Research into the London Mental Health Street Triage Pilot

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MOPAC Evidence and Insight

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Executive Summary

The London Street Triage pilot is one of nine national pilots funded by the Department of Health. Street Triage aims to enable mental health professionals to work alongside the police, providing officers with 'real-time' information and advice to ensure people who need mental health support receive it as quickly as possible. The pilot ran in four south London boroughs (Croydon, Lambeth, Lewisham and Southwark) and provided a 24 hour telephone advice/helpline staffed by mental health professionals. Additionally, in all boroughs when clinically required, a face-to-face assessment service was trialled, consisting of mental health professionals attending certain incidents requested by an officer, to conduct an assessment at the scene alongside police officers.

Evidence & Insight, the research capacity of the Mayor's Office for Policing And Crime (MOPAC) were tasked with conducting research and evaluating Street Triage, running concurrently with the national evaluation. The aims were broadly to explore the processes and potential impact of a mental health Street Triage service, through the interrogation of basic performance data such as usage of the service and examination of the views of those using and experiencing the service. A range of research methods were drawn upon to achieve this (e.g., performance data, police officer surveys, and service user and carer focus groups).

Overview of Findings:

- It is estimated that one quarter (26%) of occasions where officers encountered individuals with mental health difficulties during their duty resulted in a call to the Helpline. This is a total of 1,179 calls within 12 months. This is a solid start to the helpline, although improved communication and promotion may encourage use.
- Between April 2013 and March 2015 London as a whole has seen increases in both the number of criminal incidents involving mental health aspects (64% increase) and the number of vulnerability reports recorded (31% increase) as well as a reduction in section 136 detainees taken to police custody as a Place of Safety (71% decrease). The Street Triage boroughs are consistent with these trends, therefore it is not possible to attribute any changes observed to Street Triage.
- Officers provided positive views around Street Triage, appreciating the timely and professional advice and felt that it improved their confidence when working with vulnerabilities including mental health.
- Learning was obtained in terms of the implementation of the service – with staff highlighting challenges such as training, limited pathways (such as a lack of designated specialist places of safety) and partnership working. These issues could be 'designed in' to any subsequent roll-out of the service to enhance delivery.
- Poor communication between the police and mental health professionals emerged as a key theme. This was perceived as a general barrier to effective everyday working and could result in misperceptions between partners (e.g., that officers are using custody as an alternative more than they actually are).
- Feedback from officers, mental health professionals, service users and carers indicated mental health training should include human engagement from service users so officers understand how their reactions/body language can affect an individual in crisis.

For Street Triage to be sustainable in the future, the focus moving forwards needs to be on training, identifying appropriate pathways for individuals, working with partners to help effective communication of the services provided and integrating this service into current commissioning plans.

Background

There has been a long and disjointed history in terms of how organisations respond to people with mental health needs. From a national perspective, there is often little standardisation across services or geographical boundaries, which can make it problematic when trying to provide appropriate care pathways. A number of recent reviews highlight the inadequacies of joint working by the police and health care partners (NHS, London Ambulance Service), particularly around how to effectively respond to individuals living with mental health needs.[i] [ii] [iii] [iv] [v] [vi] [vii].

The prevalence of individuals experiencing mental health needs in the UK further strengthens the need to prioritise these discussions. It is believed in Britain around one in four people will experience mental health issues each year[viii]. Within London more than one million residents live with mental health needs, a higher prevalence than in other counties across the UK[ix]. As a result, the MPS routinely come in to contact with members of public, victims of crime and offenders who are experiencing mental health needs[x]. Between April 2014 and March 2015, the MPS dealt with 79,811 emergency (999) or non-emergency (101) calls receiving a mental health qualifying code[xi] and a recent report by the College of Policing[xii] suggests a typical officer, in a typical force, might deal with an average of 14 incidents per day that are flagged as linked to mental health issues.

For those individuals experiencing mental health crisis, the police can act as gatekeepers, with officers regularly facing the tough challenge of having to identify mental health need and responding in an appropriate manner. This raises questions around the very nature of policing, responsibilities and partnership working – a theme that runs through the report. Police intervention may play a significant role in preventing the impact of deteriorating mental health[xiii][xiv], making the interface between crisis services and emergency services vital to manage and support individuals in need[xv].

London is not without its own misalignment between services, with a number of different NHS Trusts working in close conjunction, and multiple police officers working largely on their specific boroughs. London also contains 33 Clinical Commissioning Groups (CCG's), each running independently with no London-wide network to communicate and share information, knowledge and good practice. Therefore, London boroughs receive different funding for a range of interventions, with little calibration, creating a very confusing landscape to navigate.

This is evidenced on a number of occasions including when officers invoke Section 136 of the Mental Health Act (1984) (S136 MHA) and are required to take the individual to a Place of Safety, and when officers choose not to rely on S136 MHA and take service users voluntarily to Emergency Departments, with some departments accepting mental health patients, and others not. Borough disjoins are demonstrated through the difficulties police officers and NHS staff have in accessing Places of Safety (POS) (namely 136 suites) within other NHS Trusts when there is no immediate available spaces within their own Trusts[xvi]. New ambitions are being discussed around co-commissioning joint Places of Safety to alleviate these issues.

Pressures on Police Practice

Learning from the Independent Commission[xvii] into how the MPS responds to policing incidents involving mental health highlights the pressures that the police are under. Previous in-depth analysis of police performance data from the MOPAC E & I team[xviii], demonstrate the complex and demanding aspect of policing mental health related incidents, particularly in terms of:

- The individual's journey through the organisation – there is a heavy and rising demand of individuals in contact with the police when in mental health crisis.
- Places of Safety - the use of custody as a POS was seen, but often remains inappropriate.
- Training – officers continue to feel training is inadequate around identification, needs and management of mental health.
- Partnership Working – there are gaps in terms of appropriate access to mental health partners.
- Audit and Review – there is a lack of rigorous data collection and capture around mental health needs[xix].

In addition to the demand and overlap between policing and mental health – the MPS are under considerable pressure to deliver on effectiveness, efficiency, professionalism and to improve public confidence in the police[xx]. In a time of austerity, implementation and progression of schemes are under threat – highlighting the need for cost effective, partnership and innovative solutions[1].

[1] This is particularly relevant given the potential changes occurring around S75 of the National Health Service Act 2016 between London Local Authorities and Mental Health Trusts.

Reviews of Mental Health

Over the past years there has been a number of reviews and reports exploring mental health provision with a view to improve treatment and pathways across different sectors. Reviews have detailed how partnership agencies should respond to individuals, with the 2009 Bradley Report[xxi] making 82 recommendations for improving the treatment of people with mental health needs and learning disabilities in the criminal justice system. A later independent review, The Bradley Report Five Years On[xxii] suggested significant progress had been made over the five years in key aspects, such as the introduction of the Liaison and Diversion services (L&D)[2].

