access to accurate mental health assessment**

One of the most commonly mentioned benefits of Street Triage was that individuals were now getting much quicker access to a professional assessment of mental health. There was

a perception that the mental health assessments carried out in A&E departments were of lower quality, being briefer, less comprehensive and carried out by non-mental health specialists.

The benefits of quicker access to thorough mental health assessments were seen both for clients encountered in urgent need of crisis care but also for individuals in the community about whom Safer Neighbourhoods officers and PCSO had lower level but perhaps more longstanding concerns:

*It's an immediate professional help for them, isn't it. They're not waiting hours on end, they're not waiting for a couple of days. It's at the point that they are in crisis that they are getting that support (police officer)*

*It was a struggle before and you could be waiting weeks for social services to get anybody out to do some- any form of assessment. Now, you speak to Triage, and if it isn't that day it's the following day (police officer)*

*It's about seeing the right person at the right time, isn't it. Otherwise everybody is there for much longer, and in the middle of it all, you've got someone really distressed (Triage team)*

The benefit of an accurate mental health assessment was that individuals were then dealt with in the most appropriate way, whether that be down a mental health service pathway, a broader social support route or – where appropriate – through criminal proceedings. This engagement into appropriate support could in turn reduce the likelihood that individuals would re-present in crisis to health or other services on multiple occasions. Importantly, accurate assessment of mental health meant that individuals were less likely to be treated as having committed a criminal offence where a mental health problem underpinned the behaviour.

#### **Case example**

Police were contacted by a female who had concerns about her husband. The husband was hitting out at her and showing difficult behaviours both in the home and when out in public. Triage assessed the gentleman in his home environment, spoke with the wife as well as the husband to obtain both opinions on the situation and also liaised with the doctor. The behaviours were assessed as relating to mental health. The police officer who had attended this incident noted that, prior to Street Triage, the incident would simply have been dealt with as a domestic violence issue: *'It was all sorted out within house, with doctor's appointments, proper assessments, etc. That's how it worked. It could have been domestic violence, because he was hitting out at her, but it was something to do with his mental state'*.

The speed of response of the Triage service was compared favourably to Crisis team intervention, which was perceived to be less rapid and less flexible in terms of when, where and under what conditions they would assess an individual.



One officer highlighted the benefit of bringing the service to the user, given that people experiencing mental health problems might find it very difficult to initiate help-seeking or self-referral:

*We're bringing the help to them, aren't we, rather than them having to seek it themselves. And people will accept the help if it's there, because it's easy. Whereas if they have to get up and do something themselves, it's hard ... Even if it is just a phone call and it's easy to you and I, someone who's depressed or whatever, they find it difficult (police officer)*

Some participants were of the firm belief that there were occasions where a suicide had been prevented by Triage's intervention.

Triage's police-led referral route and early point of intervention meant that the service was reaching some individuals who might otherwise not come into contact with mental health services at all, or who had previously been known to services but had disengaged. There was felt to be a cohort of individuals who might never present to services either due to lack of insight into their mental health problems or because they were reluctant to engage with services:

*There's a client group out there that don't engage. That will always present in crisis. They don't engage with community mental health teams, they don't attend appointments, they don't take their medication. And I think that that's a service kind of we provide to them. They will always present in crisis, you won't ever engage them in services, and I think it's important that our service is there, because they do need a service (Triage team)*

*We tend to see people who mental health services maybe wouldn't be aware of otherwise, because it's people who are contacting the police because of paranoia or whatever, and they genuinely believe that the police can help them when actually it's a mental health issue. So they wouldn't access the GP or mental health services, cos they don't believe that it is a mental health issue. So we do get to see people, quite new people, who aren't known to services, obviously got chronic a mental health problem. So it's good in that sense cos we can actually get them help. Whereas they probably wouldn't ever come to mental health services otherwise (Triage team)*

### **5.6.2 Liaison, referral and signposting**

More accurate assessment of mental health led in turn to more appropriate onward referral and signposting. Clients were now getting support and onward steps that were far more relevant to their situation, rather than spending hours in custody or A&E only to have no constructive outcome or follow up care. The Street Triage service had the capacity to do a small amount of follow up work for each client, and this could include both additional contacts with the client (face-to-face or by telephone) and liaison work with relevant services such as GPs or care coordinators.

The Triage team's NHS affiliation, along with their multiagency liaison and information sharing capabilities, contributed to their effectiveness in securing positive outcomes for

clients. Triage was able to expedite referrals to GPs, community mental health teams, the Crisis team and also direct inpatient admissions. Importantly, however, Triage's role extended beyond making referrals into mental health services and encompassed the facilitation of a far broader range of social supports. Examples included securing access temporary housing through liaison with the council, and referral or signposting to relationship counselling, bereavement, employment, sexual health, drug and alcohol or befriending services.

### **5.6.3 A better experience for clients**

There were several ways in which the introduction of Street Triage was seen to have improved the experience of individuals in mental distress. These included: being seen in their own homes; the better engagement that could be achieved with non-uniformed personnel; and the reduction in use of s.136 detentions, custody and A&E.

#### ***Seeing clients in their own homes***

Despite the name of the service, the Street Triage team mostly saw clients in their own homes and this was highlighted as a particular benefit of the service. Some participants drew a contrast here with the Crisis team, who were understood not to make home visits out of hours.

The home environment was felt to be a much more comfortable setting for clients in mental distress. Police felt that being able to wait with a client inside their home was more reassuring for the individual and could help with trust and engagement. There were also benefits to the Triage team of being able to observe the individual's living conditions during the assessment:

*You build up that trust, because they know that someone else is coming for them, and we're not going to arrest them. Cos if we keep them in the van, they start panicking that they are going to get arrested. Whereas we take them home, they're a bit more comfortable, more relaxed, they know they're going to get the help that they need (police officer)*

*To be able to be seen really quickly in your own home, I think that a lot of patients are quite grateful for that, because normally, out of hours, they would have to go to A&E. And often it's just that we can get that done in the comfort of their own home really and it's better to see them, I think, in that kind of environment as well (Triage team)*

As noted earlier, a multiagency respondent highlighted the effectiveness of Street Triage in de-escalating domestic situations, particularly those involving young people and their families, meaning that issues could be '*nipped in the bud*' before reaching the point of custody detention or hospital attendance.

A further advantage of seeing clients in their own homes related to the geographical scale of the SWR locality. The main A&E department serving this area was at Scarborough General

Hospital which could mean that individuals transported there from outlying areas of the region could be left 'stranded' at A&E in the early hours of the morning:

*When you've got people living out at boundary of York and top side of Whitby, and then they don't need admitting to hospital, there's no means of getting people home, there's no pot of money to pay for transport home, there's no ambulance transport out of hours that we can use. So then people are kind of stranded in Scarborough, having been brought here by the police ... and then the crisis team are left with somebody at, you know, eleven o'clock at night, two o'clock in the morning, many miles from home and no way of getting home, and that's kind of been a real problem. Whereas if we take the service to them, it's just much, much more appropriate (Triage team)*

Where people were discharged from A&E out of hours, this could mean waiting around at the hospital until daytime public transport services resumed, attempting to contact a relative who could collect them, or could in some cases, where an individual was particularly vulnerable, incurring a large taxi fare at the expense of the health service.

### ***Better engagement with non-uniformed personnel***

It was felt that individuals in mental distress were more willing to engage with a mental health professional in civilian clothing than with a uniformed police officer. Police officers felt that their presence sometimes exacerbated an individual's distress and could raise levels of anxiety and aggression:

*It's always better there's someone in a non-uniform role, who's speaking as someone else. Because people still see the uniform; they don't like it, and they won't open up as much to you. Some will, some won't. But I think the majority would rather speak to a medical professional ... they will talk a little bit more to someone in civilian clothing (police officer)*

*They see us in our uniform and panic. They see someone else who actually understand what they're going through, casually dressed, calm, and can speak to them, and knows what they're talking about, saves hours. Vastly reduces the violence (police officer)*

*[People] see the cops as the enemy all the time, so they won't engage with them, whereas with a health professional they will. So it just brings things to a peaceful resolution, so much earlier sometimes. Whereas if it was just left to the Old Bill it would drag on for probably, for another two or three hours (police officer)*

Related to this, it was felt to be useful that Street Triage were seen as completely separate from the police service. Instances were noted where Triage had succeeded in making telephone contact with a missing individual where police calls had been ignored. It was speculated that the individuals concerned recognised the police telephone number and were rejecting the calls, whereas the Triage team had been able to establish contact via their own telephone number – which was perhaps also known to the individual but viewed more positively.

The better engagement achieved by the Triage team led to better outcomes and next steps, because through this engagement more detailed information could be gleaned about the individual's situation. Bringing people in mental distress into contact with health professionals was seen as '*doing the right thing*' for the individual:

*You just feel that you've done the right thing for the person themselves, by putting them in contact with the professionals (police officer)*

*You can only sort of sympathise with somebody so many times before you're repeating yourself, and you're thinking, "Well I'm gonna have to make a decision here, what do we do?". If [Triage] are on their way and coming, then it's a case of they then take over and do it properly. So it's kind of, not a confidence booster, but it just means you're going into it knowing that there's gonna hopefully be the right outcome (police officer)*

#### **Case example**

A female who was known to the Crisis team had taken an overdose. Police had been called to the individual's home but she was not willing to go with police to the hospital.

Having access to patient records, including her previous contacts with Crisis, the Triage team was able to get a level of engagement with the individual and build some rapport. The individual then agreed to go to hospital.

Later that night, the individual went into heart failure. Had she remained at home and not been in hospital at this point, she may have died from this. The Triage team's ability to engage the individual, through use of access to background information, was seen as critical in bringing her to the right place at the right time when urgent healthcare was needed.

It was noted that awareness of the Street Triage service was beginning to get embedded among some clients in the community and the sense from research participants was that the service was positively perceived. Indeed, there had been a few occasions where service users had presented at police stations and directly requested to see Street Triage. This was not felt to be an appropriate route into the service, but did reflect the positive reputation that the service was developing among service users. Where individuals had had more than one contact with the Street Triage team, the continuity of personnel was perceived to be positive, in that clients were more comfortable to engage with a professional with whom they already had some existing history and rapport.

As will be discussed in detail in Chapter 6, quicker access to professional mental health assessment was perceived to have reduced the use of s.136 custody detentions by police officers. This had the obvious benefits to clients of a less distressing and less threatening experience in the immediate term, but also avoided the longer term implications for the individual of having had a detention under the Mental Health Act, such as perceived

implications for employment, driving licenses, overseas travel and obtaining insurance or mortgages.

