Street Triage

Report on the evaluation of nine pilot schemes in England

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Executive Summary

This evaluation was commissioned by NHS England and compiled in partnership with NHS England, the Home Office, the Department of Health (DH) and nine participating police forces. It reports on the effectiveness of the operation of nine Street Triage schemes.

Background

Street Triage schemes in Leicestershire and Cleveland were initially established on a trial basis, both for approximately a year, and tested a new kind of service in which health professionals worked in close liaison with and supported police officers in responding to suspected mental health problems that presented in public places. Both schemes reported some early evidence of success.

As a result, in 2013 the DH invested £2 million to explore the possibility of other local areas using the approaches developed in Leicestershire and Cleveland. Nine pilot areas were selected, based on a number of considerations, such as geographic spread, a mix of urban and rural settings, and current performance on the numbers of people being taken to police custody under section 136 (s136) of the Mental Health Act 1983 (MHA). The pilots each ran for 12 months, the first starting in Sussex in October 2013. These nine pilot areas are the focus of this report.

Street Triage

Street Triage involves a joint mental health service and policing approach to crisis care. Based on locally agreed protocols, Street Triage aims to support access to appropriate crisis care, to provide more timely access to other health, social care and third sector services, and to reduce the use of police cells as places of safety for s136 detentions.

Methods

The evaluation comprised three phases:

1. A description of the operation of the nine Street Triage pilot schemes.
2. An exploration and analysis of the quantitative data available on the operation and outcome of the Street Triage teams.
3. An analysis of available qualitative data from interviews with health and police staff, service users and family members involved in the pilot schemes, supplemented by additional interviews undertaken specifically for this project.

The nine pilot schemes

The DH provided funding for nine pilot schemes, which were managed by police forces in partnership with Clinical Commissioning Groups (CCGs), NHS England and Police and Crime Commissioners. The nine forces were asked to establish an operating

model for Street Triage that was appropriate and relevant to local circumstances. The British Transport Police (BTP) C Division developed a Control Room model of service provision, whereby a mental health professional (MHP) was based in a police Control Room and was able to share information with police controllers to assist front-line officers. In, Sussex, Thames Valley and Derbyshire a police officer and a trained mental health nurse, using a patrol car, responded to all calls with a mental health aspect. The West Midlands model was similar but also included a paramedic. In Devon and Cornwall, and the Metropolitan Police Service (MPS), a team of mental health nurses based in the police Control Room or a Mental Health NHS Trust gave advice over the telephone to police officers at the scene but did not attend incidents in person. In both West and North Yorkshire a team of mental health nurses provided telephone support and if required responded to incidents face to face.

Quantitative data analysis

Data collected from the nine schemes were aggregated and analysed to provide an overall picture of the work of the teams. The retrospective nature of the evaluation, and some variation across schemes in the nature of the data collected, imposed some limits on the data collection, however it was of sufficient quality to support the aims of the evaluation.

Qualitative data analysis

All pilot schemes completed a final report for the DH, which included qualitative data on staff and client experiences of the services. These qualitative data were synthesised using a thematic framework. Following initial data analysis, some gaps were identified in the existing data concerning the implementation, objectives, outcomes and sustainability of the Street Triage schemes, particularly from an organisational perspective. As a result, six interviews were conducted with senior staff with the aim of providing a higher-level organisational perspective.

Conclusion

All but two of the nine Street Triage schemes resulted in a reduction in the use of s136 detentions, when compared with an equivalent timeframe from the previous year; s136 data for one scheme were not available. Overall, the mean difference across the pilot schemes was 11.8%; when comparing the six sites where a reduction in s136 use was seen, the mean reduction was 21.5% (15.5% to 27.5%). In addition to the reduction of s136 detentions, more people were placed in Health Based Places of Safety (HBPOS) compared with police custody and those in police custody spent less time there than indicated by previous reports. Given the design and data limitations of the study, and the variation in the models operated, it was not possible to establish whether one model was superior to any other model. However, drawing on both the quantitative and qualitative data, it was possible to identify certain functions of the Street Triage model that may be associated with better outcomes and longer-term sustainability. These include:

- Joint ownership of the scheme at a senior management level to support the development of effective partnerships.
- An established and regular process to review joint working arrangements.
- Clarity about the population to be served by Street Triage.
- Provision of information on agreed referral pathways to health and community services at the point of crisis or after its resolution.
- Joint training programmes for all staff involved in the Street Triage schemes and enhanced mental health training for all police officers.
- Co-location of health and police staff (e.g. linked to a Control Room) or dedicated phone line(s).
- The development of agreed protocols for:
    - effective information sharing between services, in particular, access to health information including services to which people could be triaged e.g. bereavement, counselling and alcohol;
    - provision of timely advice to police officers at the point of initial contact and during the assessment process;
    - integration of Street Triage schemes with the health service-based crisis and alcohol pathways.

Recommendations

Based on a review of the outcomes, the different models for the delivery and the qualitative data available for the evaluation of nine Street Triage pilots, the following recommendations are made:

1. An extension of the hours of all Street Triage schemes should be considered so that they can provide a 24-hour service seven days a week.

2. The role of Street Triage schemes should be reviewed in relation to referrals from and contacts in private settings.

3. A number of key functions appear to be associated with better outcomes and operation of the services and these functions should be considered when developing or extending Street Triage schemes; they include:
    - joint ownership of the scheme at a senior management level to support the development of effective partnerships;
    - regular reviews of joint working arrangements;
    - clarity about the population to be served by Street Triage;
    - effective information sharing between services, in particular, access to health information;
    - provision of timely advice to police officers at the point of initial contact and during the assessment process;

- integration of Street Triage schemes with the health service-based crisis pathway;
- provision of information on agreed referral pathways to health and community services at the point of crisis or after its resolution;
- joint training programmes for Street Triage staff;
- improved recording of causes of crises so that this information can be presented to the local safeguarding board and be included in the Joint Strategic Needs Assessments chapters on mental health prevention.

4. Co-location of health and police staff (e.g. linked to a Control Room) or dedicated phone line(s) appear to be an important component of effective Street Triage schemes and could support a cost-effective roll out of the programme.

5. New and existing technologies to support effective information sharing could be used both within and between health and police services.

6. A national curriculum and associated training materials for Street Triage staff and enhanced mental health training for all police officers should be developed.

7. A common dataset should be developed and the appropriate resources monitored to ensure that data are collected consistently and support a review of the cost-effectiveness of the scheme, which should be undertaken to provide evidence for its long-term sustainability. The review could take the form of an evaluation based on routinely collected data. Alternatively, a formal research study, which tests different models of Street Triage (for example, Control Room-based models versus community team-based models) could be undertaken.

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Abbreviations

AMHP	Approved Mental Health Professional
BME	black and minority ethnic
BTP	British Transport Police
CAMHS	child and adolescent mental health services
CCG	Clinical Commissioning Group
DH	Department of Health
HBPOS	Health Based Places of Safety
HMIC	Her Majesty's Inspectorate of Constabulary
HSCIC	Health and Social Care Information Centre
L&D	Liaison and Diversion
MH	mental health
MHA	Mental Health Act 1983
MHP	mental health professional
MPS	Metropolitan Police Service
S135/136	section 135/136 of the Mental Health Act 1983
SLaM	South London and Maudsley NHS Foundation Trust
WTE	whole time equivalent

Table of Contents

List of Figures

List of Tables

Evaluation of the Street Triage Services

Introduction

In February 2014, the Mental Health Crisis Care Concordat[1] was launched. This is a joint statement, agreed by health, social care, police, justice, and local government agencies, setting out how public services should work together to respond to people who are in mental health crisis. The Mental Health Crisis Care Concordat[1] and the related document, Closing the Gap[2], both reinforced the principle that no one experiencing a mental health crisis should be turned away from services. These documents specifically highlighted the nine Street Triage pilot schemes funded by the DH as examples of how the principles of the Crisis Care Concordat could be put into action. Seen within the context of the Crisis Care Concordat, Street Triage is one element of a crisis response pathway, which may begin with a person presenting to their GP, calling 111 or 999, presenting at the emergency department or being identified as troubled or disturbed in a public place. Following the initial success of Street Triage schemes operating in Leicestershire and Cleveland, the nine Street Triage schemes were funded to explore the feasibility of other local areas using similar approaches.

Although the provision of mental health crisis interventions initiated through contact with the police or other members of the emergency services is not a preferred route into care, it is widely recognised that police officers remain a gateway to care for some people in crisis.[2] A significant amount of police time and resources can therefore be used in responding to incidents involving people with mental health problems.[2] Police officers typically lack specific training to support people with mental health needs and therefore are not always aware of the most appropriate ways to help people in crisis.[3] In addition, when faced with a person in crisis, whether in a public or private place, police officers have often experienced difficulty in gaining an adequate response from local health and/or social care agencies. These problems can be exacerbated by the reluctance of some agencies to share information about the person in crisis and an unwillingness on the part of some services to accept referrals from police officers.

If a police officer believes that a person is experiencing a mental health crisis in a public place, and that person is deemed to be in immediate need of care or control, section 136 (s136) of the MHA provides the authority for a police officer to take a person to a ‘place of safety’ so that their immediate mental health needs can be properly assessed.[4] The current Code of Practice[5] clearly states that in all but “exceptional circumstances”, this should be in an HBPOS such as a hospital, or other health setting. However, current provision of HBPOS is variable across England,[2] which can mean that people may be taken into police custody instead of to an HBPOS. Findings from the Care Quality Commission survey (2014) found that the use of police

stations as places of safety was directly linked to the lack of provision and capacity of HBPOS.[6] It has been reported that the average length of time for detention in a police cell under s136 is ten hours, and often occurs overnight.[2] Police custody has also been when a person is excessively intoxicated and cannot be safely managed or they pose a risk of serious violence to themselves or others.[7] A large proportion of mental health crisis calls to which the police respond are from people in private premises[1]. In such situations, the police have no powers to respond to the person in crisis and therefore require the support of mental health and social care services to assist in the management of these calls.

An HM Inspectorate of Constabulary (HMIC)[7,8] report found that in 2011/12, more than 9,000 people were taken into police custody under s136. A review of 70 individual cases found that people as young as 14 years were detained and a large proportion of people were detained following an attempted suicide or an episode of self-harm. The report also found that the average length of stay in custody was 10 hours and 32 minutes (the law allows detention for up to 72 hours without a review). In 2014, the DH and the Home Office[9] published a literature review summarising the published evidence relating to the operation of section 135 (s135) and s136 detentions in England and Wales. The review found that the number of people being detained in hospitals under s136 had increased considerably since the mid-1990s, with a large and continuing increase from 2007. However, the trend relating to people detained in police custody was less clear as no data on this were collected before 2008 and recent data were incomplete and of poor quality. The use of s136 detentions was highly variable across the country and in some areas it was evident that police cells were routinely used as places of safety. The review also found that the majority of s136 detentions were made outside of normal business hours when other mental health services were not always available.

The factors described above contribute to a distressing experience for people in crisis, along with unacceptable delays in accessing treatment. One solution to these problems is the development of Street Triage schemes, which by providing a multi-agency response to the problems identified above may contribute to a reduction in the use of police custody suites as places of safety, and more effective care for those in crisis who do not need to be taken to an HBPOS. Street Triage schemes (described more fully below) involve mental health staff and police officers responding jointly to incidents where police believe an individual has a need for mental health support. The aim is to ensure that people get the health care they need as quickly as possible.

The 2014 HMIC Core Business report[3] into crime prevention, police attendance and the use of police time provided the following recommendation:

"By 31 March 2015, those forces without a mental health triage programme should carry out analysis to assess whether adopting such a programme would be cost-

effective and beneficial in their particular areas. Where the analysis indicates this would be positive, all forces should work with their local mental health trusts to introduce such a programme by 1 September 2015."

The HMIC report recommended that the police build multi-agency partnerships in order to meet the objectives of the Mental Health Crisis Care Concordat[1] and to improve the pathways for people experiencing a mental health crisis.

This report was commissioned by NHS England and presents the evaluation of nine Street Triage pilot schemes operating throughout England. This report includes a description of the Street Triage approach, an outline of the established schemes and an exploration of the pathways into care. The aggregated quantitative data supplied by each Street Triage pilot are also analysed. In order to support and extend these quantitative findings, a review of the qualitative feedback obtained by the pilots along with additional stakeholder interviews undertaken for this report are also provided. Finally, conclusions and recommendations for the future development of the Street Triage schemes are presented.

1. Street Triage services

'Street Triage' is a generic term used to describe a range of services based on a number of key principles underpinning a joint mental health service and policing approach to crisis care. Street Triage aims to improve outcomes for those people in a mental health crisis who come to the attention of the emergency services for a number of reasons, including being a victim of crime, having an exacerbation of the problems associated with a mental health problem, learning disability, or a substance misuse problem. In other circumstances, people in crisis come to the attention of the police because they are suspected of committing an offence. In either scenario Street Triage services aim to ensure timely access to appropriate care.

While there may be some local variation in the terminology and the delivery of services, the following statement best describes the functions of street triage services.

"Street Triage is a mechanism to ensure coordination, cooperation and information sharing across police and health systems which ensures that decisions taken by emergency services are most likely to meet the needs of people in crisis because of shared decision-making and inter-professional cooperation. It is better understood as a process of inter-agency exchange which could take one of several forms, rather than a defined operating model, and aims to improve the experience of those in crisis whilst minimising restrictive practices and the use of force. Conceived and applied correctly to local circumstances, it offers the potential to improve the service user experience whilst also reducing the overall resources expended in ensuring crisis care after

contact with emergency services. The advice and information shared between Street Triage, the police and other relevant agencies ensure that those in crisis have access to the right care at the right time and that the emergency services are supported in their decision making with regard to vulnerable people". (NHS England and the College of Policing, 2015)

Despite its name, Street Triage is not limited to problems that present in the street or other public places, and local schemes vary in their delivery of services (these variations are described in this report). Street Triage pilot schemes, while committed to the same core objectives, have not conformed to one particular operating model, with variation driven by a range of local factors, including geography, the specific needs of agreed 'target populations' and resource constraints.

1.1 The objectives of Street Triage

The objectives of Street Triage services may differ according to the local partnership arrangements in place, however they typically include:

- Improved service user experience.
- Improved and prompt access to the crisis care pathway.
- Improved working relationships between health, police and other emergency services.
- Reductions in:
    - the use of police cells as places of safety for s136 detentions;
    - the numbers of individual service users being repeatedly detained under s136;
    - the use of HPBOS;
    - A&E attendance for those in crisis conveyed by the police or ambulance service; and,
    - the avoidable use of section 12 doctors, Approved Mental Health Professionals (AMHPs), police and other emergency services.

These objectives aim to support improved access to mental health services for the emergency services, underpinned by real-time sharing of information, timely identification of appropriate care pathways, shared decision making and the use of alternatives to s136. The process also ensures that members of the emergency services are supported in their decision making with regard to vulnerable people**.**

Further, these objectives reflect best practice as outlined in the revised MHA,[10] the associated Code of Practice[5] and the Royal College of Psychiatrists standards and their guidance to commissioners on use of s136.[11] Standards of best practice support

local commissioners to identify gaps in existing service provision, relating to s136 pathways and HBPOS.

1.2 Overview of the pilot services

The DH provided £2 million funding from October 2013 to April 2015 for nine pilot schemes throughout England, which were managed by local police forces, in partnership with CCGs, NHS England and Police and Crime Commissioners. In addition to these pilot services, the remaining police forces around the country have engaged in partnerships to deliver a model of Street Triage. The additional force areas, which have developed a model of Street Triage, along with those areas that are planning a Street Triage model and their sources for continued funding are outlined in Appendix A.