In 2013 the Independent Commission on Mental Health and Policing detailed a further 28 recommendations for change, falling under three broad areas for action including leadership, on the frontline and interagency working. In response to these recommendations, and the recognition of both the shortfalls in 'health' and that all agencies should engage in collaborative working, the Crisis Care Concordat[xxiii] was introduced in 2014. This provided a national agreement between services and agencies involved in the care and support of people in crisis. The Concordat sets out how organisations will work together better to make sure that people get the help they need when in crisis. Twenty two national bodies including health, policing, social care, housing, local government and the third sector have

[2] L&D services exist to identify offenders who have mental health, learning disability or substance misuse vulnerabilities on their first contact with the criminal justice system. This way they can be supported through the criminal justice system pathway, and if necessary, diverted into treatment, social care services or other relevant intervention or support services. L&D services aim to improve health outcomes, reduce re-offending and identify vulnerabilities earlier, thus reducing the likelihood offenders will reach crisis-point.

now signed up to the Concordat, with the aim of focusing on:

- Access to support before crisis point through availability of 24 hour services;
- Urgent and emergency access to crisis care;
- Quality of treatment and care when in crisis;
- Recovery and staying well through referrals to appropriate services.

National Street Triage Pilot

The introduction of Street Triage was, in part, to respond to elements of the action plans set out through the Concordat, particularly addressing the provision of 24 hour access to professional services and encouraging collaborative working relationships between partner agencies to achieve such goals.

As a national pilot, Street Triage attempted to embrace learning from previous reviews providing a comprehensive triage service to individuals coming into contact with the police for reasons relating to mental health needs. This approach intended to provide a more timely intervention from mental health professionals and reduce unnecessary detentions for people under S136 MHA. A key objective was to ensure individuals detained under S136 were not taken to a police custody as a place of safety. It was thought the implementation of such a service may also achieve cost saving for police services.

The aim of Street Triage was to enable mental health professionals to provide 'real time' advice to police officers 24 hours a day, seven days a week. Advice included a professional opinion on a person's condition, or appropriate information sharing about a person's health history. The aim was to assist police officers to make appropriate decisions, based on a clear understanding of the background to these situations. A wider aspect of the Street Triage service was to encourage individuals into better care pathways and referrals to appropriate services through the use of 7 day follow ups.

Funded for one year through the Department of Health, nationally there were nine Mental Health Street Triage pilot projects. Each participating police force had a local variation of the operational model, predominately deploying NHS mental health nurses in police response cars to assist with mental ill health on the street[3]. For example, the British Transport Police and NHS London conducted joint assessments of all cases over the preceding 24 hours and formulated joint plans to reduce the risk of harm and engage relevant care pathways. Differing in their approach, Leicestershire operationalised a Street Triage Car, jointly operated by Leicestershire Police and Leicestershire NHS Partnership Trust. The car was driven by a police officer and contained a mental health nurse from the crisis service. The car provided an initial point of contact for officers first at the scene who encounter incidents with a mental health element, before exercising their police powers.

London Street Triage Pilot

Commissioned by the Mayor's Office for Policing And Crime (MOPAC) and NHS England Health and Justice Team, the London Street Triage was a collaborative project between South London and Maudsley NHS Trust (SLaM) and the Metropolitan Police Service (MPS). SLaM Foundation Trust was chosen to

[3] Many of the pilot areas have commenced their own evaluation of the pilot scheme, each adopting different approaches and methodologies. Additionally, the Department of Health have employed University College London to conduct a national evaluation of all the pilot schemes, appraising the different operating models in comparison to each other. London Street Triage pilot have already supplied information to this evaluation.

participate within the pilot as they recorded the highest uses of S136 MHA for each year (from 2009 – 2012) in comparison to all other London NHS Trusts.

The pilot commenced on 31st March 2014 offering a slightly different operating model to many of the other UK pilots. Due to the size of London, limited resources, the number of officers and volume of mental health related incidents, it was decided primarily a helpline and limited face-to-face services would be provided.

- *Helpline*

  A dedicated and direct 24 hour telephone advice helpline was available to MPS officers in four south London boroughs within the SLaM Trust (Croydon, Lambeth, Lewisham and Southwark). Officers could call and speak to mental health professionals to obtain advice, background information on known individuals, and to be aware of the availability of places of safety.

- *Face-to-face Assessments*

  Additionally, a face-to-face assessment service was trialled, operating 24 hours a day. If appropriate, mental health professionals were asked to attend mental health related incidents with the police present. With their specialist knowledge, the professionals provided assessments in person and aided the police in their decision making.

The introduction of London Street Triage held a number of aims, including:

- Reduce the use of S136 MHA amongst the police;
- Provide a more timely intervention by mental health professionals;
- Improve the experience of people who come into contact with the police through either detention under S136 or for other reasons related to their mental health;
- Ensure that individuals detained under S136 are not taken to a police station as a place of safety;
- Help officers make appropriate decision making for those people who were not subject to a S136 MHA;
- To include the service user in the outcome of the contact;
- Achieving a substantial cost saving for police services.

It was expected that individuals who came to the attention of the Street Triage Service would be treated and managed within a whole care pathway approach. Collaborative working between health and the police was in order to ensure individuals receive a coordinated approach to address their health and/or social care needs.

The implementation of the Street Triage service has provided a platform from which to standardise the mental health response in four boroughs within London, enabling an exploration of the issues that arise.

Evaluation of London Street Triage

The Mayor's Office for Policing And Crime (MOPAC) Evidence and Insight Team (E & I) is a team of social scientists who were commissioned to conduct research on Street Triage – specifically to explore the process and potential impact of the service.

Results are structured into holistic learning about 1) the implementation of Street Triage; 2) the impact seen from the service; and 3) wider learning relevant for mental health policy and practice.

Methodology

This evaluation was conducted using a range of methodologies looking at the process and potential impact of implementing the Street Triage service.

Exploring the Impact

One aspiration of the research was to explore the potential impact of Street Triage on a range of key measures (e.g., the time spent dealing with an incident, number of people in crisis who are taken to custody) through the interrogation and analysis of MPS data systems and NHS data. In the absence of randomisation, a quasi-experimental matched comparison group was the most robust feasible approach.

Matched comparison boroughs were identified from factors theoretically relevant to Street Triage, for example volume of mental health calls and socio-demographic factors. It became apparent a number of those best matched boroughs were already receiving an additional service, the Liaison and Diversion (L&D) scheme, at the time of matching. As this may have acted as a confounding variable, four of the best matched L&D boroughs, as well as an additional four of the top matched boroughs acting as the control (no L&D services) were chosen (see Appendix A for further details).

Initially the analysis had planned to compare the results from the Street Triage boroughs to those in the L&D matched boroughs and the control boroughs. However on initial inspection of the data, there were very few differences emerging between the L&D boroughs and the Control boroughs in terms of impact measures such as number of crime incident reports and number of calls to Computer Aided Dispatch (CAD) [4], resulting in the decision to combine the findings of these 8 boroughs together under the name of "Matched boroughs" (in effect generating one robust control to compare to Street Triage). The analysis presented here compares the Street Triage borough data to that of the Matched boroughs, and a wider pan London view that includes all London boroughs.

Exploring the Process

This aspect was focussed upon describing the Street Triage process and generating learning. This evaluation focused on the process of embedding a new system within two established organisations (the MPS and NHS). The E & I team adopted a holistic approach, incorporating a range of qualitative and quantitative methodologies including (full methodologies can be found in Appendix B):

- Attitudinal surveys of police officers and NHS staff who were involved in the pilot;
- Focus groups with service users and carers.

The evaluation methods have not been without their difficulties. Response rates to the police officers surveys were low (<6% of respondents, a lower response rate than the typical 10% rate of online survey returns[xxiv]). This low uptake could be perceived as a finding in itself. Reports were received to indicate the Post-Phonecall survey was not readily distributed to officers who had contacted the phone line due to lack of staff members within the MPS Central Mental Health teams, and ambivalence about who would pick up this work.