Street Triage had also led to perceived less use of A&E either as a formal place of safety under s.136 or on a voluntary basis. The benefit of incidents being concluded more quickly overall, with far less time spent waiting at A&E departments was noted as equally of benefit to clients as to police personnel. Summing up the benefits to clients, a member of the Triage team commented:

*Traditionally the police would have either taken them to the cells and ordered a 136 assessment, taken them to A&E and ordered a 136 assessment, or not really known what to do and taken them to A&E anyway. So for those service users' experience and for their carers' experience, they're getting on the spot, not quite instant, but as instant as you can get in the real world, on the street or at home assessment, to decide what is the level of mental health need, how are we gonna meet it or help this person meet that need, and what is our next step, straight away. So it's much quicker, much more person-centred, much more immediate (Triage team)*

A multiagency respondent highlighted the positive impact Street Triage had had in reducing custody detentions of young people who were known to mental health or social services. Triage's intervention and de-escalation of domestic situations, along with appropriate follow up, had meant that young people who regularly presented were now being seen less often in custody and families were being helped to manage behavioural situations at home:

*We get certain kids that will present at the police station every day and there is this thing about kids shouldn't be in custody and we should look for alternative. But where Street Triage go in – usually it's [Triage] and a police officer – sometimes it's kicking off in the house, it actually nips it in the bud then and there. We don't get parents saying "I don't want this kid back. I'm putting the child on the street". So it's really preventing them from coming into the police station. And this is where I've found Street Triage invaluable (multiagency respondent)*

#### **5.6.4 A better experience for carers**

Intervention from Street Triage was seen as a more positive experience for the families and carers of individuals experiencing mental health problems, in contrast to where situations were handled by the police working alone. The perceived reduction in use of s.136 detentions and associated reduction in use of custody or A&E departments contributed to experiences being less distressing. Where carers and family members were present during an assessment, their views would be taken in to account, and they would also be involved in any follow up as appropriate.

A service user and carer consultation group was convened at intervals by TEWV and feedback on experiences of the Triage service was very positive. Contrasting these families'

experiences with the period before Street Triage was in place, a member of the Triage team described feedback from the consultation group in this way:

*Before Triage was around, they would not know where their daughter or son was, because they'd have been arrested and taken to custody. So 24 hours on, they wouldn't know where they were, they'd get a phone call at half four in the morning, saying "We're just gonna release them from custody". Whereas with Triage being on, they feel it's a better approach, it's a nurse, they're getting the appropriate help, they feel supported, they felt it was collaborative, and they felt that they were getting help as opposed to it's just task-orientated (Triage team)*

### **5.6.5 Short-term negative impacts**

Although impacts on clients were felt to be positive overall, it was noted that in the short term a small number clients were not happy about the immediate outcomes of their assessment. For example, there were instances where individuals (or their carers) had been hoping that more medication would be prescribed or had in fact wanted an admission to hospital, but the assessment was that this was not the appropriate action:

*Some patients just won't be happy. They won't be happy with the fact that actually what you've done is you've gone and they've wanted admission and you've said "No, you don't need admission" or they've wanted more medication and you've said "No, you don't need more medication, you've got what you've got" type of thing, and they won't be happy with that judgement (Triage team)*

*I think always in mental health, particularly mental health crisis work, not all clients are going to be satisfied because they don't all get what they want and what they expect from the service. People that think they've got they've got a mental illness who are assessed not to have a mental illness. So you will always get some conflict with the client. And the carers, you know, "My son, my daughter, my husband must have a mental illness because he's behaving this way", and that's not always the case. So there's always going to be that kind of dilemma in mental health crisis (Triage team)*

The experience of a mental health assessment could be unpleasant for an individual in the midst of crisis and where a section was advised, this could be distressing for individuals and carers. However, decisions and actions were always taken with the patient's long-term interests at heart, based on the mental health nurses' professional assessment. An example was given of a female who regularly went missing from home, leaving four children unattended. From the police perspective, their primary role at these times was to ensure the wellbeing of the children and when the mother was taken into hospital on a section, the police could at least be sure that the children would be taken care of for this period of time:

*'It's awful for her being sectioned, but what it does is that period of time, we know the kids are safe' (police officer).*

It was noted that these situations were not unique to the Triage context, and that the challenge of making the best decision for the patient when this may not match with their own wishes or expectations was common to any branch of mental health services.

## 6 Impact on use of s.136 detentions

### 6.1 Quantitative evidence

#### 6.1.1 Overall rates of s.136 detentions

Table 6.1 shows the total number of s.136 detentions per month taking place in the Scarborough, Whitby, Ryedale area during the period of the 12 month Street Triage pilot (24 March 2014 to 23 March 2015) and, for comparison, the preceding 12 month period. The table combines figures for:

- detentions to custody
- detentions to the Health Based Place of Safety (HBPoS)
- detentions where there was a transfer from custody to the HBPoS (or vice versa)

**Table 6.1 Section 136 detentions in SWR region during Triage pilot and preceding year**

	M	A	M	J	J	A	S	O	N	D	J	F	M	TOTAL
<b>2013-2014</b>	1	5	5	5	7	6	4	5	3	5	4	7	6	63
<b>2014-2015</b>	1	4	8	8	6	5	3	11	7	8	5	2	7	75
<b>Change</b>	0	-1	+3	+3	-1	-1	-1	+6	+4	+3	+1	-5	+1	+12

Figures show an overall increase in the use of s.136 detentions to custody and/or the HBPoS in the pilot year as compared to the preceding year. On this basis, the pilot did not meet one of its key objectives. However, one possible explanation for this may be the lack of recorded figures for s.136 detentions which were taken to A&E departments. This was a challenge described by NYP and TEWV personnel from the outset of the evaluation. Whilst police kept robust records of s.136 custody detentions and, following the opening of the HBPoS on 27 January 2014 records of all detentions admitted to the s.136 suite were maintained by the Trust, it was believed that hospital staff did not routinely maintain records of patients seen in this context<sup>8</sup>. NYP and TEWV attempts to obtain figures on s.136 detentions from A&E (prior to and separate from the present evaluation) have proved unsuccessful.

Following the opening of the HBPoS, there was a decrease in the use of police custody as a place of safety. Custody detentions from 24 March 2013 to 26 January 2014 numbered 48; from 27 January 2014 until the end of the pilot on 23 March 2015, custody detentions totalled 34 (of which 16 transferred from custody to the HBPoS). Although a somewhat crude calculation, this suggests an approximately 50% reduction per month in custody detentions (4.8 over the 10 months prior to the opening of the HBPoS; 2.4 per month over the 14 months following the opening of the HBPoS).

<sup>8</sup> It was recognised that in some cases, A&E staff may not in fact have been made aware by police officers that a patient was there under a s.136 detention.



As such, the increase in s.136 detentions during the pilot year was predominantly concentrated in the HBPoS. Some of this was a diversion from use of custody and it is worth noting that there was also a comparable increase in the use of s.136 detentions in the neighbouring Harrogate area over the same period (see Table 6.2, below). Whilst Harrogate had a smaller number of s.136 detentions overall, the increase in use of s.136 over the two years was in fact somewhat larger. Harrogate also gained access to a HBPoS in early 2014. This suggests there may have been an overall trend to greater use of s.136 following the opening of HBPoS's in each locality.

**Table 6.2 Place of Safety use: Scarborough and Harrogate 2013/14 & 2014/15**

	Custody	Transfer	HBPoS	TOTAL
<b>Scarborough 13-14</b>	52	1	10	63
<b>Scarborough 14-15</b>	14	15	46	75
<b>Harrogate 13-14</b>	32	0	1	33
<b>Harrogate 14-15</b>	16	2	26	44

However, it is possible that the apparent overall increase in s.136 figures in SWR also reflects a shift from use of A&E as a place of safety (figures for which are not available) to the use of the HBPoS at Cross Lane hospital. In other words, s.136 detentions which previously taken to A&E and went unrecorded were now appearing in the statistics as detentions were diverted away from A&E and to the HBPoS where more accurate records were kept. Thus the apparent increase in detentions may be an artefact of recording, rather than a true increase.

### 6.1.2 S.136 detentions within and outside of Triage hours

By combining data from s.136 custody records, HBPoS records, the master data set of Street Triage activity maintained by NYP, and staff duty rotas provided by the Triage team, it was possible to go some way towards understanding patterns in use of s.136 when Street Triage were and were not on duty.

From these data sources, it could be determined that of the 75 s.136 detentions during the pilot year:

- 24 (32%) took place during hours when the Triage team was on duty and there was Band 6 staffing (i.e. an assessment could be conducted if requested)
- 25 (35%) took place outside of Triage service hours or at times where there was no Band 6 on duty (i.e. assessments could not be carried out) or there was no staff cover despite it being within timetabled service hours<sup>9</sup>

<sup>9</sup> See Chapter 3 for discussion of challenges in consistently staffing the service during timetabled hours of operation

- 26 (35%) took place on a day where the Triage service was operational and staffed but available data did not include a time of detention hence it could not be established whether the Triage team would have been on duty at that particular time

Excluding this third category leaves 49 detentions where it could be determined whether or not Street Triage could potentially have been involved. Of these 49 detentions, 49% took place during Triage operating hours and 51% took place outside of service hours or at times when the service was not staffed by a Band 6 nurse or was entirely unstaffed. Although there are a substantial number of s.136 detentions which we have been unable to assign to either of these two categories, these figures tentatively suggest that rates of s.136 detention were fairly similar when the Triage team were and were not on duty.

The data records provided by NYP and TEVV explicitly note Triage team involvement in 20 of the 24 s.136 detentions (83%) which took place during Triage operating hours. This suggests that police officers were, in the main, involving the service in instances where they suspected a s.136 may be called for – in other words, it did not seem that s.136 detentions were regularly being made by police during staffed Triage operating hours *without* involving the Triage team (although descriptive notes in the data records included a small number of cases where a s.136 detention was used without first consulting Triage team even though there were already on scene).

Although we have been able to offer above one possible explanation for the overall lack of reduction in use of s.136 (relating to a diversion of *unrecorded* s.136 detentions away from A&E following the opening of the HBPOS), the finding that rates of use of s.136 barely differed when Triage were and were not on duty adds support to the conclusion that the introduction of Street Triage in SWR had not met the aim of reducing the use of s.136. However, s.136 rates in SWR are low in comparison to larger urban areas and it is possible that it is difficult to decrease them further. It could be argued that uses of s.136 were appropriate and Street Triage was not able to avoid its use. These figures, though, stand in contrast to the qualitative perceptions that Street Triage had noticeably reduced officers' use of s.136.

