

# Essex Street Triage Evaluation December 2015

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Author: Dr Sarah Senker & Matthew Scott (TONIC)  
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# Street Triage Evaluation 2015

## Contents

<b>Street Triage Evaluation 2015 .....</b>	<b>2</b>
<b>Executive Summary .....</b>	<b>3</b>
<b>1. Introduction .....</b>	<b>5</b>
1.1 Background.....	5
1.2 National Picture .....	6
1.3 Models of Street Triage Across the Country .....	6
<b>2. Street Triage in Essex .....</b>	<b>9</b>
2.1 The Task.....	9
2.2 Methodology .....	10
<b>3. Qualitative Findings .....</b>	<b>11</b>
3.1 Police .....	11
3.1.1 Findings .....	11
3.2 Mental Health Trust Staff .....	16
3.2.1 Qualitative Findings.....	16
3.3 Service Users and Family .....	20
3.3.1 Qualitative Findings.....	20
3.4 Case Studies .....	22
<b>4. Quantitative Findings .....</b>	<b>29</b>
4.1 Methodology .....	29
4.2 The National Picture .....	30
4.3 Street Triage Activity .....	32
4.4 Costs Benefit Analysis.....	37
<b>5. Conclusions .....</b>	<b>40</b>
<b>6. Recommendations .....</b>	<b>43</b>
6.1 Key Considerations.....	43
6.2 Efficiencies and Improvements.....	43

## Executive Summary

### CONTEXT

Individuals with mental health problems frequently come to the attention of police. Police recognise they have limited powers to deal with these issues effectively and appropriately. This has historically resulted in some individuals being detained under section 136 (S136) of the Mental Health Act 1983, when this may not necessarily be the best course of action. Street Triage allows police and mental health professionals to work together to improve outcomes for individuals experiencing mental health crises or distress.

Street Triage (ST) in Essex has been operating from 6pm to 2am since the end of 2014, increasing from 3 days a week to 7 in April 2015. **Our evaluation found that Street Triage is cost effective for CCGs and Police, achieves better outcomes for service users, and has a positive impact on staff practice.**

### EVALUATION FINDINGS

We conducted 46 semi-structured interviews with police officers, mental health nurses and ST service users. Thematic analysis was used to examine the results, which demonstrated that all interviewees advocated the effectiveness of the scheme:

- Police reported improved confidence when attending mental health incidents, reduced use of S136, and speedier resolution of incidents – making police more efficient and therefore available for other call outs
- Nurses reported improved partnership working with police and more appropriate use of S136
- Street Triage service users reported a positive experience with police, better treatment than on previous occasions where they had been sectioned or detained, and a higher level of professionalism and ability to diffuse fraught situations

Quantitative data compared the first six months of the pilot (since operating 7 days a week) with the same calendar period the year before ST came into operation. There was some difficulty collating a comprehensive set of quantitative data due to there being no single source, and some potential under reporting, which means the benefits found are likely to be under-estimates of the positive impact.

During the first six months of daily operation **103 Section S136s were recorded as prevented by ST** - contributing to an overall reduction of 124 (23%) when compared to the same period in the previous year (before ST was in operation). This is set against a rising national trend in use of S136.

Projecting for a full year from these figures shows that Street Triage in Essex is likely to produce estimated:

- **Gross realisable savings for CCGs of £347,200**
- **Benefits of £99,650 to Essex Police** in reduced use of custody and officer time attending S136 incidents
- **Net benefit of £179,758** - when taking into account the cost of running the scheme

## RECOMMENDATIONS

For the above reasons, **the continuation of Street Triage is strongly recommended**. We also identified a number of recommendations that would further improve effectiveness and value for money:

- **Secure the future of ST** and mainstream the funding arrangements
- **Extend the operating hours** of the scheme
- **Improve the geographical coverage** of the scheme - considering the use of an additional car or improved operational practices
- **Improve the data capture** for all S136s and ST attendances to allow more accurate and ongoing evaluation of the scheme's impact
- **Promote the scheme more actively** across the police force to maximise the usage and efficiency of ST

Further considerations for Police, CCGs and Social Care include:

- Providing nurses with the equipment to facilitate access to notes and allow police to scan live jobs whilst on shift
- Improving rota management - pairing clinicians and police more efficiently according to locality
- Revisiting the training package offered to officers around mental health and re-deliver to current officers with input from NHS clinicians
- Removing Street Triage as an overtime option to ensure it continues to attract appropriately motivated individuals and continues the positive reputation the scheme has developed
- Having a clinician based in the Force Control Room or a dedicated phone-line where officers can contact a mental health professional for advice or information on individuals
- Allowing the ambulance service to request attendance of Street Triage
- Provide nurses with the option of using protective clothing

# 1. Introduction

## 1.1 Background

Formally initiated in the UK in 2013, and strengthened by the commitment made in the Crisis Care Concordat in 2014, Mental Health Street Triage (ST) contributes to improving outcomes for people experiencing a mental health crisis. It is acknowledged that much of police business involves attending incidents where individuals are experiencing extreme distress and are in the midst of a crisis. Estimates of police incidents linked to mental health in England and Wales vary widely between 2-40% (College of Policing, 2015; Home Affairs Committee, 2015). Although Mental Health (MH) awareness does feature as part of the National College of Policing and Essex Police's curriculum, police report that they do not feel empowered or competent in dealing with mental health issues. This creates a challenge for police who are regularly faced with incidents and individuals with a mental health component that they feel are particularly difficult to deal with.

There are several powers available to police when dealing with someone with a mental health concern. Section 136 is one such power. If a police officer believes that someone is suffering from a mental disorder in a public place, and that person is in immediate need of care or control, section 136 of the Mental Health Act 1983 (S136) provides the authority to take the person to a "place of safety", so that his or her immediate mental health needs can be properly assessed. A person can then be detained in a Place of Safety for up to for 72 hours while waiting to be examined by a doctor and interviewed by an Approved Mental Health Professional (AMHP). They decide if treatment is needed, and, if so, whether it should be administered in a hospital or elsewhere (for example, at home, with care provided by a Community Mental Health Team).

Historically, police custody cells were often used as a Place of Safety for an individual detained under this section. However, recognition of potentially inappropriate use of section 136 and police custody stimulated initiatives such as Health-Based Places of Safety (HBPoS) and joint working between health and criminal justice in the form of Street Triage programmes. HBPoS are usually found within a hospital setting and allow the individual to be treated more in line with a patient than an offender where no offence has otherwise been committed.

## 1.2 National Picture

Nationally, the use of S136 has been rising. In their 2015 report, the Quality Care Commission reported a 12% increase in the use of S136 between 2012/2013 and 2013/2014. This equates to a total of 24,489 reported uses of section 136 in 2013/14. The Commission also expressed concern about the way HBPoS were being used, with individuals frequently being turned away due to intoxication or lack of available beds. As a result they remarked that police custody suites were too often being utilised for individuals sectioned under 136.

“If you have a mental health issue, you will invariably come into contact with the police, as the professional involved. That cannot be right. It is not the job of the police to be that first point of contact; they should be the last resort”  
Rt. Hon. Mike Penning MP, Minister of State for Policing,  
Criminal Justice and Victims, 2014

## 1.3 Models of Street Triage Across the Country

Street Triage provides an opportunity for mental health and police to work together in partnership and to agree on the best outcome for individuals presenting to the police in mental distress. As there is no national operating model, Street Triage has been interpreted in multiple ways, including having a dedicated point-to-point contact for nurses to offer phone assessment and support to police, and/or nurses physically accompanying police on their patrols and attending at mental health incidents.

Since its inception, Street Triage has been shown to have positive effects across the Country (Dyer et al., 2015), with regards to:

- Reduced use of S136 and improved diversion to other support streams (e.g. substance misuse services)
- Increased use of HBPoS
- General empowerment for police and those in crises in dealing with such incidents more appropriately

As Street Triage remains open to interpretation in terms of implementation and standardisation, it is imperative to understand what constitutes best practice. This project will contribute to this broader objective as well as influencing local commissioning decisions.

The following examples indicate ways in which Street Triage has been adopted across England - accompanied by data of their impact.

#### **North Yorkshire Police**

North Yorkshire Police adopted Street Triage to cover the areas of Scarborough, Whitby and Ryedale. The scheme is operational between 3pm-1am, 7 days a week, with no police presence in the team, Force Control Room (FCR) requests 2 nurses (one Band 6 and one Band 3) to attend the scene, arriving in an unmarked vehicle. The team can also monitor police radio during their shift and provide advice over the phone or radio.

An evaluation in September 2015 indicated that S136 detentions *increased* during the pilot year (by 12%). This may have been due to HBPoS opening meaning police custody was less likely to be used and A&E admissions which were previously unrecorded were now diverted to S136 suites. In essence S136 may have been more likely now there was an appropriate place for people to be assessed.