[4] Met Central Command Unit houses the CAD team who receive all 999/101 calls and if necessary dispatch officers/vehicles to attend. When a call is received, an operator takes the details of the call, and assigns it a code which details the nature of the call and any significant factors. One code that can be applied is known as a mental health code (Qualifying Code: 612).

Process Findings: Implementing London's Street Triage

Early Implementation

The research evidence is clear that well designed and implemented schemes are more likely to get better outcomes. Documenting learning from implementation is also beneficial, gathering learning, insights and enabling replication in similar operational settings. It is well recognised that a key issue when attempting to produce robust evidence for policing is that research faces challenges to implementation within 'real-life' policing environments as opposed to 'clean' medical trials[xxv].

One implementation issue identified was that for the first four months of the pilot the SLaM Street Triage team was not fully staffed, making it problematic to cover all the necessary shifts and attend face-to-face assessments[xxvi]. It took up to four months until a full team was assembled, due to difficulties in recruiting staff with appropriate experience and qualifications for this specialised work. Previous research[xxvii] highlights the potential early implementation 'teething issues' and the lasting impact these can have.

The method of recording data was challenging as data was collected by both health and police, and specific data requests were often received from the national pilot and local evaluation. This was hampered further by the lack of funding for administrative support, team leader or senior input within SLaM, impacting on the level of commitment at times to the pilot, especially around data and report writing[xxviii].

It became apparent during the research that communications around Street Triage to police officers was a key issue in terms of ensuring effective implementation. The pilot was slow to take off, with only 47 calls within the first month[xxix], due to a perceived lack of knowledge and understanding from the officers about the service. To illustrate, six months into the pilot only 49% (n=54) of officers who responded to the survey indicated they had heard about the service. To promote use, officers were provided with a card detailing the telephone number and encouraged to use it whenever they came into contact with someone with suspected mental health needs (see Figure 1).

Procedures were inaugurated to improve knowledge of the service in the form of additional localised briefings by Borough Mental Health Liaison Officers and members of the Central Mental Health team. A number of briefings were conducted throughout the year pilot to remind officers to utilise Street Triage.

Early on in the pilot it became clear that officers were contacting the Street Triage

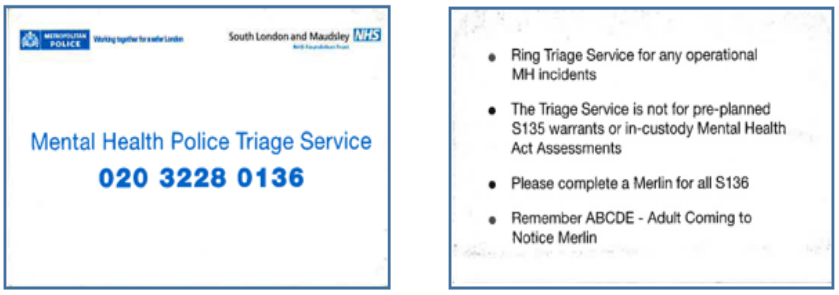

Figure 1. Street Triage contact cards.

team too late – for example, contact was often made *after* a decision to detain an individual was made[5]. If contact had been made earlier then the team could provide more options which may have resulted in a potentially better care pathway for the individual. In an attempt to address this the clinical lead for Street Triage and Lambeth Crisis services also attended the MPS Communications Command[6] in Lambeth and spoke to dispatch personnel, informing them of the Street Triage service and encouraging them to remind officers to contact the Street Triage number if suitable when attending incidents. It is important to acknowledge however that police often get involved in mental health crisis incidents as a last resort. It is not always appropriate or possible to contact Street Triage prior to acting, especially if a spontaneous response is required. Although mentioned in the Codes of Practice, there is currently no legal provision to 'detain' someone whilst an officer consults the triage service.

The model implemented within London was unique in comparison to other pilot sites nationally. It was important to focus on the implementation of such a scheme to enable valuable learning for future models and compare, where possible, to the other methods used nationwide. There is a need to standardise the Street Triage process, to provide a more streamlined approach and ultimately better care pathways for individuals.

Use of Street Triage

The success of the Street Triage project is difficult to judge. This is often found within evaluations of pilots or newly established programmes.

In terms of usage, in total, within the year Street Triage was running (April 2014 – March 2015), there were:

- **9,434 recorded CAD** call's that received a resolution code of mental health.
- A total of **4,453 incidents that officers attended** (47%) (Remaining CAD calls required telephone advice or appointments).
- **Street Triage team received 1,179 calls** suggesting officers used the Street Triage service for around **26% of occasions**. On average, this is approximately 90 calls to the Street Triage team a month (Figure 2).

As can be seen from figure 2, calls to the helpline gradually improved over the duration, peaked in November then levelled out. Findings from the survey regarding usage were less positive, few officers reported being **aware of the availability of the Street Triage service** (41%, 85 officers out of 205) and only **47 officers** out of 205 (23%) who responded to the evaluation surveys indicated they had actually **called the telephone helpline**. Those who did contact the Street Triage team called on average three times over the year period. This could be associated to the implementation and communication issues previously highlighted.

The level of usage seen in the Street Triage pilot would appear a solid start to the helpline. However, it remains clear that there were many incidents where Street Triage was not called in eligible cases. On such occasions officers may have drawn on their own expertise, local knowledge or signposted individuals to other services without the need to call Street Triage or there may have already been health and social care professionals or LAS at the scene due to the nature of the

[5] This is anecdotal evidence only, as this detail of information was not recorded.

[6] MET Communications Command answers all 999/101 calls and dispatches officers to incidents.

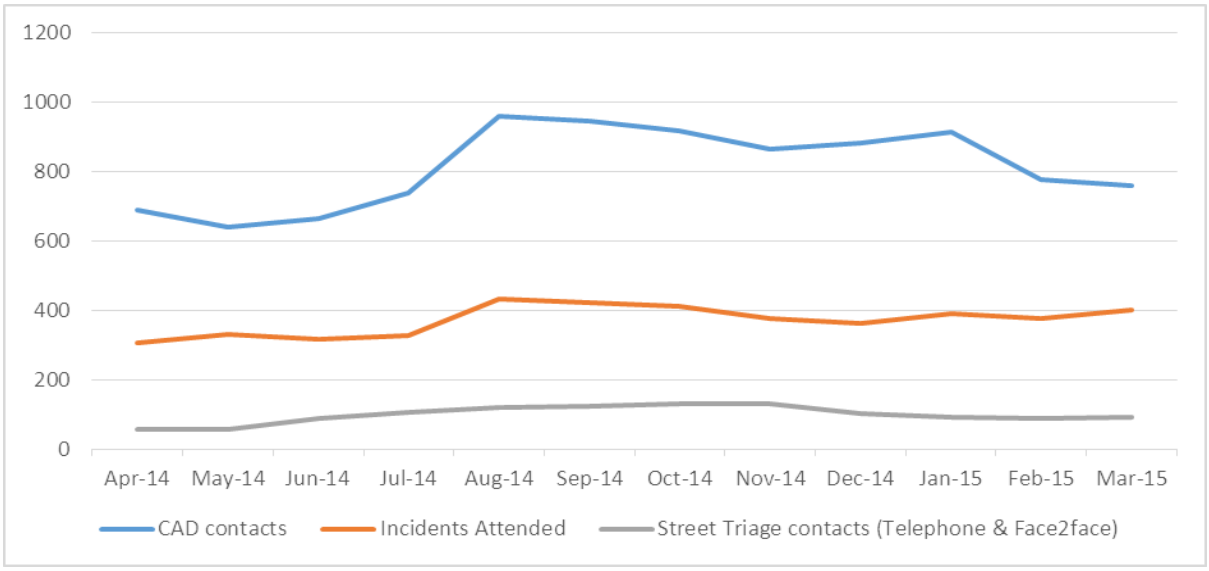

Figure 2. Time series analysis of CAD calls in relation to calls to Street Triage service.

incident. On the contrary, there is wider research on the challenges in encouraging staff to use new or innovative programmes (for example the implementation of Body Work Videos with the police[xxx],[xxxi]). Regardless of the explanation, more communication and promotion of the service would likely be helpful in encouraging use, especially whilst the new scheme takes time to embed and everyday practices begin to change.