## **6.2 Qualitative perspectives**

### **6.2.1 Reasons underpinning a perceived reduction in use of s.136 when Triage on duty**

Although not reflected in the available quantitative data, police officers' perception was that they *were* using s.136 detentions less when Street Triage was available. A key reasons for this, as has been noted in Chapter 5, was the improved access to quick and accurate assessment of mental health alongside access to information on patients' mental health history, meaning that s.136 did not need to be used as a '*catch all*' or precautionary measure:

*Before we had them, we were basically dealing with so many people with mental health problems, with little or no training whatsoever on how to deal with that, and basically we were just using our powers under 136. And because we're not medical experts, we were kind of arresting everyone under 136 because we didn't know whether they were gonna be a threat to themselves and we weren't in a position to make that medical judgement, we would just simply go down the Section 136 route (police officer)*

*If we're not quite sure, there's a possibility they're going to harm themselves or somebody, they're in a public place, yeah, let's get them under 136, just to cover our backs basically. Whereas now, with Street Triage, they come and they've got the knowledge and the training to be able to assess the situation, and "Yeah, actually it doesn't fall within that remit, but this is what we can do. Leave it with us, we'll take over, we'll sort it", then that's great (police officer)*

Precautionary use of s.136 detentions was linked to officers' concerns about the consequences both for the individual and for the police force should there be a negative outcome. Officers stressed that they did not want to risk the individual (or members of the public) coming to harm, but were also mindful of the implications for themselves and the wider reputation of the force should harm come to an individual who they had left alone at a scene. In essence, without the input of Street Triage, officers generally felt the need to err on the side of caution and detain an individual, even though s.136 detentions rarely led to hospital admissions under the Mental Health Act. Despite its resource implications, without the support of Street Triage s.136 was seen as *'the safest option'*:

*[If] we let them walk away and then they kill themselves, we'd have of answer to that, and rightly so. So the safest option was to always go down the 136 route. So lots and lots of people getting arrested for 136, but hardly anyone was ever getting sectioned from it, which said, quite clearly, that maybe our assessments were wrong. But having not had that training, how, you know, we're kind of forced into this position where we're damned if we do and damned if we don't (police officer)*

*A lot of the time it's about covering your own back, isn't it, and making sure the person's safe ... The last few times I've had people like that, Street Triage haven't been on, so it's been, "Will you voluntarily go with ambulance, because of what you've said? If you won't then we're gonna have to take you ourselves under 136", that's been the answer (police officer)*

A commonly noted scenario was where someone threatened self-harm or expressed suicidal intent. Without Street Triage, police officers did not have the expertise to assess the sincerity of these expressions and so felt they had to treat them as genuine and use powers of s.136. Where Triage was present, the mental health nurses used their professional expertise to assess the extent to which an individual had true intent to self-harm or take their life. In some cases Triage would determine that the individual was not a suicide risk and with appropriate de-escalation, liaison and referral the person could remain in their home environment once the assessment had been concluded:

*If Triage is saying that they are fit to be taken home, we trust that judgement then ... and touch wood, the judgement has been right each time. And having them has stopped that 136. 136, over 90 per cent of the time isn't the right thing. We've done it because we have no other option, and our clientele, some of the people we deal with, I'll do anything to stop you harming yourself, anything. But if Street Triage tell me they know them, they aren't gonna harm themselves, it's stopped them from going to custody again (police officer)*

*It's the experience of working with them, the confidence that the Triage team are actually capable of assessing these people and from what we've seen, most people don't get 136'd any more. So we know we don't need that power (police officer)*

Use of s.136 had also been avoided in scenarios where Triage was able to establish that a physical health problem underpinned unusual behaviours or cognitive confusion, and in cases where there was an assessment of no mental illness and police could validly pursue a criminal course of action.

*They help the people with genuine mental health problems, but the flip side of it as well is that they will quite happily say, "You have no mental health issues" and we've got some, certainly in Scarborough, that will play agencies off against each other and they are, in my view anyway, just attention seekers ... And it's really helpful when Street Triage will come and say, "Well no, they haven't got a mental health problem". Whereas these people we've probably been bringing in 136, [as a] back covering exercise, now we sort of have a little bit more sort of faith in being able to sort of say "Well, no. Actually, we're not gonna deal with you in this way" (police officer)*

As noted earlier, the consequences of this change of approach by police officers sometimes resulted in a reduction in demand on police time from prolific callers. Where these individuals were no longer receiving the response and attention they sought, inappropriate contacts to the police tailed off, which again contributed to less use of s.136:

*The figures might have gone down because some of the ones that were attention seeking were having to be brought in for 136 because they were saying that they were gonna be a risk to themselves. Despite knowing that that's not necessarily the case, you can't leave them (PCSO)*

#### **Case example**

A young female repeatedly came to the attention of the police, sometimes several times a week, because a friend of hers regularly reported that the individual was planning to harm herself. Each time, numerous officers were deployed to try to locate the individual, and Triage had also been requested on multiple occasions. These incidents were perceived as deliberate attempts to gain attention, through being detained under s.136.

On all occasions, the outcome of the Triage assessment was that there was no mental illness, the individual was fine, blamed her friend for raising the alarm, and 'just wanted to go home'. After a time, because the Triage assessment on each occasion remained as finding no mental illness, the police began to arrest the individual.

Prior to the triage pilot, this individual was being detained under s.136 '*almost every other week*', either in custody or in the s.136 suite. Triage's intervention prevented the use of s.136 in that any suggestion of mental ill health could now be dismissed. This did however mean that the individual was now being arrested on criminal grounds.

The knock-on benefits of a (perceived) reduction in use of s.136 detentions were multiple, including:

- reduction in police time spent waiting with a detainee in custody or A&E departments, which could instead be spent attending to other policing duties
- reduction in health and social services resources that would be required to conduct a Mental Health Act assessment
- avoiding inappropriate and distressing use of detention (particularly in custody) for individuals in mental health crisis
- avoiding the escalation of violence or aggression that sometimes resulted from a custody detention
- avoiding the tensions, arguments, delays and to-ing and fro-ing that could result from A&E departments' reluctance to be considered a Place of Safety
- for individuals, avoiding the future implications of a s.136 detention relating to, for example, job applications, travel and insurances.

When Triage were not on duty, police officers typically referred to their options in a mental health incident as being either a s.136 detention to custody or A&E (interestingly there was limited mention of the s.136 Suite at Cross Lane) or a voluntary attendance at the A&E department. There was no suggestion in the qualitative data that the partnership with Street Triage was having a knock-on effect on officers' confidence to *not* use s.136 at times when the team were not on duty. This suggests that officers still felt a need to 'cover their backs' with precautionary use of s.136 in the absence of Street Triage.

### **6.2.2 Situations where s.136 would still be used**

Officers noted certain scenarios where they would still feel it necessary to use s.136 detentions even when Triage were on duty. This included where there was an immediate risk to the individual's safety (or that of others around them) which needed to be contained quickly and could not be delayed until Triage's arrival. Examples included where there was a weapon or violence involved, or an immediate threat to life. The challenges of geographical distance in the SWR region along with the reduced staffing capacity (described in chapter 3) contributed to there being occasions where use of s.136 was seen as unavoidable. Although officers were willing and accustomed to waiting up to an hour for service, there were times when Triage were already engaged in another incident and would not be able to attend for some time. There was also some indication that officers in a Response role might feel pressure to resume to other duties and so use s.136 as a means of progressing an incident more quickly:

*If it's kicking off and busy, we're not gonna wait an hour and a half for [Triage] to get there, because we know we've got a colleague needing something else and we're thinking, "We'll just section them and..."* (police officer)

There were also occasions where Triage themselves agreed that use of s.136 was appropriate, given that there was an assessment of serious mental illness but engagement was proving impossible and the individual was not willing or able to come voluntarily to a place of safety. Use of s.136 in such scenarios was seen as a means of getting the individual the appropriate support. The result of more accurate and appropriate assessments of mental health was that, where they did happen, the 'quality' of s.136s was seen to have improved. In other words, it may not be possible to eliminate the use of s.136, but where it did happen, this was truly in the individual's best interests. In support of this view, a multiagency respondent involved in conducting Mental Health Act assessments commented that where Triage had recommended the use of s.136 this was invariably an appropriate decision:

*What I can say is if Street Triage have been involved and they feel that this person needs a Mental Health Act assessment, it's usually the Full Monty and it is genuinely necessary ... it's not a waste of time* (multiagency respondent)

### **6.2.3 Residual inappropriate use of s.136**

Beyond the situations where use of s.136 was felt to be necessary, there was a view from mental health practitioners and some police personnel that s.136 was still being used inappropriately on some occasions. In particular, this was where the Triage team *was* on duty and *could* have been consulted prior to this action being taken, but was not<sup>10</sup>. Even more frustratingly for the Triage team, there had been occasions where they were already at the scene but officers had nonetheless implemented a s.136 detention. A member of the team described one such incident:

*We were called out to the bridge because the person was on the railings. The police negotiator had been involved, and the minute the person came down from the bridge, they were detained on a 136. And we're sat there, on the bridge. And that's kind of a real frustration, because we know that person absolutely could have been dealt with, without the detention* (Triage team)

The Triage team also noted an occasion where resources could have been deployed more effectively. Whilst on route to an individual who was giving a low level of concern, a more serious crisis incident was called in. Triage offered to divert to this new incident but were told to continue to the first incident as this had been 'on the log' for longer. Meanwhile, a s.136 detention was used in the other scenario. The team felt this could have been avoided had their offer to reprioritise deployment been taken up.

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<sup>10</sup> Although, as noted above, the data suggest that this scenario was relatively infrequent; the available data indicate that Triage were in some way involved in over 80% of s.136 detentions when on duty.

The implications of these inappropriate uses of s.136 included a need to raise and maintain the profile of the Triage team and also educate officers further on the role of the team and appropriate use of s.136 (discussed further in Chapter 9). Concerns were also raised by strategic level personnel that the use of custody as a place of safety remained unacceptably high.

## 7 Street triage usage and outcomes

### 7.1 Street triage usage

Data were collected for the Department of Health on usage of Street Triage from 24 March 2014 to 24 March 2015 by the Street Triage team. As discussed in chapter 2, some people appeared more than once in this dataset so a distinction is made between *service users* (data about individuals) and *referrals* (data about incidents) in this section.

#### 7.1.1 Demographics

The mean age of the 379 users of street triage was 43.5 years (range=13-91). 212 (56%) were male and 363 (96%) were white British (table 7.1).

**Table 7.1 Ethnicity of street triage users**

	n	%
White British	363	95.8
White Irish	3	0.8
White Other	4	1.1
Asian	2	0.5
Other	2	0.5
Not stated	5	1.3
Total	379	100

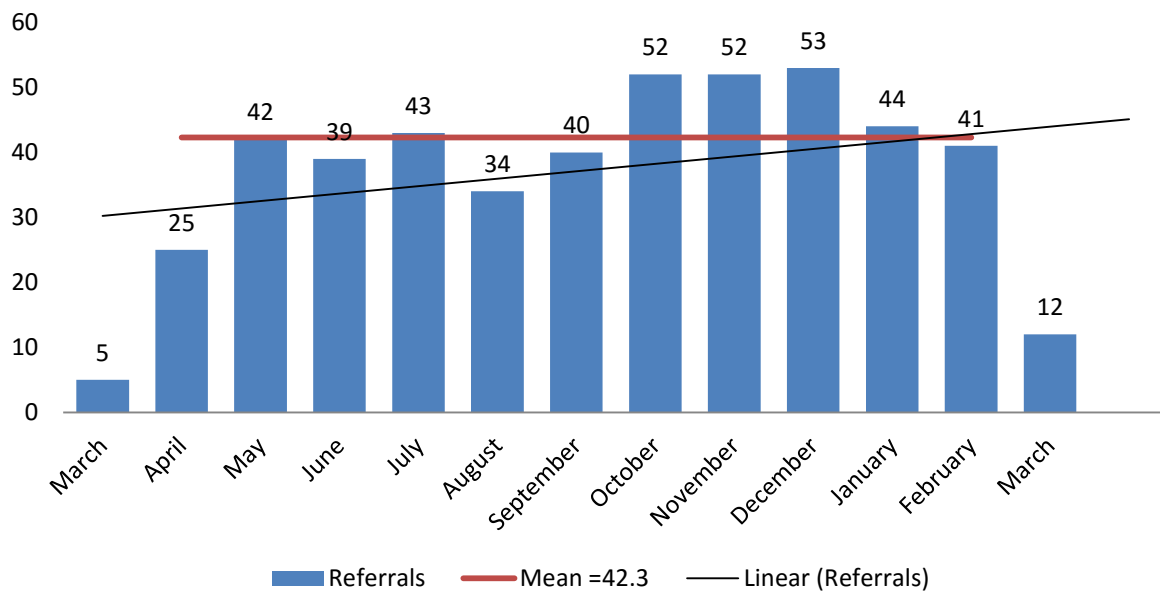
#### 7.1.2 Referral patterns

A mean of 42.3 referrals per month were received between April 2014 and February 2015 with a rising linear trend over this period (figure 7.1). Demand for the service was constant throughout the week, with no significant variation according to day of the week (figure 7.2). Almost all initial assessments (n=481, 92%) took less than three hours to complete. Of the 328 face to face contacts, 78% (n=256) were seen within one hour of referral from the police. Following the model of triage and assessment, 82% (n=310) of people seen by street triage were open to the SWR Street Triage team for less than one week. However, 42% (n=159) were followed-up by the team because of their clinical needs.