The nine partnerships funded by DH were asked to establish an operating model of Street Triage that was appropriate and relevant for their local circumstances. Each area considered their s136 data, geographical area covered, available resources and other local service issues. A Memorandum of Understanding was created between each partner and outlined requirements to work collaboratively to provide a Street Triage model in their area. Street Triage Boards and project implementation groups designed to oversee the development plans and direct the progression of the services were established. During the development phase, all forces were required to establish working relationships with CCGs, Police and Crime Commissioners and local Mental Health Trusts in order to build trust and ensure an effective service. The five operating models developed by the nine pilot forces are outlined in Table 1.

In developing the model, the size of the geographical area covered was a key consideration. For example, given the area covered by the BTP (C Division), which spans the Pennines, Midlands, South West and Wales, a Control Room model of service provision, involving telephone advice and follow up, was deemed the most appropriate. In Sussex, Thames Valley and Derbyshire, a police officer and a trained mental health nurse, using a patrol car, responded to all calls with a mental health component. The model adopted in the West Midlands was similar to that in Sussex, Thames Valley and Derbyshire but also included a paramedic in the team. In Devon and Cornwall and London (MPS), a team of mental health nurses based in the police Control Room or Mental Health Trust gave advice over the telephone to police officers at the scene, but in contrast to the BTP, the nurses attended incidents in person if thought necessary and practical. In West Yorkshire and North Yorkshire a team of mental health nurses provided telephone support and if required would respond to incidents face to face but with no direct police involvement. Hours of operation varied across the pilots but all operated during evening times when the need is greatest and mental health services tend to be less accessible.

Table 1. Operating models of nine pilot schemes.

Control Room: telephone response	Control Room and Face to Face	MHP - responding when requested by an officer	Police Officer & MHP responding together	Police Officer & MHP & Paramedic
BTP	Devon and Cornwall Police (based in police Control room)	West Yorkshire Police	Sussex Police	West Midlands Police
	MPS (London) (based in Mental Health Trust)	North Yorkshire Police	Thames Valley Police	
			Derbyshire Constabulary	

2. Methods

This project has three components:

1. A description of the operation of the nine Street Triage pilot schemes.
2. An exploration and analysis of the quantitative data available on the operation and outcome of the Street Triage teams.
3. An analysis of available qualitative data from interviews with health and police staff, service users and family members involved in the pilot schemes, supplemented by additional interviews undertaken specifically for this project.

2.1 Description of the nine pilot schemes

The report provides a description of the nine Street Triage pilot services. Data were obtained from individual pilot reports, supplemented by data provided by NHS England and from discussions with pilot leads and stakeholders. Where information was missing, schemes were contacted to provide additional clarification. In addition to a description of the nine Street Triage models, ongoing developments in models of operation in local teams over the course of the evaluation are also described.

2.2 Collation of key outcome data

Before implementing services, the Home Office and the DH provided each Street Triage scheme with a dataset to ensure data were collected consistently across the

forces (see Appendix B). Data collected by each of the pilot schemes during the evaluation period were aggregated. Key outcomes were compared against local data derived from a comparable period before the introduction of Street Triage and, where appropriate, national datasets. Since this evaluation was conducted retrospectively, it was not always possible to account for missing data and this does impose some limits on the conclusions that can be drawn. While the quality and extent of data vary between locations, descriptive data are presented including:

- Numbers of people in contact with the teams.
- Demographic information on people in contact with the teams.
- Previous or current contact with mental health services.
- Location and type of encounter with Street Triage service.
- Use of s136 detention and place of safety information.
- Health related outcomes for people subject to s136.

2.3 Qualitative staff, stakeholder and service user feedback

Qualitative data provided by pilot schemes in their individual reports were reviewed and synthesised. Each of the reports from pilot services provided data on the local experience of the services and presented a range of qualitative material, including comments received from service users, families, carers, community members, police officers, MHPs and senior colleagues (i.e., police sergeants, police hub commanders and team managers). Following a process of familiarisation with the qualitative data, an inductive approach was used to identify codes and themes progressively throughout the analysis.[12] The thematic framework developed by the NICE *Service User Experience in Adult Mental Health* guideline,[13] was adapted so that the themes were relevant for Street Triage and was used to index and organise all relevant themes and sub-themes systematically (see Table 2).

Following initial analysis, the results were discussed with the research team and gaps were identified in the existing data in terms of understanding the implementation, objectives, outcomes and longevity of the Street Triage schemes from a senior organisational perspective. As a result, further data from stakeholder interviews with senior staff were sought. A schema of questions was developed according to the set of themes identified in existing qualitative feedback. Six stakeholder interviews, covering five schemes, were conducted with individuals directly involved with existing Street Triage schemes. The results of these interviews were combined with data obtained from the pilot sites.

2.4 Service start dates and duration of operation

Nine Street Triage pilot schemes were established following the initial success of Street Triage schemes operating in Leicestershire and Cleveland. The nine pilot services received initial funding from the DH ranging from £191,000 to £265,000 to implement and evaluate the outcomes of a local Street Triage scheme (Table 2). Funding was predominantly used to finance resourcing costs for NHS staff (mental health nurses). All of the schemes involved in the pilot study have since received further funding and continue to operate, in some cases with significant amendment to the models based on the outcomes of the pilot period. It should be noted that this report describes the structure of the schemes as they were during the evaluation period.

Table 2. Location, start date, and funding and CCG/Trust of the pilot schemes.

Police Force	Location	Start Date	Initial NHS Funding	CCG / Trust
Sussex	Eastbourne	16/10/13	£191,241	CCG – Coastal Community Healthcare covering Eastbourne, Hailsham and Seaford. NHS – Sussex Partnership Foundation Trust
West Yorkshire	Leeds	01/12/13	£200,000	CCG/s - Leeds North, Leeds South and East, and Leeds West NHS – Leeds and York Partnership Foundation Trust
Thames Valley	Oxfordshire	31/12/13	£200,000	CCG – Oxfordshire NHS – Oxfordshire NHS Foundation Trust
West Midlands	Birmingham and Solihull	10/01/14	£265,000	CCG – Birmingham Cross City Local NHS – Birmingham and Solihull Mental Health Trust
Derbyshire	D Division – Derby City, South Derbyshire and Erewash	02/14	£200,000	CCG/s - County South and Erewash NHS – Derbyshire Healthcare Foundation Trust
Devon and Cornwall	Devon (telephone), Exeter and Plymouth (face-to-face support)	06/03/14	£200,000	CCG – New Devon NHS – Devon Partnership NHS Trust
North Yorkshire	Scarborough, Whitby and Ryedale	24/03/14	£198,895	CCG/s - Scarborough and Ryedale, and Hambleton and Richmondshire NHS – Tees, Esk and Wear Valleys Foundation Trust.
MPS	London boroughs of Lambeth, Lewisham, Croydon and Southwark	31/03/14	£260,000	CCG/s – Croydon, Southwark, Lambeth and Lewisham NHS – South London and Maudsley NHS Trust
BTP	BTP C Division	06/05/14	£200,000	NA

3. The initial nine pilot schemes

A full description of the nine Street Triage schemes is provided in Appendix C and discussed in the sections below.

3.1 Key components of each service

The BTP Street Triage scheme, launched by the BTP C Division, is unique among the schemes involved in the pilot evaluation due to the large geographical area and nature of the environment covered by this force (i.e., railways and light-rail systems). Division C covers the Pennines, Midlands, South West and Wales. The BTP scheme included four NHS nurses (3 x Band 6 and 1 x Band 7), three BTP civilian staff and one police officer. The model involved the nurses providing telephone advice to officers from a central Control Room. The service operated from 9:00am-9:00pm Monday to Sunday. Nurses were able to provide rapid access of information to officers, including sharing information relating to the places of safety and mental health history. Nurses also conducted follow up calls with individual service users focusing on their engagement with services and offered support to families and relatives following a suicide. Nurses liaised with local crisis teams and could make referrals to such services. The BTP Street Triage scheme had a problem resolution procedure with local NHS Trusts to ensure processes and actions were correctly put in place. The Street Triage team engaged with and built relationships with a range of services across the C Division such as local mental health charities (i.e., Papyrus) local authorities and HBPOS.

The Devon and Cornwall Police Street Triage scheme operated seven days a week from 9:00am-5:00pm Monday to Friday and 8:00pm-6:00am Thursday to Sunday. The service was delivered by a team of three Band 6 nurses who were already employed within the local liaison and diversion (L&D) teams. They were based in two Control Rooms within Exeter and Plymouth and were subject to full police vetting and access control as well as relevant IT training before being approved for access to the police Control Room and command and control systems. The nurses provided police officers with telephone advice and had a role in providing face-to-face support in the Exeter and Plymouth areas. As the triage team was integrated with the L&D service all nurses had a role working in L&D teams when not undertaking Street Triage responsibilities.

The Derbyshire Police Street Triage scheme covered three divisions. The Derby Division had access to telephone advice and face-to-face mental health assessments and the Buxton and Chesterfield divisions had access to telephone support/advice provided only by triage nurses. The team consisted of three dedicated police officers and three nurses on a rota basis from a pool of seven nurses. The operating hours were 4:00pm-12:00am seven days a week. The model involved a mental health nurse

accompanying a specially trained, dedicated Street Triage police officer. The officers who initially attended the incident would request the Street Triage team's presence if they believed a person needed immediate mental health support. The Street Triage scheme was, therefore, a secondary response to incidents. Requests were made via the triage team's dedicated mobile phone line, police radio, or through the police live incident reporting network. Street Triage nurses reported that they found it useful to be located close to crisis, liaison or AMHP duty teams as it allowed access to information and to discuss cases in a timely manner. In Derbyshire the Street Triage nurses were seconded from the criminal justice mental health team. The three police officers were from the Safer Neighbourhoods and Response Service. Before the implementation of the scheme all police and health staff received training on self-harm and suicide, mental health legislation, and attended relevant conferences. In addition, all police officers within the force were briefed on the role of the Street Triage scheme.

The MPS Street Triage scheme operated in four South London boroughs (Croydon, Lambeth, Lewisham and Southwark) where South London and Maudsley NHS Foundation Trust (SLaM) are the local mental health provider. The partnership for London was led by NHS England, the Mayor's Office for Policing and Crime (MOPAC) and MPS. During the development phase it was established that SLaM consistently had the highest rates of s136 presentations of all the London Mental Health Trusts; they were therefore selected to host the pilot. The London model involved a telephone helpline, which operated 24 hours a day seven days a week, and nurses based within a Mental Health Trust provided advice and support over the telephone to officers. Based on the individual needs of service users, nurses could provide face-to-face assessments if needed. The Mental Health Trust recruited four Band 6 nurses with prior experience as home treatment team staff, L&D teams, or criminal justice workers. There was a particular focus in the Street Triage team on the experience of the black and minority ethnic (BME) community's use of the service. The service was managed within the SLaM Crisis Service Line and was integrated into the Trust's crisis care pathways. Referrals were generated from direct calls to the Street Triage nurses from front-line police officers. Weekly operations meetings took place between local police officers and the triage team to build relationships and resolve any issues.

The North Yorkshire Police Street Triage scheme operated seven days a week from 3:00pm-1:00am in the Scarborough, Whitby and Ryedale areas. This service did not have a police presence within the team; one Band 6 nurse and one Band 3 support worker were deployed together on any given shift. In total, the North Yorkshire pilot scheme funded 2.26 full time equivalent Band 6 nurses and 2.24 full time equivalent Band 3 nurses. The Street Triage nurses occupied a dedicated office at a local hospital. Referrals were generated from direct calls to the Triage team mobile via the police Control Room. If attendance was required, the triage nurses would travel from the hospital base to the incident in a vehicle equipped with a police airwave radio. The nurses had direct access to their local patient information system. While nurses did

not have access to the police records system, police had clearance to share information with the triage team. Weekly operations meetings took place between local police officers and the triage team to build relationships and address any operational issues.

The Sussex Police Street Triage scheme operated in Eastbourne five days a week from 4.30pm-12:00am Wednesday to Sunday and from 9:00am-4:00pm Saturday and Sunday. The Sussex Health and Criminal Justice Street Triage team consisted of a Police Constable and a Band 7 nurse responding to reports from police and members of the public regarding individuals who were thought to be in immediate need of mental health support. Before the implementation of the scheme, both health and police staff attended a joint training day. The team was based in the police response team's office and operated in an unmarked police car. Together, they provided mental health and criminal justice support, which would otherwise be managed by Sussex police officers. The Street Triage team did not provide the initial response to emergency or life threatening calls. In these incidents, response officers took the initial call until the Street Triage team arrive on scene.

The Thames Valley Police Street Triage scheme operated seven days a week from 6:00pm-2:00am in Oxfordshire. The Thames Valley partnership consisted of two Band 6 nurses and one analyst. The Thames Valley model consisted of a nurse and police officer who provided a mobile response to police reports of individuals in mental health crisis. If the need for face-to-face assessment was identified, the triage nurse attempted to arrive within 30-45 minutes at an agreed location with the officers who had requested the support. Outside of these hours, a 24-hour advice line operated via the mental health crisis team who were able to provide information and advice to assist officers and the Control Room in making informed decisions and about how to access pathways. The scheme was integrated as part of a 'Night Assessment Service' ensuring access to mental health assessment and advice, and creating robust multi-agency working.

The West Midlands Police Street Triage scheme had a dedicated car, which operated from 10:00am-2:00am seven days a week in Birmingham and Solihull. The West Midlands Street Triage team included four Band 6 mental health nurses, three paramedics, six constables and one sergeant. Before implementing the scheme, staff attended a five-day training programme. Training included information around care pathways and available services, risk assessment, background around the Street Triage model, the MHA, Mental Capacity Act, and other relevant legislation, and policies and procedures. The operating model consisted of a police officer, mental health nurse and a paramedic who were deployed via 999 through police or ambulance Control Room staff. The team had access to a plain ambulance with blue lights covertly fitted. The paramedic's role was to support the team at the scene in order to reduce inappropriate attendance at A&E and the model provided an additional

layer for the AMHP service to mobilise resources more appropriately. The service utilised a risk-based model by which all staff signed off on the pathways intervention. As in London (MPS) there was a particular focus on the experience of BME communities' use of the service. The governance structure included all key stakeholders (the CCG, Local Authority, Mental Health Trust, Ambulance Service, and West Midlands Police Service).

The West Yorkshire Police Street Triage scheme operated from 3:00pm-1:00am seven days a week in Leeds. Outside of those hours health care staff were engaged in general crisis team work. This model did not have a police presence within the team, which consisted of one Band 6 mental health clinician (either a nurse, AMHP, or occupational therapist) and one Band 3 health support worker. Staff were based within the Crisis Assessment Service and referrals were accepted from front-line police officers to a dedicated telephone line. The service was also made available to the BTP and Yorkshire Ambulance Service. Initially triage staff aimed to gather information via telephone enquiries in order to ascertain whether a face-to-face assessment was required. If it was, the team aimed to be on the scene within 45 minutes; if this was not required, triage intervention would be conducted over the telephone. The team provided support for adults aged 18 years and over; young people under the age of 18 years were referred to alternative care pathways through child and adolescent mental health services (CAMHS).

3.2 Impact of the model on existing care pathways and developments of the models during the pilot period

As the pilot services progressed there were a number of changes made to the original models throughout the evaluation period. Changes generally involved extension of the schemes such as expanding geographical areas or operating hours to better meet the needs of service users. These changes are briefly summarised below:

The BTP Street Triage scheme did not implement any changes to their model during the trial period. The geographical spread of the service meant that full integration with local pathways was not possible, however nurses liaised with and referred to local crisis teams and engaged with services across the C Division in order to promote the service and build links with a range of services.

The Devon and Cornwall Police Street Triage scheme was embedded into crisis and liaison pathways and included onward referral to health, social care and third sector agencies, based on the individual's needs including people who were disengaged with or not previously known to services. For people who found it difficult to engage, the Street Triage team could provide extra support to facilitate connections with services on their behalf. The service extended its operating hours. When the Street Triage scheme was introduced in March 2014, it operated between 08:00pm-

06:00am on Thursday to Sunday. From January 2015 the service was extended to cover 09:00am-5:00pm Monday to Friday.

