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Title: **Mental Health Street Triage**

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Word Count: **4,533 (inc. title, abstract and key words; exc. tables and references)**

Title: **Mental Health Street Triage**

Abstract:

This paper explores the implementation of Cleveland Police's pilot Street Triage service. The service aimed to reduce the number of section 136 detentions under the Mental Health Act and improve referral pathways for those presenting with mental health issues. The initiative was funded by Tees, Esk and Wear Valleys NHS Foundation Trust. Dedicated Street Triage mental health nurses accompanied police officers to incidents where it was suspected that mental health issues were a presenting concern. Semi-structured interviews were conducted with sixteen strategic and operational stakeholders to review whether the project was successful. Analysis was supplemented with secondary data from the Street Triage Team. We conclude that there were significantly fewer section 136 detentions, and identify continuing challenges.

Introduction

Responding to people presenting with mental health issues is a difficult area of police work not simply confined to matters of enforcement (Riley et al, 2011a; Morgan et al, 1991). Reports from across the globe suggest that the level of contact between the police and the mentally ill continues to increase (College of Policing 2015; Clifford, 2010; Coleman and Cotton, 2010; Moore, 2010). Various service delivery models have been introduced to support the police in dealing with people with mental health issues (Chappell, 2010).

In this paper we explore one model trialled in England since 2012. 'Street Triage' (ST) was initially introduced in two police force areas to "improve the experience, outcomes and access into health services for individuals at the point of crisis" (Fleming and Smith, 2014, p.5). We investigated the

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operation and impacts of a ST service developed in the North East of England to determine its level of 'success'.

The Problem

Estimates of police incidents linked to mental health in England and Wales vary widely between 2-40% (College of Policing, 2015; House of Commons Home Affairs Committee, 2015). However using an average of 20% provides a national estimate of almost 4m mental health related incidents per year.

Attempts to explain the reasons behind the increasing contact between the police and people with mental health problems include the deterioration of mental health services so that the police have become the de facto first aid response to mental distress (House of Commons Home Affairs Committee, 2015; Reuland et al, 2009; Cherret, 1995).

There are various powers available to the police in England and Wales if they encounter someone who they believe is a risk either to themselves or others because of their mental health, including Sections 135 and 136 of the Mental Health Act 1983 (amended 2007). Using these sections, police officers are able to detain people against their will and take them to a place of safety in order that they can undergo a mental health assessment by a qualified practitioner (Greenberg et al, 2002). According to a report by the Health and Social Care Information Centre (2014) the number of those detained under s.136 has increased by 5% (1,166) to 23,343 since 2012/13.

Concerns about the use of s.136, include police reports of feeling unqualified or lacking in confidence (House of Commons Home Affairs Committee, 2015; Adebowale, 2013; Bather et al., 2008; Royal College of Psychiatrists, 2008), potentially leading to growing numbers of short-duration s.136 detentions i.e. where people are detained by the police but immediately released following mental health assessment as no mental health problem is identified; or because there are more appropriate referral pathways for those who do have mental health problems.

The levels of cost involved in the use of s.136 in both negative personal experiences (Gregory and Thompson, 2013; Riley et al, 2011b) and resource terms are high. North Yorkshire Police estimate the average length of time in custody for a person detained under S.136 is 10 hours. Therefore, for the 6,028 people in 2013/14 held in a police cell, this equates to 60,000 hours of officer/staff time per year. When a health based place of safety was used, waits of 6 to 8 hours for police officers were not uncommon. For the 17,000 people in 2013/14 held in hospital, this equates to an additional 62,000 hours a year (College of Policing, 2015).

Recommendations to support police officers when dealing with someone with mental health problems generally centre on the need for improved partnerships between the police and health services. However a study carried out in Scotland to investigate police officers' views on their roles in dealing with people with mental health problems (Mclean and Marshall, 2010) reported a number of recurrent themes including failures of collaborative working with health services. Pre-arrest 'diversion' was recognised as an option by police officers – there may be no indication for arrest, and they did not want to arrest individuals unnecessarily – but gaps in health services could result in inappropriate detention in police cells, reminiscent of the so-called 'mercy booking' reported in the USA (Watson et al., 2008). Many services are already in place across the UK providing health expertise into the criminal justice system, but these have been piecemeal and tend to focus on events after the individual has been detained (Dyer, 2013).