#### **Nottinghamshire Police**

Nottinghamshire Police adopted a model similar to Essex, using a North and South car. The hours of operation were 4pm-1am, 7 days a week. At the start of the project in April 2014 the hours were 5pm-2am but were modified in response to demand. Each car received approximately 7 calls per shift. An evaluation undertaken 18 months into the project revealed a 21% decrease in S136 overall and a 75% decrease in S136 in police custody (in the period of August 2014-August 2015). In addition, the report notes that more people went on to be admitted to the ward after S136 – indicating an improvement in the appropriateness of sections. During an interview with the Chief Inspector with oversight of the scheme, she highlighted that they had used an external consultancy company to train their front-line staff on mental health, funded by the Home Office Police Innovation Fund. The success of this means they are now looking to train PCSO's and FCR operators.

#### **Thames Valley Police**

Thames Valley operate Street Triage differently across the region. Oxfordshire Street Triage scheme runs between 6pm and 2am seven days a week and in the year to date there has been an 85.7% reduction in S136 detentions.

Milton Keynes Street Triage scheme started in January 2015 and runs between 6pm and 2am seven days a week. Since the scheme began, 48%

fewer people have been detained under S136. Aylesbury Vale work alongside police officers between 5pm and 4.30am, seven days a week. The scheme has seen incidents being resolved in minutes rather than hours and S136 detentions have been regularly averted.

### **Kent Police**

Kent Police initiated their Street Triage scheme in September 2013 adopting a model, which saw a nurse accompany officer to incidents in a car provided by health. This initially had Thursday to Sunday coverage but this was extended to 7 days a week in September 2014. A SWOT analysis undertaken in October 2014 ahead of funding coming to an end in March 2015, indicated that although there *had* been a reduction in S136s, this was not necessarily attributable to Street Triage. The car had approximately 3 incidents per shift and was felt not to be economical to the police. To this end, the car was discontinued in June 2015 although the option to contact the mental health nurse by phone still exists.

### **West Midlands Police**

West Midlands Police use Street Triage from 10:00 – 02:00/03:00. Based out of Bournville Lane Police Station, the car is staffed with police, MH nurses and paramedics. The scheme is operational 7 days a week including Bank Holidays. Street Triage can be deployed by either police or ambulance control rooms and attend in a plain ambulance responder. Those involved with the scheme say this approach allows them to deal with physical *and* mental health issues. Figures from January to December 2014 indicate a 48% decrease in S136 detentions.

### **House of Commons Home Affairs Committee Reports**

A recent House of Commons Home Affairs Committee report outlined some further success of Street Triage across the Country. In Leicestershire, there has been a 30% to 40% reduction in the use of S136 powers since 2013 and in Cheshire, there was an 80% reduction in the use of S136 in the first six months of Street Triage.

Collectively information on the adoption of Street Triage across the Country shows the variation in the approaches used as well as the range of success that can be achieved.



## 2. Street Triage in Essex

Street Triage in Essex commenced in December 2014 as a pilot for 4 months. This initially operated with nurses on patrol with police officers between 6pm and 2am on a Friday, Saturday and Sunday night. During this initial period, a phone-line was also available between these hours Monday to Thursday.

In April 2015 the scheme was rolled out to have one nurse on shift with an officer 6pm to 2am, seven days a week. There are two Street Triage shifts each evening – one covering the North of the County and one covering the South of the County. Officers currently opt in to Street Triage as overtime where as clinicians have it factored into their rota or bank staff are used. Police use a marked vehicle to collect the nurse at the start of the shift and they can then be contacted through the Force Control Room (FCR) to request them to attend an incident. Another police unit should be on scene before Street Triage arrives on scene in order to assess risk and confirm that Street Triage is needed.

### 2.1 The Task

The Office for the Police and Crime Commissioner for Essex (OPCC) and the MH Crisis Concordat Programme Board sought an evaluation of the Essex Mental Health Street Triage programme. The aim was to conduct robust analysis and produce a report to inform future developments of the service and efficient use of resources. The objectives of the evaluation were to:

- Review performance of the Essex Street Triage programme in order to make an assessment of the effectiveness and efficiency of the programme
- Undertake a desktop review of other Street Triage programmes outside of Essex in terms of good practice and learning
- Undertake a qualitative assessment of the impact of the programme on practitioners, i.e. how have police officers practice changed as a result of Street Triage
- Undertake a VFM assessment of the programme, in relation to resources invested and savings subsequently or potentially made. This should include any added value benefits
- Analyse the impact of the programme in relation to use of S136 and reductions in episodes after a street triage intervention

## 2.2 Methodology

The qualitative arm of the evaluation involved 39 interviews with professionals across police and mental health fields, 7 interviews with service users and shadowing of two street triage shifts. The Street Triage shifts were both weeknights, once on a Wednesday and once on a Thursday. Coincidentally, the same clinician covered both shifts although the accompanying officer differed.

The qualitative researcher was provided with email details of all staff working on Street Triage across Health and Police services. Each member of staff was contacted, inviting them to take part in a telephone interview or, for health, a focus group. For service users, police and clinicians were asked to provide contact details of individuals they had encountered through Street Triage who were willing to be interviewed. This could be individuals who had used Street Triage prior to the inception of the evaluation or during the course of the evaluation. Information sheets were produced and disseminated to practitioners to take out on Street Triage shifts, this included a brief synopsis of the project, a space for the individual's signature of consent to be contacted and space for written feedback on their experience.

Interviews were semi-structured, with the objective of understanding the individual's perception and experience of Street Triage, what components of the service work well, and what could be done in the future to improve the scheme. Verbatim notes were taken during the interviews to allow accurate representation of content and utilisation of quotes to ground any recommendations. Thematic analysis was then applied to the data to draw out important themes to be fed back to the commissioning board.

For the purposes of the quantitative analysis element of this evaluation, we are focusing on the first 6 months of the full Street Triage project, operating from 6pm to 2am, 7 days a week, from 01/04/2015 – 30/09/2015 (Referred to as "Full ST"). We then compared this with the same period of 6 months the previous year (referred to as "Pre-ST") – namely 01/04/2014 to 30/09/2014 – to give an understanding of the impact on activity and costs that the Street Triage programme has contributed towards.

## 3. Qualitative Findings

### 3.1 Police

The following interviews were undertaken with individuals from Essex Police:

- 20 interviews with officers (constables and sergeants) working on Street Triage
- 1 interview with deputy custody commander
- 2 Street Triage Shifts shadowed
- 1 interview with Chief Inspector in Nottinghamshire with oversight of Street Triage for comparative data

#### 3.1.1 Findings

##### The Value of Street Triage

Officers advocated the use of Street Triage, as well as its continuation in Essex.

*"It's a good scheme and it was a long time coming. If it were to go we would miss it. I know money is tight but if they lost the triage car we would be in a worse position"*

*"It has really made a difference and I would be gutted if it didn't carry on"*

Echoing national findings, officers in Essex reported that someone threatening suicide had historically been enough for them to use S136 as a result of a lack of alternatives and an emphasis on being risk-averse. Officers reported feeling uncomfortable leaving someone alone if they were threatening self-harm or suicide. Subsequently, officers acknowledged that they have historically been "over-cautious" when using the power to section resulting in it being used too frequently. Officers stated they were in a "damned if you do and damned if you don't" culture.

*"As police we were a bit stuck with what to do, our powers are limited, we face lots of criticism and therefore are over cautious. Street Triage helps people get access to the right care and it helps police because*

*we are accompanied by someone with relevant knowledge and someone we can "pass the buck" to - and walk away feeling more confident".*

The introduction of Street Triage was therefore said to be very welcome as it provided officers with a level of reassurance around their decision making. Officers felt more comfortable leaving an individual threatening self harm or suicide if the nurse had conducted her assessment and felt this was safe to do so.

*"From working on the car - most officers listen to what the nurse has to say. It has made people question 136 and gives officers that back up. Officers get worried about leaving someone and we feel happier leaving someone when the nurse has done her assessment"*

Often the nurse was able to reduce the level of agitation and risk by offering an appointment or contact the following day. The impact of this was also said to translate outside of Street Triage, officers reported more confidence in their decision-making skills, a more in-depth understanding of risk of suicide, an awareness of alternatives to S136 and an improved understanding of the challenges faced by the Mental Health Trusts:

*"I have learnt a lot from the nurse - trying to find the right level of talking to people. The signs to look out for to indicate if someone is serious about killing themselves, for example, do they have future plans, protective factors. We talk about mental health in the car so I am constantly learning"*

Officers reported anecdotally that, since the inception of Street Triage, they felt they were using S136 much less frequently, in fact hardly ever, especially when on a Street Triage shift. In addition, they stated that when S136 DOES take place on an ST shift, they are organised and executed much more smoothly, taking up less time:

*"Last week, a woman we attended and was threatening to kill herself, she would have been a 136 100% but the nurse I was with got her straight on the ward with no hassle and no complications. It was resolved a lot quicker"*

Having the nurse on scene meant that the situation was able to be diffused rapidly, officers reported that individuals opened up much quicker to the

nurse and they were often able to make useful suggestions about how the situation could be resolved:

*"A nurse recommended using an elastic band instead of self-harming – 'I would have never of thought of that'. This was a big man and she handled it amazing - if she wasn't there he would have run into the road and tried to kill himself or we would have had to cuff him and drag him to a 136 suite"*

*"I have been to so many incidents and they won't talk to us at all. With the street triage system every one opens up every time, it really is quite amazing".*

Overall, officers perceived that Street Triage reduced resources required around the management of mental health incidents with officers being available to attend other incidents rather than tied up at Accident and Emergency (A&E) units for example.