The Derbyshire Police Street Triage scheme was also embedded into crisis and liaison pathways. Within this scheme it was nurses' role to advise on the appropriate onward referral to local health, social care or third sector services. The team developed partnerships with the mental health liaison team, crisis home treatment team, East Midlands Ambulance Service, and Samaritans. Initially the Street Triage car was only available for people involved in incidents in the city of Derby area and telephone advice was available for the rest of the county. Following a review in March 2014, one month after the pilot commenced the team extended its cover to include the whole 'D Division' area. Telephone advice remained for the rest of the county.

The MPS Street Triage scheme had a pathway that included onward referrals to health, social care and third sector agencies, along with a seven day follow up by the Street Triage team. Outcomes included referrals to community mental health teams or home treatment teams, liaising with existing teams, A&E attendance or assessment under the MHA. Initially the pilot was designed to offer a face-to-face service in two of the four boroughs from 8:00pm-6:00am. However, after two months the service was extended to include the remaining two boroughs and to operate 24 hours a day seven days a week across all four boroughs.

The North Yorkshire Police Street Triage scheme was embedded into the crisis and liaison pathways. The outcomes of a Street Triage intervention varied depending on the individual's needs. The team, however, formulated a Street Triage discharge plan, which included planned follow ups and further steps that may be required (including liaison with GPs, community mental health teams and social service teams), referral or signposting to statutory or non-statutory services, and follow up appointments with the individual either face to face or by telephone. The service model was designed to include up to three follow-up contacts per incident. However, some delays were experienced in staff recruitment to the team. Throughout the pilot period, staff recruitment and turnover prevented the North Yorkshire scheme from operating at full capacity. The Street Triage scheme initially operated from 3.00pm-1.00am seven days a week. Based on demand, the operating hours were extended in early January 2015 to provide a service from 10.30am-10.30pm seven days a week.

The Sussex Police Street Triage scheme was also embedded into the crisis and liaison pathways. Triage nurses actively followed up individuals and services to ensure service users were engaging and attending appointments. For all appropriate incidents, the Street Triage nurse wrote to the GP to advise them of the contact and outline where further follow up was needed. Following an evaluation in October 2014, the service extended its geographical area beyond Eastbourne to include the wider East Sussex area.

The Thames Valley Police Street Triage scheme was embedded into crisis and liaison pathways and involved working with GPs and community services and was an integral part of the Night Assessment Service ensuring access to mental health assessment and advice, and creating robust multi-agency working. Thames Valley trialed a number of different models of operation to establish the most effective option during the initial six months of the pilot. Between January and April 2014 two models were tested. The first model involved a MHP partnered with a police officer with the ability to be deployed to incidents by the Police Control Room. The second model included an unaccompanied MHP who could be deployed to incidents where there was already a police response unit present. In April 2014, model 1 was adopted for the Oxfordshire area because it was felt that it would result in quicker response times, increased information sharing, and the ability to release a two-person unit to respond to other incidents.

The West Midlands Police Street Triage Scheme referred people onward to third party organisations, substance misuse services, and special support networks. The scheme was also embedded into crisis care pathways. In addition, the team established links with housing, employment and education training support services. All three members of the staff (police, paramedic and nurse) were involved in the assessment and agreed together whether the referral decision was the most appropriate for the individual. Where appropriate, follow-up appointments were conducted with service users every seven days and the team ensured that individuals were registered with health services if they were not already. Contacts with the service always resulted in correspondence with a person's GP. No changes were made to the model throughout the evaluation period. However, the team initially envisaged that the service would predominately involve contacts in public contexts/environments but it became apparent throughout the pilot that they were largely called to respond to incidents in private premises, which required a shift in focus by the team.

The West Yorkshire Police Street Triage scheme was embedded into crisis care pathways. Clear pathways to access mental health services were agreed within the service and included referrals to crisis assessment service (and admission to hospital if necessary), CAMHS, community mental health teams, substance misuse services, early intervention services for psychosis, learning disabilities support, and Improving Access to Psychological Therapies (IAPT) services. The service was initially provided seven days a week between 3.00pm-1.00am; in December 2014 funding was granted to expand the service to operate 24 hours a day. The service was also made available to the BTP and the Yorkshire Ambulance Service in order to refer service users who did not require physical health interventions for self-harm but who would have normally been taken to the emergency department for assessment.

3.3 Summary

Most services were embedded or had strong links to local crisis care pathways, although they varied considerably in the amount of support they provided subsequent to the immediate resolution of the crisis. All but two of the services (BTP and West Midlands) made important changes in the pilot phase usually involving some extension of the hours the service was available or the geographical area covered. One service (Thames Valley) used the early phase of the pilot period to choose a preferred model of operation. All but one of the Street Triage schemes operated seven days a week and generally during evening times when community mental health services tend to be less accessible and therefore the need is greatest. The MPS and West Yorkshire schemes operated 24 hours a day seven days a week. Sussex was the only pilot scheme that operated five days a week.

4. Contacts made by the Street Triage teams

Before initiating a Street Triage pilot the Home Office and the DH provided each scheme with a data collection model to support collection of a consistent dataset (see Appendix B). The pilots were asked to collect data for all incidents with which the Street Triage team had contact. Depending on the agreed local arrangements, data were collected either by police or health staff and amendments or additions were made to the datasets depending on the concerns of individual services. Therefore, data were not always collected consistently across the sites. All pilot forces reported challenges with data collection and therefore the percentage of missing data is reported. The dataset covers only incidents captured during the hours of operation for each scheme. This differed between forces and changed throughout the evaluation period as outlined in section 3.2. It is expected that there may be variation in the quality and extent of datasets across locations, however, the following basic descriptive data are reported:

- Number of contacts.
- Face-to-face and telephone contacts.
- Location of the encounter.
- s136 data by region.
- Action taken by Street Triage.
- s136 detention information.
- Previous conviction.
- Known to mental health services.
- Previous s136.
- Current care plan.
- Engagement with services.
- Subsequent informal section under the MHA.

- Subsequent informal admission.

In order to aid analysis and provide context, relevant data from national datasets are co-presented. The data collection period varied across force areas (see Table 3)

Table 3. Data collection period in months by force area.

Force area	Data collection period	Total months
BTP	June 14 – Mar 15	10
Derbyshire	Feb 14 – Mar 15	14
Devon and Cornwall	Mar 14 – Mar 15	13
MPS	Apr 14 – Mar 15	12
North Yorkshire	Apr 14 – Mar 15	12
Sussex	Oct 13 – Apr 15	19
Thames Valley	Dec 13 – Mar 15	16
West Midlands	Jan 14 – Mar 15	15
West Yorkshire	Dec 13 – Mar 15	16

4.1 Contacts made by the Street Triage schemes

The total number of contacts made by the Street Triage scheme along with an estimate of the total population for the area covered by each scheme are presented in Table 4. Spanning the largest geographical area, the BTP C Division had the largest number of contacts (*n*=3015) by force area (data were collected over 10 months). West Midlands reported 3128 contacts over 15 months. In order to provide a basis for comparison across the pilot schemes, data were compared over the same 12-month period from April 2014 to March 2015. As the BTP figures were only available for 10 months, data were adjusted to 12 months by an inflationary factor of 20%. When comparing the pilots over a 12-month period, the BTP Street Triage contacts remained the highest (*n*=3618), however when examining the rates of contacts per 100,000 head of population, Sussex had the highest number of contacts (*n*=564).

Table 4. Force area population and number of Street Triage contacts.

Force area	Total population	Total Street Triage contacts	Estimated Street Triage contacts over 12 months	Estimated Street Triage contacts over 12 months per 100,000
BTP	NA[1]	3015	3618*	NA
Derbyshire	779,000[2]	799	711	91.3
Devon and Cornwall	1,135,700[3]	891	816	71.8
MPS	1,288,727[2]	1182	1182	91.7
North Yorkshire	114,000[3]	596	596	522.8
Sussex	101,547[2]	844	573	564.3
Thames Valley	666,100[4]	1354	1245	186.9
West Midlands	1,300, 000[3]	3128	2532	194.8
West Yorkshire	848,140[5]	1371	1080	127.3
Total		13,180	12,353	

*Adjusted figures (20% inflation). [1]BTP do not have a residential population but instead a travelling one, which makes estimation inappropriate. [2]2014 estimate. [3]Approximate figure provided by force. [4]2013 estimate. [5]Recent approximate figure provided by CCG.

Table 4 shows very considerable variation in the numbers of contacts per 100,000 head of the population covered by forces with a range low of 71.8 per 100,000 in Devon and Cornwall to a range high of 564.3 per 100,000 in Sussex. It is unlikely that these figures represent actual differences in need for Street Triage schemes between areas, but may reflect differences in the: (a) populations served; (b) particular local circumstances (e.g., the location of Beachy Head in the Sussex Police area); (c) data recording protocols; (d) criteria for access to the services; (e) availability of community mental health services both to respond to crises and to provide sufficient support to avert crises, and (f) alternative community crisis provision. The much higher levels of contact in North Yorkshire are more difficult to account for compared with the Sussex scheme, however may reflect the team taking on a more expansive community support role beyond that expected of a Street Triage team.

Figure 1 shows that the Street Triage teams came into greater contact with males, compared with females, across all force areas, with the exception of MPS, which had a higher number of contacts with female service users (39.5% male, 53.7% female, 6.8% missing data). A large proportion of data is unavailable in the North Yorkshire sample, with 26.8% of data relating to gender coded as missing. For all other force areas the level of missing data was below 5%.

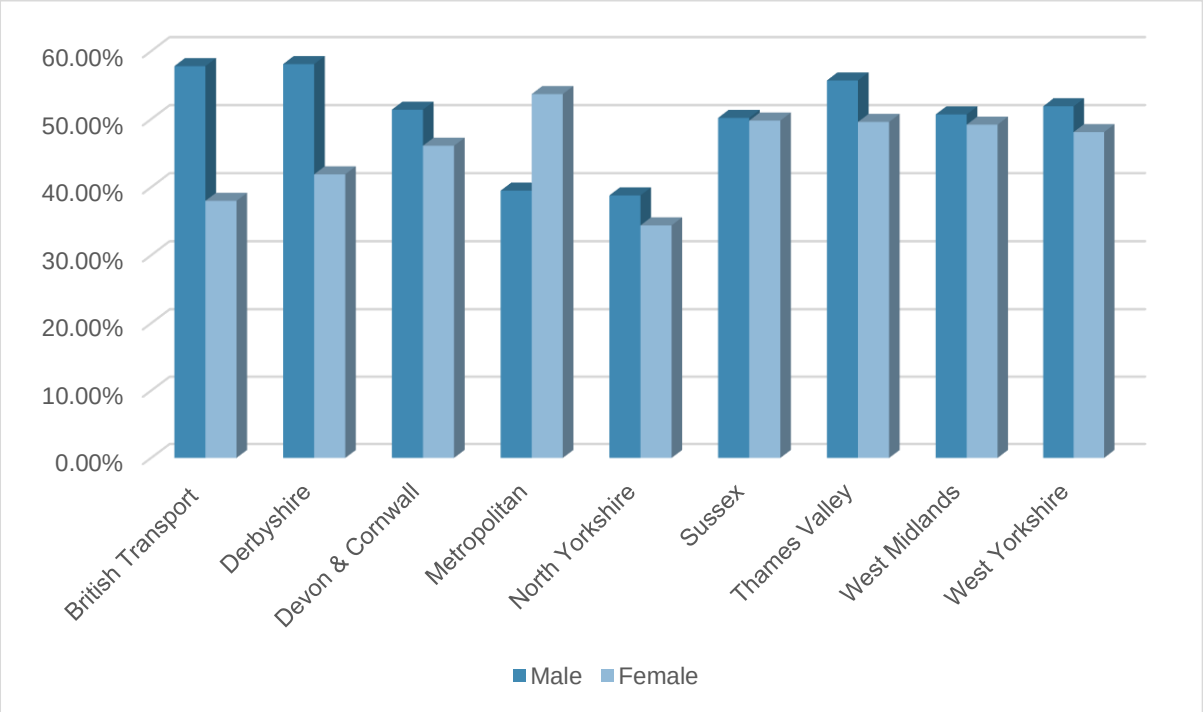

Figure 1. Percentage of people seen by Street Triage teams by gender.

The age distributions for service users contacted by each Street Triage scheme is presented in Appendix D. The BTP, MPS, West Midlands and West Yorkshire schemes predominately had contact with service users aged between 25 and 34 years. The Derbyshire and North Yorkshire schemes saw a greater number of service users aged between 35 and 44 years. In Sussex and Thames Valley, 45 to 54 year olds had the most contact with Street Triage teams. In Devon and Cornwall the data were categorised differently and therefore are presented separately from the other schemes. Age was documented where available, however more than 5% was missing in the datasets provided by the BTP (13%), Devon and Cornwall (10%), MPS (22.9%) and North Yorkshire (26.8%).

All Street Triage schemes sought to review the experience of BME communities' use of the service. Table 5 outlines the proportion of people from BME groups as contacted by the schemes across the nine pilot areas. The number of people from BME communities contacted by the schemes ranges from 0.6% in North Yorkshire to 42.1% in the MPS; in the case of the MPS, the figures are broadly proportionate to the BME representation in the local population (7.6% in North Yorkshire and 45% in the area covered by the MPS scheme).

Table 5. Percentage of BME groups in contact with Street Triage.

	BTP	Derbyshire	Devon & Cornwall	MPS	North Yorkshire	Sussex	Thames Valley	West Midlands	West Yorkshire
White	79.6	83.0	78.2	47.6	71.8	71.3	73.6	61.0	64.2
BME	4.7	12.8	1.20	42.1	0.6	3.50	7.50	26.4	9.6
Missing data	15.7	4.3	20.5	10.3	27.7	25.0	24.5	6.8	26.3

Unsurprisingly the type of model adopted resulted in the variation in face-to-face and telephone contacts (Table 6). As the BTP only offered a telephone service, it was not used to calculate a mean for the pilot services. In Derbyshire (67.6%), Devon and Cornwall (83.3%), MPS (91.4%), and Thames Valley (83.8%) advice was predominately provided by Street Triage nurses via telephone. In contrast, North Yorkshire (37.9%), Sussex (25.8%), West Midlands (29.3%), and West Yorkshire (16.6%) telephone contacts accounted for the minority of contacts. It should be noted that the four schemes with the lowest percentages of telephone contacts had the highest numbers of contact per 100,000 head of population and also high rates of contacts in private places.

Table 6. Percentage and total number of face-to-face and telephone contacts.

Force area	Face to face	Telephone	Missing data
BTP	0.0%	1.2% (35)	97.5%
Derbyshire	31.7% (253)	67.6% (540)	0.8%
Devon and Cornwall	1.5% (13)	83.3% (742)	15.3%
MPS	8.4% (99)	91.4% (1080)	0.3%
North Yorkshire	62.1% (370)	37.9% (226)	0.0%
Sussex	73.8% (623)	25.8% (218)	0.4%
Thames Valley	21.7% (294)	83.8% (1134)	0.1%
West Midlands	70.7% (2211)	29.3% (915)	0.1%
West Yorkshire	58.3% (799)	16.6% (228)	25.1%
Total	41.0% (excludes BTP)	54.6% (excludes BTP)	

A number of force areas commented on the unexpected finding of a substantial proportion of contacts occurring on private property (e.g., service users' and family members' homes), although it was unlikely to be simply a function of the mode of contact with Street Triage (see above). This was confirmed by the analysis of the data

showing that 46.6% of contacts concerned people who were identified in crisis on private property. While a significant number of these contacts were by telephone (29.9%) and therefore would not involve police officers or others going on to private property, this was not always the case (Table 8). It is important to note that s136 detentions do not apply to and therefore cannot be enforced in private dwellings, therefore alternative pathways to care must be sought. As shown in Table 7 the Street Triage schemes in Derbyshire (76.1%), North Yorkshire (54.9%), Thames Valley (56.9%), West Midlands (64.8%) and West Yorkshire (61.1%) reported that the majority of their contact was with service users whose crisis was in a private place. When interpreting the BTP figures, the specific circumstances of the service should be considered because officers often come in to contact with service users on private land (e.g., a train line). However, to ensure safety, officers will attempt to move people to public areas and therefore, the majority of BTP encounters were recorded as having been in public places. In the other eight forces the majority of contacts were in private places with only the MPS (73.5%) and Sussex (53.0%) exceeding 50% of contacts in public places.