One solution to the lack of early intervention has involved the development of ST teams, initially piloted in 2012 in Cleveland and Leicester. Funded by the Department of Health and supported by the Home Office, they were subsequently rolled-out to a further nine areas in 2013. The broad aim of ST is to prevent s.136 detentions where possible and therefore the consequent negative impacts on individuals and resource costs. The service delivery model has varied across the pilot areas, and we focus specifically on the approach adopted by the Cleveland ST in the North East of England.

Current Study

This study was commissioned by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) to describe the initial problem which prompted the development of the Cleveland ST team, a process evaluation of current service delivery, and a critical analysis of the extent to which the service aims were being achieved. The Cleveland ST team had been developed and introduced in 2012 because the number of s.136 detentions was considered disproportionately high (Docking, Grace and Bucke, 2008). Figures from Cleveland Police for the period 2010-2011 indicated that 511 people were detained on a s.136 and around three quarters (388) were released as no mental health issue was identified (King, 2014; Short and Whitelock, 2013; Cleveland Police et al, 2012). The cost of detention was estimated at £1,780 per person (based on a methodology developed by the Sainsbury Centre for Mental Health, 2009). Cleveland Police's analysis suggested that if the three quarters of people (76% or 388) had not been detained, there would have been a cost saving of £690,000 to Cleveland Police from their budgets over the year (Cleveland Police et al, 2012). It was also acknowledged that there would be less distress for the individuals concerned and more appropriate support provided.

The Cleveland Street Triage Service

The aim of the ST team is to reduce detentions under the Mental Health Act where appropriate and instead provide more appropriate referral pathways for people of all ages presenting with potential mental health and social care issues (King, 2014). The mental health ST nurses are based at Police Headquarters between 12 noon and midnight where they monitor calls for indications of mental health problems or can be directly requested to attend an incident by police colleagues. The nursing assessment informs further care planning including decisions to 'section' or refer to other support services.

Study Design

Our methodology comprised an exploratory design that included interviews with sixteen key stakeholders, a retrospective analysis of case notes and interrogation of a dataset collected for administrative purposes by the ST staff from 2012-2014.

Results

An overview of referrals and activity

Analysis of the ST dataset, from August 2012–February 2014 inclusive, reported the ST service had received 572 referrals (4% of the total number of Cleveland Police incidents reported 12 midnight-12 noon as 'concern for safety' PS10, n=15937). This is consistent with research that suggests that 2-40% of police incidents are linked to mental health (College of Policing, 2015; House of Commons Home Affairs Committee, 2015). There was an average 30 referrals per month (minimum 15, maximum 63); the majority were adult, male, and over half (51%) were already known to the local Mental Health NHS Trust. 39% of those assessed had a primary or co-morbid substance misuse problem, 33% a mental health problem, 2% a learning disability, and 1% ADHD.

During the period when ST were on duty (August 2012-February 2014, 12 noon-12 midnight), a total of 13 s.136 detentions were made (i.e. 0.08% from a total n= 15937 incidents reported as 'concern for safety' PS10; although only 2 were detained as a direct result of ST advice, the remainder were against advice or people were already detained when nurses arrived at the incident), compared with 558 detentions when ST were not on duty (August 2012-February 2014, 12 midnight-12 noon; 7% from a total n=7995 incidents reported as 'concern for safety' PS10) (Table 1).

(Table 1 here)

The police made 545 more s.136 detentions than those involving the ST Team. The Cleveland ST Steering Group estimated the current ST pilot costs NHS commissioners £170,000/year. Based on the assumption that each s.136 costs £1,780, the cost of the police detentions was £993,240

compared with £23,140 for the ST (a difference of £970,100 for detentions alone – or £800,100 including the cost of the ST pilot) – although caution is advised as it is unclear whether the unsupported police group were dealing with a more unwell population, or what the situation would have been like if the ST team was on duty during the same period.