*"The key thing is that it doesn't tie officers up as much. A lot of the jobs we would go to without the nurse or before the nurse - we would section them, and that would mean that we would have to go through the hospital - it's saving us a lot of time especially now Shannon House [Harlow's Health Based Place of Safety] is closed"*

*"It would be a great shame to lose Street Triage, I know we need to save money but the time we spend sitting in a 136 suite is horrendous, I certainly think it's a great idea"*

*"I would love to see Street Triage continue, it's a strangely fabulous use of resources. If it saves two officers sitting in the Mental Health unit for hours and hours on end, or if someone goes missing from A&E then that's a huge man-hunt"*

### **Areas for Improvement**

Although unanimously in favour of Street Triage, officers were able to ruminate on ways in which the scheme could further be improved.

Several officers stated that they often had to drive long distances across the County, which meant officers already on scene were left waiting for attendance. Therefore, the **addition of another car** to cover West was spoken about as a potentially helpful addition.

Officers felt that having Street Triage for longer during the day would be beneficial, as many pointed out that mental health was not bound to any particular times of the day and, in the absence of a 24 hour service, they would like **some provision, either a phone line or one car, available outside of 6pm-2am.**

It was observed during the shadowing of Street Triage, and reported by officers at interview, that time was often wasted at the start of the shift when collecting the nurse. It is therefore rare that the shift can take jobs on earlier than 7pm as a result of this. Therefore a recommendation would be to **co-ordinate officers and nurses** (e.g. Colchester Officer collects nurse from Colchester) or build in time for this before the shift starts to avoid delay in being ready to respond.

Officers reported sometimes receiving pressure from FCR or their Sergeant to attend incidents where another crew was not yet on scene. They reported discomfort about this as they were essentially carrying an unprotected civilian with them. Therefore, there should be **clear communication of policy** to reduce pressure on Street Triage to be first on scene.

In light of this observation about the nurse being a civilian, some officers recommended the nurse had the **optional provision of having some protective clothing**. This was suggested to be covert or clearly labeled as 'nurse' to avoid losing the impact of rapport building .

*"I have 16 years in service, not a lot phases me but the control room does need to think about how they rota. For example, sending out one female nurse and one female officer and that nurse isn't in protective clothing"*

Officers identified some frustration when waiting between jobs. They recommended **access to a "joint base"** to facilitate access to patient notes and live jobs would maximise their down time.

*"We are sitting waiting for a job but can't do any admin in the mean time. ...access to a computer terminal for both police and nurses. Police could look at incident log for the County and see what we could attend - be more proactive rather than waiting for force control room to contact us"*

Officers felt that Street Triage should **continually be promoted**. One example given was to use a screen saver on police computers to remind other officers that the resource is there to be used.

Some officers recommended that Street Triage **should not attract overtime** in order to ensure that officers working on the scheme were motivated to learn about mental health. This was felt to be an important component to maximise the utility of the provision, as well as build a strong reputation for it.

### Summary of Key Points

Officer motivation for being involved in Street Triage varied from being interested in financial gain from over time to having an improved understanding of mental illness. Overall, officers felt appreciative of the Street Triage scheme and expressed some relief at its existence.

Police felt their knowledge and working relationships with Mental Health (MH) staff had vastly improved as a result of working together. They reported an improved understanding of each other's roles and challenges within these parameters, which helped resolve some previously noted frustrations (e.g. difficulty getting someone admitted due to bed availability).

Officers reported it was rare to section someone now during an ST shift and knowledge gained throughout partnership working also had an impact when they were performing their usual duties. Police stated it was a great use of resources in a context where the police were "stretched to the point of snapping".

Officers felt it helped reduce stigma and belief from the public that police will only arrest or detain – and subsequently improved community relationships.

## 4.2 Mental Health Trust Staff

The following interviews were conducted with staff from the two Essex Mental Health Trusts involved in the scheme; South Essex Partnership University NHS Foundation Trust (SEPT) and North Essex Partnership University NHS Foundation Trust (NEP):

- 2 focus groups held with SEPT and NEP clinicians with a total of 8 practitioners
- 3 further interviews with SEPT bank staff
- 6 interviews with other Trust staff (bed manager, ward manager, operational service manager, clinical managers, senior nurse within emergency department)

### 4.2.1 Qualitative Findings

#### The Value of Street Triage

Nurses reported having a much higher threshold for risk than police. They found they were much more confident and able to leave someone at home despite threats of self-harm or suicide. Learning more about the police's approach and constraints around this was helpful in understanding why, historically, people had sometimes been brought in under section when MH professionals may have felt this was unnecessary. Nurses described that, in their experience, it was very infrequent to have to section someone under 136 and therefore it was important to be able to present diversionary options in order to reduce pressure on police and the Trust as well as distress to the individual.

*"Since 2004 I have seen so many inappropriate cases of police bringing in a 136. They have the power but not the knowledge - I get it, they are covering their backs. AMHPS are so stretched, maybe 2 covering the whole County - so if we can reduce unnecessary 136's - that's so important. Someone might be clogging the suite when a genuine one comes in"*

*"From the moment I heard about it I thought it is such a brilliant scheme and it has educated me from the police side - I just think it is a brilliant scheme. Financially, it is reducing unnecessary 136, and stopping people being frightened in a 136 suite when they shouldn't be there. It is freeing up beds, people might need help but they can be treated in their own homes. It helps AMHPs, police, ambulance and us as nurses".*



The ability of police and nurses to work together when presented with someone in distress was said to facilitate the 'bigger picture' – ensuring more accurate decisions were made around risk. Police could provide information on an individual's offending history and risk of assault, use of weapons whilst the nurse could give information around medication, diagnosis and care plans.

*"We can problem solve together"*

*"There's been a tremendous reduction in 136 and also the scheme has benefitted many communities in Essex - there is a common shared knowledge now with the nurses and the force, we are sharing ideas and learning from each other. It has created an awareness and has equipped police with a wider knowledge and understanding of mental illness"*

Clinicians reported a macro-context of people making flippant remarks about suicide and self-harm. This was said to have contributed to an increased pressure on the system where these have to be investigated. The closure of Shannon House (the Health Based Place of Safety in Harlow) has added further pressure. Both of these circumstantial factors meant that Street Triage had come at an important moment and was welcomed:

*"Due to Shannon House closing, sometimes we get more 136 coming this way so Street Triage is needed more than ever. But it has reduced even with this closure"*

Clinicians described several occasions where Street Triage had led to individuals being identified in the community who had previously not had input from services. Some of these cases involved people who were acutely unwell and may not have otherwise come to the attention of Mental Health services as their route to support was a result of Street Triage, i.e. through the police and criminal justice system.

### **Areas for Improvement**

Some staff reported ongoing challenges with inappropriate S136's, intoxicated individuals and a lack of staff within the unit to cater for those who are being brought in. Although there was diversion, there was still a pressure on staff within the hospital.

*“There is a feeling that the police in some instances are still favouring 136 rather than taking people to A&E for assessment as they are able to exit from the situation once the patient has arrived in the 136”*

To this end, clinicians recommended **extending hours of Street Triage** to continue to reduce S136 admissions during the day, **after 2am and on Bank Holidays**. In the absence of this they supported the use of a **telephone line** during the day when Street Triage is not available.

*“If Street Triage were extended, it would further reduce the number of S136 cases we receive, perhaps drastically”*

Nurses reported a sense that the responsibility for S136 cases is not fully shared, and despite police taking the advice of the nurse, officers still feel that their *“neck is on the line”*, which can make them reluctant not to use S136. It was suggested that there should be some **acknowledgement in policy that responsibility** over the dispersal options of an incident attended by Street Triage **is shared** and it was felt this could contribute to further reductions in S136's.

Clinicians rarely finished at 2am and had to continue working for additional hours to write up notes. Having a **better rota management system** or the **ability to access notes** whilst out on shift would alleviate some of this pressure.

Clinicians reported a qualitative difference between officers who were motivated to learn about mental health and those that were attracted to the scheme as a result of overtime payments, which sometimes led to the police officer sometimes acting simply as a *‘chauffeur’*.

They too reported a perceived **pressure to attend incidents** first and a relative discomfort in this as this limited the amount of information able to be ascertained before they arrived.

Paramedics were known to request Street Triage and this had to be rejected due to the current policy that it can only be requested by FCR or officers on scene. Clinicians felt **paramedics should have access to Street Triage**.

Clinicians discussed that there were still some difficulties when patients are **not sectionable**, not least because they may be in their own home, and will not come voluntarily to hospital. In addition, some patients were reportedly

still getting **“stuck” at A&E** and then sent home after a long wait. This suggests some wider systemic issues that Street Triage has yet to resolve.