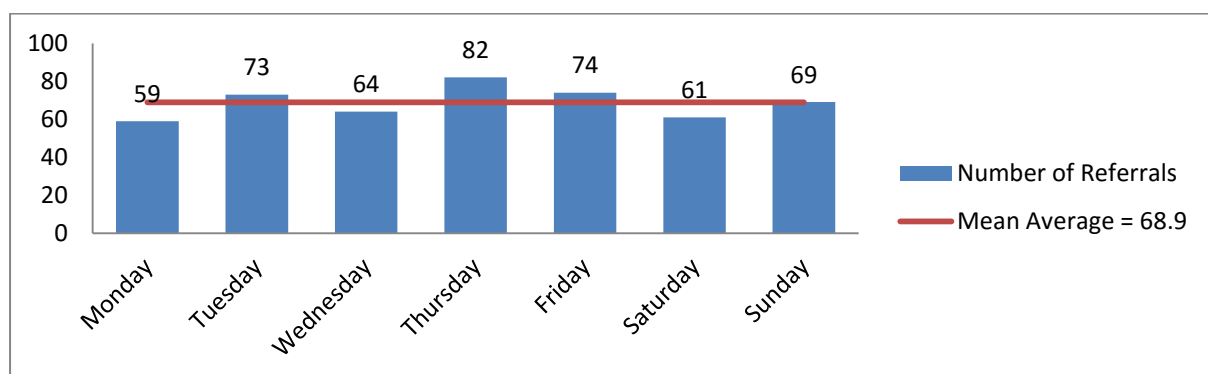
Most of the referrals (n=430, 82%) were of people known to mental health services but only 214 (41%) referrals had an active care plan and 228 (43%) referrals were open to mental health services at the time of the Street Triage intervention. A small, though not insignificant, proportion were known to CAMHS (n=56, 11%). Only 8% (n=44) of referrals had previously been detained under s.136.



**Figure 7.1 Referrals received by SWR Street Triage team by month**



**Figure 7.2 Referrals received by SWR Street Triage team by day of the week**



## 7.2 Outcomes of street triage interventions

### 7.2.1 Referral outcomes

Data about the outcomes of the street triage interventions were not recorded for 40% (n=212) referrals. As the proforma was incomplete, the following findings need to be treated with caution.

173 (33%) referrals were marked as ‘informal referral to mental health services’ and a further 123 (23%) as ‘community referral’. However, the notes column shows overlap in the use of these two codes. Other recorded outcomes were s.136 detentions (n=11, 2%) and arrests for breach of the peace (n=5, 1%).

Analysis of the notes column showed that 57 (11%) referrals were intoxicated and no further action was taken by the SWR Street Triage team. A further 79 (15%) required no further action from the STR Street Triage team. 59 (11%) were marked as open to mental

health services and individuals were referred back to them. 36 (7%) referrals subsequently led to detentions under s.2 or s.3 of the Mental Health Act and 24 (5%) led to an informal psychiatric admission. Only 7 (1%) were recorded as declining a service. Other notes identified that information had been shared or the individual was referred to another community service.

### **7.2.2 Impact on health service usage**

To explore the impact of street triage interventions on use of TEWV services, we extracted data from the PARIS database for a cohort of street triage users in its first nine months of operation. All those who were referred to the SWR street triage team between 24<sup>th</sup> March and 24<sup>th</sup> December 2014 were included in this analysis. Data were extracted for a period six months prior to their first contact with the team and six months afterwards to ascertain secular trends in their service usage.

308 individuals were included in this analysis. Their mean age was 43.4 (s.d.=18.2), 54% (n=166) were male and 87% (n=267) were white British (this is likely to be an underestimate as ethnic coding was missing for 10% (n=30) of the sample). As these characteristics are very similar to the whole sample of SWR street triage users, it is reasonable to conclude that they form a representative sample.

Only 11% (n=33) were on the Care Programme Approach, which contrasts sharply with the 43% of referrals who were open to mental health services (see section 7.1.2), but this is likely to be a recording artifice. The SWR street triage team were in contact with these individuals for a median of 70 minutes (IQR=30-120).

Service use data is presented in table 7.2 and are explored in more depth below.

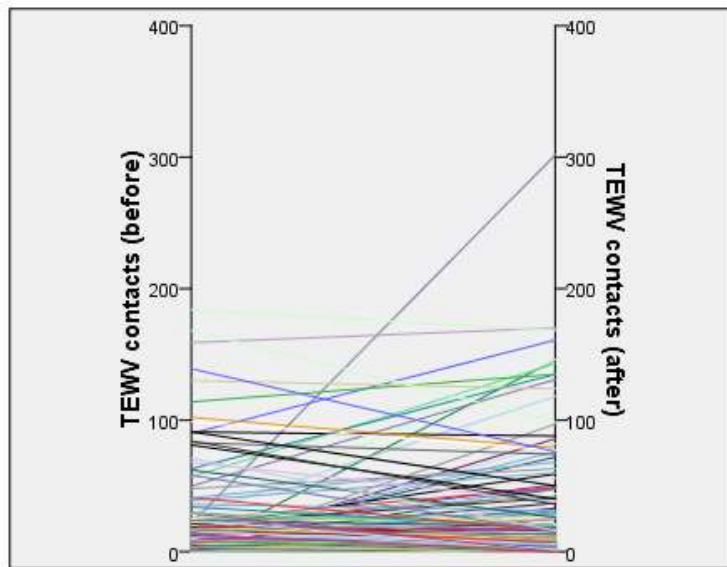
**Table 7.2 Analysis of TEWV service usage before and after first contact with SWR Street Triage team**

	6 months pre-street triage				6 months post-street triage				Statistical significance
	Total	Range	Median (IQR)	At least one	Total	Range	Median (IQR)	At least one	
<b>Number of TEWV contacts</b>	3,399	0-184	1 (0-7)	166 (53.9%)	4,936	0-302	1 (1-13)	156 (50.6%)	p=0.004**
<b>Total length of TEWV contacts (mins)</b>	131,624	0-10,230	25 (0-305)		166,127	0-10,727	2.5 (0-320)		p=0.286
<b>No of episodes with crisis team</b>	160	0-7	0 (0-0)	76 (24.7%)	40	0-4	0 (0-0)	28 (9.1%)	p<0.001***
<b>No of days with crisis team</b>	1,188	0-182	0 (0-0)		299	0-51	0 (0-0)		p<0.001***
<b>No of episodes with liaison</b>	5	0-2	0 (0-0)	4 (1.3%)	2	0-1	0 (0-0)	2 (0.6%)	p=0.180
<b>No of days with liaison</b>	21	0-16	0 (0-0)		5	0-5	0 (0-0)		p=0.343
<b>No of episodes with other community team</b>	181	0-6	0 (0-1)	124 (40.3%)	15	0-1	0 (0-0)	15 (4.9%)	p<0.001***
<b>No of days with other community team</b>	18,570	0-182	0 (0-182)		1,228	0-182	0 (0-0)		p<0.001***
<b>No of episodes with street triage (other team pre, SWR post)</b>	5	0-3	0 (0-0)	2 (0.6%)	12	0-3	0 (0-0)	9 (2.9%)	p=0.200
<b>No of days with street triage (other team pre, SWR post)</b>	6	0-5	0 (0-0)		39	0-16	0 (0-0)		p=0.085
<b>No of episodes with primary care mental health team</b>	22	0-2	0 (0-0)	19 (6.2%)	3	0-2	0 (0-0)	2 (0.6%)	p=0.001**
<b>No of days with primary care mental health team</b>	1,365	0-182	0 (0-0)		293	0-182	0 (0-0)		p=0.005**
<b>No of inpatient admissions</b>	24	0-6	0 (0-0)	15 (4.9%)	104	0-7	0 (0-0)	47 (15.3%)	p<0.001***
<b>No of inpatient days</b>	580	0-182	0 (0-0)		2,724	0-182	0 (0-0)		p<0.001***
<b>No of inpatient days on section</b>	10	0-3	0 (0-0)	6 (1.9%)	1,826	0-182	0 (0-0)	22 (7.1%)	p<0.001***

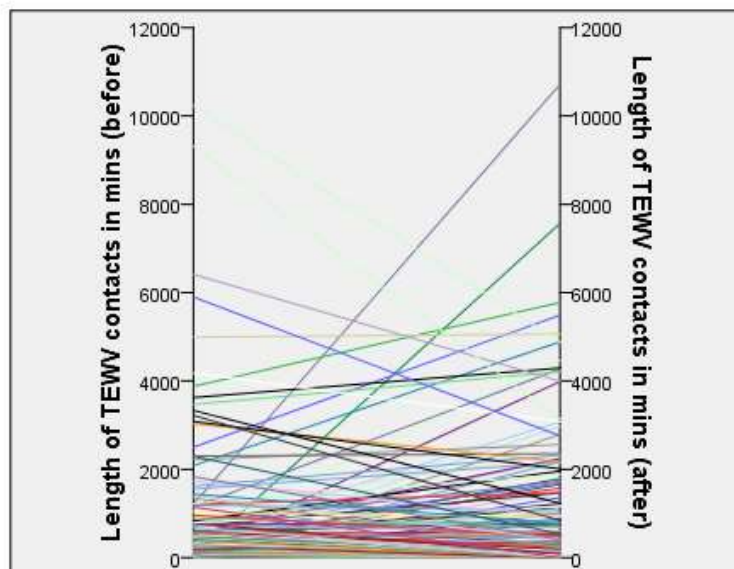
### Contacts with TEWV

The number of people who had contact with TEWV services in the six months after their first contact with the STR street triage team increased to 156 (51%) from 166 (54%) in the six months prior to the first contact. However, although the total number of contacts with TEWV these people increased overall (figure 7.3), the length of time they spent in contact with TEWV staff did not change (figure 7.4).

**Figure 7.3** Change in number of contacts with TEWV



**Figure 7.4** Change in length of contacts with TEWV



### Contact with crisis team

The proportion of the sample who were in contact with the TEWV crisis team decreased from 25% (n=76) to 9% (n=28) in the six months following their initial contact with the street triage team. Both the number of episodes (figure 7.5) and the number of days open to the crisis team (figure 7.6) decreased for this sample after their initial contact with the SWR street triage service.