Individuals, for whom the police contacted the Street Triage team about, were usually already **known** to SLaM as current patients (n=866, 74%[xxxii]). Being known to services enabled the Street Triage nurse to provide up-to-date medical information to the officers, aiding the decision making process. Unlike other services (e.g.: Home Treatment Team) when the individual was not known to SLaM, the mental health professional can still provide relevant information based on the behaviours presented by the individual.

Officers very infrequently contacted Street Triage when the individual with mental health needs was actually involved in a crime, whether as a suspect (5%) or a victim/witness (2%)[7].

Instead, over 90% of the contacts with Street Triage were individuals encountered in the community (whether within their own home or in a public place). When first implemented, the majority of calls were for attendances in an individual's private property with officers asking for advice as they were unable to conduct a S136.

However, over time officers started to utilise the Street Triage expertise when they encountered individuals in public spaces and over the year pilot this was the predominant use of the service (n=868, 74% of incidents were in public locations[xxxiii]). Whilst this could reflect that officers are phoning for advice (n=371, 40%)[xxxiv], the types of engagement recorded by SLaM would suggest that officers used the Street Triage service more to obtain a space within a suitable place of safety (n=488, 52%). On only 8% (n=72) of occasions did the Street Triage professionals advise the police to invoke S136 procedures[8xxxv]. This

[7] Data covering July 2014 – March 2015 (Quarter 2, 3 and 4) only due to data collection methods within SLaM.

[8] Anecdotal evidence indicates that in the early stages of Street Triage, some officers were advised to take the patients to A&E

may reflect the anecdotal evidence suggesting officers were calling the Street Triage team once they had already invoked a S136, rather than calling them for initial advice. This may indicate that a cultural shift in officer's thoughts and behaviours is required to encourage use of the service.

It became apparent that certain 'mental health triggers' were repeatedly the main issue present at the time of contact from the police. Observations over the year highlight that the two main reasons why officers called the helpline were self-harm (28%) and unusual behaviour[9] (37%)[xxxvi]. The majority (58%) of contacts with the Street Triage team resulted in the outcome of a S136, however officers had usually invoked the S136 prior to calling the helpline. Other frequently used outcomes included sending the individual to A & E (10%), providing a community referral to mental health services (17%) or returning the individual to an inpatient ward (3%)[xxxvii].

Analysis of a CAD dip sample with a mental health code (n=342) indicated that from the pilot boroughs mental health repeat callers are a regular occurrence; 41.5% of calls received were from repeat callers. This indicates a level of recurrence and relationship in understanding this demand. Officers only called for additional support a third of the time, and this was usually additional back up from the MPS (55%) or support from the London Ambulance Service (32%). Throughout the dip sample, the Street Triage service is mentioned very infrequently (4% of CAD records) and when it was mentioned, it was rarely contacted (2%, 6 occasions).

rather than use S136. On many occasions officers felt therefore it was inappropriate so used S136 against the Street Triage professional advice.

[9] Unusual behaviour is hard to describe, but a few consistent behaviours that are deemed unusual include being semi undressed/naked, shouting using language that does not appear to make sense, and running in and out of traffic or wandering in the road. A clear definition needs to be addressed as part of the new Crisis Line.

Street Triage Impact and Outcomes

Data reported here examines the impact analysis in terms of Street Triage boroughs in comparison to the Matched boroughs and pan London picture. The time period for the analysis is April 2014 – March 2015, during which time the Street Triage service was in action.

Key Outcomes

Records indicate an increase in both recording of vulnerability[10] (Merlin S136) and criminal incidents where there is evidence of mental health issues (CRIS), both in the pilot boroughs, matched boroughs and across London (Table 1). In this way there appears to be consistent pan London trends in terms of a rising demand around mental health in London. The Street Triage boroughs are entirely consistent with the broader picture – although given the wider context it is not possible to attribute any changes observed to Street Triage. This rising level of demand would appear to warrant attention – not only for Street Triage boroughs but for policing (and partnership working) as a whole for London.

Additionally adult Merlin records were only introduced in April 2013; therefore the findings may reflect the embedding period where officers are adapting to completing Merlin's regularly. An increase in records may be expected as this practice becomes routine, rather than an actual increase in the number of S136s being conducted across London.

When placed under S136, officers have the responsibility to take the individual to a Place of Safety[11]. Historically police custody has been used as a PoS when the person has not committed an offence and has been solely detained under S136. This tends to occur when there are no other 'health' based Place of Safety alternatives available. The pilot boroughs previously had the highest number of 136 detentions in custody[xxxviii], but recently there has been a significant positive reduction in the use of custody. Across London, between 2008 – 2011 individuals were taken to custody as a Place of Safety an average of 65 occasions per year[xxxix]; a figure that has remained largely static over longer timeframes[xl]. However in 2014/15 this reduced to just 17 occasions in the pilot boroughs[xli]. Similar reductions (21 occasions) have also been seen across the whole of London in the same time frame, indicating that whilst this reduction cannot be credited to the Street Triage pilot, there has been a move towards a more positive approach to individuals with mental health needs by the police and a desire to find an appropriate response and places of safety for the individuals in crisis.

[10] MPS Vulnerability Assessment Framework definition of vulnerability includes being exposed to the possibility of being attacked or harmed, either physically or emotionally. Additional factors to vulnerability may include Mental Health, Disability, Age or Illness

[11] The London Ambulance Service has the responsibility to transport the patient to a Place of Safety, with the assistance of the police in the escort.

Table 1. Data from Merlin, CRIS and Place of Safety records across London.

	Merlin Records with a S136		
	Apr '13 - Mar '14	**Apr '14 - Mar '15**	**% change**
Street Triage Boroughs	261	385	47% increase
Matched Boroughs	381	795	109% increase
Pan London	1,721	2,829	64% increase
	Mental health related CRIS Records		
Street Triage Boroughs	1,314	1,677	28% increase
Matched Boroughs	2,067	2,786	35% increase
Pan London	7,605	9,978	31% increase
	Number of Detections in Custody as Place of Safety		
Street Triage Boroughs	46	17	63% decrease
Matched Boroughs	10	2	80% decrease
Pan London	73	21	71% decrease

Street Triage aimed to reduce the time officers spent dealing with such incidents, by providing them with the advice and information required to make decisions that would result in a positive outcome. Police data was used to assess whether the time spent at an incident involving someone with mental health needs had reduced during the time the Street Triage pilot was running. For cases when an individual has mental health needs, this may include assisting the individual to A&E or a S136 suite and waiting with them until they are attended to. Analysis of a dip sample of CADs during November 2014 (see Appendix C) provided an average duration from the 'time of arrival' (when an officer arrives on scene) to a 'de-assigned' time (when an officer has completed their time at the incident). This provides a 'dealing with' duration figure.