When analysing the number of contacts by both type and location, as shown in Table 8, the MPS is shown to be the only force with the majority of contacts involving telephone support for people in public places (72.3%). Derbyshire and Thames Valley largely provided telephone support to people in private places, 58.2% and 53.4% respectively. In contrast, the North Yorkshire (43.7%), Sussex (36.4%), West Midlands (46.1%) and West Yorkshire (58.2%) Street Triage schemes provided the majority of their support in person with people in private premises.

Table 7. Percentage and total number of private and public contacts.

Force area	Public	Private	Missing data
BTP	74.4% (2244)	9.5% (286)	16.1%
Derbyshire	23.9% (191)	76.1% (608)	0.0%
Devon and Cornwall	27.0% (241)	24.4% (217)	48.6%
MPS	73.5% (869)	25.5% (301)	1.0%
North Yorkshire	18.3% (109)	54.9% (327)	26.8%
Sussex	53.0% (447)	46.6% (393)	0.5%
Thames Valley	35.7% (484)	56.9% (771)	7.4%
West Midlands	34.8% (1087)	64.8% (2028)	0.4%
West Yorkshire	30.6% (419)	61.1% (838)	8.2%
Total	41.2%	46.6%	

Table 8. Percentage and total number of contacts by type and location.

Force area	Telephone x Public	Telephone x Private	Face to Face x Public	Face to Face x Private
Derbyshire	14.7% (93)	58.2% (367)	7.8% (49)	19.3% (122)
MPS	72.3% (769)	19.4% (206)	3.8% (40)	4.6% (49)
North Yorkshire	8.7% (38)	33.0% (144)	14.6% (64)	43.7% (191)
Sussex	15.4% (75)	13.0% (63)	35.2% (171)	36.4% (177)
Thames Valley	27.7% (250)	53.4% (481)	8.5% (77)	10.4% (94)
West Midlands	8.2% (171)	18.9% (395)	26.7% (556)	46.1% (959)
West Yorkshire	3.4% (20)	13.2% (77)	25.1% (146)	58.2% (339)
Total	21.5%	29.9%	17.4%	31.2%

Note. Data reported from June 2014 to March 2015; BTP excluded as all contacts were via telephone; Devon and Cornwall excluded due to the significant proportion of missing data reported in Tables 6 and 7.

4.2 Section 136 detention data

When looking at s136 detentions for the total force areas there was a reduction of 11.8% compared with the same timeframe from the previous year. These data include the use of s136 during hours when Street Triage services were not operating. Table 9 presents the percentage difference, in the number of s136 detentions per 100,000 head of the population during the pilot period and the absolute numbers for s136 detentions during the pilot period. West Midlands, Derbyshire and Thames Valley saw the largest reductions in s136 detentions with decreases of 27.5%, 25.3% and 22.7% respectively. Significant reductions were also found in West Yorkshire (19.8%), Sussex (18.3%) and Devon and Cornwall (15.5%). Overall, the mean difference across the pilot schemes was 11.8% (excluding BTP), and if MPS and North Yorkshire are excluded this leads to a reduction of 21.5%.

When looking at the rate of change per 100,000 head of the population, Sussex revealed the largest reduction with 80.6 fewer s136 detentions per 100,000 head of the population, followed by West Yorkshire with 25.5 fewer s136 detentions per 100,000 head of the population. Based on rates per 100,000 head of the population Derbyshire (3.1) reported the lowest reduction in s136 detentions. The data in Table 9 also show considerable variation in the use of s136 (from 9.1 per 100,000 in Derbyshire to 124.3 per 100,000 in West Yorkshire and 359.4 per 100,000 head of the population in Sussex). The Sussex Street Triage scheme was located in Eastbourne, situated close to Beachy Head, a site notorious for its high rates of completed suicides.

Table 9. s136 detentions for the evaluation period and the same timeframe from the previous year.

Force area	Total s136 figures before Street Triage	Total s136 figures during Street Triage	Number of s136 during Street Triage per 100,000	Percentage difference (absolute number)	Change per 100,000
Derbyshire[1]	95	71	9.1	-25.3% (24)	-3.1
Devon and Cornwall	592	500	44.0	-15.5% (92)	-8.1
MPS[2]	205	236	18.3	+15.1% (31)	+2.4
North Yorkshire	62	74	64.9	+19.4% (12)	+10.5
Sussex	447	365	359.4	-18.3% (82)	-80.8
Thames Valley	418	323	48.5	-22.7% (95)	-14.3
West Midlands	759	550	42.3	-27.5% (209)	-16.1
West Yorkshire[3]	1092	876	124.3	-19.8% (216)	-30.6
BTP	NA	785[4]	NA	NA	NA
Mean	458.8	374.4	88.9 (50.2)[5]	-11.8% (-21.5%)	-17.5 (-25.5)[6]

[1]Derby City. [2]Four London boroughs involved in pilot. [3]Leeds area. [4]Number of s136 detentions by BTP and by local forces on BTP jurisdiction. [5]Mean excluding Sussex. [6]Mean excluding MPS and North Yorkshire.

It should be noted that in some cases figures reported by forces in their final reports differ from those identified in the current evaluation. These differences can be explained by the manner in which forces collected s136 data, as well as the varying reporting periods and geographical areas included. Final reports from each force cover their 12-month pilot period of operation. However, some forces continued to provide data beyond their evaluation period and therefore the figures represented by the individual force reports and this evaluation may differ (see Table 3).

The outcomes of the contact with the Street Triage team are reported in Table 10. In some cases the action taken by the Street Triage team was unreported, which resulted in a proportion of missing data at an average rate of 34.2% with a range between 11.6% and 88.3%. (Interpreting data from BTP [65.6% missing] and Devon and Cornwall [88.3% missing] was particularly problematic). The results show that the use of s136 detentions following contact with the Street Triage teams were relatively low across the forces, ranging from 2.0% (North Yorkshire) to 15.6% (West Yorkshire), with the exception of the MPS scheme. The MPS scheme reported s136 detentions in 53.5% of cases following use of the more complex stepped-care system whereby

Street Triage nurses responded independently and advised police. However, these data should be interpreted in light of the numbers seen by the teams and the proportion of the population seen by the teams.

Table 10. Outcome of contact with Street Triage.

Action	BTP	Derbyshire	Devon & Cornwall	MPS	North Yorkshire	Sussex	Thames Valley	West Midlands	West Yorkshire
s136	12.4% (373)	3.0% (24)	4.4% (39)	53.5% (632)	2.0% (12)	3.2% (27)	4.1% (56)	9.5% (296)	15.6% (214)
s135	0.2% (5)	1.0% (8)	0.0%	0.1% (1)	0.0%	0.2% (2)	0.1% (1)	0.0%	0.0%
A&E / hospital	0.0%	11.0% (88)	0.8% (7)	9.5% (112)	0.0%	8.8% (74)	0.0%	23.8% (743)	0.0%
Arrested l offence	0.2% (7)	3.9% (31)	0.0%	1.2% (14)	0.0%	1.9% (16)	0.0%	1.2% (36)	0.0%
Detained MHA	0.0%	1.1% (9)	0.0%	0.1% (1)	0.0%	0.0%	0.7% (9)	0.0%	0.0%
Not detained	0.2% (5)	15.6% (125)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Referral mental health service/ CAMHS	7.9% (240)	9.4% (75)	1.5% (13)	16.6% (196)	31.7% (189)	17.7% (149)	20.8% (282)	18.8% (589)	56.5% (775)
Referral community	1.9% (56)	11.1% (89)	1.0% (9)	6.8% (80)	25.5% (152)	37.2% (314)	31.0% (420)	26.2% (820)	0.0%
Telephone advice	0.0%	0.5% (4)	4.0% (36)	0.8% (9)	0.0%	0.0%	24.3% (329)	0.0%	0.0%
Triage discharge	0.0%	30.2% (241)	0.0%	1.1% (13)	0.0%	0.2% (2)	0.0%	0.3% (8)	0.0%
Other	0.07% (2)	0.5% (4)	0.0%	0.5% (6)	2.7% (16)	0.1% (1)	1.8% (25)	11.0% (345)	0.0%
Missing data	77.1%	12.7%	88.3%	9.8%	38.1%	30.7%	17.2%	11.6%	27.9%

As shown in Table 11, the rates per 100,000 head of the population are somewhat different from the percentages. MPS (49.0), Sussex (26.6), West Yorkshire (25.2) and West Midlands (22.8) had the highest reported s136 detentions following contact with the Street Triage teams. Sussex (72.9) and West Midlands (57.2) reported the highest number of admissions to A&E or hospital among the schemes. For all force areas, s135 detentions following contact with the Street Triage teams were very rare. Referrals to mental health and community services (including GPs) were common

outcomes for service users in contact with Street Triage schemes, particularly for North Yorkshire (57.2%), Sussex (54.4%) and West Yorkshire (56.5%).

Table 11. Outcome of Street Triage rate per 100,000 population.

Force area	s136	s135	A&E/hospital admission	Referral mental health service/CAMHS
Derbyshire	3.1	1.0	11.3	9.6
Devon and Cornwall	3.4	0	0.5	1.1
MPS	49.0	0.1	8.7	15.2
North Yorkshire	10.5	0	0	165.8
Sussex	26.6	1.9	72.9	146.7
Thames Valley	8.4	0.2	0	42.3
West Midlands	22.8	0	57.2	43.3
West Yorkshire	25.2	0	0	91.4
BTP (Control Room)	NA	NA	NA	NA

For the s136 and 135 detentions enforced following contact with the Street Triage teams, information was provided on the transportation used to convey service users to places of safety, the location of the place of safety and, where available, the duration of the detention. Again, the level of missing data is significant. Where data were available, it was found that police vehicles were the most common form of transportation in all of the pilot areas, with the exception of West Midlands who operated in a dedicated Street Triage vehicle (47.7%) (see Table 12). Ambulances were utilised regularly by the BTP (31.8%), MPS (34.8%), North Yorkshire (25.0%), Thames Valley (33.3%), West Midlands (40.9%) and West Yorkshire (20.6%) to transport people to a place of safety.

Table 12. Transportation of s135 and s136 detentions.

Force area	Police car	Ambulance	Triage vehicle	Missing data
BTP	33.9% (128)	31.8% (120)	0.0%	34.3%
Derbyshire	62.5% (20)	0.0%	0.0%	37.5%
Devon and Cornwall	84.6% (33)	15.4% (6)	0.0%	0.0%
MPS	38.4% (243)	34.8% (220)	0.0%	26.8%
North Yorkshire	41.7% (5)	25.0% (3)	0.0%	33.3%
Sussex	72.4% (21)	3.4% (1)	0.0%	24.2%

Thames Valley	50.9% (29)	33.3% (19)	0.0%	15.8%
West Midlands	8.8% (26)	40.9% (121)	50.3% (149)	0.0%
West Yorkshire	28.0% (60)	20.6% (44)	5.6% (12)	45.8%

HBPOS were the most commonly used places of safety during the pilot period (68.4%) (see Table 13). Overall, the use of HBPOS increased during the pilot period. When police custody (6.9%) was used to detain people under s136, it was often reported this was because of a lack of capacity within the healthcare setting.

Table 13. Location of s135 and s136 detentions.

Force area	HBPOS	Police custody	Other place of safety	Missing data
BTP	83.9% (317)	8.2% (31)	1.3% (5)	6.6%
Derbyshire	50.0% (16)	3.1% (1)	0.0%	46.9%
Devon and Cornwall	59.0% (23)	17.9% (7)	2.6% (1)	20.5%
MPS	58.1% (368)	1.4% (9)	4.3% (27)	36.2%
North Yorkshire	66.7% (8)	8.3% (1)	0.0%	25.0%
Sussex	6.9% (2)	10.3% (3)	0.0%	82.8%
Thames Valley	78.9% (45)	1.8% (1)	1.8% (1)	17.5%
West Midlands	93.9% (278)	0.0%	1.0% (3)	5.1%
West Yorkshire	55.6% (119)	11.2% (24)	0.0%	33.2%

While the Closing the Gap[2] report found that the average length of a detention under s136 was 10 hours, the findings from this evaluation suggested that detentions most commonly lasted less than three hours. However, because of the level of missing data, this number may not be an accurate reflection of the time spent in detention, and therefore only those schemes with less than 40% missing data are analysed. As seen in Table 14, in the MPS (30.0%), North Yorkshire (41.7%) and Thames Valley (80.7%) the typical length of stay for service users in a place of safety was less than three hours, while in the West Midlands the typical length of stay was four to six hours (43.6%).

Table 14. Duration of s135 and s136 detentions.

Hours	BTP	Derbyshire	Devon & Cornwall	MPS	North Yorkshire	Sussex	Thames Valley	West Midlands	West Yorkshire
0-3	1.6% (6)	25.0% (8)	28.2% (11)	30.0% (190)	41.7% (5)	0.0%	80.7% (46)	34.8% (103)	20.1% (43)
4-6	0.3% (1)	3.1% (1)	2.6% (1)	8.7% (55)	16.7% (2)	0.0%	1.8% (1)	43.6% (129)	14.0% (30)
7-9	0.5% (2)	3.1% (1)	0.0%	7.7% (49)	0.0%	0.0%	0.0%	9.5% (28)	8.9% (19)
10-12	0%	3.1% (1)	0.0%	5.7% (36)	0.0%	0.0%	0.0%	3.0% (9)	4.2% (9)
13-15	0.3% (1)	0.0%	12.8% (5)	3.5% (22)	0.0%	0.0%	0.0%	1.7% (5)	2.3% (5)
16-18	0.0%	0.0%	0.0%	1.7% (11)	0.0%	0.0%	0.0%	0.3% (1)	2.3% (5)
19-21	0.0%	0.0%	0.0%	1.7% (11)	0.0%	0.0%	0.0%	0.6% (2)	0.5% (1)
22+	0.0%	0.0%	0.0%	4.4% (28)	8.3% (1)	0.0%	0.0%	0.0%	2.8% (6)
Missing data	97.3%	65.7%	56.4%	36.6%	33.3%	NA	17.5%	6.5%	44.9%

4.3 Current or previous contact with mental health services

On average 60.6% of service users who came into contact with Street Triage were already known to mental health services, with figures ranging from 30.8% (BTP) to 80.5% (North Yorkshire) (Table 15). The average number of service users currently engaged with services was relatively low (19.2%) within a wide range from 0.0% (West Midlands, likely a data recording problem) to 55.9% (West Yorkshire). From the nine pilot schemes, an average of 33.9% of service users had a care plan within a range from 0.9% (BTP) to 49.9% (Thames Valley). Overall 15.3% of service users had a previous s136 detention within a range from 3.4% (BTP) to 32.3% (West Yorkshire). Street triage forces also recorded where subsequent sections were made under the MHA and where subsequent informal admissions were made, however these data may again have been under-reported. In the Derbyshire sample a high proportion (39.9%) of service users were identified as having a previous conviction.

Table 15. Current and previous history with services.