Figure 7.5 Change in crisis team episodes

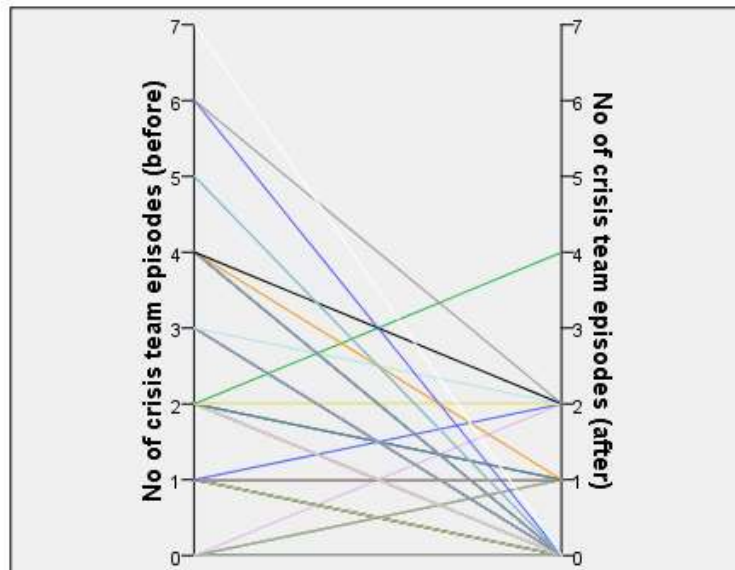
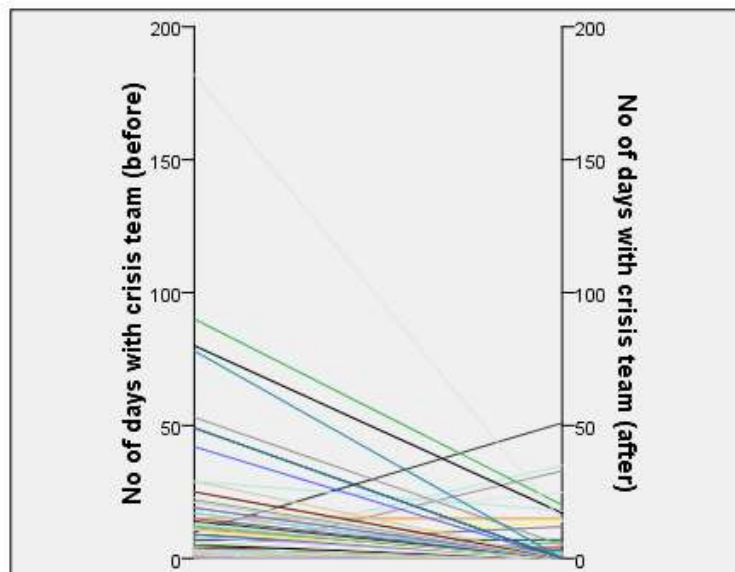


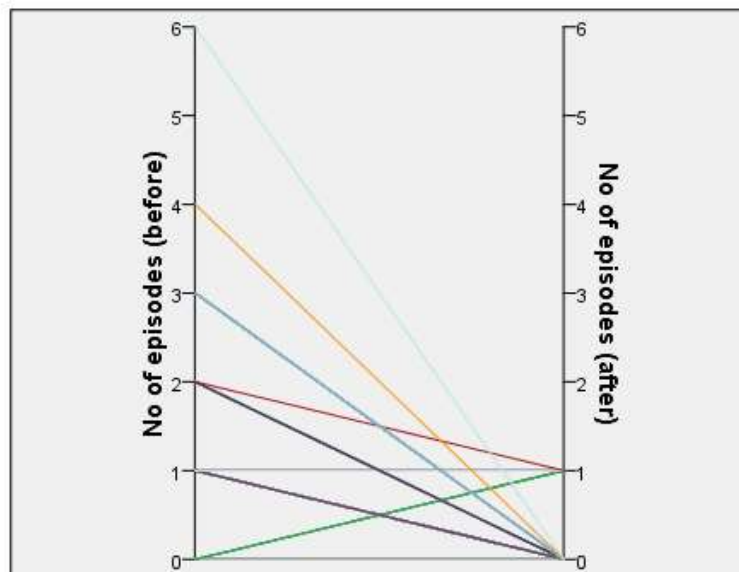
Figure 7.6 Change in length of time spent with crisis teams



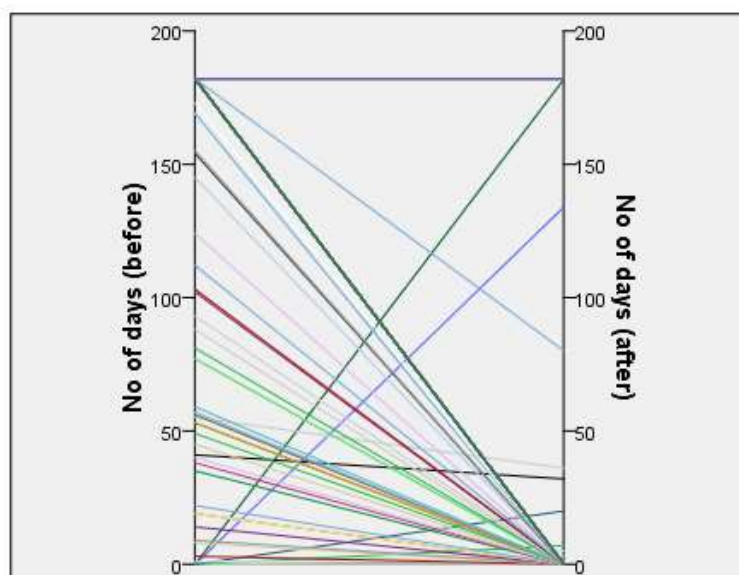
### Contact with other community mental health teams

The proportion of the sample who was in contact with another community mental health team (CMHT) decreased from 40% (n=124) in the six months before their first contact with SWR street triage to 5% (n=15) in the six months after. Both the number of episodes (figure 7.7) and the number of days open to a CMHT (figure 7.8) significantly decreased after the first contact with the SWR street triage team.

**Figure 7.7** Change in number of episodes with CMHTs



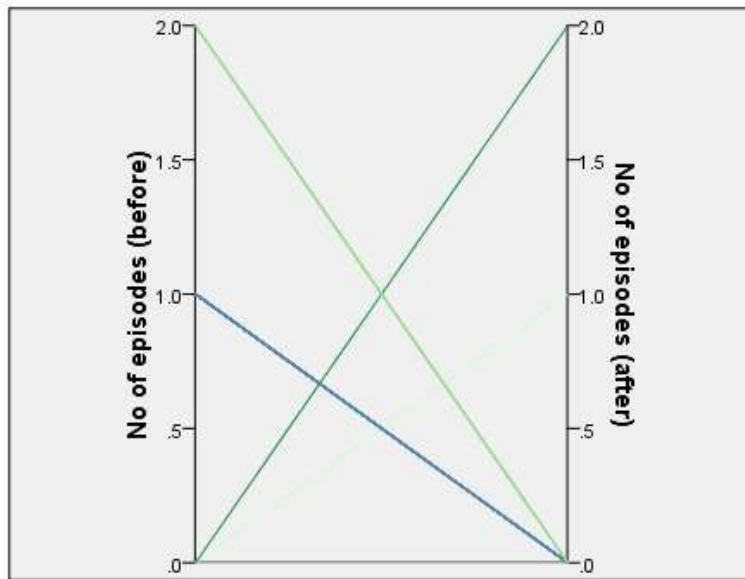
**Figure 7.8** Change in number of days open to CMHTs



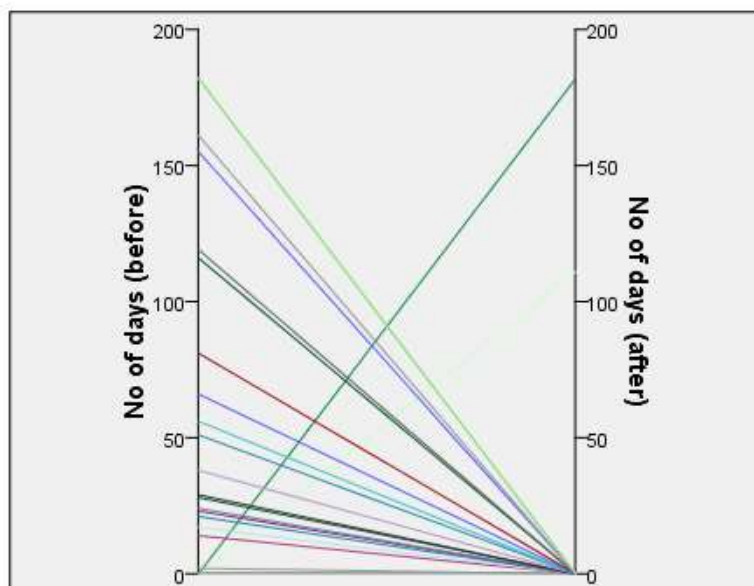
### Contact with primary care mental health team

The number of people in contact with a primary care mental health team decreased from 16 (6%) to 2 (1%) after the first contact with SWR street triage. Both the number of episodes (figure 7.9) and length of time open to a primary care mental health team (figure 7.10) significantly decreased.

**Figure 7.9** Change in number of episodes with primary care mental health team



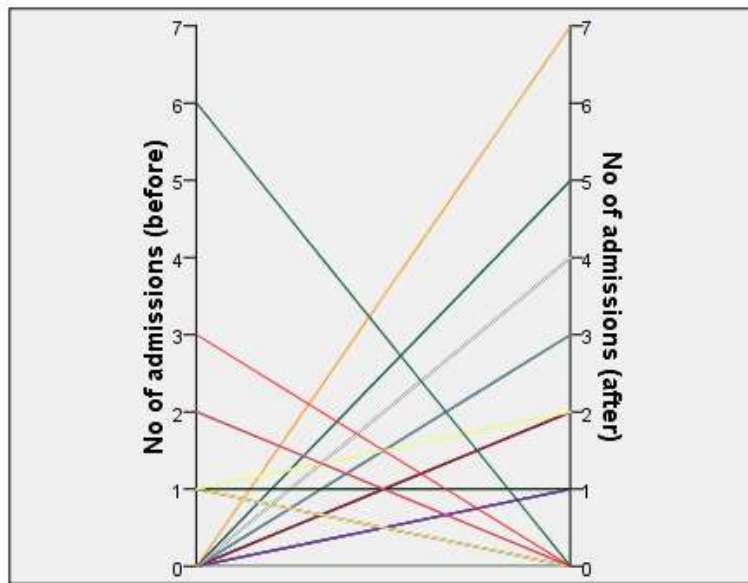
**Figure 7.10** Change in number of days open to primary care mental health team



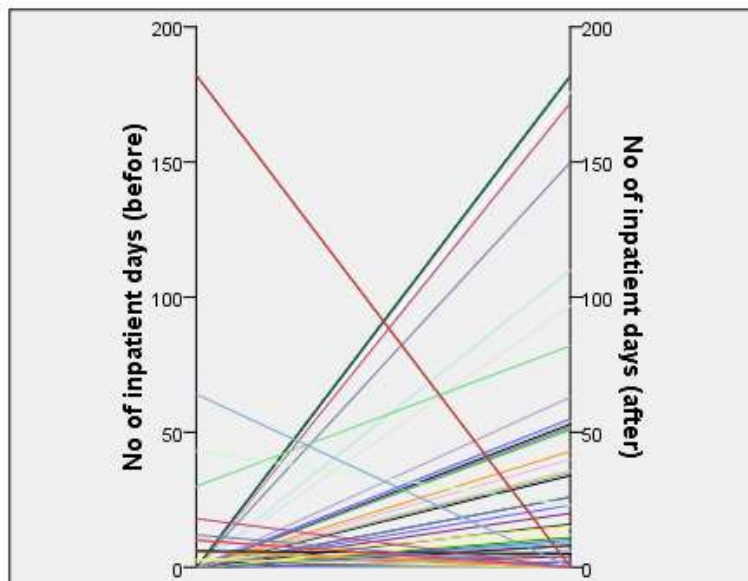
### ***Inpatient admissions***

The proportion of the sample who had an inpatient admission rose from 5% (n=15) to 15% (n=47) in the six months after the first contact with SWR street triage team in contrast to the previous six months. Both the number of admissions (figure 7.11) and the number of days spent as an inpatient (figure 7.12) significantly increased after the first contact with SWR street triage.