During the pilot period, on average, incidents on the **pilot boroughs were 'dealt with' in 3 hours and 53 minutes**. This is faster than incidents on the **Matched boroughs (4 hours and 26 minutes)** and examining a random dip sample of 400 across **all London boroughs** for the same month indicates that the average deal with time is **4 hours and 44 minutes**.

Looking specifically at the dip sample CAD's for incidents when a S136 was invoked, officers on the pilot boroughs made six S136s in November 2014. On average, officers were assigned to these incidents for 2 hours and 14 minutes. On the matched boroughs however the average time for dealing with their nine S136s was considerably longer (6 hours and 34 minutes). Although there is no specific indication that Street Triage helped reduce these time durations, as it was not mentioned in the majority of these incidents, speculatively it may have had a wider positive impact on relationships between the police and SLaM, consequently improving the S136 process.

It is important to remember however, that just because officers are located within the pilot boroughs, they may not have utilised the Street Triage service (only an estimated 26% called) thus not receiving the potential benefits and time saving advantages the service could provide. Additionally, these times need to be caveated, as different boroughs across London are covered by different NHS Trusts, each with different numbers and access protocols to places of safety, therefore it is expected that there is some variation in timings.

Officer & SLaM Staff Attitudes

When asked specifically about the Street Triage service, officers and SLaM staff were[12]:

- ✓ **Generally positive**, with feelings of satisfaction around the service received.
- ✓ **Willing to use the service again**.
- ✓ Those officers who called the helpline also felt it had **improved their confidence** in working with mental health and SLaM staff felt confident in their role advising officers.
- ✓ **Take action on advice provided.**
- ✓ In terms of care for individuals in crisis, the phone line was seen as **making the Section 136 process easier**, as well as the sharing of information which ultimately helped with the continuation of patient care.
- ✓ Mental health professionals also felt the **officers handled the situation well.**
- × Officers noted a continual **complexity with relationships with partnership agencies** (health organisations in general)**.**

Calling the helpline was seen as **reducing the amount of time officers spent dealing with incidents** involving mental health – reflecting the findings which indicate Street Triage may help reduce the length of incidents. Going further, analysis suggests that if officers felt that the Street Triage service reduced time spent dealing with incidents, this was correlated with a positive feeling towards the Street Triage service assisting officers to reach a decision (r = .506, n = 149, p = .001). SLaM staff noted that the time spent with individuals could have been reduced further if officers contacted the helpline before they decided to invoke a S136, rather than after.

Thoughts around potential services/tools officers would find helpful in the future included:

Face-to-Face Assessments

The opportunity to have a mental health professional attend an incident was used infrequently, with only **99 assessments** made over the year period. This may be due to officers not requesting attendance by the mental health professional, or limited capacity within the SLaM Street Triage team, operating on limited resources. Such low usage has meant that it is not possible to explore the element of the pilot scheme in more depth and further research is required if this aspect of Street Triage is to be rolled out in future.

However, mirroring officers and SLaM staff views of the telephone helpline, those who used the face-to-face aspect found it:

- ✓ **Positive and helpful**.
- ✓ Appreciated the detailed **medical knowledge** of the professionals.
- ✓ The professionals were **taking responsibility** for the individual.
- ✓ Resulted in a more **positive outcome for the service user** too.

[12] Data from Police Officers Attitudinal Survey's and NHS SLaM Street Triage staff Survey.

- A continuation of the Street Triage telephone helpline.
- Mental health professionals attending police incidents.
- Mental health professionals in 999/101 call centres to offer advice to operators and officers over the radio.
- Mental health professionals based within A&E[13] [xlii].
- Better training for police to understand mental health needs.

Other learning emerged from staff in terms of the daily hassles of everyday working around mental health. One issue that contradicts other MPS feedback is that when specifically asked about working with mental health, officers did not want access to a Smartphone or Tablet offering information as it was seen as taking up valuable time and providing no firm answer. Officers also did not want direct access to personal medical information, possibly because officers felt this was an intrusion of their privacy, or a reflection that they were not trained medical professionals.

[13] There are mental health liaison teams based within A&E departments so it is not clear what the officers mean by this comment. It could be speculated that officers would like closer working relationships with these teams.

Wider Learning from Street Triage

As well as providing detailed information about the embedding process of the Street Triage service, elements of the evaluation have provided wider learning around working with mental health in London. A number of issues were identified, focussing mainly on training of officers, perceptions of officers, service users and carers, pathways, confidence in working with mental health and the importance of partnership communication.

Training

One method of improving officers understanding of mental health needs is through training. Over the years, research[xliii] has repeatedly suggested that police officers attitudes and response to individuals with mental health needs is strongly mediated by the training they receive. The current research continues to highlight the importance of training, but also that Street Triage is not a plug for the current training gap: at the time of interviewing officers did not find the current MPS training adequate.

Our work suggests that officers identified the issues lay less in the *amount* of training they currently receive, but ensuring content and delivery is in a manner that can be easily understood, learnt, remembered and applied in real life. In particular, a need for adequate training around the identification of, response to, and legal aspects of mental health was highlighted. These findings continue to raise the challenge of providing appropriate training around management of those with mental health needs, in a way that embeds the knowledge in officer's everyday practice[xliv]. This is further illustrated by a third of officers reporting they do not feel supported by borough management, suggesting the MPS attitude to the relevance of understanding mental health issues in the work place would require further attention[xlv].

Mental Health service users and carers reported that police need more training to increase the fairness of encounters (e.g., procedural justice training). In particular, service users suggested police needed to obtain 'real life experience' to be able to address situations more appropriately. One method of introducing this into training could be through the joint workings of service users and trainers, to provide officers with examples of 'lived experiences' from the service users.

A further reoccurring theme from service users and carers was the importance that police are able to understand culture and culturally specific mental health needs. Research demonstrates a moderately strong benefit of culturally adapting mental health interventions[xlvi]. Specifically, interventions targeted to a specific cultural group were four times more effective than generic interventions[xlvii]. Training focused around culturally specific aspects of mental health would aid officers understanding of individual's different reactions, enabling officers to provide a more holistic approach to those they encounter.

Perceptions of Mental Health Needs

This section provides an understanding of the different perspectives of the service users and carers, as well as the police officers. A unique voice captured within the research, that of the service users and carers, were able to provide original insights and an in-depth perspective on how the police are experienced in times of crisis. Additionally, through survey questions officer's

perceptions when encountering individuals with mental health needs were attained. These two perspectives should be read in conjunction, as they provide contrasting viewpoints.

Mental Health Service Users and Carers

Through discussions with service users and carers, three themes emerged around how police are experienced in times of crisis:

A Fair Encounter: Consensus amongst participants was that the police do not understand the people they are encountering and this may have the end result of officers aggravating a situation making it worse than it needs to be. It was also felt that officers can be overly result focussed (e.g., arrest, charge) instead of considering the wider encounter or individual needs.