History	BTP	Derbyshire	Devon & Cornwall	MPS	North Yorkshire	Sussex	Thames Valley	West Midlands	West Yorkshire
Known to mental health services	30.8% (928)	73.0% (583)	69.2% (617)	69.0% (815)	80.5% (480)	36.7% (310)	63.1% (854)	52.0% (1625)	71.4% (979)
Engagement with services	25.3% (762)	3.3% (26)	9.1% (81)	25.5% (302)	38.9% (232)	14.3% (121)	0.4% (5)	0.0%	55.9% (767)
Current care plan	0.9% (26)	45.3% (362)	20.8% (185)	42.3% (500)	40.4% (241)	40.9% (345)	49.0% (663)	31.0% (971)	35.3% (484)
Previous conviction	23.9% (721)	39.9% (319)	19.6% (175)	20.4% (241)	9.1% (54)	9.4% (79)	0.1% (2)	0.4% (13)	6.6% (90)
Known to CAMHS	4.6% (138)	8.1% (65)	3.4% (30)	10.1% (119)	9.7% (58)	3.9% (33)	16.6% (225)	6.4% (200)	1.9% (26)
Previous s136	3.4% (102)	20.0% (160)	12.8% (114)	26.6% (314)	11.1% (66)	12.9% (109)	4.7% (64)	13.6% (424)	32.3% (443)
Subsequent section MHA	4.2% (127)	2.8% (22)	1.7% (15)	17.6% (208)	9.7% (58)	7.2% (61)	0.0%	8.4% (263)	15.8% (217)
Subsequent informal admission	5.1% (154)	2.9% (23)	1.0% (9)	8.0% (95)	4.0% (24)	2.3% (19)	0.0%	0.0%	0.1% (2)

4.4 Children and young people

Table 16 presents the number of contacts the Street Triage teams had with young people under the age of 18 from June 2014 to March 2015. The BTP Street Triage scheme had the highest number of contacts (telephone) with young people under 18, of which four of these contacts were with children under 12. The Thames Valley Street Triage team saw 70 (5.2%) young people over the 10-month period, with the youngest reported to be aged 11. In Thames Valley, young people under 18 were immediately referred to CAMHS. The Devon and Cornwall Street Triage scheme reported having contact with one person under the age of 12 years and the Derbyshire scheme reported that the youngest person dealt with by the Street Triage team was aged nine. The West Yorkshire Street Triage scheme was primarily available to adults (aged 18 and over), however for those under the age of 18 the teams provided advice to officers and endeavoured to find an alternative care pathway through CAMHS. When looking

at the rate of change per 100,000 head of the population, North Yorkshire (17.5), Sussex (12.8) and Thames Valley (10.5) had the highest proportion of contacts with young people under the age 18. West Yorkshire (0.4) had the lowest number of reported contacts with young people under 18 per 100,000 head of the population.

Using available data, Table 16 reports the estimated number of s136 detentions for young people aged under 18 across the pilot areas during the evaluation period. Due to the high proportion of missing data in Devon and Cornwall and North Yorkshire, it is predicted that these figures do not represent actual numbers. In one case a child under the age of 12 was detained under s136 in an HBPOS for 4 to 6 hours. In all other cases reported, the young people were between 13 and 17 years old. With one exception, in which a 17 year old was detained in police custody, HBPOS were routinely used. The reason for using police custody in this one case was not reported. In 80.0% of the incidents, s136 was invoked following reports of self-harm.

Table 16. Number of contacts with children and young people under 18 years.

Force area	Number and percentages under 18 years	Rate per 100,000 of population	Estimated number of s136 detentions
BTP	231 (7.7%)[1]	NA	11
Derbyshire	24 (3.0%)[1]	3.1	1
Devon and Cornwall	18 (2.0%)[1]	1.6	0[3]
MPS	13 (1.1%)[1]	1.0	5
North Yorkshire	20 (3.4%)[1]	17.5	0[4]
Sussex	13 (1.5%)[1]	12.8	0
Thames Valley	70 (5.2%)[1]	10.5	2
West Midlands	85 (2.7%)[1]	6.5	10
West Yorkshire	3 (0.2%)[1]	0.4	0
Total	477 (3.6%)[2]	53.4	29

[1]Percentage of the Street Triage contacts by area; [2]Percentage of the total Street Triage contacts; [3]>80% missing data; [4]>30% missing data.

4.5 National picture

The Health and Social Care Information Centre (HSCIC) reported that from 2013/14 to 2012/13, the number of Place of Safety Orders for people formally detained in hospitals under the MHA increased by 5% (from 1,166 to 23,343).[14] Using s136 of the MHA, 23,036 Place of Safety Orders were made, which resulted in an increase in the use of hospital-based places of safety, compared with police custody, from 64% (14,053) during 2012/13 to 74% (17,008) from 2013/14. This result reflected a 21% increase in the use of hospital-based places of safety and a 24% decrease in police

custody-based Places of Safety Orders. Over the last 10 years there has been a 30% increase in patients detained in hospitals as a place of safety and this number has continued to rise (see Figure 2).[14] The largest increase occurred after 2007, corresponding with an increased investment in HBPOS.[15] A small proportion of these people would have been taken to A&E departments rather than dedicated 'Place of Safety' suites, but this number is not known.[14] Further, using police data, the HSCIC reported that at least 3% of s136 detentions resulted in people under the age of 18 being detained in police custody, compared with at least 2% in an HBPOS.[14]

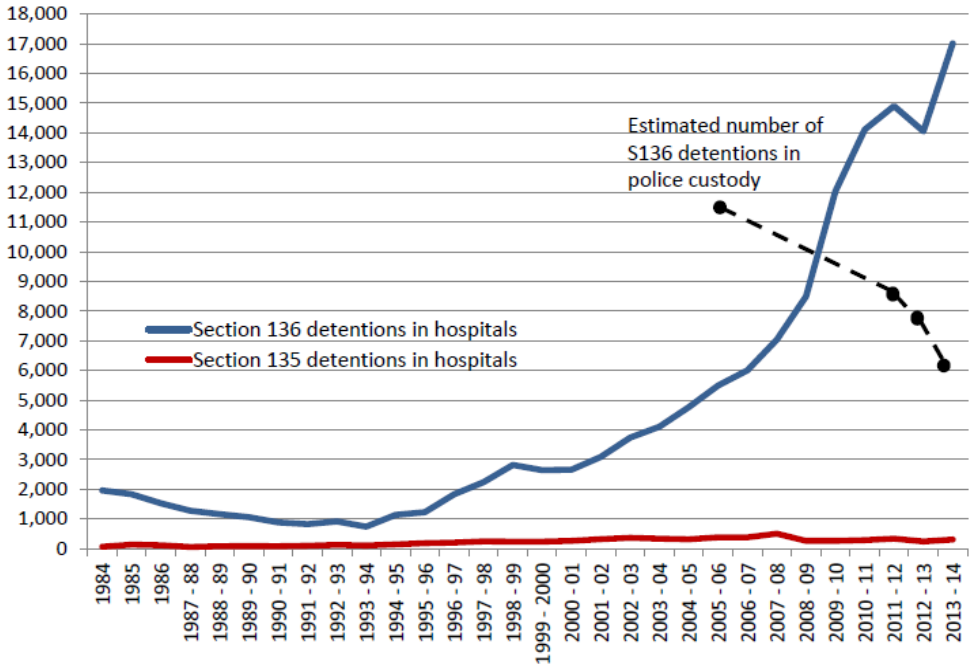

Figure 2. The annual number of place of safety orders (s136 and s135) to hospitals in England between 1984 and 2013/14.[14]

While data collection is limited, s136 detentions have been shown to vary widely across the country and are likely to depend on the local level of provision of suitable health facilities, in concurrence with the findings of the current evaluation. As shown in Figure 3,[14] during 2013/14, where data were available, the use of s136 detentions was recorded more than 1,000 times in 11 policing areas, while the remaining 21 policing areas recorded fewer than 500 s136 detentions over the same period.

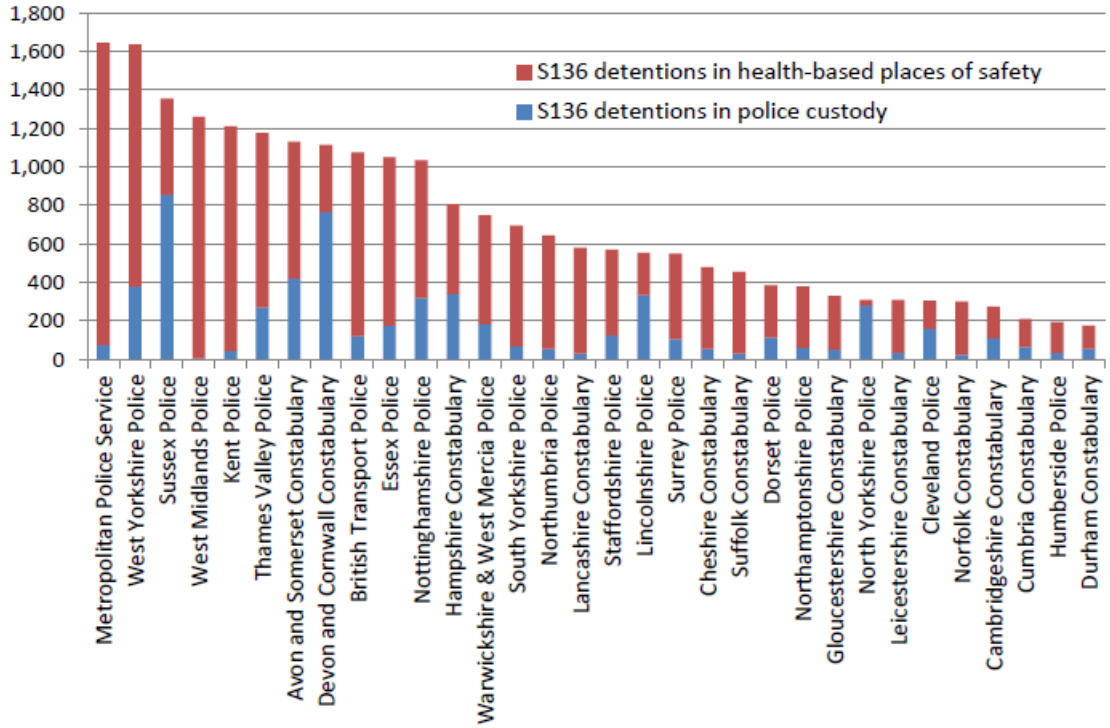

Figure 3. Number of s136 detentions recorded by the police in England, 2013/14.[14]

While reports show a reduction in the use of police custody as a place of safety, and an increase in the use of HBPOS, the overall rate of s136 detentions show an increase in detentions from 2012/13 to 2013/14. Table 17 presents the number of people detained under s136 and who were taken to either a police cell or to an HBPOS in the previous three years.[16] The findings demonstrate that while the number of HBPOS is increasing and the use of police custody is decreasing, in the three year period there is little variation in the overall number of s136 detentions.

Table 17. National s136 figures from 2011 to 2014.[16]

People detained under s136 and taken to a place of safety			
Year	Total	Police cell	HBPOS
2011/12	25,000	9,000	16,000
2012/13	22,834	7,761	15,073
2013/14	24,489	6,028	18,461

4.6 Summary

When looking at the rates of s136 detentions across all of the pilot schemes there was an overall reduction of 11.8% when comparing the evaluation period with figures for the corresponding period in the preceding years. In all sites, with the exception of MPS and North Yorkshire (which saw increases by 15.1% and 19.4% respectively), there was a reduction in the use of s136 compared with the previous year (21.5% when excluding the BTP, MPS and North Yorkshire). When looking at the rate of change per

100,000 of the population, Sussex revealed the largest change among the pilot schemes, with 80.8 fewer s136 detentions per 100,000, followed by West Yorkshire with 25.5 fewer. Derbyshire reported the lowest change in s136 detentions (3.1).

There are a number of possible explanations for the lack of change in recorded s136 detentions in the MPS and North Yorkshire. In the MPS, the increase in s136 detentions during the evaluation period may reflect the level of demand in London and the complex nature of the population this scheme was serving. Given that the Metropolitan area has the most diverse and rapidly growing population of the pilot schemes, with the highest reported BME population (42.1%), there may be added complexities to consider when understanding why the change was not as large as in other pilot areas.

In North Yorkshire, there were issues with the scheme reaching full operation as noted in the individual force report. The scheme experienced delays in some staff starting due to the enhanced level of security clearance required for the roles. For the first few months, the pilot operated with two Band 6 nurses and only one Band 3 nurse. After five months a second Band 3 nurse began allowing the team to operate at full capacity. However, the team subsequently lost one Band 3 nurse and later one Band 6 nurse, who were not replaced due to the short-term nature of the pilot and the uncertainty about future funding at that stage. Another possible explanation for this finding may be due to the lack of recorded figures for s136 detentions taken to A&E departments. Such factors may have contributed to the results seen in North Yorkshire, however the current data only allow for speculation.

Generally, there were few reported contacts with young people under the age of 18 by the Street Triage teams. North Yorkshire (17.5), Sussex (12.8) and Thames Valley (10.5) had the highest proportion of contacts with young people under 18 per 100,000 head of the population. Whereas West Yorkshire (0.4) and the MPS (1.0) had the lowest number of reported contacts with young people under 18 per 100,000 head of the population. There were 29 reported s136 detentions among this sample of young people, with the highest reported by the BTP (11), West Midlands (10) and the MPS (5). Based on the level of missing data in Derbyshire and North Yorkshire, it is predicted that these estimates reveal the lower limit of s136 detentions and therefore suggest a cause for concern.

When comparing the findings from the pilot schemes with the national figures, it appears that the findings from the pilot schemes differ from the national trend which showed that the rate of 136 detentions increased slightly from the period 2012/13 (22,834) to 2013/14 (24,834).[16]

When comparing the pilots over an annualised period (April 2014 to March 2015) there were 12,353 contacts (257.9 per 100,000) with service users made by the nine Street

Triage schemes. Street Triage teams most frequently came into contact with males (except the MPS which saw a higher proportion of female service users) aged between 25 and 54. Based on the available data, service users identified as white had the largest proportion of contact with Street Triage schemes. However, data provided by the MPS outlines its reach to BME communities (42.1% of the Street Triage contacts).

For more than half of the schemes, telephone contacts were more frequent. In Derbyshire (67.6%), Devon and Cornwall (83.3%), the MPS (91.4%) and Thames Valley (83.8%), advice was predominately provided by Street Triage nurses over the telephone. In North Yorkshire and West Yorkshire the number of face-to-face and telephone contacts are almost half. In each of these models MHPs based in NHS facilities provide telephone advice to police and attend incidents when deemed necessary. In Sussex (73.8%) and the West Midlands (70.7%), the majority of contact was face to face.

An unanticipated outcome for the schemes was the large number of incidents that occurred in private premises, where often police officers' legal powers are less clear. North Yorkshire, Sussex, West Midlands and West Yorkshire found that the majority of their contact was in person in private dwellings. This differed to the experience in Derbyshire and Thames Valley where telephone support was largely provided to people in private places. The MPS and Sussex were the only force areas to report a higher number of contacts in public spaces. The BTP figures were interpreted differently because incidents that occur on train lines are viewed as private property. Due to the nature of these incidents and the risk to safety, officers often attempt to move these incidents to public areas. Therefore, the majority of BTP encounters indicate that they were in public places while they may have begun on a train line (i.e., a private place).

5. Qualitative staff, stakeholder and service user feedback

Each report provided by the pilot schemes presented some qualitative material including feedback received from service users, families, carers, community members, police officers, MHPs and senior colleagues. For this report, data were synthesised using an established thematic framework (see section 2.3) to collate views and experiences of the service that was delivered, received and commissioned.

Each of the reports was thoroughly screened and the relevant text extracted. Varying approaches to the collection of qualitative data were used by each scheme including focus groups, telephone interviews, face-to-face interviews, postal surveys and service user groups. Table 18 outlines the participants and methods used to obtain feedback in each pilot area. Forces were contacted to provide additional detail regarding the sample and method where details were missing.