Practitioners raised concerns about occasions where they had been threatened with violence. This prompted suggestions about the **provision of covert body-wear for the nurses**, especially as they may only be with one other officer on the scene.

Clinicians were able to identify that some parts of the County benefitted from the scheme more than others. They therefore advocated **wider promotion of the scheme**. This included nurses advocating the provision of a **3<sup>rd</sup> car** to cover Harlow, Epping and Loughton to reduce waiting times and long drives across the County. They also felt that **force-wide training** around mental health would be welcome to extend the learning from officers on Street Triage to the broader force.

Those working on the scheme thoroughly enjoyed it. It was acknowledged that if the scheme were to be permanent this would likely **attract staff to apply for secondment or full time roles rather than utilising bank staff**, which could result in a saving on delivery costs and improvements in specialisation.

Finally, clinicians felt the utility of Street Triage would be increased further by allowing them the ability to **prescribe 2-3 days worth of medication** to ease with sleep, agitation or hallucinations. They also indicated they would **like time to follow up on referrals** and recommendations made during the shift, e.g. to GP or Home Treatment Team. Clinicians often referred individuals to ‘Therapy for You’ in the absence of statutory recommendations.

### Summary of Key Points

On the whole, clinicians and ward managers were pleased with the impact of Street Triage and it was said to provide a solution to a problem that has been in existence for many years.

Staff anecdotally reported a reduction in S136’s and felt confident that the scheme had had a positive impact on police, the Trust and patients.

Clinicians admitted they were not always strictly attending “crisis” incidents where a S136 would have been considered but did not see this as problematic and instead, maximised the resource to its full capacity.

Most call outs were to people's home rather than on the "street" as the name implies and this sometimes presented a challenge when someone did require sectioning as they were not in a public place.

There was some room for improvement to make the scheme more effective – including extending the hours of operation and an additional car based in underserved areas and to facilitate shorter waiting times and greater impact.

### 4.3 Service Users and Family

14 individuals were contacted through text message and invited to interview. The majority of service user details were passed on to the qualitative researcher by the police. The MH Trusts did also share contact details but largely provided case studies. The following interviews were conducted with service users or their families.

- 5 individual interviews were conducted over the phone with people who had been assessed by Street Triage
- 1 face to face interview with the wife of someone who had been assessed by Street Triage
- 1 phone interview with the mother of someone who had been assessed by Street triage
- Access to case-studies, Street Triage return sheets and emails from family members

#### 4.3.1 Qualitative Findings

##### The Value of Street Triage

Feedback from service users was unanimously positive. Individuals were able to reflect on the success of the scheme based on their feelings about of how things would have differed in its absence:

*"Normally, I would have to go to A&E and that makes me lose my temper. I have to sit for hours and hours and that makes me worse"*

Some people had previously been sectioned and the experience of Street Triage was consistently favourable in comparison:

*"I was taken to hospital before against my will and it made me want to leave and runaway. This time was so much better it didn't waste police or nurse time. It saves a lot of time"*

Individuals felt reassured and calmed by the nurse's presence and appreciated the fact the incident was resolved often in their own home without having to go to hospital or custody.

*"Being nicked makes me more distressed and aggressive – this whole thing was calming. It was the first time I have heard of this and it was absolutely brilliant"*

*"I felt the nurse was honest – normally they would have taken me away but there was no mention of that and I thank them for that, the whole thing was resolved remarkably well"*

The scheme was also reassuring for family or friends who were often at the scene, which was predominantly the service user's home, when street triage attended.

*"It worked 1000% - I would recommend it to everyone. We have had a really difficult time and [our family] haven't had any support until now"*

Those in first contact with the scheme said they would definitely approve of its continuation and advocate it for others in a similar situation.

*"I think they should keep that service going for people like me, who need that extra support"*

*"I would say what you're doing now is a great help to the community. It's very helpful. If the nurse wasn't there it could have turned out differently. She made the world of difference"*

Those who were well known to the Mental Health system valued having a recognisable face attend the scene. In this way, having a small team of clinicians work on the scheme was beneficial. Service users praised the nurse for their approach:

*"She did her job, she did it well, she was polite and her attitude was spot on"*

*“Good idea for the nurse to come out because she understands things better”*

*“It was nice, she was telling me other things I could do - that calmed me right down”*

#### **Areas for Improvement**

Although prompted for any recommendations for improvement, service users were not able to make any suggestions for change. Where service users had had to wait for the car to attend, this did not impact on their positive feedback and they felt it ‘was worth waiting for’.

#### **4.4 Case Studies**

To further augment the qualitative evaluation, we reviewed a series of case studies. The first six anonymised case studies involve individuals who were interviewed or directly observed for the Street Triage Evaluation. The second set of seven case studies were provided by clinicians or taken from return sheets completed at the end of Street Triage shifts.

##### **Case Study 1**

Mr A was suffering after an accident that left him unable to work and the sudden death of his son. He started drinking and fell into a spiral of depression. Mr A’s daughter called the police to notify them he was missing, he had told a friend he ‘wanted to end it all’. Police found Mr A in a shed in a nearby allotment and called the street triage team as he was highly distressed and intoxicated. As a result of this, Mr A was able to be taken back to the comfort of his home, where he was assessed by a nurse. Mr A was given advice and the number for talking therapy. The nurse also identified that Mr A was on the wrong dosage of anti-depressants which was contributing to his difficulty sleeping. She gave the family advice on how to address this with the GP. Mr A’s wife reported the following at interview:

*“Amending the medication made the world of difference. Without Street Triage, he would have been taken to hospital, left to sober up and assessed and that would have made him worse, he would have gone mad and never forgiven my daughter for getting the police out. Instead it was resolved in a professional way and he got the help he needed. The police and nurse worked so well together it made a tense situation more relaxed. They stayed until he went to bed”*

*"It's fantastic and it saves time and money, I would support this wholeheartedly, I dread to think what would have happened if ST wasn't there. I hope and pray the powers that be decide to keep it"*

### **Case Study 2**

Police were called to attend Mr B in his home address after he had attempted to hang himself. Police on scene called street triage. As a result of the assessment the nurse recommended intervention from the local drug and alcohol recovery service and the GP which Mr B has subsequently engaged with.

*"Normally they would have arrested me, and I thought they were going to arrest me, waiting for the nurse was well worth it, everyone was calm, everyone was reassuring, kind and courteous. The nurse and me sat in a room on my own, she was asking how I was feeling. I wasn't looking forward to seeing her, at first I wasn't prepared to engage but when she arrived I was happy to talk to her"*

*"I can't complain whatsoever – it took a long time because she had to travel from Harlow but I understand why that was. I have no complaints, she was great and the police were great. I trusted the nurse more than police"*

*"It's a service I would definitely recommend, 110%"*

### **Case Study 3**

Following the breakdown of his relationship, Mr C attempted to hang himself. He left voicemails for his family who then notified the police. Mr C reported that the rope had snapped which was the only reason why the attempt was not successful. Police attended his residence and street triage were called to the scene. At interview Mr C reported that he was not 'mentally insane' but suffering from a broken heart. He described that the nurse being in the house helped diffuse the situation as there was much anger being directed at him from family members. As a result of the street triage, Mr C voluntarily went to hospital and was given subsequent support by the crisis team who call him daily. Mr C has experience of being sectioned under 136 and described street triage as much better for everyone involved.

*"She put me in touch with "therapy for you" and she sorted out the crisis team; they come round and call me every day. I am still high risk*

*and live on my own but having someone to talk to about how I feel definitely helps. I didn't have that before ST came round"*

*"I had some family here when street triage came, 3 paramedics, police and then ST turned up. Everyone was giving their opinion and the nurse took me away from it all. She took me into the bedroom and talked to me privately and listened to what I had to say. I went into hospital that evening, I didn't want to at first, but then she convinced me, I understood she wanted to keep me safe"*

#### **Case Study 4**

Mr D is an adolescent with learning difficulties and Asperger's syndrome. His mother reports him to be isolated and he has experience of being severely and persistently bullied, ridiculed and humiliated throughout his school years. Mr D's grandmother called police after an altercation at home between Mr D and his mother who is struggling to cope with his behaviour and presentation. Mr D consistently discusses suicidal ideation. ST attended and were able to diffuse the situation within the family home as well as making referrals and follow up calls to social care and a specialist autistic support service.

*"They were fantastic I can't fault them. I think they did all they could. It was so much better to talk to someone in the home. It would be more comfortable for him especially because of his autism - they spent time listening and calling him down. Hospital isn't the place for him. The officer was really good and explained things in a way that he understood"*

#### **Case Study 5**

Mr E is a nurse who has been living in the UK for about 6 years. He started to feel depressed as a result of a lack of contact with his parents and siblings who were living abroad, the impending birth of his son and financial pressures. After drinking one evening he threatened to kill himself with a knife. He was restrained by friends who called the police. Mr E reported being very afraid at the mention of the police as he associated this with getting into trouble and losing his job. He was therefore relieved when the nurse arrived and explained the process of Street Triage. He was given the number of the crisis team to call if he ever felt suicidal again and was able to stay in his own home.