**Figure 7.11** Change in number of inpatient admissions



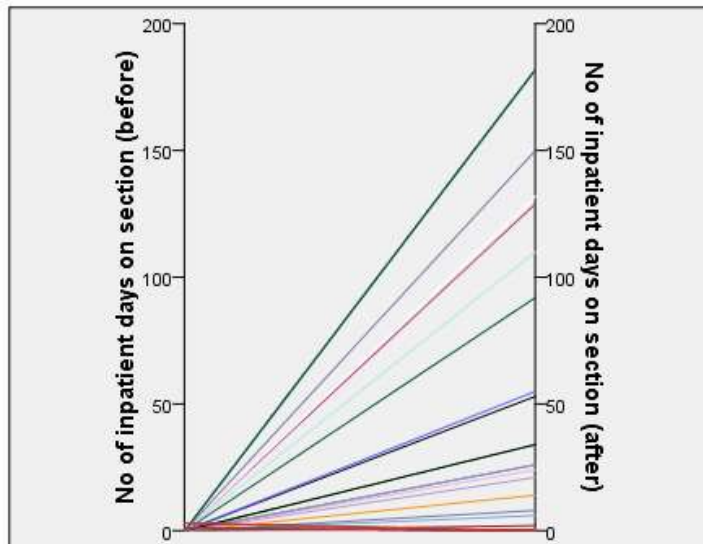
**Figure 7.12** Change in number of inpatient days





The proportion of the sample who spent time as an inpatient on a section of the Mental Health Act also significantly increased after the first contact with SWR street triage from 2% (n=6) to 7% (n=22). The length of time spent as an inpatient on section also significantly increased after the first contact with SWR street triage (figure 7.13).

**Figure 7.13** Change in number of inpatient days spent on section



#### **Contact with liaison team**

The number of people in contact with the liaison team was very low (n=4 decreasing to n=2 after contact with STR street triage), so changes over time were not statistically significant.

#### **Contact with street triage teams**

The number of people who had previously had a contact with another TEWV street triage team (n=2) and those who had a further episode with the STR street triage team (n=9) were low, so changes over time were not statistically significant.

## 8 Cross cutting themes

This short chapter draws out a number of themes that emerged through the qualitative research strand, which point to broader issues around mental health and policing. The Street Triage pilot shed light on the themes of:

- The changing role of policing
- Risk assessment and risk management
- The need for multiagency approaches to supporting this client group
- Capacity and mental illness

This chapter also reflects on the findings of the quantitative analysis and its implications for the NHS.

### 8.1 The changing role of policing

Street Triage was welcomed for the benefit it brought of taking mental health jobs away from the police and allowing them to get back to what were seen as their proper duties:

*It's not really a police role, you know, we aren't mental health professionals, we shouldn't be there to babysit people because A&E can't cope or they don't have the staff to sit with people. And we have spent hours and hours and hours tied up with people [when] it's not really our job, which means we can't then do our job ... [Triage] is freeing up our time to let us get on with policing (police officer)*

However, there was also recognition that the role of policing was changing, with the traditional crime fighting focus being modified to incorporate a much greater remit around protecting vulnerable people and community welfare:

*The face of policing has changed and very much there's less emphasis on chasing burglars and car thieves and punch ups in the town centres on a night time, to providing mental health and support and multiagency meetings, vulnerable people, Child Sexual Exploitation ... Now that's very alien to traditional policing, and that change has happened very quickly over a matter of a year – two years, 18 months (police officer)*

While Street Triage was a valuable part of supporting this new remit, it was acknowledged that a cultural shift was also required within both operational policing and at the strategic level. Although supporting vulnerable members of the community had always been a fundamental part of the role of Safer Neighbourhoods teams, there was a view that this shift was more challenging for response officers, who were more accustomed to the traditional policing functions. There was a perception that among some response officers, there was still a desire to close down incidents quickly either as a s.136 detention or an arrest, without taking the time to engage with the individual or draw upon outside expertise such as Triage services.

The police service was seen to be in a period of transition in which mental health was now part of the role of operational policing but was an area in which front line officers did not yet feel confident. In the words of one participant, '*mainstreaming mental health*' within policing work was now essential, with explicit recognition and support from the highest organisational level, so that officers could feel confident in embracing this aspect of the contemporary role. Reflecting on this issue, another officer noted: '*It is a cultural shift. This isn't about writing a strategy, this is about changing the culture of an organisation*'.

Officer training programmes were not felt to have kept pace with these changes in the front line policing environment; there was a need for more effective education in how to approach encounters with individuals in mental health crisis. Street Triage were seen to have already had an impact in beginning to broaden police understandings of mental health, but it was felt they could contribute much more. Potential inputs to officer training are discussed in Chapter 9.

## **8.2 Risk assessment and risk management**

Partnership working between police officers and mental health nurses during the Street Triage pilot had brought to light differences in the approach that each service took to risk assessment and risk management. As has been discussed in earlier chapters, when faced with an individual in mental health crisis, police officers invariably worked on the basis of the 'worst case scenario' if an individual was expressing thoughts or intentions about self-harm. Without specialist training, officers felt they could not risk ignoring such expressions and so needed to treat them as potentially genuine in all cases:

*I think the key ethos of policing nowadays is the management of risk, and it's not necessarily in a particularly intelligent way that we manage that. Because when we look at risk ... we always look at what the worst possible thing that could happen is, and very rarely have the opportunity to take into account how likely that would be. Because every time you look on the news, it's 'The Police Fail Somebody Else' so we've got that kind of Daily Mirror approach to risk: what happens if we don't do something and something bad happens, then I'm gonna lose my job, I'm gonna lose my pension, possibly go to jail. So we respond at a very high level for pretty much everything (police officer)*

In contrast, Triage nurses were able to draw on their professional understandings of mental health presentations in making assessments of the likelihood that an individual would cause themselves harm. This had led to occasions where police officers had been surprised and sometimes rather concerned that a decision had been made to leave an individual in their home and not detain them to a place of safety:

*By the nature of the job that we do, we're quite big on positive risk taking, whereas the police are quite risk averse, so it's sometimes justifying why you've decided to leave that person in their home when they've just self-harmed, and saying "Well they are likely to self-harm again, however this is a chronic presentation and it's quite low risk really, the self-harm*

*that they do". And it's just [the police officers] getting their head round "Why would you leave somebody to self-harm again if you know that's going to happen?", or if people take overdoses regularly ... I think that they may have been surprised that we leave as many people at home (Triage team)*

*I think the word 'suicide' is a really frightening word that people panic when they hear. I can't think of many days, certainly not any weeks in my career when I've not heard it. And we have a very different view and we do look at therapeutic risk taking, and just because people have thoughts of suicide doesn't make them a suicide risk (Triage team)*

*There have been times where I've sort of thought Christ, you know, this job, you know, when it came in an hour or two ago, the report was that this person was likely to kill themselves and do this and that. And then all of a sudden Street Triage are like "They're fine, we left them at home", and you think "???" but obviously they're the experts and they go off what they see (police officer)*

Triage nurses spoke of 'therapeutic' or 'positive' risk taking, an approach whereby individuals who have mental health problems are enabled - within reason and based on a professional assessment - to take responsibility for their own risk-taking behaviours. This meant that mental health professionals may not always intervene and prevent the individual from carrying out certain potentially harmful behaviours. As one Triage team member explained:

*From a mental health point of view, you kind of reinforce behaviours if you're responding in that way all the time. And so from the patient's mental health wellbeing, the best thing to do is not respond. As long as the risk hasn't changed and the presentation's the same (Triage team)*

Whilst police officers participating in the research had observed the different approach to risk taken by the Triage nurses, this had not led to a change in their own practices in the absence of Street Triage. Street Triage had brought in a more expert level of risk assessment, but as yet this was not something that police felt equipped to implement themselves. Officers felt that without the input of a mental health professional, they would still need to err on the side of caution in crisis situations, detaining or at least remaining with the individual, given the weight of negative consequences which may occur should their assessment be incorrect. Far more education and deeper cultural change around approaches to risk were needed before officers would feel confident to make these types of decision without professional mental health input.

### **8.3 The need for multiagency approaches to supporting this client group**

It was noted by several research participants that individuals assisted by Street Triage were often known to multiple services in the locality, for example, health, social care, housing, probation and substance use services. This reflects the fact that mental health problems

rarely occur in isolation and are frequently caused by or associated with other vulnerabilities or challenging social circumstances.

What was clear from the experiences of the Triage team, police officers and other agencies participating in the research was that this was a 'multiagency' client group requiring coordinated partnership responses. Police officers recognised that their organisation had needed to change and become more receptive to partnership working, and that this cultural shift was now under way:

*We are becoming better at listening. We now know we can't do it alone like we used to. And we did, we were a cellular organisation (police officer)*

*I think we're gradually getting to the stage where we realise we can't solve everything ourselves and we have to have help (Inspector)*

Where Street Triage had been able to engage in multiagency meetings during the course of the pilot, this had been highly valued as the team not only brought direct mental health expertise but also served as a bridge or conduit to both police and wider health services. As will be discussed in Chapter 9, there was a desire among police and other agencies for the Triage team to become much more involved and embedded in multiagency activity in the locality.

Recognition of the multiagency nature of the client group also raises broader questions about the remit of Street Triage, about who these clients 'belong to' and therefore about whom the service should be available to and who it should be funded by. These are ongoing questions that need to be addressed in a real and non-theoretical way by those involved in providing and funding the service. The wide range of situations addressed by Street Triage during the pilot year demonstrates that it is not a clear cut case of the service being primarily a gateway to secondary mental health provision. Although this was a pathway appropriate to a proportion of clients, other users of the service had variously required primary mental health referrals, referral to social services, signposting to non-statutory support of various types or diversion into a criminal or civil justice pathway. As such, a wide range of agencies stood to benefit from or be affected by Triage's activity. The extent to which the service retains its unique partnership role with the police or alternatively broadens its remit, referral routes and (in turn) potential funding sources is something that warrants further strategic discussion.