However the primary aim of the Cleveland ST service was to prevent short-duration detentions under the Mental Health Act where better alternatives were possible. One way to measure this is to consider the numbers of subsequent hospital admissions – what proportion of those detained by the police were subsequently assessed by health professionals to be sufficiently ill or in crisis to warrant detention in hospital for further assessment or treatment?

In order to compare the impact the ST service had on s.136 detentions we took referrals to the ST team as a tentative proxy for police s.136 detentions when ST are not on duty, i.e. if the team had not been on duty the referrals made to them would otherwise have resulted in a s.136 (although the caution advised above regarding the lack of information about the comparability of the two cohorts remains) (Table 2).

(Table 2 here)

Table 2 describes a total of 558 people were detained by the Police on a s.136 when ST were not on duty i.e. between 12 midnight-12 noon (column 1); the majority (82%) were NOT admitted to hospital following assessment by mental health professionals because they were not considered sufficiently ill or in crisis to warrant admission (column 4) and might therefore have benefited from alternative referrals pathways rather than s.136 detention. Of the 572 assessments carried out by ST (column 5) the team recommended 2 people should be detained on a s.136 (column 6) both of whom were subsequently admitted to hospital, meaning all s.136 detentions as a direct consequence of ST advice were appropriate pathways. However 11 people were detained by police against ST advice (column 7), and all 11 were NOT admitted to hospital. Overall therefore while they

were on duty ST failed to prevent 2% (or 11 of 572 ST assessments) of s.136 police detentions where an alternative referral pathway might have been more appropriate, substantially lower (2% vs 82%) compared with the period they were not on duty.

Rather than detention under the Mental Health Act the Cleveland ST service aimed to provide more appropriate referral pathways: 19% were already current to services at the time of referral, of the remainder services referred to included GPs (11%), Mental Health Crisis Teams (11%), Substance Misuse Services (11%), and Counselling/Talking Therapies (11%). 47% were followed up by the ST team and 61% of these reported engaging with services. The majority of those seen by the team were not re-referred within the 19 month data collection period (n= 432, 88%); 56 individuals were referred more than once (12%; including 9% twice, 2% three times, 1% four times, and 0.2%, 1 person, six times). Although more information is needed to support a detailed analysis, initial examination of the data available suggests that those re-referred were more likely to have substance misuse problems, social issues around relationship and housing problems, and multiple, short-term contacts with mental health services.

Strengths and Achievements

A number of advantages to the co-location of mental health nurses with police officers were described during interviews with key stakeholders including reduction in the number of s.136 detentions through the provision of timely on-scene advice and support for police officers leading to improved impacts and outcomes for service users.

There was recognition that the role of police officers is increasingly complex and that they are often dealing with people who are experiencing complicated health, welfare and social care issues, for which officers are not equipped:

> *"Somebody always has to take a lead…The NHS must take a lead and the police must support …I think police officers are being expected to do things that are beyond their...responsibilities…"* (Police and Crime Commissioner's Office)

The services offered by the ST team differed from those offered by existing services such as the Crisis Team (mental health emergency care). This was because nurses are based with police officers and are available to immediately respond (providing they are on duty) to police requests for assistance:

> *"…I think it's the immediacy that the police were seeking… we [Crisis Team] couldn't, you know, as soon as the police rang us, just go straight to number 7 [X] Street to see what was going on with that person …the police always wanted someone they could, just immediately call on to respond…we're not a blue light service, we've never been a blue light service."* (Crisis Team Staff)

The positive impact on service users including the avoidance of unnecessary distress, stigma and criminalisation was acknowledged by police officers:

> *"…when the street triage team go, they get a better service. Certainly get better handling … where ever the person is at a time of crisis, and threatening to harm themselves, saying, I want to hang myself…I just want to kill myself, leave me alone… then giving them a bit of a brief intervention, talking to them, and making arrangements for them, their care, moving forward, to speak to their family has to be a good thing. For a mental health professional to be able to do that is fantastic because that person then does not go into detention, they do not end up in police cell or a hospital where they don't want to be… whereas the police couldn't make those sorts of judgement calls, so the service user often ends up in custody at the police station."* (Police Officer)