*"I would say a police officer would have a different idea of what is going on and if only the officers came it could have definitely gone a*



*lot different. The nurse was really good - she wasn't subjective, she wasn't trying to judge me, she was trying to get everything out of me, she was there to make me help myself"*

### Case Study 6

Miss F is 16 years old. Street Triage were called to her home as a result of her holding a large kitchen knife threatening to harm herself following a family argument. The first responders had to coax the knife out of her hand. Street Triage attended some hours after the call came in and were able to assess the level of risk the young lady presented to herself. She was able to remain in the family home. One officer who attended in the first instance said he would have considered a section 135 in the absence of street triage. The family reported they were exceedingly glad the nurse had arrived and they had not even had to go to A&E.

The following case studies were not observed or interviewed in person but were provided by clinicians from NEP and SEPT.

### Case Study 7

Police were called by Mr G's neighbour to report that he had assaulted her and was behaving strangely, claiming children's toys as his own amongst other things. Police attended and were concerned about Mr G's presentation. Street Triage were called and a background check revealed he was not already known to MH services. The nurse reported Mr G required further Psychiatric assessment as he appeared to be experiencing numerous persecutory delusions that his neighbours were trying to kill him and were spying on him. He was not able to engage with the nurse in a rational or coherent manner. He was unwilling to speak to her and was verbally very hostile and agitated. Mr G was dressed inappropriately for the time of year and it was apparent he was neglecting both his personal care and his environment, as the dust on every floor and surface was very thick. It was difficult to see out of his windows due to dirt. He had sheets covering up the window in the lounge and it was very dark. He would not allow the officers to switch any lights on. Street Triage and officers on scene felt that Mr G lacked the capacity to understand why they were there and were very concerned that if left he could pose a risk of harm to others and was also highly vulnerable himself. Officers considered their use of S135 MCA to remove Mr G from his home on the basis that he lacked capacity and then could take him to A&E for a MH assessment, however the nurse was concerned that Mr G would not agree to leave and felt sure that a level of force would be required. Instead a mental health act assessment was conducted in the safety

of Mr G's home and he was detained under Section 2 of the MHA. When Mr G was advised of his detention he did not appear to understand and continued to repeat that he would see his own Dr in the morning. He refused to leave the flat and required restraint by the 3 police officers in attendance in handcuffs due to his high levels of agitation and aggression. Mr G has subsequently been diagnosed with Delusional Disorder and prescribed regular antipsychotic medication. The nurse reported:

*"In this situation it would have been difficult for Police to take any action in terms of Mr G's mental health as he was in his own home and so Section 136 MHA would not apply. Mr G would therefore not have been able to receive any form of mental health assessment until the following day at the earliest, meaning that he would have been left home alone for the situation with his neighbour to potentially escalate further. It is possible that Mr G could have been arrested due to the incidents that had taken place, however Officers on scene felt that Mr G was clearly unwell and did not consider it appropriate that he be taken into Police Custody"*

#### **Case Study 8**

Police were called to Ms H's property this evening as she was reported to be shouting abuse at a passer by from her window. Information on Ms H stated she was previously known to MH services with a diagnosis of Paranoid Schizophrenia, but had been discharged from MH services since 2012 as she had been coping and functioning well with her medication and the support of her GP.

On arrival Ms H was very distressed and verbally abusing two female PCSO's who were with her. She was shouting about her 12 year old son being sexually abused at school today, she reported that since she was 8 years old there have been 2 girls following her around and they "bully" her. When she goes abroad on holiday they follow her and upset her young son. Ms H told the nurse to "get out of my house", and was shouting and screaming for a few minutes, verbally abusing her children and shouting that they didn't care about her and wanted to have her young son taken away. Ms H agreed to take some of her medication as she had not yet taken any that day. She admitted that she had not been taking it recently as she doesn't feel she has anything wrong with her and doesn't understand why people don't believe the things that she says. It was clear that Ms H was acutely unwell and distressed by her delusional beliefs and could provide no rationale to support the things she was saying. She was tearful and was initially reluctant

to be admitted to hospital as she thought that her son would be taken away if she did. With reassurance that her older adult children were happy to care for him however, Ms H agreed to be admitted. Police and the nurse conveyed Ms H to the ward and provided staff with a verbal handover. Ms H made good progress on the ward and was able to go home for extended periods of leave. She was referred to the specialist community team for a Care Co-Ordinator to provide support for her discharge back to the community and was discharged after a month. The nurse reported:

*“Given Ms H’s level of distress she would have been either taken to A&E for a mental health assessment if willing to attend, or detained under Section 136”*

### Case Study 9

Police and subsequently Street Triage were called to attend Mr I by his mother in Tenerife. On arrival Mr I was sitting on his sofa staring at the ground and repeating over and over "I am evil, I am evil". He would not acknowledge or engage with the nurse. The nurse was aware that Mr I had been a missing person since he absconded from a Psychiatric hospital in July whilst detained under Section 2 MHA 1983/07. He was found as he arrived in Gatwick airport on an inbound flight. Police were alerted at that time. It was considered that Mr I could not be left at home alone overnight due to the lack of engagement in assessment, his presentation as being acutely unwell and his reported intention to end his life. It was considered that the only safe option for Mr I was admission to hospital. Mr I agreed to leave the property with Street Triage to go to hospital, however the nurse was later advised that there were no hospital beds available to admit Mr I to hospital. Due to this there was unfortunately no option but to detain Mr I under S136 in order to take him to a place of safety for further assessment. Mr I was sectioned under section 3 of the Mental Health Act and continued to be acutely unwell.

*“Without the street triage facility being available, Police would not have been aware of the extent of Mr I’s illness. It is likely that they would have taken him to A&E for an assessment by the MH team, but he would have posed a high risk of absconsion and so Police would have been required to remain with Mr I until he was triaged in A&E and referred for a MH assessment, or to make the decision themselves to detain him under S136, which would have been unlikely given that he was willing to attend hospital for assessment”*

#### **Case Study 10**

Male expressing suicidal ideation in public park, had hidden a knife to stab himself, Street Triage attended for over an hour and were able to arrange an informal admission instead of sectioning him.

#### **Case Study 11**

Male reporting thoughts of suicide but heavily intoxicated. Street Triage arrange assessment the next day which removes the need for officers to sit with him in A&E whilst sobering up.

#### **Case Study 12**

Male attempting to drown himself in public place – known to Mental Health services and therefore able to arrange meeting with care co-ordinator the following day avoiding section.

#### **Case Study 13**

Female self-harming in public, Street Triage diffused situation and organise assessment for following day, avoiding section.

#### **Summary of key points**

The case studies demonstrate occasions where the provision of Street Triage allowed incidents to be resolved appropriately, often without the use of S.136. Both clinicians and individuals involved reported that this was greatly beneficial in diffusing highly charged, volatile situations. The case studies also evidence further utilities of Street Triage such as identifying individuals who are unwell and struggling in the community and not currently receiving any input from services.

## 4. Quantitative Findings

### 4.1 Methodology

For the purposes of the quantitative analysis element of this evaluation, we are focusing on the first 6 months of the full Street Triage project, operating from 6pm to 2am, 7 days a week, from 01/04/2015 – 30/09/2015 (referred to as “Full ST”). We compared this with the same period of 6 months the previous year (referred to as “Pre-ST”), namely 01/04/2014 – 30/09/2014, to give an understanding of the impact on activity and costs that the Street Triage programme has contributed towards.

National data suggests there has been a rising trend in the use of S136 over recent years and it is fair to assume that this would be the same in Essex. However, as the data we received is not sufficiently robust or detailed to allow an estimate of the likely rate of increase in Essex to apply to the Full-ST figures, we have decided not to factor this likely rise into our calculations – instead, taking the more cautious view that numbers would be expected to be at least the same in 2015 as in 2014. This means that stated reductions in S136 are likely to be an underestimate of the impact.

We have examined the locally accepted costs (as used in Essex Police’s 4 month pilot evaluation) and applied them to the data for the two time periods we are studying, in order to estimate the likely benefit of continuing this investment.

It is important to acknowledge the difficulties experienced in collating and analysing the data for this evaluation. There is no single data source giving details of all S136s that take place across Essex for the two periods being analysed. In future, this is likely to be remedied by compulsory use of the Home Office Toolkit for reporting all S136 by Essex Police, which will make future evaluation simpler.