## **8.4 Capacity and mental illness**

The final cross-cutting theme to emerge from this research was the matter of capacity and mental illness. As has been noted in previous chapters, for the police and for other agencies whose clients were assisted by Street Triage, an important and valuable function of the service was to identify those cases where an individual *did* have capacity to understand their actions and therefore could reasonably be expected to face appropriate consequences. This

was important for the police in enabling them to address criminal behaviours, for the community safety team in dealing with antisocial behaviour and also for the Triage nurses in supporting individuals to take responsibility for their actions as part of a therapeutic pathway. Interestingly, whilst it may have been expected that police were more in favour of a prosecution route with Triage nurses advocating for leniency on mental health grounds, views expressed during the research suggested the opposite, with mental health nurses placing more emphasis on the importance of recognising capacity and responding appropriately:

*I think that the thing with the police is that they see somebody who's got a mental health problem and they then don't want to arrest them because they just automatically assume that that's the cause of the behaviour. Whereas actually it's less about the fact that they've got a mental health issue and more about whether they've got the capacity to understand what they're doing, which on most occasions they actually have got the capacity and they sometimes do need to be dealt with by the police and not by mental health services (Triage team)*

*Just because people have mental illness does not mean they're not capable of committing a crime. And it's a bit of an insult to suggest that they're not [capable]. It is really quite discriminatory to suggest they're not. The key thing for me is does the person have capacity, not do they have a mental illness. Because sometimes the mental disorder, the mental illness might be what's influenced them to commit a crime, but there's many time when it's nothing to do with the act of crime. And they have capacity, and they should be dealt with in the way that everybody else should be dealt with, and mental health shouldn't be a defence in those cases (Triage team)*

In essence, this comes back to the key point (discussed in Chapter 4) that the Triage service was providing a genuine triaging function, leading to a range of outcomes which may variously involve a combination of mental health, social support and/or criminal or civil justice pathways.

## **8.5 The role of street triage within NHS mental health services**

The quantitative analysis of TEWV service use before and after an individual's first contact with the SWR street triage team provides valuable data about the wider role of street triage within NHS mental health services.

Firstly, our analysis supports the qualitative data that many of the people seen by street triage are already known to mental health services, though are not necessarily engaging or open to a team. Also, there are many who do not meet the criteria for secondary mental health services. It appears that SWR street triage effectively diverts people from community mental health services (crisis teams, CMHTs and primary care mental health teams) who do not require it. Street triage practitioners refer people to other appropriate services and appear to act as effective gatekeepers to community services.

Secondly, a small number of people seen by street triage subsequently require inpatient treatment for a mental health crisis. For these people, street triage is on their pathway to increased use of mental health services, which appears appropriate for their particular needs at that time. In this regard, the triage service appears to be effectively assisting people to obtain the treatment they require and diverting elsewhere those who do not.

## 9 Future Directions

This chapter looks at research participants' suggestions for ways in which the service could be developed and improved. Sections discuss:

- Expanding referral routes
- Changes to the operating base
- Including paramedics in the team
- Increased multiagency involvement
- Involvement in court diversion and probation services
- Training for police officers
- Increasing service user and carer consultation
- A countywide service

It should be noted that many of the developments suggested below relied fundamentally on an increase in staffing numbers for Street Triage. The Triage team recognised that there was much more that they could – and would be keen to – contribute, particular in terms of multiagency activities, early intervention and training for police officers. However, they were currently unable to devote more time to this due to challenges of capacity to deliver even their basic remit, given reduced staffing.

The chapter concludes with some thoughts about future evaluations of street triage which may address some of the limitations of this study.

### 9.1 Expanding referral routes

Some participants suggested that it would be useful if other services in addition to the police could make referrals into Street Triage, in particular the other emergency services of Fire and Ambulance. An example given was that the Fire service often encountered 'hoarders' whose behaviours posed a fire safety risk but also indicated mental health problems. Social Services had also expressed interest in being able to make referrals to Street Triage.

Echoing the benefits to the police, expanding referral routes would allow rapid access to professional assessment for clients of these other services, potentially diverting inappropriate referrals away from the Crisis team, community mental health teams and primary mental health care. Triage's referral and signposting role would mean that individuals were more likely to get appropriate support whilst reducing pressures on other services:

*People do need an assessment, but actually what they need is an assessment by the right person, and not be put into a waiting list or a waiting pool, to be seen by a service that's gonna see them for an hour and say "You're not for us" (Triage team)*



However, the point was raised that in considering the widening of referral routes, the distinct role and identity of Street Triage as a primarily a police partnership, would need to be retained. Street Triage did not want to risk becoming a duplication of social services or indeed the Crisis team.

## 9.2 Changes to the operating base

For the duration of the pilot, the SWR Triage team had operated out of an office at Cross Lane Hospital. However, a number of possible alternative operating bases were discussed by research participants, including police stations, the Force Control Room, and the multiagency 'hub' located at Scarborough Town Hall.

Some participants saw advantages of Triage being based alongside officers in police stations. This would allow for a higher level of information sharing, more opportunities for informal cross-agency learning and would generally strengthen the working relationship between the two organisations:

*I think it would be really good for educating the police about mental health, just to have that close relationship, because we don't have much time, really, to speak to the police during the assessments ... So I just think being in a closer proximity with the police would just improve relationships and help their understanding about mental health, and remind them that we're here as well ... If we were there then they would be more likely to approach us about things and just get our opinion about people that they see quite often, and also to discuss people's risks and people's history (Triage team)*

Being based in a police station could also allow the Triage team to access Niche directly, both for information gathering but also to input their own job updates into the system, improving the level of detail and accuracy. However, the benefits of being co-located with the Crisis team (as at present) were also noted, and moving to a police-based location could mean the loss of some important connections:

*I'd be concerned that we'd lose our links particularly with Crisis team, cos we do an awful lot of information sharing between us and the Crisis team. They'll tell us the people they're concerned about or people that they've had to advise to phone the police because it's emergency urgent risk. And equally we're sharing information that "This person's pitched up, you might see them in A&E later". So I think if we were based with the police, we'd lose those connections and I think they are quite important connections (Triage team)*

The critical importance of facilitating access to the patient records system from any police-based location was also re-emphasised.

One suggestion was for the Triage team to have multiple operating bases, both in NHS and police premises, but it was recognised that this could be logistically difficult in practice. Additionally, there were some doubts that level of demand would be high enough in certain areas of the locality to warrant mental health nurses based in those local police stations:

*You've got to weigh up the costs, haven't you. You can't have another team [in Whitby] because there's just not that volume of incidents for them to deal with every day (police officer)*

The possibility of Triage being based in the Force Control Room was also discussed. This was seen to have advantages in providing on the spot access to mental health expertise and advice for control room staff and would again facilitate direct access to Niche. However, it again brought questions about logistics and effective use of resources. A short pilot had recently run in the City of York, where a Band 6 mental health nurse operated out of the Force Control Room for one 12½ hour period and was dispatched with an officer whenever a mental health incident was called in. This had worked well in the York locality. Speedier attendance at the scene was enabled through the use of a 'bluelight' police vehicle to transport the mental health nurse. The nurse was fully occupied throughout the shift and there were more incidents that could have benefited from their input had capacity allowed. However, it was recognised that the larger, more dispersed geography of the SWR locality and lower levels of demand could make this a less practical operating model for the SWR Triage service.

A slightly different but closely related possibility, currently being investigated by the North Yorkshire Police, was to have a mental health nurse permanently located in the Force Control Room. The role of this nurse would be to access patient histories, provide information and guidance to Dispatch staff based on this information and on the details of the incident in progress, and to advise on whether the deployment of Street Triage, police officers, or both in tandem was the most appropriate response. In effect, this would bring the triaging stage one step forward, and could potentially contribute to even greater resource savings for the police where it was not deemed necessary to deploy an officer to the scene.

There was strong support from some participants for the Triage team to join a number of other services based at a multiagency 'hub' that had been established at the Borough Council offices at Scarborough Town Hall. Services based in this office either on a permanent or flexible basis included ambulance, fire, housing associations, environmental and community departments of the local and county councils, schools, health, social care, drug and alcohol and domestic abuse services. A team of Safer Neighbourhoods officers and PCSOs had also recently relocated to have this hub as their main base.

Collectively, this group was known as the Community Impact Team and its role focused on safety and problem solving in the community as well as focused multiagency work around a number of particularly challenging or 'chaotic' individuals. There was seen to be much overlap in client group between the Community Impact Team and Street Triage, and as such, it was felt that Triage would be a very valuable addition to this collaboration. Triage had provided input on individual cases, but there was a feeling that having them as a core part of the team would bring great benefits:

*We're actually missing a vital resource down here in this multiagency room ... We have all the agencies sitting down here, and [Triage] do come down here to meetings, but it would be so beneficial to have them down here as part of the team ... They're so knowledgeable about things (police officer)*

*What we don't have on a day-to-day, and what we'd benefit from in the Community Impact Team, is someone sat alongside us ... It would be absolutely brilliant if [Street Triage] instead of being based somewhere else, was based within the team, because the individuals they're dealing with are a lot of the ones that we're dealing with. So it just makes sense to link it across really (multiagency respondent)*

Although representatives of mental health services attended the monthly Multi Agency Problem Solving meetings, the Community Impact Team had not yet succeeded in establishing a permanent mental health service presence in the office. Street Triage were seen as the team that could have particularly positive impact as they would not only bring mental health expertise, but also provide that information sharing bridge between the police and mental health services. As has been described in earlier chapters, for the Community Impact Team, benefits of closer links with a triaging service would be twofold, on the one hand engaging unwell individuals with appropriate mental health services, but also endorsing a civil justice pathway where it was established that an individual had capacity and understanding of their actions.

On a practical level, the multiagency office was already equipped with police radio functionality, Niche access had been established for the Safer Neighbourhoods team now based at this multiagency office and it was felt that access to the patient records system would not be difficult to facilitate given that other offices within the Town Hall were already networked into this system.

### **9.3 Including paramedics in the team**

Some Street Triage services across the country include a paramedic as an integral part of the response team. The inclusion of a paramedic in the SWR Triage team had been trialled for short period during the autumn of 2014, running over five weekend shifts. Summary outcome data provided by the ambulance service showed that:

- The paramedic attended to ten patients with the Street Triage team
- Reasons for the call included overdoses, suspected dementia, intoxication, and other mental health issues
- No treatment was instigated on scene
- One person was referred to A&E
- No persons were referred to 136 Suite
- Three persons were referred to Crisis team
- One person was referred back to their carer
- One person was taken home by police

- One person was admitted to hospital

Advantages noted of having a paramedic alongside the Triage team were that cases of overdose could be established without (necessarily) requiring a trip to A&E and that if an individual needed to be taken to the Health Based Place of Safety under a s.136 detention, the paramedic could carry out the medical assessment at the scene, again avoiding a trip to A&E and enabling quicker transfer to the Place of Safety. However, although the paramedic had provided useful input in a small number of cases during the brief trial, there was a view among officers, the Triage team and the ambulance service that demand for medical skills would not be sufficient to justify the full time attachment of a paramedic to the team. For much of the trial period, the paramedic had been unoccupied: *'just sat there and listening to the assessments ... they didn't really have much of a role'*.

Alternative suggestions to bring this level of medical skill into closer working with the Triage service included having a direct line to community first responders or to include a registered (medical) nurse within the team.