> "Police make the situation hot and heated so they can get the result they want." *Service User*

The perception was that the location of the incident affects the response. When the police were called to a home address, Carers suggested that the police were more respectful. However, on the street, or in hospital, the police response was perceived much more "menacing".

Fair treatment within the encounter also emerged as paramount[xlviii, xlix]. This included aspects such as body language, mannerisms of the officer, tone of voice and personal contact. It is also worth highlighting that some carers/service users reported to be intimidated by the uniform itself. Some of these aspects cannot necessarily be altered (e.g., uniform) but some are more open to be addressed. The point to highlight here are the range of factors that such a vulnerable group hold important to them during the encounter.

> "Uniform is very intimidating. In the height of crisis all you are is uniform. It's like a 'red rag to a bull'". *Service User*

Carers reflected that at times police attendance was necessary and they themselves would contact the police. It was recognised that some service user's behaviours may be seen as 'threatening', requiring a response from the police. Whilst carers felt police encounters could be improved, they understood the necessity of their actions in certain situations.

Culture & Community: Service users and carers perceived they were viewed akin to a minority group. They felt the officers they had encountered lacked local engagement/knowledge, and held narrow views, in particular around culture and mental health. Participants suggested there needs to be education not only in mental health but in cultural backgrounds, so that officers can understand the different ways people react may be due to their culture rather than a mental health related issue.

> "Police need to understand cultural issues first - may be wrongly viewed as mental health issues, such as speaking too quickly or passionately is seen as pressure of speech". *Service User*

Information Sharing: The sharing of confidential information and Care Plans was seen positively, especially if it helped to reduce risk and provided officers with information that could help them approach and "deal with them [service users]" in a more appropriate way. However, it was felt important to keep the information focused on the necessary details and, if the individual has numerous encounters with the police whilst in crises, then service users wanted the information to be fully shared with them in advance.

Police perceptions of mental health

This section provides an overview of officer perceptions when encountering individuals with mental health needs. Key results relating to officer perceptions are[14]:

- Over a third of officers (37%, n=40) describe **fearing for their own safety** when dealing with individuals with mental health needs
- **Not wanting to make the situation worse** (55%, n=32),
- Worrying about taking the wrong choice of actions (30%, n=17)
- Being **concerned about the legal reprisals** of the actions taken (83%, n=48)
- Only **sometimes knowing how best to help** (78%, n=45).
- There are frequently lots of unknown circumstances (39%, n=40),
- Being **concerned the individual will 'lash out' and become violent** (36%, n=21).

This illustrates a mental health encounter from a police perspective. The unknowns and perceived risks appear to run through the situation. Whist there are links between certain mental health issues and violence [I] these links are often exaggerated[li]. If police response to people with mental illness is driven by perceptions of dangerousness and potential for violence, this will likely influence the subsequent encounter and police are likely to draw more deeply on their use of force options[lii]. Research suggests Taser is used[15] considerably more on individuals with mental health needs[liii],[liv]. The MPS and College of Policing are in the process of producing national guidance documentation for all UK Police Forces that will detail restraint issues, particularly with individuals with mental ill health, and will include information on Taser use. This paper is due for consultation in 2016.

To investigate officer's fear of safety and use of tactical options when encountering individuals with mental health needs, half of respondents to Survey 2 were provided with a vignette regarding a violent incident (n = 48), the other half received a vignette regarding a violent incident when the suspect had mental health needs (n = 63).

Officers ranked which tactical option they would consider using. Positively (albeit a very small sample size) results indicated officers reported **very little difference in their use of tactical options** whether the individual had mental health needs or not. The majority of officers would try **verbal de-escalation as a first resort**, followed with an open-hand strike. In terms of using a weapon, officers ranked a baton above either Taser or CS Spray.

"I would attempt hands on first to pull them off, then escalate my use of force if that didn't work. This would be the same regardless of whether they had MH or not." *Police Officer – Mental Health and Violence condition*

"[Verbal de-escalation is] least force. However rapidly switch to Taser if verbal shock/de-escalation is not effective". *Police Officer – Violence Only condition*

[14] Not all officers who responded to the survey answered every question, therefore the number of respondents (*n*) per question varies.

[15] The term 'used' in reference to Taser includes the removal of the Taser from the holster, red dot and firing the Taser.

Pathways

By the nature of their job, police officers are focused at the front end of the service delivery in terms of mental health, often only being present when an individual is in crisis. In a similar vein, Street Triage by its very name is a triage service, and should be situated at the initial stages of the individual's journey through the mental health services. It is important to improve this front end service, so that at least the start of the mental health service journey is directed in the correct way. One major aspect in delivering this service would be the earlier uptake (as discussed previously) of officers, as well as implementation of innovative, adequate and responsive health based mental health services.

When encountering an individual with mental health needs, officers have a **few options at their disposal**. Officers report they most *frequently*[lv] deal with the situation at the scene, or in line with MPS training, **offering individuals 'Time - Distance - Space'**[lvi]. Following the Standard Operating Procedures[lvii], other options less frequently used include **detaining an individual under Section 136 Mental Health Act** (S.136) and taking the individual to a place of safety, but also delivering the individual to a place of safety without a S136, such as the A&E Department, or arresting and taking the person to custody. Officers highlighted that they would appreciate more options available to them (e.g., access to designated substance misuse centres), and clearer guidelines about which pathway to use in different situations[16].

Confidence in mental health

It is important for officers to feel and act confident in their role, to portray an element of authority in particular around mental health crisis. Confidence here is closely linked with training and much research has shown that officers are negative towards their mental health training. To demonstrate this, when engaging with individuals with mental health needs, **only half of officers reported they always feel confident in their actions,** which could impact on the encounter and again stresses the need for enhanced training. This call for enhanced training is not a new one and it may be that training such as the Mental Health Briefings and MAST (Mental Health Awareness and Safeguarding Training) may be able to meet this challenge[17].

The importance of partner communication

Much has been written in terms of the importance of partnership working[lviii] [lix]. There were many signs of this within the research, in particular a lack of communication and collaboration between agencies.

To illustrate, police officers often described resistance to cooperate from partnership agencies as one of the biggest barriers they face, as well as poor communication between partner agencies hampering good practice in day-to-day working.

Indeed, this communication between different services can be made more difficult by numerous terms used to describe mental health needs. A lack of consistency and standardisation is not an enabler of partnership working. The findings indicated SLaM staff members were not always fully aware of, or understood specific police related frameworks or models in relation to mental health. Officers also admitted not being fully aware of certain terminologies either. Despite all Territorial Police officers receiving training, from the Pilot Boroughs:

[16] This has since been addressed, as the MPS MH Team briefings, delivered in October/November 2015 provided clear operational guidelines.

[17] E&I conducting RCT on MAST and exploring staff perceptions, due to report end of 2015.

- 1/4 of officers reported understanding the Vulnerabilities Assessment Framework (VAF).
- 1/3 had not heard of the ABCDE model.

The use of a variety of different data recording systems may also act as barriers to partnership working. Both within and between services (Police, NHS, etc.), data management systems often do not integrate with each other, hampering data sharing abilities and collaborative working.

Another example of the necessity for effective partnerships is that of meeting needs and providing pathways. This was apparent in the survey when respondents outlined the overlap between substance mis-use and that A & E are unwilling to accept S136 patients, thus leaving officers with a limited number of options.