Table 18. Targeted sample and method for obtaining qualitative feedback.

Pilot Force	Sample	Method
Derbyshire	• Service users (*n*=15) • Police (sexual offences liaison officer, response officer, sergeant) • Health (crisis team, triage nurse) • Other services (Head of Service for Safeguarding Adults and Professional Standards)	An external agency carried out an evaluation over a 4-week period and included patient feedback via paper questionnaires, telephone contact and face-to-face surveys. No formal methods were in place for receiving feedback from staff, senior colleagues and partners.
Devon and Cornwall	• Service users • Family member	Feedback sought from service user groups Be Involved Devon and Devon Recovery.
MPS	• Service users (*n*=4, 2 male, 2 female) • Carers (*n*=3, 1 male, 2 female) • Police • Triage nurses	Focus groups with service users and carers. Feedback surveys from AMHPs and police.
North Yorkshire	• Police (*n*=37, inspector, sergeant, constable, Police Community Support Officer, Deployment Manager, Dispatcher and Police Crime Commissioner). • Street Triage (*n*=5, registered mental health nurse, community support worker, health trust manager) • Other services (*n*=4, Ambulance, Emergency Duty Team AMHP, third sector support organisation, County Council Community Support Team)	An academic partner conducted an evaluation, which included qualitative data collection comprising a combination of individual interviews, paired interviews and focus groups. Focus groups and paired interviews were conducted face to face. Individual interviews were conducted face to face and by telephone, according to participant availability and practicality.
Sussex	• Service users • Police • Triage nurses	Independent study was conducted with external funding. Interviews were conducted with consenting adults over 18 who have been detained under s136 in Sussex, or have had a mental health assessment via the Street Triage pilot. Focus groups were conducted with triage nurses and Response Officers.
Thames Valley	• Service users • Police • Triage nurses	Independent focus groups conducted by an external group. Service users who had contact with police during a mental health crisis were invited to attend. Participants were asked about their experiences and how they felt. User feedback was also obtained through postal surveys.
West Midlands	• Service users • Family member	No formal methods for receiving feedback. Letter received from service

	• AMHP • Paramedic • Community	users, card received from family member. Feedback from AMHP, paramedic, community unknown.
West Yorkshire	• Service users • Police (Police Hub Commander, sergeant, constable, Leeds District Senior Leadership Team) • Health (AMHP, triage nurses, health support worker)	Service users were randomly selected and interviewed via telephone using a questionnaire designed by support staff. No formal methods were noted for receiving feedback from staff, senior colleagues and partners.

Following the initial thematic review of the qualitative data, the results were discussed among members of the research team and gaps identified in the existing data in terms of understanding the implementation, process, outcomes and potential sustainability of the Street Triage schemes. As a result, further stakeholder interviews were undertaken with senior staff from a range of participating organisations with the aim of providing a higher-level organisational perspective. A total of six stakeholder interviews were conducted.

Using thematic analysis, verbatim quotations from the interviews were coded according to eight identified themes, including:

- Organisational objectives.
- Assessment and identification of service user needs.
- Pathways through the care system.
- Care coordination and effective inter-agency working.
- Quality of care provided.
- Attitudes to service users with mental health problems.
- Availability of resources.
- Staff support, supervision and training needs.

The results of each theme are discussed in detail, integrating both service users' and service providers' experience of care.

5.1 Theme 1: Organisational objectives

From an organisational perspective Street Triage models were seen as being designed to meet key organisational objectives. During the development phase these were focused on reducing s136 detentions where police custody was used as a place of safety, with the ultimate aim of reducing the demand on the police service. In order to achieve these objectives strong partnerships between police and health services were seen as an essential factor to support this change:

"We set out in our terms of reference that we wanted to have clear reductions in the use of section 136 and supporting 135 assessments. And also build that strength in partnership as a collaborative approach." (Mental Health Police Lead 1)

"From a force level it is really helping us reduce the number of people that are detained under the mental health act." (Mental Health Police Lead 2)

"Reducing the demand on the police service in terms of calls coming into our service that are very much health related." (Mental Health Police Lead 3)

Mental Health Police Leads praised the success of Street Triage in terms of achieving its stated objectives. Numerous examples were provided of other unintended positive outcomes of Street Triage particularly in terms of the strong collaborative partnerships that were formed as a result of the schemes:

"From the time we launched the pilot… It became obvious that this was going to be a good thing to do and the results have exceeded all of our expectations. For us it has always been an immensely positive move." (Mental Health Police Lead 3)

"Co-locating the nurses into the police station and actually forming them as a team, so that they started their shifts together and they ended their shifts together. Worked as a team from day one and that really helped to build trust and confidence and also a greater understanding of each other's roles and responsibilities." (Mental Health Police Lead 3)

"The fact that we have a Control Room model with mental health practitioners and police staff working together so it feels like one team. They have good working relationships, support each other and educate each other." (Health Team Manager 1)

"The impact its [Street Triage] had on the community. For the first time in Sussex it meant that there was a mental health crisis response which up until Street Triage there hadn't been, people had to go to A&E especially if it was out of hours." (Mental Health Police Lead 3)

"What we've done over the last 18 months to two years has created a really strong collaborative approach with both our local authority Mental Health Police Leads and our nurses from the mental health trust and the ambulance service… which has been really positive. Everyone from the response teams are saying don't get rid of it because it really works." (Mental Health Police Lead 1)

The value of information sharing between police and health was noted as one of the greatest successes of the schemes. The ability to access detailed information early

on in the process allowed police to make more informed and appropriate decisions for service users and therefore reduced their reliance on the use of s136:

"We didn't realise how valuable the risk information would be. The risk information we have access to on our health system. Everyone anticipates that the police will have information but they certainly didn't have a lot of the information that we had. On some occasions potentially having access to the risk information helped manage people's safety and police's safety." (Health Team Manager 1)

"The greatest thing that has come out of it is the ability for the police to get information early on about the individual because often it means that we can change what we would normally do." (Strategic Mental Health Police Lead 1)

When discussing the reduction in s136 detentions, police described how they now have access to more appropriate information, available through the Street Triage nurses, that allows them to make better decisions in the best interest of the service users:

"We would previously use our power of 136 because we didn't want to leave somebody who was in crisis at risk. A definite outcome would be that 136's have reduced. That doesn't mean that police were misusing 136, it's just that we've had no other power." (Strategic Mental Health Police Lead 1)

"We have been doing a lot of other work around preventing people ever going into police custody because somebody who is just sick should never end up in police custody. We've been doing lots of other things to help that but the Street Triage pilots have definitely assisted in that because we've been given alternative places to take individuals." (Strategic Mental Health Police Lead 1)

Senior staff described the challenges and barriers of offering a Street Triage service in their local areas. Challenges included clarifying the purpose of the scheme and educating local services about the function of Street Triage. Clarity around police officers' role in private premises and the legality issues relating to s136 detentions and conducting voluntary assessments, were often seen as barriers that police faced, including ensuring that nurses understood the limits to police powers. However, a Strategic Mental Health Police Lead who was interviewed commented that this misperception improved as the Street Triage schemes progressed:

"Had to make it very clear that this is about reducing demand on the police service, it's not about providing additional support to health. We had to do quite a lot of education around the role and function of Street Triage." (Mental Health Police Lead 2)

"One of the ongoing issues is the grey area between street and home because understanding the role in people's homes is really interesting and ensuring that we aren't coercing individuals out by our uniforms… The legality of what we do and how we do it. To ensure that what we do we do it right and we do it appropriately." (Mental Health Police Lead 1)

5.2 Theme 2: Assessment and identification of service user needs

From a police perspective, comment regularly focused on the assessment and identification of service user needs that had an impact on service users' pathways through the care system. A Control Room staff member commented that the Street Triage team is able to increase the support given to service users by providing:

"Prompt relevant information to determine risk levels/actions." (Control Room 1)

"The instant access to information is vital in making quick and informed decisions that don't make you feel like you are leaving that person vulnerable when you leave the scene." (Response Officer 1)

Response Officers from two forces reported positive experiences of the care delivered by the Street Triage teams. Officers described incidents when the Street Triage team's presence helped to better identify the needs of the service user and so improve access to care:

"*We discussed the assessment and all agreed on a strategy… it was not straight forward… had they not attended the male would have either ended up in a police cell or tied up several Officers at the hospital for a much longer amount of time. Neither would have been the right way to resolve this…"* (Response Officer 2)

A Response Officer also reported that the Street Triage scheme was more time efficient by allowing Response Officers to attend other incidents while the Street Triage team dealt with mental health-specific cases, which are often time consuming. Response Officers also stated that having a Street Triage scheme within the force improves officers' knowledge of the options available and therefore they feel more confident making decisions in mental health cases, including decreasing the use of s136 detentions and police cells as a place of safety.

"I would just like to say how brilliantly this worked tonight and saved us and the victim a lot of time. I feel this was the exact level of intervention needed as she was not ill enough to be sectioned and yet I was not comfortable leaving her to go home alone. [Service user] left the police station a much happier person and expressed her thanks for the support and guidance given. She came back to tell us how much she appreciated the help as it gave her the level of advice and information she needed to

get the help she requires. I hope we utilise your unit more in the future." (Sexual Offences Liaison Officer 1)

When describing the assessment and identification of service user needs, health staff provided mixed feedback. An AMHP from West Yorkshire felt that police were still likely to use s136 detentions when health staff were not present as a method of ensuring that service users receive quicker assessments. This staff member also expressed concern that teams might become complacent if they provided the majority of advice over the phone. This same staff member felt that it was important to continue to have face-to-face contact with service users.

Reports from service users indicate that at times they felt their needs were not properly identified or managed. A service user also described some problems in communicating with Street Triage nurses:

"In my situation I did not feel I was helped as much as I would have liked. I also felt a bit confused by the language used (not swearing) but felt a bit alienated and didn't understand what she was saying." (Service user 1)

"Was distraught already when they arrived, nurse helped calm me down but felt they were telling me what everyone told me before, that they can't help me straight away." (Service user 2)

In comparison to the service that police could offer before the Street Triage scheme started, a mother of a service user from Devon and Cornwall commented on her views towards her son's experience of care:

"The mother of a service user, a young male who had been the subject of a police s.136 detention some months earlier, was adamant that if this information sharing was in place when her son came into contact with police, then the police reaction to her sons actions would have almost certainly been different and his subsequent treatment within the criminal justice and health systems would have been more appropriate." (Force report)

5.3 Theme 3: Pathways through the care system

A key aim of Street Triage is to improve access to mental health services for the emergency services when they have come into contact with people in crisis during the course of their duties. Street Triage supports enhanced information sharing in order to ensure that service users are linked in with appropriate services and engagement is monitored through follow ups and partnerships with services, as described below:

"With every incident whether it's over the telephone or a face to face meeting there is an assessment done by the nurse. Whatever the outcome of that assessment is, they would be looking to gather as much background information as they can about the person to establish first of all whether they're already known to services. If someone's known it's about making sure they're engaged with the services that they should be and the Triage nurse will then make any appointments or contact any key workers. If it's someone who's not known to services then it's for the Triage nurse and the Officer to make the decision… One thing that always happens is that everyone's GP gets a letter to say they've had contact with the Triage team… The Triage nurse is actually recommending to the GP that they might need to look at changing their medication or that they need to have an appointment with them review what's going on with them and if they need to have an amendment to their care plan. From there it is really depends on the needs of the individual as to what Street Triage can recommend for them… The Triage team however will do some follow up." (Mental Health Police Lead 3)

Street Triage teams saw both intended and unintended changes in the pathways to care following the introduction of the schemes. During the interviews, senior members of staff described their experiences of the changes observed in the pathways to care for service users:

"We've got mental health nurses who were never able to refer directly into home treatments or crisis. But the process we've written enables them to do that and to be accepted." (Mental Health Police Lead 1)

"Up until Street Triage we had no connection with the crisis teams… There was just no relationship at all. What this did was open up access to the police into the crisis teams. Even now when they're not working in Triage, because of the relationship they've built, the officers are now able to phone the crisis teams and have conversations with them and do some information exchange with them. I think health to start with were very nervous about this because I think we were going to inundate them with calls. I think potentially had it not be done through Street Triage that may have been the outcome. But because of Street Triage and a raised level of understanding of the officers it meant then that the calls going into the crisis team were much more appropriate." (Mental Health Police Lead 3)

"We wanted to make sure that everyone we dealt with got a pathway. Which is actually a complete change in process. Normally we would have made referrals and not really followed it up. But what we were really clear about is that everyone who came to the service had the opportunity to have some form of support network put around them, either sector voluntary or statutory. We also did follow ups within seven days to make sure that they'd engaged and if they didn't plan what we were going to do. One of the biggest issues for us is that we didn't realise the demand of people who were unknown

to services and weren't registered with help. So we made step to get them registered with GPs and therefore ensure that they had access to services." (Mental Health Police Lead 1)

"It was the hope that it [Street Triage] would improve people's access into services and it certainly has. We regularly encounter people who are already known to services but need support to engage or reengage or people have been known to services but have disengaged completely, so reconnecting them. For people who have never been known to services we have had them referred into services. Or it might be someone who just needs to see their GP… we can help facilitate that as well. For those people who find it difficult to engage with services then we can give them that extra support or be assertive and make that connection on their behalf." (Health Team Manager)

Feedback gained by police and health staff indicates improvements to pathways through the care system for people who are generally unengaged or not known to services. Examples are set out below of this improvement:

"The majority of service users who have benefited from the pilot have been open or known to services, however, there have been those who have accessed mental health services for the first time directly from the involvement of Street Triage. In addition there have been many cases that were once open but fell out of a care pathway but due to Street Triage have re-entered services. For many service users incidents involving police do not automatically get referred to health and such they are unable to inform their treatment. For all those service users who have come into contact with the pilot continuity of care has been achieved by real-time updates to clinical systems and referrals during daytime hours." (Sergeant 1)

"We tend to see people who mental health services maybe wouldn't be aware of otherwise, because it's people who are contacting the police because of paranoia or whatever, and they genuinely believe that the police can help them when actually it's a mental health issue. So they wouldn't access the GP or mental health services, cos they don't believe that it is a mental health issue. So we do get to see people, quite new people, who aren't known to services, obviously got chronic a mental health problem." (Street Triage nurse 1)

Mental Health Police Leads also discussed the logistics of ensuring Street Triage is sustainable, which may involve transforming the structure of the service over time to ensure cost effectiveness and collaborating with L&D teams and other health initiatives:

"I think there is a worry for everybody regarding the longevity and sustainability of project. I don't see Street Triage in its current form as a lasting model. I think it is a short term fixed to mobilise our health partnerships and enable a more effective 24/7

capability. I think the sustainability will be dependent on how we move that forward." (Mental Health Police Lead 1)

"As a whole the concept of what we are trying to achieve is great, but it is a sticking plaster because why are police involved in health care. When you look at all the pilots the one that's most appropriate and cost effective is Devon and Cornwall where you have a nurse in the call centre filtering calls before the police even get there. Because we are the 24/7 service that responds to crisis but should we be the service that's pitching up to somebody who is in a mental health crisis because we wouldn't pitch up to somebody with a broken leg. So the concept is fantastic and what it has achieved is brilliant and it has helped to put mental health on the agenda but it does raise a lot of questions strategically about funding and why are police involved in the first place. In some areas… we can call the nurse if we need to come out to us to help us [police]… sometimes it will be us who are first on the scene but we should be able to hand that over, it shouldn't be us that's trying to find somebody who will come out and do an assessment and 12 hours later we are still with the person and can't find an available bed." (Strategic Mental Health Police Lead 1)

"What we're also now doing… I am sitting on the acute care pathway now. So working with our health colleagues we're not just looking at Street Triage we're looking at liaison and diversion, Triage, rapid assessment intervention discharge within a primary care health setting. Also looking at the 136 and 135 process. Trying to mold all of those together into one acute care pathway so the commissioning for all of that come through and our projects become normal business as arms of that. That's what we've got to get to, I think in terms of moving forward." (Mental Health Police Lead 1)