Feedback from service users was obtained by the ST staff asking two short questions when they completed their follow up telephone interviews during March to May 2014. The comments that were received indicated a high level of satisfaction with the service and an appreciation of the support that they would not have received before the introduction of ST:

> *"Talking to the team helped put things in perspective and got me help very quickly."* (Service User)

Challenges and Limitations

A number of tensions were identified as a result of the ST project that for some, detracted from the perceived successes associated with it. These included concerns about the rise in the number of 'self-presenters', repeat referrals, and tensions in relationships between services. Some of these issues, it was suggested, arose in part because of funding limitations which meant the team

operated part-time impacting on the availability and timeliness of the response they could offer, as well as a lack of understanding and agreement about the focus of the ST Service which highlighted tensions between services and teams.

The first challenge related to concerns about the rise in 'self-presenters' and centred on the claim that the number of people taken to hospital by the police on a 'voluntary' basis (driven to the hospital by police officers and left at the front desk) was rising. Some police officers, it was suggested, were bypassing the ST service because the team were unavailable; some police officers argued it was easier and quicker to take the person to hospital themselves if the individual agreed to attend on a voluntary basis rather than wait for ST to attend the scene; or they disagreed with the advice given by the ST nurse:

> *"…it's been borne out that…they've* [police officers] *ignored advice, they've detained someone and brought them to a place of safety only for them to be released as not being mentally ill, and that was the advice in the first place…you're always going to get that, that's human nature, that some people will disagree and think they know better. And for others, you know for whatever reason, they'll think, I'm not bothering waiting for Street Triage I'm going to do this anyway."* (Street Triage Steering Group)

It was acknowledged that part of the problem related to the 'part-time' nature of this pilot service. The team are available 12 noon-12 midnight:

> *"…we've looked at a 24/7 service…it's what the police want. Unfortunately, nobody seems to have the money to pay for that"* (Street Triage Staff).

As with other criminal justice/ health initiatives cost saving tends to happen for one agency based on investment by another other – so the cost saved by the police from reductions in s.136 detentions is based on investments by health services:

> *"… the police are the ones who are seeing the most direct benefit…there's not a lot of crumbs on the table at the moment…big financial pressures across various part of the health service…If there was evidence to say, suggest that this is actually saving the NHS a lot of money in urgent care costs… then I can see the CCG being interested in it. But, in hard times, these decisions are harder to get pushed."* (Clinical Commissioning Group)

The Cleveland ST Steering Group estimated the current ST pilot costs NHS commissioners £170,000/year; a fully staffed 24/7 service was estimated to cost £520,000/year – however overall cost savings were estimated at 1.2m/year (although this was confirmed as a Police Service saving only; a properly funded national evaluation is needed to estimate savings to the NHS in acute care costs):

> *"... the last 12 month's monies, what they did was gave us the same funding as we had for the pilot - £170,000 for 12 months which isn't sufficient to run the service on, it's the bare bones. It doesn't take into account any management costs or you know, full staffing cost...5 days a month we can't cover and that's down to annual leave... sickness and all that because none of that was built into the process...when you set up a pilot you work on a bare bones of something 'cos you're looking at a model to see if it'll work. You're not looking at a full blown service at that time... so to expect us to run now a full service on pilot monies is unreasonable...If we're looking at a service to go 24/7... looking at about £520,000...total cost...About £220,000 would see us continue on a 12 hour service, but fully covered...full 24 hours service...would be over £500,000 but the projected savings on that would be about £1.2 million...[over a year]."* (Street Triage Steering Group)

The second challenge related to repeat referrals which while not completely unexpected as people in touch with mental health services may suffer relapse, could also reflect issues with the ST aim to improve outcomes for service users and lack of cooperation or tensions from other services. A small but significant cohort of people had been referred to the ST service more than once (572 referrals for 490 individuals; 58 individuals - 12% - referred more than once). The time elapsed between repeat referrals varied between 0 – 497 days (average 106 days, median 57 days); a third (33%) re-presented within a month of their last referral. The characteristics of those repeatedly referred suggested they were more likely to have substance misuse problems, social issues around relationship problems and housing, and multiple, short-term contacts with services (possibly because of a lack of engagement by service users and/or from services) – a finding in line with Docking, Grace and Bucke's (2008) review of the use of s136s and police custody as a place of safety who found those presenting as repeat referrals often had more complex needs, frequently compounded by substance misuse issues.