There were a number of internal and external issues around access to 136 suites, as the Street Triage nurse was the key contact for officers when arranging a suitable place of safety. This resulted in Street Triage nurses often being seen in a negative light by some health and police staff members, and having to bear the focus of frustrations on all sides. This pilot highlighted a need for a robust system, both internally and externally around the process for escalation and resolution when there are no 136 suites available. This would help avoid delayed access to suites where patients are left waiting or officers have to cross boroughs and NHS Trusts to find suitable accommodation.

Discussion

The data indicates a heavy and rising demand of mental health within London. There are also pan London trends in terms of rising number of criminal incidents relating to mental health and adult Merlin's recording S136s. Street Triage boroughs were completely consistent with this wider pan London data. There was no 'impact' per se on these issues - equally no signs that Street triage had a negative influence on the boroughs.

In terms of usage, figures estimate that officers used the service on approximately **26% of occasions**, suggesting Street Triage would appear to have a solid start in terms of usage but with more to do to encourage staff and partnership working. This reports outlines and discusses issues that have arisen throughout the implementation process, which need to be considered for wider roll out across London.

To progress, wider issues need to be discussed including sustainability, training and promotion of the service.

Sustainability

During the final few months of the Street Triage pilot, discussions turned to the sustainability of the service provided once the pilot duration came to the end. Both SLaM and the MPS were keen to continue with some sort of service, whether in the same guise or a condensed model as there was a strong belief that the Street Triage pilot had provided an invaluable service to officers as well as a requirement set out in the Crisis Care Concordat to provide a 24 hour mental health crisis service.

The face-to-face service is part of the new service but will possibly be limited due to resources, as two staff members will not always be available. Staff working hours will be flexible whilst the needs of the service are established. This element was seen positively by the mental health professionals from SLaM and the MPS.

The new service, which continues to be commissioned by all four boroughs involves a 24hour telephone line for the use of police officers (both MPS and British Transport Police) and London Ambulance Service. Additionally there will be a free telephone number for service users and carers.

At present this amalgamation of the Street Triage service and crisis line is only available within the four SLaM boroughs. Elsewhere in London, this service is unavailable, although individual boroughs may be introducing different schemes and services. There is currently no definitive pan-London plan to standardise the crisis services, nor provide a London wide service to police officers dealing with mental health related situations, however high level discussions are afoot.

It is clear that when used, the Street Triage option was welcomed by officers, who appreciated the help and advice provided my mental health professionals in a timely fashion. However, this is in conflict with the reasonably low-level usage of the service over the year period.

A broader view of the current services also needs to be taken to understand how they currently fit with those using the services. For example, as illustrated in the report many of the callers that the police encounter when in crisis are known to mental health services. They are, in effect, returning through a 'revolving door' system. This issue is currently under discussion with the Mental Health Partnership Board Operational Group, who

are mapping work to understand what this looks like in London.

For sustainability of the service to be effective, it is important to make adaptations to current processes, including training of officers, the audit process and recording of data, and effectual communication of the service provided.

Training

Officers and NHS staff need to be fully equipped to understand not only mental health situations, but also the legal powers and abilities of each other. Many of these issues could be addressed via appropriate, challenging training to all involved. This is an issue that has been highlighted previously and a common theme running through this evaluation.

Both police officers and mental health professionals were able to offer alternatives for future interventions. One of the most common themes emerging is around the involvement of service users and other agencies within the content of the training to provide a more holistic approach. Engagement of this nature may potentially improve the perception of fairness within the police, thus increasing legitimacy and policing by consent.

"Workshops with the police and service users would help to educate them. This is the way you treat us…this is the way you should have treated us…" Service User

"Speak in the same language - communicate on a humanitarian level and build trust". Carer

Service users themselves also identified elements that could be easily implemented in the future with few resources. For example, a fair encounter with more respect and humanitarianism from the officers would benefit.

"Stop using computer packages like NCALT to deliver important legislation changes and guidance". Police Officer

To achieve these, it was suggested that officers attended workshops run by service users, or have joint training to address this. In late 2015, there are plans to conduct training sessions on mental health which will involve a session from service users from a charity called 'HearUs' in Croydon - a potentially valuable innovative aspect of training. Equally, E&I are in the process of evaluating MAST, which could also yield insights as to improving police training.

"Don't ask for personal details – seems like you're being questioned. Just ask if I am ok." Service User.

"Speak directly with someone who had a Mental Health Crisis and what their advice would be for police to assist them". Police Officer

Over the past year, work has taken place with members of service user groups within SLaM, in an attempt to develop and formulate a specific set of four questions the police could use. Police would be made aware of such questions and trained to use them when approaching someone they believe to be in crisis. Although not yet finalised, and would need the agreement of the Central Mental Health team within the MPS, the questions would be based around "asking the individual if they are ok", "providing their own name rather than asking for the individual's name" and "offering help". Through the focus groups, participants highlighted that if officers

approached in a friendly, non-accusing manner, then they would be much more likely to cooperate.

Promotion of the Service

Street Triage was promoted through briefings from the Central Mental Health team and Local Borough Mental Health Officers/Leads to frontline officers and the distribution of information cards (Figure 1). However the importance of effective communications and promotion of the service has been identified throughout this pilot. Moving forward, to increase success, key police officers with experience of working with mental health who can influence practice need to be identified. This often works best with officers who are frontline rather than coming from senior officers or trainers, as has been the case thus far (i.e., VAF training being delivered by MPS trainers). Officers who have had successful interactions with the Street Triage service previously could be asked to encourage other officers to use the service, enabling them to learn by experiences.

Conclusions

The data indicates a heavy and rising demand of mental health within London. Street Triage has helped foster joint working by staff from MPS and SLaM NHS. The pilot fits well with the broader aims of the Mental Health Crisis Care Concordat to improve the standards of care provided to those experiencing any form of mental health distress. Street Triage has had a strong start and sits at the crisis point of ones' mental health journey. It is important to look forward, focusing on embedding elements of Street Triage into the current NHS commissioning[lx] and MPS processes to establish the best pathways and parity of esteem for individuals in mental health crisis.

Appendices

Appendix A: Matching Boroughs

The four pilot boroughs (Croydon; Lambeth; Lewisham; and Southwark) are all situated in the South East of London, and are covered by the South London and Maudsley NHS Foundation Trust (SLAM).

In forming the main control group a robust matching process was used to identify the boroughs within London which were best matched, in theoretically relevant ways, to each of the Street Triage pilot boroughs.

Each of the pilot boroughs was compared against all other (non-Mental Health Street Triage) London boroughs in terms of:

- No. of calls flagged as MH related (2014)
- No. of S.136 (2011/12)
- Estimated cases population aged 16-74 years with mental health issues (2010)
- Total population by borough (All Ages) (2013)
- Crime rates per thousand population (2012/13)
- Indices of deprivation average score (2007)

For each variable, where the comparison borough was found to be within a certain percentage comparable to the pilot boroughs a score was applied. See Table 2.

Summing across the criteria resulted in an overall score for each non-Mental Health Street Triage borough, which represented the strength of its match to the pilot borough in question. The scored comparison boroughs were then ranked and the best match for each Street Triage borough was chosen as the four matched boroughs. Where one non-Mental Health Street Triage borough best matched more than one of the pilot boroughs, the second closes match was chosen.