#### **9.4 Increased multiagency involvement**

Street Triage was seen to have brought substantial improvements in multiagency working both between mental health services and the police but also with other agencies in the community whose remit and client group overlapped. It was also noted that both police and other agencies often struggled to get mental health service presence at their multiagency meetings and where Street Triage had been able to attend on occasions, this had been seen as greatly beneficial. Several suggestions were made as to how this positive start could be built upon with increased involvement of the Triage team in various multiagency activities.

Opportunities to bring Street Triage more closely into the regular activities of police and other services included:

- Resuming attending police daily briefings and duty tasking meetings
- Attending the multiagency meetings which took place weekly in each of the Safer Neighbourhoods areas
- Participating in multiagency 'walkabouts' which were conducted in targeted areas of the community
- Attending Multi Agency Problem Solving (MAPS) meetings which took place monthly
- Casual visits to one another's operating base, for informal conversations and observations of routine working practices

Involvement in this range of activities was seen to bring benefits to all parties, through mutual information sharing about particular individuals who were known to multiple services:

*If we had people like that in these meetings, I'm sure that they'll have something that they can share and tell us, and it would guide us (police officer)*

*If we had a get together every so often ... like we have a housing association meeting regarding problem tenants and things like that, just so we have a meeting every so often so they could say "Look, these are the people that we've been called out to this month, this is what we're doing with them, just in case you get called to them" (PCSO)*

*We have a MAPS meeting every month and we discuss people who are targeted, vulnerable, at risk ... It would be really useful for them to come along to that, cos most of the people on our agenda have got mental health issues ... I bet they've got a wealth of information they could come along with. And it'll help them, because then when they then go and deal with these people- cos I bet you, if you looked at the agenda for MAPS, I bet they've dealt with nearly every person on there (police officer)*

Becoming more involved in multiagency activity would also contribute to developing Triage's early intervention work, taking their role beyond that of 'responder' to also becoming involved in more casework, supervision and guidance, and triaging of issues at the non-crisis point.

One note of caution was raised however, in that officers did not want to lose the valuable service that Street Triage brought to the Response side of policing. There was a need to maintain a balance between being available to officers attending live incidents and becoming more deeply involved in longer-term community issues.

## **9.5 Involvement in court diversion and probation services**

Street Triage was seen to be well placed to take on a role in court diversion, advising on alternatives to punitive measures where mental health problems were a significant factor in an individual's offending behaviour. This was a service that did not currently exist in the SWR region and there was believed to be support from the magistrates' court to develop such provision. There was also felt to be scope for the Triage team to contribute to probation work, where individuals released from prison came to the area and required assistance to bring together an appropriate package of social support. Once again, Triage's input to such situations could helpfully contribute to a reduction in demand on secondary mental health services:

*We get quite a lot of people released from prison in York, and they've often got housing issues, so they're put in emergency bed and breakfast in Scarborough. And they might have numerous mental health needs as well as substance misuse needs. They get referred into Crisis team routinely, whereas that would probably better fit with Street Triage ... Triage have a level of intelligence, because they've police radios, that Crisis team doesn't have. So they have open airwaves, they have access to the information, and from a risk management point of view, these people don't just fall under the health service's responsibility. It's the*

*police, probation, social care, housing. And Street Triage fits more nicely into that model (Triage team)*

## 9.6 Training for police officers

Training in mental health for operational police officers was agreed to be minimal and largely ineffective in delivering useful knowledge and understanding of how to work with individuals experiencing mental illness. Officers commented that a lot of their awareness had been picked up through experiences on the job through trial and error in approaching situations and there were indications that officers could lack confidence in their ability to respond appropriately. Whilst officers noted the informal learning that had taken place through observing the Triage team in their work (see Chapter 5), there was much support for Street Triage to have an enhanced role in developing and delivering more formal officer training on mental health:

*I see the Street Triage service as absolutely essential in not just providing a service, but also helping our organisation as a police service actually learn about how to approach mental health, people on the ground who are in crisis in some way, and beginning to understand this whole issue of mental health without having had the formal training behind it (police officer)*

*Going forward it would be nice if we could get training from the experts. I think that would be fantastic, because we go into these situations and we hope for the best really, that we're not making things worse, or we're not saying the wrong things for these people. But quite often we probably are saying the wrong things (police officer)*

*That would be really helpful for us, because we have never had any training. We've learned the hard way - through it going wrong; through people kicking off; through "Actually that worked really well..." (police officer)*

Street Triage had already made some contributions to more formal officer training. A training day on mental health had recently been delivered for Force Control personnel, which had included a presentation by the Triage team. Comments from research participants who had taken part in this event indicated that it had been very well received. Suggested ways that Street Triage – and the mental health Trust more broadly – might contribute further to officer training in mental health included:

- Student officers spending their one-week placements with the mental health Trust, potentially to include time spent with: Street Triage, Crisis team, CMHT, inpatient wards and primary care mental health
- Student PCSOs spending their four-day placements with the mental health Trust, to include time spent with services as noted above
- The Trust to produce an accessible guide to the different strands of mental health services, explaining the role and remit of each service, their times of operation and how to contact them

- Officers visiting the Triage team at their Cross Lane base on a casual basis, to have informal chats with the Triage team and observe them in their work
- Co-location of services to enable informal learning and knowledge sharing
- Training selected officers and PCSOs to become specialists in mental health

With regard to the final point, however, it was noted that training officers to become mental health specialists would be a lengthy process (possibly taking years) and there were some reservations about establishing specialist roles as this would place the responsibility on a limited number of individuals, who may not always be available. Importantly, it was recognised that awareness and understanding of mental health was something that all officers needed to be engaged with and it would be better to develop a broad and universal understanding amongst all personnel rather than to focus on developing in depth knowledge among a limited set of individuals.

Regarding the format of training, officers stressed that the programme needed to be personally delivered, rather than through a computer-based package as was currently the case. It was also important that it was delivered by a trained mental health professional and not somebody who was a professional ‘trainer’ but with no specific experience as a mental health practitioner.

It was recognised by officers and Triage nurses that mental health is a broad and complex area, and that training would necessarily have to take a selective focus on key issues of most importance to the police. When asked what areas might usefully be covered, suggestions included:

- Basic information about the presentation of different mental health conditions
- What to say to people in crisis and how to say it
- Recognising vulnerability and knowing who to call
- Understanding appropriate use of s.136 and its implications

The point was made that, for police officers, the important skill was in recognising the signs and knowing where to go, rather than becoming expert in delivering mental health intervention oneself:

*‘I don’t want folks to feel confident in being able to diagnose the difference between psychosis and depression. What we need to do is to be able to recognise that there’s a vulnerability there and know who to call’ (police officer).*

## **9.7 Increasing service user and carer consultation**

It was noted that increased communication with service users would be important as part of shaping the future direction of the service. A service user and carer consultation group was

brought together to provide feedback on experiences of Street Triage and met on one occasion during the pilot year, for a four hour event. With the confirmation of continued funding for the service (received in early summer 2015), plans were put in place for the consultation group to become more established and to meet bi-monthly from July 2015, facilitated by the Triage team's Community Support Worker.

## **9.8 A countywide service**

The vision of senior personnel within the police force and the NHS Mental Health Trust was for a countywide Street Triage service covering the entire Force area. Whilst the DH-funded SWR pilot was running, a separately funded pilot had also been launched in the City of York area, but there were still parts of the Force which did not benefit from Street Triage.

Regarding the form that such a countywide service might take, it was noted that there should be streamlined access with single point of initial contact for all areas of the force, but that there would need to be flexibility in the operating model to account for variation in the geography of different areas of the region and also different population densities and characteristics.

## **9.9 Future research**

This evaluation had some important limitations which need to be addressed in future research.

Firstly, it was not possible to speak with users of street triage, or their carers, due to the limited time and resources available for this evaluation. While feedback was obtained indirectly through the user group and via street triage practitioners and police officers, further evaluations must include the voices of street triage users to ensure their experiences are related accurately. Their interpretation of both the qualitative and quantitative data discussed here would also add depth and a valuable perspective on our findings. Additionally, service users' perceptions of their outcomes following contact with the SWR street triage team are missing from this evaluation and need to be captured in future research.

Secondly, we had planned to obtain data on SWR street triage users from police Niche records, but there was insufficient time or resources available for the manual data extraction which was required. This would have helped us to understand changing patterns of contact with the police after first contact with the SWR street triage service in addition to its impact on TEWV service usage. Additionally, to obtain a full understanding of the impact of street triage on public services, data is required from the A&E department at Scarborough General Hospital, the ambulance service and North Yorkshire County Council social services department about these individuals. Data protection may make this process complicated, but linkage across records should be possible even if undertaken manually.



Thirdly, the way in which the data was recorded by the SWR street triage team changed during the course of the pilot, which made it more difficult to analyse. There were high levels of missing data, particularly in the outcome fields. This is a common problem with using routinely recorded data for evaluation purposes. Future research will benefit from prospective data collection by SWR street triage team practitioners which is appropriate for both clinical and research purposes. It is essential to ensure that practitioners are not overburdened by data collection and any proformas which are to be completed must be minimal and serve the dual purposes of clinical practice and evaluation. Ideally this will include measurement of outcomes important for service users and services alike such as mental wellbeing, goal attainment or recovery, for example.

Fourthly, to move beyond descriptive analysis, it will be important to obtain data on a comparison cohort of people with mental health problems who come into contact with the police but not street triage. It was too difficult to obtain data on such a cohort in this small-scale evaluation, but this should be the focus of future research to help us understand if the impacts are due to the contact with the police or the street triage team.

Fifthly, although we have measured TEWV service use, a full economic evaluation of street triage is required which includes the costs of informal care and use of a full range of services such as primary care and social care. Ideally this will be in the context of an experimental or quasi-experimental study, though this is understandably difficult to design and implement in the context of a triage service.

Finally, we have reflected on different models of street triage and considered if they might work for the SWR region. Future research needs to explore the comparative merits of these different models of street triage to weigh up their respective advantages and disadvantages (including outcomes and costs) to inform future policy and practice in North Yorkshire and beyond.

## 10 Conclusion

This evaluation found near-universal praise for the SWR street triage service. We found it very difficult to elicit negative feedback about it, though the perspectives of service users, carers and family members are missing.

Street triage was described as *'the filling in the sandwich'*, providing a bridge between police and mental health services. It was seen to enhance mental health provision in the SWR region by providing a service for people of all ages with no exclusion criteria. It appears to fill a gap in the mental health pathway in terms of sub-threshold presentations of mental distress and related social and emotional need. Further, it was apparent that although street triage was a brief intervention, it did not leave service users without advice or somewhere to go with their concerns, whether that be a new referral into mental health services, liaison with existing linked practitioners, signposting to broader social supports in the statutory or third sector, or some follow-up support from the team itself, for example.

Street triage was described as a service that *'prevents and avoids unnecessary escalation to admissions'*. Its most significant impact appears to be a reduction in the use of community mental health services, though it is on the pathway to inpatient admission for a small number of people who require this. Its introduction was not associated with a reduction in s.136 detentions, but these appear to be already used sparingly in the SWR region where there is arguably no surfeit to reduce.

There are some limitations in this evaluation including the lack of a control group and the perspectives of service users. These will need to be included in future research. However, there are very clear indications from the data collected and analysed for this evaluation that the SWR street triage team are providing an important service which brings benefits to both the police and the NHS.

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