While there is a tendency to point the finger of blame at this group of clients and what is often described as their 'chaotic' lifestyle, research which seeks the opinions of service users themselves suggests engagement and retention problems often lie with the services themselves (Dean, 2003; Jeal & Salisbury, 2004; Rosengard et al, 2007; Anderson, 2011). Difficulties accessing services; a range of systemic barriers that impede access or are detrimental to care and can lead to repeated experiences of service rejection or delays in receiving help; and poor experiences of services following access (Anderson, 2010; Rosengard et al, 2007) have been identified.

Issues around access to services are also the basis of the third challenge facing the pilot team. ST's work meant that they came into contact with a number of different teams and had to manage a complex set of inter and intra-agency relationships, including with police officers, mental health service providers in the voluntary and statutory sectors, as well as manage their own internal networks. The main relationships, which involved the Police and the Crisis Teams, were overwhelmingly described in positive terms, with both services particularly supportive of the establishment, and continuing development of the pilot service. There were, however, ongoing issues. Those with the police have already been discussed in relation to 'self-presenters'. In relation to Crisis Teams, this seemed to centre on the lack of clarity, or disagreement, or the testing of tolerances around roles and responsibilities. Before ST, the Crisis Teams were the services responsible for responding to crisis situations, including calls from the police. With the introduction of ST it seemed details were still being negotiated as new situations arose:

> *"...and the police brought a gentleman ...if you self-present, it's like you see the Crisis team but because the police had brought ...the Crisis team asked us ...there's nothing set in stone that because the police have brought him it has to be Street Triage. He'd actually self-presented and wanted to come here to see the Crisis Team because he thought he was in psychiatric crisis but [Street Triage] assessed him."* (Street Triage Staff)

Discussion

The development of the ST model is not a new idea – various models of support ('prebooking diversion programs') have already been trialled in the USA. These include: Crisis Intervention Teams (CIT) where police officers have special mental health training to provide crisis intervention services and to act as liaisons to the formal mental health system (Morabito et al, 2012; Canada et al, 2010; Compton et al, 2010; Fisher and Grudzinskas, 2010; Ritter et al, 2010); and the Co-Responder model (most similar to that being trialled in England) which partners mental health professionals with law enforcement at the scene to provide consultation on mental health-related issues and assist individuals in accessing treatments and supports (Rosenbaum, 2010; Reuland et al, 2009). Steadman et al (2000) compared the outcomes of three major models of police responses to mental health emergencies in the USA – including the CIT/ Police Officer model; a variation on the CIT/Police Officer model, referred to as CIT/ CSO, where community service officers (civilian police employees with professional training in social work or a related field) assist police officers in mental health emergencies by providing crisis intervention and some follow-up assistance; and the Co-Responder model. The most popular and most likely to be called to a scene was the CIT/ Police Officer model – the CIT/ CSO and Co-Responder models suffered from lack of availability and delayed response times – limitations also recognised in relation to the Cleveland ST delivery model. The CIT/ CSO service was most likely to resolve incidents at the scene, the Co-Responder/ Mobile Crisis Unit models were most likely to refer people to specialist mental health services, and the CIT/ Police Officer model was most likely to physically take individuals to treatment locations. Overall these services were a third less likely to result in arrest compared with contacts between non-specialised police officers and people with mental health problems.

The ST teams currently being trialled in England are most similar to the USA Co-Responder model. As with the American models, the co-location of expert support has had a significant impact on reduced detentions under the Mental Health Act, with the Cleveland ST team demonstrating an 80% reduction compared with police officers acting alone (the Leicestershire service reports a 40% reduction, MIND and Victim Support, 2013).