To attempt to build an overall picture of S136 and Street Triage activity, we collated data from the following sources:

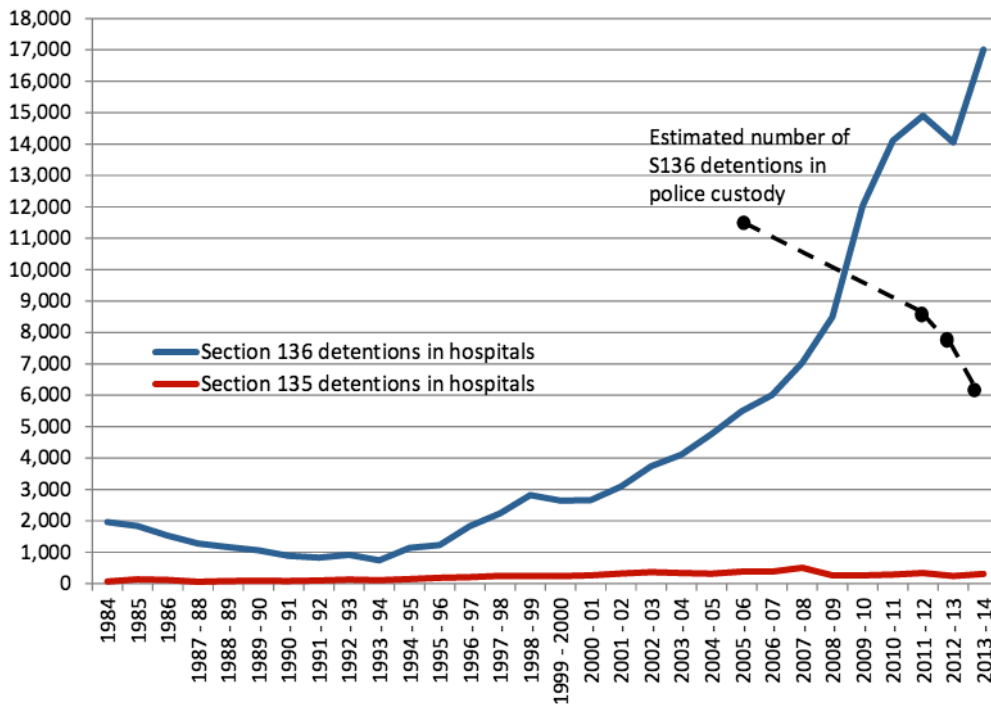
- South Essex Partnership University NHS Foundation Trust (SEPT)
- North Essex Partnership University NHS Foundation Trust (NEP)
- Essex Police - Athena, Storm, S136 database
- Essex County Council - EDS data

- Unit costs from a range of other evaluations of Street Triage – Nottinghamshire, Essex 4 month-Pilot, Devon Police, Kent Police, Penine Police, etc.

#### 4.2 The National Picture

The number of people being detained in hospitals under S136 has increased considerably since the mid-1990s and especially after 2007, and is still rising.<sup>1</sup>

The data collected in England show an increase in rates of detention in hospital under S136, increasing from 1,959 detentions in 1984 to 17,008 in 2013/14 - an increase of over 850%.



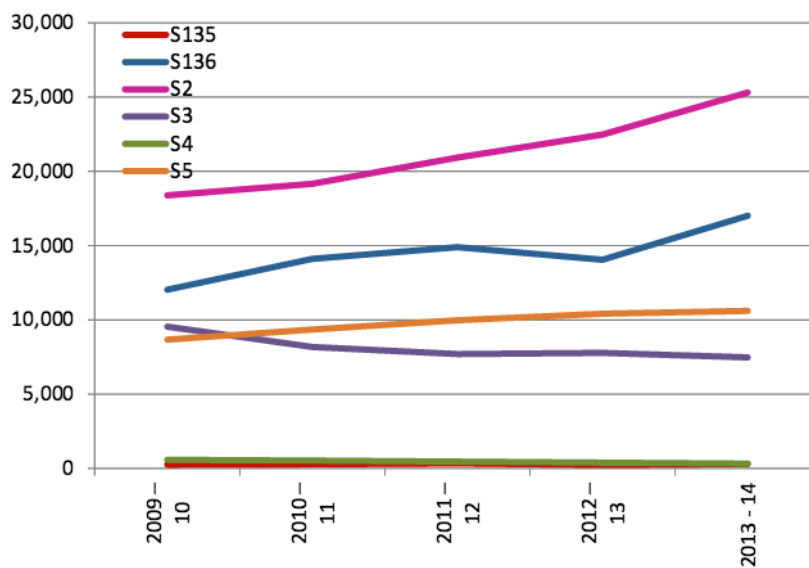
The annual number of place of safety orders (Sections 136 and 135) to hospitals in England between 1984 and 2013/14.

The use of custody as a place of safety for S136 has fallen since 2005-6 and is variable across the country. It is still considered to be too high in many areas

<sup>1</sup> Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983 A Literature Review (Dept of Health & Home Office, December 2014)

and there have been moves to reduce this – including through the introduction of Street Triage schemes.

The ratio of S136 per 100,000 population suggests that until 2000/01 there was very little change, and then the use of S136 increased rapidly from 5.4 S136 per 100,000 population in England, up to 26.27 S136 per 100,000 population, meaning that the chances of being detained under S136 in hospital in England are now five times higher than in 2000.



	Section 135 <sup>27</sup>	Section 136 <sup>28</sup>	Section 2 <sup>29</sup>	Section 3 <sup>30</sup>	Section 4 <sup>31</sup>	Section 5 <sup>32</sup>
2009 – 10	262	12,038	18,385	9,545	587	8,672
2010 – 11	288	14,111	19,163	8,174	535	9,351
2011 – 12	338	14,902	20,931	7,701	458	9,977
2012 – 13	243	14,053	22,477	7,776	396	10,420
2013 - 14	307	17,008	25,300	7,481	326	10,609

*Detentions under the Mental Health Act 1983 in NHS facilities and independent hospitals by legal status, 2008-09 - 2012-13<sup>33</sup>*

A 2013 study also found that the rate of detention under S136 in hospitals in England increased more than six-fold between 1984/5 to 2010/11, from 5.2 to 33.4 per 100,000 adult population (1,959 in 1984/5 to 14,111 in 2010/11).

In Essex, numbers of S136 were around 860 in 2013-14, with over 200 held in custody in 2012-13.

### 4.3 Street Triage Activity

The initial 4-month evaluation looked at the Street Triage pilot across Essex from 01/12/2014 – 31/03/2015. During this period, triage cars operated for 3 nights (Friday, Saturday and Sunday), supported by a telephone advice line outside of operating hours.

#### Call Out Activity

During the Full-ST period (Apr-Sept 2015), two triage cars staffed by a police officer and a mental health nurse operated between 6pm – 2am, 7 days a week. In this time they:

- Attended 548 call outs
  - 265 in the North
  - 283 in the South
- Of which, the individuals at the centre:
  - 277 were female and 270 male
  - 203 were under the influence of drugs or alcohol (37%)

#### Frequent Flyers

51 people (11% of the total) had been seen by Street Triage on at least two occasions during the six-month period, with:

- 8 being seen three times
- 6 being seen four times
- 4 being seen five or more times

The cases of frequent flyers seen 3 or more times in the six month period by Street Triage should be reviewed by Police and Trust staff to identify opportunities to improve care management and reduce further call outs.



### Call Outs by District

The most frequent call out areas were Southend (18%), Basildon (17%), Chelmsford (15%), Tendring (11%), Colchester (11%) and Thurrock (10%) – together accounting for 81%. Whereas Braintree, Harlow, Epping Forest, Uttlesford, Brentwood, Maldon & Rochford cumulatively account for only 16%.

District	Street Triage call outs (Apr-Sep 2015)	Percentage of total call outs
Basildon	94	17%
Braintree	28	5%
Brentwood	11	2%
Castle Point	12	2%
Chelmsford	82	15%
Colchester	60	11%
Epping Forest	7	1%
Harlow	8	1%
Maldon	7	1%
Rochford	8	1%
Southend	100	18%
Stanstead Airport	1	0%
Tendring	62	11%
Thurrock	56	10%
Uttlesford	5	1%
Other	7	1%

This suggests that the use of the Street Triage service is not geographically equitable across Essex, and as a result there may be unmet need in some areas.

### Outcomes from Street Triage

From the 548 incidents attended by the Street Triage team, a range of outcomes followed assessment:

- 1 in 4 result in no further action
- 1 in 5 result in either detention under S136 (8%) or being admitted under Section 2 or 3 (19%)
- 1 in 5 have prevented a S136 from taking place (as self assessed by the team)
- 1 in 3 have "other" outcomes - covering a wide range of outcomes, such as signposting, followed up by CMHT, referred to GP etc.