5.4 Theme 4: Care coordination and effective inter-agency working

The Street Triage schemes report improvements in care planning, care coordination, and effective inter-agency relationships. In terms of the impact Street Triage has had on policing, the ability to share information has been viewed as extremely beneficial. Police have reported an increase in mental health knowledge, an improvement in the management of people with mental health problems, awareness of appropriate outcomes for people with mental health problems and greater familiarity with related legislation, for example:

"They [MHPs] provide knowledge that otherwise we [police] wouldn't have and therefore when we attend these situations we know better how to deal with it." (Response Officer 3)

"I have learned a lot about mental health, the powers used by the mental health teams and the services available." (Accompanying Officer 1)

During interviews, officers described having greater confidence and reported that Street Triages' presence has resulted in improved responsiveness from hospitals when a MHP was involved. Officers commented on Street Triage's ability to offer better access to services and highlighted its value in providing better knowledge to officers and therefore reducing the need for unnecessary 136 detentions:

"To have a MHP assess the person at the time gives us confidence. I have also noticed that there is a better response from the hospitals." (Response Officer 4)

"It helps officers out by giving them an expert on the ground which in turn educates them more about mental health." (Control Room 2)

"Worth its weight in gold, saved many unnecessary use of 136 powers and in turn valuable police time." (Response Officer 5)

Not only are there positive accounts from police regarding the value of Street Triage as a service but there are multiple examples in which police officers have expressed their confidence and gratitude in having support from triage nurses:

"Generally as police, we always find fault with something, and I think this is one of the few things that nobody can find fault with, you know, it's a brilliant service." (Response Officer 6)

"*We're not the experts basically. We're Jack-of-all-trades and previously we've gone and put a plaster over it and done our best, whereas now we can call those guys out, if they're on duty, to come and assist us and give us some actual expert assessment and advice."* (Response Officer 7)

Feedback from senior staff in West Yorkshire offered further examples of improved care coordination, supporting responses given by Street Triage nurses. However, that the need for sufficient resourcing is identified as critical to ensuring an effective operation along with the support from partners:

"When Street Triage colleagues attend the scene they have the best opportunity to see and assess the risk that I have identified. Some seem reluctant to do this but when I have been involved in incidents where Street Triage colleagues have attended, I have found them to be really knowledgeable and we have made what I feel are good joint decisions. They also generally attend quickly and it is of huge benefit that the service is now operating 24 hours a day." (Police Constable 1)

"The scheme has provided me with a ready resource to support officers at the scene of incidents where people are suffering a mental health crisis. When staff are working and the Street Triage team is resourced, then the response times are excellent and

the impact of mental health on police resources is reduced. Funding the scheme to the right level must be a priority to ensure capacity exists at times of peak demand. An apparent lack of join up between different NHS Trusts can also be frustrating and this often leads to delays in providing care to patients, causing significant delays in the release of Officers from incidents. It often appears that different NHS functions operate to boundaries that hinder, rather than enhance, the provision of their services." (Police Hub Commander 1)

Police staff provided encouraging examples of effective inter-agency working in which Street Triage nurses were described as being proactive in their role within the team. There were multiple accounts provided by police where triage nurses heard an individual mentioned over the radio and provided background information to assist police officers:

"They're always listening. If they pick up on the name being said, they will call up and say, "Street Triage. Can I come in, I actually know that person". They're not just waiting to be sent to stuff. They are sort of actively engaging in what's going on." (Response Officer 8)

"Control Room staff also acknowledge that frontline staff work better together as a result of the triage service. This was evidenced by a reduced need for escalation of issues and communication between services." (Force pilot report)

Triage nurses commented on the value of having input from police officers. It was noted that there were few experiences of conflict with police colleagues and a better understanding of limits from a police perspective following involvement with the Street Triage scheme. Police were viewed as being valuable in aiding risk assessments and gathering information to assist nurses:

"I've found the pilot to be a good service, I've seen [people] appropriately signposted to healthcare services, thus cutting down resources of other services. The partnership with the police has been a much needed resource, proving effective in communicating mental health concerns and offering support and direction in how to move forward these cases. Police have been valuable in aiding risk assessment for the nurses, the information they gather on our behalf is brilliant. The experience for the patient in times of crisis/ trauma is much improved." (Street Triage nurse 2)

Health support staff similarly reflected the feedback offered by police in relation to effective inter-agency working:

"We've received positive feedback from the police commenting on our quick response and flexible approach." (Health Support Worker 1)

"We've contributed to raising awareness within the police of mental health issues and legal matters relating to that and how we risk assess." (Health Support Worker 2)

Triage nurses expressed positive views about utilising resources and acknowledged that their presence allowed officers time to respond to other incidents. MHPs commented that their presence has helped to calm situations when problems arose because of police in uniforms. While the presence of police in uniforms has been cited as a barrier in building relationships with service users, a triage nurse felt that police are generally good at building rapport with clients.

An AMHP from West Midlands provided the following feedback:

"*I just want to express my gratitude on the fantastic work Street Triage offer to AMHPs in Birmingham. I have been an AMHP for several years and having the support of the Street Triage team in times of crisis has been fantastic. Not only has your support improved outcomes for service users and their carers it has saved valuable time and resources. Your assistance and support has demonstrated that Street Triage has led to more timely intervention which has helped me as an AMHP reduce the unnecessary stresses involved when coordinating assessments."* (Approved Mental Health Professional 1)

Overall, care planning, coordination and effective inter-agency relationships were reported as a notable area of improvement in the qualitative interviews.

5.5 Theme 5: Quality of care provided

The quality of care provided by the triage team was viewed as an improvement on previous practice by police, health staff and service users. Police officers reported that Street Triage is valuable, timely and relevant, and has generated a positive cultural change that has benefited service users. Police felt that s136 detentions were seen in the past as *"the safest option."*

"That's another huge culture change. We'd have never done that before the triage team, because we've instantly lost our 136 power when they go into the house, and taken away what was previously our one and only option. We'd have never taken someone home. Yet that's probably the best place for them, most of the time." (Response Officer 9)

A multiagency respondent highlighted that Street Triage's capacity to intervene and de-escalate domestic situations, along with providing appropriate follow ups, meant that young people who regularly presented were now being seen less often in custody and families were being helped to manage behavioural situations at home:

"We get certain kids that will present at the police station every day and there is this thing about kids shouldn't be in custody and we should look for alternative. But where Street Triage go in – usually it's [Street Triage] *and a police officer – sometimes it's kicking off in the house, it actually nips it in the bud then and there. We don't get parents saying "I don't want this kid back. I'm putting the child on the street". So it's really preventing them from coming into the police station. And this is where I've found Street Triage invaluable."* (Multiagency Respondent 1)

Street Triage is reported to be more inclusive of the family in the care pathway, as many of the contacts occur in private dwellings (i.e., service users' homes):

"*Street Triage involves the family much more in the decision making process whereas before when people were detained s136 they were isolated from their family. Street Triage is far more inclusive of the family and the people who love and care for the person in crisis and who usually know what's best for them."* (Response Officer 10)

Similar feedback was given by triage nurses:

"As a Band 6 nurse with long experience in Crisis Intervention, I can use my skills to the best possible advantage as I'm preventing situations before they happen by organically being part of the police response. I don't know how you measure that, but it's priceless in terms of time and resources both for the NHS but also the Police… It goes without saying that it's a much better experience for service users too- they get the right kind of help nearly all the time." (Street Triage nurse 3)

Reports also outlined the benefits of the service in reducing 136 assessments presenting in hospitals. Triage nurses reported that the presence of Street Triage has improved service users' experiences by ensuring that they do not feel 'criminalised' because of their mental health problem.

"We've contributed to bringing down the numbers of incidents of service users feeling criminalised for their mental health by avoiding S136." (Health Support Worker 2)

Service users who had contact with the triage teams frequently reported that teams were helpful, friendly and made them feel at ease. Service users expressed relief about being taken to hospital instead of police custody because they found this to be less shameful. While one service user in West Yorkshire reported that they did not find support from the follow up call, service users generally commented that follow up calls were valued and gave examples of positive outcomes:

"I felt the response was excellent. Both Police and Mental Health team have supported me throughout my crisis, and continue to check on my recovery." (Service user 3)

"The support I received was excellent. The ongoing support from the staff at the (hospital) was also excellent; knowing they were there to help saved my life." (Service user 4)

"The outcome was reached quicker than it would have been if Street Triage had not attended." (Service user 5)

In supporting this claim for an improvement in the quality of care provided, a community member living in West Midlands provided feedback to the Street Triage team, that as a member from the African Caribbean community he felt engagement with the police was very positive and beneficial in bridging the gap between police and the African Caribbean community.

5.6 Theme 6: Attitudes to service users with mental health problems

Staff and service users' views of attitudes to service users with mental health problems highlight the complexities faced by police who do not have extensive knowledge of mental health and therefore are limited in their ability to offer appropriate support. A triage nurse commented on the experience of a service user who had contact with the triage team:

"Rather than deal with her as a criminal, we dealt with her as an individual with mental health issues [but] if the triage team weren't there, that's what would have happened. She would basically have been criminalised because of it." (Street Triage nurse 4)

When service users were asked to speak about their experience of the care received there is a clear indication that there is still progress to be made in improving attitudes to service users with mental health problems. Two service users spoke about their negative experiences of being detained in a police cell. One of the service users asked not to be contacted again about the experience and another service user commented:

"The night before I was sectioned I tried to hang myself in my flat, my mum has a key and she stopped me, I ran out and the police stopped me in the middle of the road, I just lost it. You're like a criminal - when I'm ill I like to wear clothes to cover myself completely but I had to strip off and wear a padded suit so I was in the police cell crying and like. I started seeing people from the past in the walls… When you are in the suite [HBPOS 136 suite] you feel more human, not so degraded. If I was in the street with a broken leg, would you put me in a police cell?" (Service user 6)

Focus groups with service users who had contact with another Street Triage team felt that police needed to work on building trust with service users, including *"speak[ing] in the same language"* and that they did not want police to *"ask for personal details."* Service users in the focus groups felt that *"the police are not equipped to understand*

me" and portrayed negative views towards authority: *"Anyone seen in authority is the enemy."*

This attitude towards authority reported by service users is supported by comments made by a number of police officers:

"It's always better there's someone in a non-uniform role, who's speaking as someone else. Because people still see the uniform; they don't like it, and they won't open up as much to you. Some will, some won't. But I think the majority would rather speak to a medical professional... they will talk a little bit more to someone in civilian clothing." (Police officer 2)

"They see us in our uniform and panic. They see someone else who actually understand what they're going through, casually dressed, calm, and can speak to them, and knows what they're talking about, saves hours. Vastly reduces the violence." (Police officer 3)

5.7 Theme 7: Availability of resources

A number of aspects relating to the availability of resources were discussed by staff, including access to information, experience of the service delivered, barriers to access and suggested improvements. It was highlighted by one team that it was crucial during the development of the scheme to consider how to access and share information on different IT platforms:

"A common misconception is that the police hold information on most people. In fact the pilot has highlighted that there are significant amounts of information held by health that the police do not have. This information has shown crucial to safeguarding those in crisis. By sending details of incidents and the request to share information electronically within one IT platform considerably speeds up decision making. Once the information has been shared a joint approach follows that is focused on safeguarding and providing the most appropriate care pathway for the individual. This may result in advice, guidance and support through a greater understanding of the individuals current/past clinical diagnosis, care plan, recovery factors to reduce crisis or indeed an initial mental health assessment." (Force report)

One police officer commented that health partners can provide a lot more information that now guides police officers to better deal with people with mental health problems. The pilot schemes have shown that prompt access to information and prior knowledge of service users is vital and assists Response Officers in making informed decisions.

A significant barrier to access reported by police was the availability of the Street Triage team, where staff felt that additional resources were needed to ensure that staff

were available to respond when needed. Concerns were raised by Control Room staff that the advice line could not be answered when staff were engaged with an incident and there seemed to be a reluctance to deploy the team in case they were not available to respond to other incidents:

"Almost a third of referrals involved direct contact with the client. This number has been declining since the start of the pilot despite being crewed with a police officer and being able to be deployed as first response. This suggests reluctance on the part of the Control Room to deploy the team as immediate either because of risk or to keep the team free to respond to other incidents. Qualitative feedback from Control Room supports this reluctance based on the inability to respond to requests from other incidents whilst deployed at a scene." (Control Room 3)

Both triage nurses and police expressed their disappointment when the Street Triage team was not operating or available during the pilot period:

"It's just very, very unsatisfactory, running half a service. We did a lot of work in the beginning to raise our profile. We were going down to police briefings, introducing ourselves, and we did that for the first couple of months, so that police officers knew who we were and knew when we were on duty, and you know, we did a lot of work. And I just feel that we're at risk of losing that, because it's that "Are they working, aren't they working?" You get to the point where people won't bother cos they don't know whether we're there or not, so they'll just do without us. And I think that's a real kind of risk." (Street Triage nurse 5)

"You hear Officers shout up when they're at the incident, for Street Triage. And when you hear that they're not on duty at the time, you can hear the disappointment in the Officers, because they're probably thinking to themselves, "Well, what we gonna do?"... I think you've got so used to them now – knowing that help's there, there's a professional there to help, to call up, and they will come straight out to you, they'll be on the radio to you, straight away – that when they're not there, it's massively disappointing." (Police officer 4)

5.8 Theme 8: Staff support, supervision and training needs

The pilot schemes used various methods for recruiting and selecting appropriate staff. In some cases police were not involved in the recruitment of health staff, however there were instances in which police staff were members of the interview panel for recruiting suitable nurses. The West Midlands described a recruitment process that involved input from police, health and paramedics:

"We do a tri-service recruitment process. So for all of our stuff we have multi-agency recruiting, so we've had a senior nurse, a police officer and a paramedic involved in

all of the process including recruiting police officers and the nurses and the ambulance staff. We've all be involved at various levels." (Mental Health Police Lead 1)

When describing the difficulties with employing appropriate staff, senior members of staff commented on difficulties with the police vetting process:

"Vetting. Police officer vetting requirements are really strict." (Mental Health Police Lead 2)

"There was a huge delay in staff getting through the vetting." (Health Team Manager 1)

Before the implementation of Street Triage, the extent of training offered to triage staff differed across the schemes as described in section 3.2. However, it became evident that as the schemes progressed there was a continual process of information sharing and debriefing between police and health staff:

*"When we devised Street Triage we had an operational policy which was sent to all of the officer's and continues to be available on our intranet and they're expected to self-brief and make sure they're aware of that. We've set up with the nurses as part of their task to give awareness raising sessions to our other officers, not just the ones involved in Triage… Since we've had Triage the level of knowledge of all our officer's has increased so much. The Triage officers are set in the car with the nurse for eight hours for their shift so they're constantly talking, reviewing, talking about the incident they just dealt with… loads of reflective practice going on." (*Mental Health Police Lead 3)

In terms of the experience of the care being delivered and received, a triage nurse in West Yorkshire reported changes in police officers as they became more confident and are now more likely to consider options other than s136 detentions, such as referrals to mental health services. Similar feedback was provided by a Response Officer involved in the London pilot:

"Officers feel confident in dealing with mental health needs and half of Officers agreed that they could identify different symptoms. Officers feel they're expected to be experts in mental health, are concerned about taking the wrong choice of action when there are lots of unknown circumstances, and feel they've received a lack of adequate training." (Street Triage nurse 6)

Other reports captured the experience of staff support, supervision and training needs by documenting where further support and training are required from both the health and police positions:

"Staff were asked about the risk of deploying an MHP and the majority felt that deployment with an Officer in PPE [personal protective equipment] would be fine, there was some concern over the lack of training and PPE for the MHP." (Control Room 4)

One scheme noted the joint training initiative being led within this region to ensure both police and health are informed about their legal positions:

"*The triage service soon highlighted there was confusion around the knowledge of powers and procedures for both organisations. Powers relating to s136 and s135 of the Mental Health Act are specific examples, Officers using S136 in a private dwelling. This has led to joint training between police and health partners. There is still more work to do in this area and this work will continue through newly developed training which is being delivered throughout 2015. What has been found during the pilot is that the majority of face to face assessments are within private dwellings; this has identified limitations in the current powers available where the nurse recommends detention to a place of safety."* (Force report)

Service users in another force offered feedback indicating that they felt there was a need for police to have more face-to-face contact with service users for training and sharing of experiences and suggested setting up an on-the-job training programme for police:

"*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 7)

"The police need training in mental health and to hear some real life experiences. I just want to get my loved ones treated with dignity." (Carer 1)

5.9 Summary

Senior staff and stakeholders described the key organisational objectives of the Street Triage schemes, including reducing s136 detentions and the use of police custody as a place of safety with the ultimate aim of reducing the demand on the police service. In order to achieve these objectives, it was felt that strong partnerships between police and health services were an essential foundation. Co-locating police and health staff was viewed as a positive means of assuring joint working and establishing the collaborative nature of the service. The value of information sharing between police and health was seen as one of the great successes of the schemes. The ability to access detailed information early on in the process was thought to allow police to make more informed and appropriate decisions for service users and therefore reduce their reliance on s136.