Conclusion

The Cleveland ST project was valued by service users, the police and other statutory partners. Although some issues were identified, it is important to bear in mind the strong and universal endorsements that ST received. The ST service delivery model had developed flexibly to provide responsive services within existing financial constraints and uncertain ongoing funding streams and therefore, as in the USA, there are some variations in the model of service provision in different geographical areas in England, e.g. in Cleveland a team of mental health nurses based at police headquarters monitor calls, give advice, and attend scenes using their own transport; and in Leicestershire a police officer and mental health nurse staff a patrol car (the 'Triage Car') and respond to calls received together. There are potential benefits to allowing difference and the 'ground-up' development of services especially during a pilot trial but there are also risks. While the Cleveland ST service meets its aims (by supporting police officers, reducing the number of s136s detentions, and providing improved service pathways to those with mental health difficulties who came into contact with the police), the challenges facing current ST pilots described by this study including 'self-presenters', repeat referrals, and relationships with other services fundamentally boil down to 'funding and focus'.

At a regional and local level, the agencies involved with the commissioning and provision of the Cleveland ST service have acknowledged the challenges associated with providing a service for clients with multiple and complex needs across the criminal justice and health systems. These challenges include developing a model which meets need within funding and staffing constraints, inter and intra-agency relationships and agreements, and engagement and retention issues. Issues around the importance of shared understanding and cooperation from other services have been noted, and 'self-presenters', repeat referrals, and related activity and outcomes will be monitored in order to identify 'good' pathways and relationships, including any gaps or issues. At some point

however there is a need to determine and nationally evaluate the funding, core principals and practice of ST if it is to continue to develop (HM Government, 2014).

Table 1: S.136 Detentions by the Police Alone and Involving Street Triage.

Month and year	S.136 Police	S.136 St. Triage
Aug-12	45	4
Sep-12	51	1
Oct-12	40	1
Nov-12	25	2
Dec-12	29	0
Jan-13	31	1
Feb-13	30	1
Mar-13	24	1
Apr-13	34	0
May-13	22	1
Jun-13	15	0
Jul-13	37	0
Aug-13	30	1
Sep-13	25	0
Oct-13	19	0
Nov-13	31	0
Dec-13	26	0
Jan-14	27	0
Feb-14	17	0
Total number	**558**	**13**
Cost estimation (£1,780 per s.136	**£993,240**	**£23,140**

Table 2: A Comparison of s.136's (not leading to hospital admissions as no mental health problem was identified or a more appropriate referral pathway not used) between the Police and those involving Street Triage (based on referrals to S.T./column 5).

Month and year	Column 1-4 = while ST were <u>not</u> on duty (12 midnight-12 noon).				Column 5-8 = while ST were on duty (12 noon-12 midnight).			
	1.s136 Police detentions (equivalent process of ST assessment)	2. s136 Police detentions - admitted to hospital	3. s136 Police detentions <u>not</u> admitted to hospital	4. % of Police s136 detentions <u>not</u> admitted to hospital	5.ST assessments (proxy for police s136 detentions)	6.s136 recommended by ST - admitted to hospital	7. s136 Police detentions - <u>not</u> recommended by ST and <u>not</u> admitted to hospital	8.% of detentions <u>not</u> admitted to hospital during ST duty
Aug-12	45	8	37	82%	63	0	4	6%
Sep-12	51	10	41	80%	20	0	1	5%
Oct-12	40	6	34	85%	41	1	0	0%
Nov-12	25	6	19	76%	43	1	1	2%
Dec-12	29	6	23	79%	25	0	0	0%
Jan-13	31	3	28	90%	16	0	1	6%
Feb-13	30	5	25	83%	18	0	1	6%
Mar-13	24	7	17	71%	26	0	1	4%
Apr-13	34	3	31	91%	15	0	0	0%
May-13	22	4	18	82%	27	0	1	4%
Jun-13	15	1	14	93%	37	0	0	0%
Jul-13	37	4	33	89%	40	0	0	0%
Aug-13	30	4	26	87%	39	0	1	3%
Sep-13	25	7	18	72%	26	0	0	0%
Oct-13	19	7	12	63%	34	0	0	0%
Nov-13	31	4	27	87%	27	0	0	0%
Dec-13	26	3	23	88%	29	0	0	0%
Jan-14	27	6	21	78%	18	0	0	0%
Feb-14	17	4	13	76%	28	0	0	0%
Total number	**558**	**98**	**460**	**82%**	**572**	**2**	**11**	**2%**

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