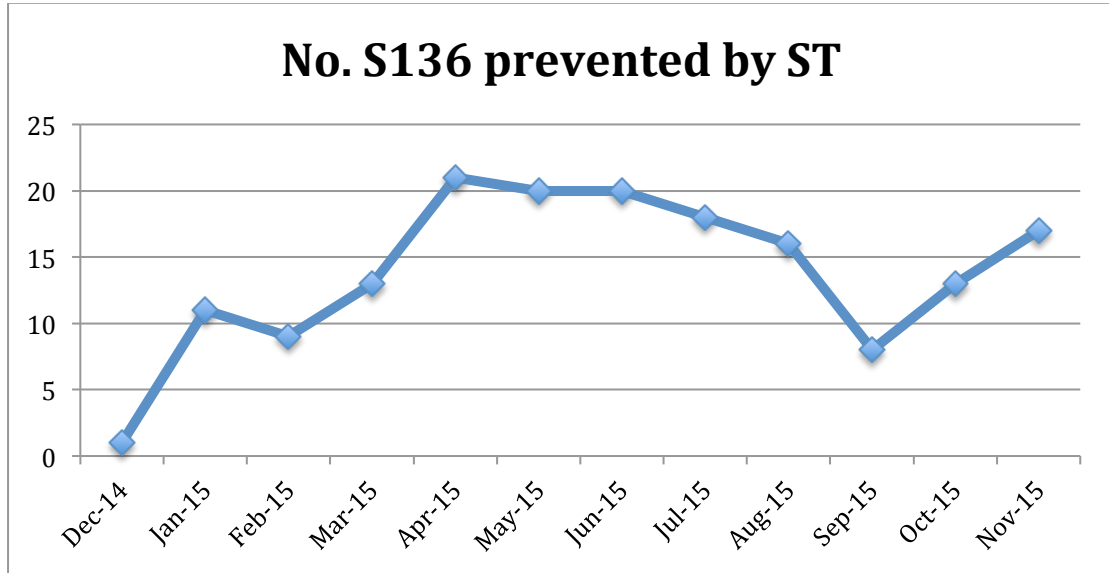
Outcome	Number	Percentage of total incidents
Admitted	60	11%
Detained under S136	42	8%
Discharged	1	0%
No Action	127	23%
Other	186	34%
Referred	132	24%
S136 prevented by ST	103	19%
Arrested	15	3%
A&E	41	7%
Informal / voluntary admission	38	7%
Taken to a Custody Suite	6	1%
Taken to a Health Based Place of Safety (HBPoS)	61	11%

One of the most important outcomes from Street Triage is where the team self assesses that without the ST intervention, S136 would have taken place. During the Full-ST period, 103 Section 136s were prevented.

The Quarter 2 analysis of the data by Essex Police states:

*"It is arguable that figures in Q2 are conservative as the police officers engaged in the Street Triage Teams have become much more confident about the assessment and management of mental health risks."*

This may be one of the reasons behind the reducing monthly trend in numbers of S136s that the team decides have been prevented by their involvement during the Full-ST phase. However, the last two months data show an increase in these figures - as set out in the following graph and table:



Month	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	TOTAL
No. S136 prevented by ST	1	11	9	13	21	20	20	18	16	8	13	17	167

The following table shows that:

- The percentage of call outs where S136 was prevented has continued to increase from 17% during the pilot phase, to 19% during the Full-ST phase, and for the last two months this now stands at 23%
- The number of call outs per month did increase from the pilot phase to Full-ST phase (from 67 to 91) – however, this is lower than would be expected given the scale up from 3 to 7 nights a week. Scaling up the 4-month pilot to 7 nights a week leads to an expected activity level of 157 incidents per month. This implies there is some spare capacity for the current ST model to respond to more cases if improvements in efficiency can be made
- The latest two months show a decrease in the number of calls responded to, falling to 65 per month

	ST Call outs	Prevented S136	Percentage of callouts where S136 prevented	Per month avg. call outs	Per month avg. no. prevented S136
4 month pilot (Dec 2014 - Mar 2014)	269	46	17%	67	11.5
6 month Full-ST (Apr-Sep 2015)	548	103	19%	91	17.2
Latest 2 months (Oct - Nov 2015)	130	30	23%	65	15

The Street Triage teams attended an average of 3.1 call outs per night between the two vehicles during the Full-ST period for an average time in attendance of 1 hour 9 minutes – this gives an average time attending incidents of 3 hours 34 minutes per session. The two cars travel an average of 218 miles per session – allowing for an average speed of 30 miles per hour for this travel gives an average travel time of 7 hours 20 minutes per session. There are 16 hours of available time per session (2 teams conducting 8 hour shifts). This means that 2/3 (68%) of their time is “up time” spent traveling to or attending incidents and 1/3 (32%) is spent in “down time”.

The rate of S136 being prevented by the attendance of Street Triage as a percentage of call outs has increased during the life of the project – which may indicate that the approach is improving its effectiveness over time.

However, the level of activity is below what was expected from the pilot phase, with each car attending fewer than 2 incidents per evening and nearly 1/3 of the operating time being “down time”. This indicates that the service may be operating slightly below capacity. Given that more S136s taking place during their operating hours than the team attends, it would appear that if they could be deployed more efficiently, the teams could attend a larger number of incidents and thus have a greater impact on preventing S136s.

#### 4.4 Costs Benefit Analysis

The Street Triage team reported that they prevented 103 Section 136s from occurring during the Full-ST period.

Using the costs agreed for the 4-month pilot evaluation<sup>2</sup>, this gives a benefit to Essex Police and CCGs equivalent to £175,100 for the Full-ST period - or an estimated £305,200 forecast for 12 months.

Also using the agreed figure from the 4-month pilot evaluation for realisable savings<sup>3</sup>, these figures give a potential realisable saving of £144,200 for the Full-ST period – or an estimated £288,400 forecast for 12 months.

It was felt that the Street Triage approach also had a wider impact on reducing the overall numbers of S136s across Essex (i.e. including those incidents that they do not attend). Comparing the pre-ST (Apr-Sep 2014) and Full-ST (Apr-Sep 2015) periods demonstrates a total reduction of 124 Section 136s. Removing those that have been directly accounted for by Street Triage’s self-assessment (103) leaves us with a further reduction of 21, which carries a realisable saving of £29,400 from a total benefit estimate of £35,700. Converting this into a forecast for 12 months shows potential realisable savings of £58,800 from this wider impact.

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<sup>2</sup> The total financial cost of an individual being detained under Section 136 MHA and taken to a Place of Safety is approximately **£1,700** where that individual is detained out of hours.

<sup>3</sup> Each assessment conducted has potential realisable savings of £400 (2 x Section 12 Doctors), plus £1000 (an approved mental health professional (AMHP) where that assessment is commissioned by Essex County Council Emergency duty team (ECC EDS). Street Triage operates outside working hours, and thus any individual detained during these hours will either be offered a MHA assessment by the ECC EDS service or will have to wait until the following working day. For example if an individual is detained after 16:00 hours, then unless ECC EDS provide access to an assessment, the earliest they could be assessed would be c.10:00 on the following Monday – some 66 hours after they were initially detained, but within the 72 hour margin of detention permissible under S136

Taken together, the total reduction in S136s from the same six-month period last year would produce realisable savings of £173,600 – or an estimated £347,200 forecast for the full year. The total benefit of this reduction can be valued at £421,600.

The scheme costs £267,092 to operate for twelve months (£67,092 for Essex Police and £200,000 for SEPT and NEP). When taking these costs into account, the net realisable savings can be estimated at £40,54 for six months, and forecast as £80,108 for the full year.

There was a 44% reduction in the use of custody – falling from 89 (Apr-Sep 2014) to 50 (Apr-Sep 2015). This has an estimated benefit of £12,997 to Essex Police<sup>4</sup>. This would give a forecast benefit of £25,994 over the full year.

The reduced number of S136 between the two periods has an estimated benefit to Essex Police of £36,828 over six months (£73,656 over twelve months) by reducing the need for two officers to attend the incident for the entire duration. This is likely to be much greater than this estimate, as it was noted that the initial officers attending the incident would often leave after handing over to the Street Triage team.

The estimated unit cost of a Mental Health Act Assessment (MHAA) has been given as £565<sup>5</sup> in the Essex four-month evaluation, however many of the other area Street Triage evaluations have used a cost of around £1,000 per MHAA. Using these two costs shows that the overall reduction in S136s in Essex has a value of £33,900 - £60,000 over the six-month period. This gives a 12-month estimated value of £67,800 - £120,000 in reduced use of MHAA.

Although the data was too fragmented to conduct meaningful analysis of further benefits, it appeared that there were likely reductions in:

- Ambulance call outs – with a unit cost of £230<sup>6</sup>
- Accident & Emergency (A&E) attendances – with a unit cost of £124<sup>7</sup>
- Non-elective admissions to hospital – with a unit cost of £1,542<sup>8</sup>

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<sup>4</sup> Figures based on a per S136 in custody unit cost of £333. This was based on Essex average of 15.5 hours in custody for S136s at a cost of £21.50 per hour

<sup>5</sup> Cost based on 2 x S12 doctors + MH Nurse/AMH

<sup>6</sup> Per Ambulance call out (CFT, 2013)

<sup>7</sup> Per A&E attendance (NHS / DH costs 2013-14)

<sup>8</sup> Per non-elective hospital admission (DH, 2013)

In summary, there are potential annual benefits from Street Triage directly preventing the use of S136 and a wider impact on reducing overall use of S136, including estimated:

- Gross realisable savings for NHS Trusts / CCGs of £347,200
- Benefit to the value of £99,650 to Essex Police in terms of reduced use of custody and reduced officer time attending S136 incidents
- This gives a gross benefit value estimate of £446,850 and a net benefit of £179,758 when accounting for the cost of running the Street Triage project
- There are other likely areas of benefit to CCGs from reduced use of MHA Assessments, Ambulance call outs, A&E attendances and non-elective admissions to hospital

## 5. Conclusions

The data demonstrates that there are significant benefits from the Street Triage scheme directly preventing the use of S136 and having a wider impact on reducing the use of S136 across Essex. Comparing the 6-month Full-ST period with the same period in the previous year Pre-ST, indicates that in a full year of operation, Street Triage there would be an estimated:

- Gross realisable savings to Clinical Commissioning Groups (CCGs) of £347,200
- Benefit to the value of £99,650 to Essex Police in terms of reduced use of custody and reduced officer time attending S136 incidents
- A gross benefit value estimate of £446,850 to Police and CCGs, with a net benefit of £179,758 when accounting for the cost of running the Street Triage project
- There are additional areas of benefit to CCGs from reduced use of MHAA, ambulance call outs, A&E attendances and non-elective admissions to hospital

The rate of S136s being prevented (as a percentage of call outs) by the attendance of Street Triage has increased during the life of the project – which may indicate the approach is improving its effectiveness over time as more officers become skilled up and processes become improved.