Table 2. Scoring used in borough matching task

Between these Percentages	Score Given to Borough
>5%	5
5 % - 10%	4
10% - 20%	3
20% - 30%	2
30% - 40%	1
40% <	No score applied

Before finalising the control boroughs, it became apparent another pilot (Liaison and Diversion (L&D)) was concurrently run across London, and at an enhanced provision in ten boroughs. As this may have acted as a confounding variable, the four top ranked of these L & D boroughs were chosen as separate group, creating two subgroups to the matched boroughs. This resulted in eight boroughs identified as the best matched to the pilot boroughs (see Table 3).

Table 3. Matched Boroughs

Matched Boroughs	
Liaison & Diversion Boroughs	Control Boroughs
Barnet (Barnet, Enfield & Haringey NHS Trust)	Brent (Central & NW London NHS Trust)
Enfield (Barnet, Enfield & Haringey NHS Trust)	Ealing (Central & NW London NHS Trust)
Haringey (Barnet, Enfield & Haringey NHS Trust)	Greenwich (Oxleas NHS Trust)
Newham (East London NHS Trust)	Wandsworth (SW London & St George NHS Trust)

Appendix B: Methodology

Surveys:

Post Phonecall Survey

A survey was distributed, via a telephone call or email, to officers who had contacted Street Triage. The survey consisted of 8 short questions asking them about their experience and immediate feedback of the Street Triage service.

- Response rate: 212 officers completed the survey (18%)

Police Officers Attitudinal Surveys

Police Officers attitudes to mental health were investigated through two surveys, distributed 6 months apart. The surveys looked to identify whether the Street Triage pilot had embedded within the pilot boroughs. In both surveys questions were divided into thematic groups including understanding and prevalence of mental health issues and services, barriers to conducting best practice on an operational basis, suggestions for improvements and specific questions on the use of the Street Triage pilot study. An invite was sent out via email to all Local Policing Teams (LRT) and Emergency Response Teams (ERT) in the four SLaM boroughs involved in the pilot.

Survey 1 was released in August 2014 and kept live for seven weeks, but response rates fell below the typical 10% response for online survey completion. The survey was sent to approximately 2,233 officers, but only 110 of these officers completed the survey (a response rate of <5%). Survey 2 was released in February 2015 and kept open for eleven weeks to try and increase response rates. Despite numerous reminder emails from Chief Inspectors, and prompts from Borough Liaison Officers, only 95 officers on the pilot boroughs (a response rate of 5%) responded.

Additionally, all LRT and ERT officers on the Matched Boroughs received the survey (between 4,000 – 5,000 officers in each wave of the survey). The number of completed surveys was again low with only 172 surveys from Survey 1 and 97 surveys from Survey 2, providing an average response rate of 3%.

Whilst matching boroughs in this way provides a more robust study, due to the low response rates received, comparative analysis of the data has not been possible.

Survey 1: The majority of respondents (from all boroughs) were:

- Male (66%; female, 29%, prefer not to say 5%);
- Aged between 25 – 34 years (44%) but respondents ranged from 18 years old to 65+ years old;
- Experienced officers – 48% had been in the police service for over 10 years and a third between 5 and 9 years;
- The rank of Police Constable (PC) (72%);
- From Emergency Response Teams (48%) and Local Policing Teams (22%)

Survey 2: The majority of respondents (from all boroughs) were:

- Male (63%, female = 33%; n=90);
- Aged between 25 – 44 years (25 – 34 years – 37%; 35 – 44 years – 38%), but respondents ranged from 22 years old to 64 years of age (n=89);

NHS SLaM Staff - Street Triage Attitudinal Surveys

SLaM Street Triage mental health professions were asked to complete an online survey regarding their thoughts and opinions of the Street Triage service on offer. This included staff members who answered the 24 hour

telephone helpline, and those who attended face-to-face assessments when required. The survey focused on their understanding of the role of Street Triage, relationships with officers and their use of the Street Triage service, types of information provided, suggestions for improvements and more specifically how they felt when attending face-to-face assessments.

In February 2015 an invitation to complete the survey was distributed via email to all staff members involved in the running of the Street Triage service over the year period. The survey was live for four weeks and received eight responses. This reflects all of staff members who have worked on the Street Triage service, providing a 100% response rate.

The respondent's demographics are:

- An equal gender split (Males = 4, Females = 4)
- Aged between 25 – 34 years (n=4; 35-44 years n=1; 45-54 years n=3).

Focus Groups:

The aim of the focus groups was to explore how individuals with mental health needs, who have come into contact with the police, are treated by both the police and NHS staff members.

Service Users were recruited via an email advert distributed to a number of Clinical Academic Groups (CAG's) and user groups within the SLaM boroughs. Participants who responded to the advert had to be currently well, and have had previous (within last few years) contact with the police when in crisis. Where possible, the mental health professional would review the participant's history and current status to ensure their suitability to participate.

Carers of Service Users who have been in contact with the police when in mental health crisis were also invited to attend their own focus groups. Carers are often involved in the service users Care Plans, and in some cases, it is the carer who contacts the police in the first instance. The aim of this focus group was to explore how carers are treated by the police and NHS staff, if they have been present when the Service User is in crisis.

Due to the nature of the subject area, there was potential for negative emotions/feelings to be exacerbated through our discussions. Time was provided at the end of the focus group for individuals to talk to the mental health professional on a one-to-one basis if required. If this occurred, SLaM also agreed to follow up the individual the next day with a phone call to the Service User or a discussion with their Care Coordinator.

Three focus groups (2 x Service Users, 1 x Carers) were held in March and June 2015 and facilitated by a mental health profession from SLaM, providing expert knowledge if required. Members of the MOPAC E&I team attended as note takers, to enable the Service Users to see that their voices will be heard, but without influencing the discussions. The sessions ran for approximately 90 minutes each.

- Six Service Users attended.
- Four Carers attended.

Topics for discussion within the focus group included:

- What are your general views of the police? CPS?
- Thinking about how the police have reacted to you/Service User in the past, have the police treated you fairly?
- How would they like the police to react on arrival?

- How much of your medical information would you like to be shared? What information would you like the police to know prior to attending?
- Thinking about the last time you were in contact with the police (because you were in crisis), how did you feel?
- Have you called the police in the past regarding the behaviour of your 'Service User'?
- Did the police discuss with you the outcomes of their attendance?
- When in contact with the police (because you were in crisis), what four questions you would like to be asked by the police? / Four things the police could do?

Appendix C: MPS CAD Data

Data extracted from an MPS computer system known as CAD (Computer Aided Dispatch) has been coded according to a bespoke framework. CAD is a method of dispatching emergency vehicles in relation to 999/101 calls. The CAD system also records information passed between the caller and operator, radio communication between operator and attending officers, locations, times and details of the incident being reported.

In total, approximately 1,000 CADs, with an Open code or Classification code relating to mental health (code 612) in November 2014 were randomly selected. Four hundred of these CADs were incidents located within the four pilot boroughs. An addition 600 CADs were in relation to incidents located within the eight Matched boroughs, split equally between L & D boroughs and non-L & D boroughs.

Although much of the data could be directly extracted from the CAD system (via DARIS), more bespoke information relating to comments and actions are recorded in the free text 'Remarks' section of CAD. In order to analyse this data, two MPS Volunteers were trained to code the required data, following a specific framework. This information included details such as whether Street Triage was mentioned or contacted, whether a S.136 was initiated, type of location (private home, street etc.), reason for mental health code, and whether the caller was considered a repeat caller.

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