However, use of the Street Triage service is not equitable across Essex, and as a result there is likely to be unmet need in specific areas. In addition, the level of activity is below what was expected from the pilot phase, with each car attending fewer than 2 incidents per evening and nearly 1/3 of the operating time being “down time”. This indicates that the service may be operating slightly below capacity. Given that more S136s taking place during Street Triage operating hours than the team currently attends, it would appear that if they could be deployed more efficiently, the teams could attend a larger number of incidents and thus have a greater impact on preventing S136s.

There was a clear indication from qualitative interviews that police and health staff and service users valued the impact of Street Triage on preventing S136s and improving the quality of the police response and patient care, and they universally endorsed its continuation. Staff felt concerned about what would happen if the service were to be lost. To this end, it seems that the argument should not be about whether or not it should be continued but how can it be made more effective and efficient in the future.



Staff interviews raised the desire to have an additional ST team focusing on underserved areas and for the scheme to be extended and operate for extra hours. On the occasions when the qualitative researcher shadowed Street Triage, there did seem to be some 'down-time' between jobs. Although this was accompanied by long journeys to attend incidents, it suggests that an additional ST team would risk further down-time for existing teams and may therefore be an inefficient use of resource. However, it is worth noting that even when individuals had been waiting some time to be seen by Street Triage they did not seem to mind. There are resource implications for the other officers on scene, however, who cannot leave until Street Triage attends.

Down time between jobs may also have been as a result of officers or FCR not knowing the operating times of Street Triage, or fully understanding the best situations to deploy the team into. Some members of staff thought it was still only operational at weekends rather than the full 7 days. In addition, there was some ambiguity around the project's name, which may have meant FCR did not request Street Triage to attend incidents in the home. Interestingly, in America, the scheme is referred to as the "Crisis Intervention Team" - which may be more indicative of its actual function.

It would seem more beneficial, particularly in light of the key aim of reducing S136, to extend the hours of Street Triage into the day or early hours of the morning as many observed that mental illness or distress is not strictly bound to the hours of 6pm to 2am. This was backed up by data showing a spread of times that S136s take place. Those working within the hospital settings stated they were still getting inappropriate S136 outside of Street Triage operating hours and it would seem extending these hours could reduce this further. This clearly comes with resource implications and therefore the offer of having a nurse within the FCR or a telephone line outside of the hours of 6pm-2am would go some way in supporting the reduction of S136 during the day. It is imperative that the shift is able to start taking on jobs as soon as it commences and improved rota management is crucial to this.

Having a core group of officers and nurses that continually work on the scheme allows rapport to be built between staff and service users and highlights Street Triage as a specialist service. To this end there was some concern about motivation levels if it were to be made obligatory to all staff although the benefit in this was also recognised in that knowledge about mental illness would be wider spread across the force. Some officers and

clinicians felt if there was a lack of motivation to learn or understand about mental health, then Street Triage would not have such an impact.

The idea of nurses wearing protective clothing received mixed views, with some were concerned that it would affect the rapport able to be built by a lack of uniform. Some pointed out that MH staff do not wear protective wear in the course of their usual duties, but officers sometimes felt under pressure operating as a single crewed unit with a civilian on board.

Intoxicated individuals still present a reoccurring issue with there being some deliberation as to where is best placed to support such individuals. Some officers felt frustrated that if someone had a physical illness but were drunk they would not be turned away, and MH professionals felt frustrated that drunken individuals were taking up limited S136 suite capacity as AMHPs would not assess until alcohol readings were zero – which often took numerous hours. Despite remaining tensions on this issue, Street Triage does offer the opportunity for these individuals to sober up at home and be assessed the next day.

Nurses are not paid overtime for their shifts and were found to be working beyond the 2am end of the ST session recording notes. Access to portable electronic devices would enable this to be carried out between jobs in a more efficient manner.

## 6. Recommendations

Based on the data analysis, interviews with staff and service users, and the review of models from other areas, the following recommendations are put forward for consideration:

### 6.1 Key Considerations

1. **Street Triage should continue** within Essex – given the positive qualitative and cost benefit findings - to allow it to maintain the positive working relationships built-up between police and MH staff achieving better outcomes for individuals experiencing mental distress
2. **Extend the operating hours of Street Triage** – the evidence indicates that the positive impact on reducing the use of S136 in a cost efficient manner could be increased if the programme were extended
3. **Addition of a 3<sup>rd</sup> car** to ensure consistent geographical coverage across the County
4. **Better data capture** is required – such as robust use of the Home Office Toolkit – to record all instances of S136 from this point forward to facilitate better understanding of the impact of Street Triage in terms of impact on S136s, and outcomes for those the team interacts with. This would allow future evaluations to be conducted more accurately and efficiently

### 6.2 Efficiencies and Improvements

5. **Conduct promotional work across the force and with FCR** clarifying the remit and value of Street Triage, encouraging officers on scene to think about using it. This could also consider re-branding Street Triage within this promotional work to make it clear that most of the incidents occur within family homes
6. Allow **Street Triage officers on duty to proactively scan live jobs** to be able to offer Street Triage assistance
7. **NHS should equip nurses with ability to access their notes whilst on shift.** This will require provision of tablets or smart phones to enable this
8. **Police and Trust staff should review the “frequent flyer” cases** that are not only seen by Street Triage but who are also regularly involved in S136 incidents. This bringing together of data should lead to

- proactive discussions on high frequency individuals, leading to a multi-agency plan to better meet their needs and improve responses to future incidents. The impact of these plans should then be monitored
9. **The pairing of clinicians and police officers needs better management** and co-ordination to avoid delays at the start of the Street Triage shift. This would be further helped by officers and nurses should **communicating clearly about pick up times and locations** to avoid any confusion and improve efficiency at start and end of shifts
  10. Consideration should be given to the potential of **placing a nurse in FCR to give advice or information** to officers on scene instead of always attending in person (a model that has been effective in Norfolk) and/or establish a **dedicated telephone line** that gives officers quick access to a specific MH point of contact within the Trust
  11. Consider allowing **paramedics to be involved with the scheme** – allowing referrals to come from them as well as FCR
  12. **Carry protective clothing** for the nurse to wear, should risk become an issue. This should be labelled as “nurse” if it is visible, or be covert and able to be worn under normal clothing
  13. Revisit policy and remind FCR and senior staff within the force that **Street Triage are not to attend first on scene**
  14. **Revisit the current mental health training for new officers** and re-train current staff using face to face methods, to ensure wider dissemination of knowledge from ST officers across the force, This could involve the creation of **mental health champions** within the force
  15. **Remove Street Triage as an overtime option for officers** to ensure the scheme uses motivated individuals and continues the good reputation built up so far

## 7. Initial Delivery Plan

From the recommendations made, an initial delivery plan can be populated to ensure timely progress on moving the scheme forward.

Recommendation	Lead	Actions
Extend Operating Hours	NHS, PCC and CCG	Consider whether to extend during day or evening or if 24 hour coverage is viable
Better data capture	NHS and Essex Police	Consider use of Home Office Toolkit; one central data collection tool available to NHS and Police
Promote ST across police force	Essex Police	Bulletin circulated to officers and screen saver created
Improve geographical coverage of ST	Essex Police	Consider the cost and benefits of the introduction of a 3 <sup>rd</sup> car to cover West or central Essex, alongside options for improved deployment to address the under-served areas
Police to scan live jobs	Essex Police	Police to determine best operational approach
Nurses to access patient notes	NHS	Provide nurses with device to access and input to patient records
Analyse frequent flyer cases	NHS	Host multi-agency frequent flyer meetings
Improve co-ordination of nurses and police	Essex Police	Revisit rota and allow nurse and police to communicate to arrange pick up location
Remove overtime option for officers	Essex Police	Inform officers of this change
Nurse in FCR	NHS and Essex Police	Pilot use of rota one nurse to be available in force control room and capture impact
Phone-line	NHS and Essex Police	Allow nurses on shift to have mobile phone operating as Street Triage helpline. Officers can either call this directly or through FCR
Paramedics able to request Street Triage	Ambulance Service, Essex Police and NHS	Organise a meeting with Ambulance Service to discuss viability and utility of this further
Protective clothing for nurses	Essex Police	Police to carry optional vests for nurses