Feedback from senior staff, police and health staff supported improvements to pathways through the care system for people who were unengaged with or not known to services. The Street Triage schemes reported significant progress in care planning and coordination and effective inter-agency relationships. In terms of the impact Street Triage has had on policing, the ability to share information has been viewed as extremely beneficial. Police have reported an increase in mental health knowledge, an improvement in the management of people with mental health problems, awareness of appropriate outcomes for people with mental health problems and greater familiarity of related legislation. Officers described having greater confidence and reported that the presence of Street Triages has resulted in improved responsiveness from hospitals when a MHP was involved. Overall, the impact on pathways into care, as well as care planning and effective inter-agency relationships, were felt to be notable areas of improvement across the pilot areas.

The qualitative feedback provided by service users, police, nurses and senior staff suggest that the quality of care provided has improved, particularly when compared with previous practice by police. Police staff reported that not only is Street Triage timely and relevant, but it also supports a more effective response for the service user and a consistent approach to mental health situations that was not previously in place. Street Triage was also reported to be more inclusive of the family in the care pathway, particularly as many of the assessments are conducted in the service user's home.

Feedback from staff on their views of attitudes to service users with mental health problems highlights the challenges faced by police who do not have extensive knowledge of mental health problems and have been restricted in their ability to offer appropriate support. When service users were asked about their experience of the care received, there was a clear indication that there is still progress to be made in improving attitudes to service users. Feedback provided by service users also indicated that at times they felt their needs were not properly identified or managed.

A primary barrier reported by police was the 24-hour availability of the Street Triage team. It was felt that additional resources were needed to ensure the service was running at full capacity and that there were staff available to respond to requests when needed. Feedback was also provided on the need for additional staff training such as joint training initiatives to ensure that both police and health services are informed about one another's legal positions. Service users offered feedback indicating that they felt there was a need for police to have more face-to-face contact with service users for training and sharing of experiences and suggested setting up an on-the-job training programme for police.

6. Discussion

6.1 Key outcomes

Analysis of the quantitative data demonstrates that the introduction of the Street Triage pilots led to a reduction in the use of s136 detentions. Overall, the mean percentage reduction was 11.8% for the eight sites for which data were available (BTP provided no data) and it increased to 21.5% if the MPS and North Yorkshire were excluded. There was some variation in the reduction of s136 detentions ranging from 15.5% to 27.5% with increases of 15.1% and 19.4% in the MPS and North Yorkshire. Individually, West Midlands, Derbyshire and Thames Valley reported the greatest reductions in s136 detentions. When looking at the rate of change per 100,000 of the population, Sussex revealed the largest change among the pilots, followed by West Yorkshire; Derbyshire reported the lowest change in s136 detentions. While it was not possible to compare the overall s136 figures for the BTP C Division over the evaluation period, the results showed that s136 was used by the Street Triage team in only 12% of incidents; the majority of people were placed in HBPOS (84%). Street Triage also led to an increase in the use of HBPOS overall. Where police custody was used to detain people under s136, lack of space within the healthcare setting was cited as the principal reason for the use of police custody. The number of hours spent in detention appeared to have been reduced when compared with the national picture.

The limitations of the evaluation, principally associated with its retrospective nature and the lack of robust comparators for each site, mean that it is not possible to use these data to determine whether a particular model or models should be adopted as the standard model for Street Triage. In addition, the likely different populations engaged by Street Triage and the quality and availability of local mental health community services will in all probability have significantly impacted on the effectiveness of Street Triage. While no particular model seems to be associated with a more favourable outcome, it should be noted that two schemes were associated with an increase in s136 detentions during the pilot period and this may be attributed to the focus of the team, other available mental health services and problems with the staffing of the services.

However, although it is not possible to identify any one model as superior to any other one, there are a number of factors, drawing on both the qualitative and quantitative data, that may be associated with more effective outcomes for Street Triage programmes. These include:

- Joint ownership of the scheme at a senior management level to support the development of effective partnerships.
- An established and regular process to review joint working arrangements.

- Clarity about the population to be served by Street Triage.
- Provision of information on agreed referral pathways to health and community services at the point of crisis or after its resolution.
- Joint training programmes for all staff involved in the Street Triage schemes and enhanced mental health training for all police officers.
- Co-location of health and police staff (e.g. linked to a Control Room) or dedicated phone line(s).
- The development of agreed protocols for:
    - effective information sharing between services, in particular, access to health information, including services to which people could be triaged e.g. bereavement, counselling and alcohol;
    - provision of timely advice to police officers at the point of initial contact and during the assessment process;
    - integration of Street Triage schemes with the health service-based crisis and alcohol pathways.

A number of contextual factors also impacted on the ability of Street Triage schemes to achieve their objectives. These include:

- The target populations for the Street Triage. The variation in the numbers per 100,000 seen by the teams and the percentages of those who are in contact or are not engaged with but known to mental health services suggests that greater targeting of the Street Triage programme should be considered. This should be undertaken along with a review of the capacity of health and social care to provide effective and responsive crisis services.
- The capacity of local health and social care services to provide good quality support to people with mental health problems in the community. Decreases in the level of such support may well contribute the number of people presenting in public places in crisis.
- The large number of contacts initiated in private premises (46.6%), where police officers' legal powers are less certain. Four of the pilot schemes found that the majority of their contacts were face to face in private dwellings (31.2%), while two schemes reported that the majority of their contacts were via telephone in private dwellings (29.9%). This finding presents challenges for Street Triage in part due to the legislative issues and potential practical implications for police officers when presented which such situations. The MPS and Sussex were the only force areas to report a higher number of contacts in public spaces, most often face to face. The experience in the MPS and Sussex may reflect the well-developed service offered by the MPS and Sussex's involvement with Beachy Head.
- The availability of 24-hour seven-days-a-week Street Triage schemes. The trend in many of the pilot schemes was to move towards full cover seven days

a week as the success of the schemes was recognised. This, however, raises important questions about the costs and sustainability of the project and the possibility that a service with increased capacity may be drawn into other areas of activity and a consequent engagement with populations outside the original purpose of the Street Triage scheme. Control Room-based models may avoid some of these risks while still offering a service seven days a week.

Street Triage schemes reported significant progress in care planning and coordination and effective inter-agency relationships. Police officers reported an increase in mental health knowledge, an improvement in the management of people with mental health problems, awareness of appropriate outcomes for people with mental health problems and greater familiarity of related legislation. Officers described having greater confidence and reported that the presence of Street Triage has resulted in improved responsiveness from hospitals when a MHP was involved. Police staff reported that Street Triage supports a more efficient response for the service user and a consistent approach to mental health situations, which was not previously in place. The primary barrier to access reported by police was the availability of the Street Triage team and that there were staff available to respond to requests when needed.

The positive impact of Street Triage on the use of s136 in the context of a national increase in their use is of considerable importance. If the gains seen in the pilot areas were replicated nationally, the potential benefits, not just on the use of s136, but also on other aspects of mental health care and the role played by the police service development, are considerable.

6.2 Limitations

While the DH and Home Office set out a comprehensive dataset, funding was often not provided for administrative support, which impacted on the completeness of data collection. This resulted in inconsistent data reporting and some missing data in some cases. While s136 data were generally complete, information relating to the processes of care and action taken by the Street Triage teams was often more limited. There were also no concurrent comparator data collected, which limits the conclusions that can be drawn. No cost-effectiveness evaluation was undertaken for this review.

6.3 Recommendations

Based on a review of the outcomes, the different models for the delivery and the qualitative data available for the evaluation of nine Street Triage pilots, the following recommendations are made:

1. An extension of the hours of all Street Triage schemes should be considered so that they can provide a 24-hour service seven days a week.

2. The role of Street Triage schemes should be reviewed in relation to referrals from and contacts in private settings.

3. A number of key functions appear to be associated with better outcomes and operation of the services and these functions should be considered when developing or extending Street Triage schemes; they include:
   - joint ownership of the scheme at a senior management level to support the development of effective partnerships;
   - regular reviews of joint working arrangements;
   - clarity about the population to be served by Street Triage;
   - effective information sharing between services, in particular, access to health information;
   - provision of timely advice to police officers at the point of initial contact and during the assessment process;
   - integration of Street Triage schemes with the health service-based crisis pathway;
   - provision of information on agreed referral pathways to health and community services at the point of crisis or after its resolution;
   - joint training programmes for Street Triage staff;
   - improved recording of causes of crises so that this information can be presented to the local safeguarding board and be included in the Joint Strategic Needs Assessments chapters on mental health prevention.

4. Co-location of health and police staff (e.g. linked to a Control Room) or dedicated phone line(s) appear to be an important component of effective Street Triage schemes and could support a cost-effective roll out of the programme.

5. New and existing technologies to support effective information sharing could be used both within and between health and police services.

6. A national curriculum and associated training materials for Street Triage staff and enhanced mental health training for all police officers should be developed.

7. A common dataset should be developed and the appropriate resources monitored to ensure that data are collected consistently and support a review of the cost-effectiveness of the scheme, which should be undertaken to provide evidence for its long-term sustainability. The review could take the form of an evaluation based on routinely collected data. Alternatively, a formal research study, which tests different models of Street Triage (for example, Control Room-based models versus community team-based models) could be undertaken.

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8. Appendix A: Street Triage / liaison and diversion - by police force areas (provided by Regional Police Lead)

Force Area (England)	Operating Model	Funding
Avon and Somerset	Planning stage	
Bedfordshire	Planning stage for mobile scheme	Police / CCG
BTP	Control Room - MHP	Police / Network Rail
Cambridgeshire	Reviewing options / planning stage	
Cheshire	Mobile – Police / MHP	Police / CCG
City of London	Reviewing Options	
Cleveland	Mobile – Police / MHP	Police / CCG
Cumbria	No ST – reviewing options	
Derbyshire	Mobile – Police / MHP	Police / CCG
Devon and Cornwall	Control Room / Mobile – MHP	Police / CCG
Dorset	Mobile – Police / MHP	Police / CCG/Local Authority
Durham	Not Street Triage - but have a Local Operating Practice	
Essex	Mobile - Police / MHP (Reviewing)	Police / CCG / Project money
Gloucestershire	Planning stage for Control Room-based model	Police / CCG
Greater Manchester	Control Room – MHP	Police / CCG
Hampshire	Mobile – Police / MHP / on call crisis team	Police / CCG
Hertfordshire	Control Room / further review	
Humberside	Not Street Triage - Local Operating Practice in Grimsby	
Kent	Mobile – Police / MHP	Police / CCG / Project money
Lancashire	Mobile – Police / MHP	Police / CCG
Leicestershire	Mobile – Police / MHP	Police / CCG
Lincolnshire	Mobile – MHP / Paramedic	Police / CCG / East Midlands Ambulance Service
Merseyside	Mobile – Police / MHP	Police / CCG
MPS	Control Room / Mobile –MHP	NHS
Norfolk	Control Room – MHP	Police / Innovation fund
North Yorkshire	Mobile – MHP	Police / CCG
Northamptonshire	Mobile – Police / MHP	Police / CCG / Project Money
Northumbria	Mobile – Police / MHP	Police / CCG
Nottinghamshire	Mobile – Police / MHP	Police / CCG
South Yorkshire	Mobile – Police / MHP	Police / CCG
Staffordshire	Mobile – Police / MHP	
Suffolk	Mobile – Police / MHP	Police / CCG
Surrey	Control Room – MHP	Police / CCG / Project Money
Sussex	Mobile - Police / MHP	Police / CCG
Thames Valley	Mobile - Police / MHP	Police / CCG
Warwickshire	Reviewing possibility of Street Triage as part of Crisis Care Concordat	
West Mercia	Reviewing possibility of Street Triage as part of Crisis Care Concordat	
West Midlands	Mobile - Police / MHP / Paramedic	Police / CCG
West Yorkshire	Mobile - MHP	Police / CCG
Wiltshire	Planning – Mobile September 2015	CCG / Innovation Fund
Force Area (Wales)	**Operating Model**	**Funding**
Dyfed Powys	Mobile - Police / MHP	Police / CCG
North Wales	In Planning Process	

9. Appendix B: Street Triage Project Common Dataset

The datasets will be returned monthly to the Department of Health and will include the following:

Description of the service:

- Time and days of operation
- Total cost of operation, including levels and grades of staff
- Overview description of activity
- Description of modus operandi of service (derived from observation of practice)
- Basis of estimation of number of s136 detentions adverted on advice of street triage services
- How they get connectivity with Community MH datasets (derived from interviews)

Activity

- Number of clients engaged with in person by a street triage team member
- Number of clients advised on, without in personal engagement
- Number of clients aged 18 or younger
- Breakdown of these issues by Offender/Suspect/Victim/Community
- Mental health issue (inc. s136, s135 advice and suicide)
- How many clients already known to Community MH services of CAMHS
- How many clients previously subject to a s136 detention?
- How conveyed (e.g. by police car or ambulance?)

Outcomes

- How many s136 detentions to health based place of safety
- How many s136 detentions to police station (with reason why)
- How many s136 detentions to other POS (home address etc.)
- Length of s136 detention
  Assessment started within 3 hours (Y/N)
- How many s136 detentions averted on advice of street triage service (estimate)
- How many clients subsequently sectioned under the Mental health Act – e.g. sections 2 or 3 of the MHA
- Clients referred to Community MH for support
- Offenders referred to Liaison and Diversion scheme (where existing)
- Follow up after 2 weeks – have clients continued to engage with health (or other) services?

Savings

- Opportunity savings in reduced service demand (i.e. cost an average s136 detention and then value the reduction)
- Number of individuals involved, at what staff grade, and for how much time (information to be provided by the pilot's mental health liaison nurse

10. Appendix C: Department of Health funded Street Triage pilot schemes (provided by NHS England)

BRITISH TRANSPORT POLICE (BTP)

START DATE	Pilot Service started 6th May, 2014 for 12 months.
FUNDING	Department of Health (DH) funded pilot - £200K - which financed x4 NHS Nurses. All BTP overheads and x3 BTP staff and 1 Officer are financed by BTP.
REGION	BTP C division - The Pennines, West Midlands, Wales through to the Scottish boards down to Lands End. This area includes approx. 132 Clinical Commissioning Group (CCGs) areas.
WORKFORCE	4 x NHS nurses (3 x band 6 and 1 x band 7) Currently 3 BTP staff and 1 Officer, and in process of recruiting an additional x2 BTP researchers.
MODEL	Due to BTP being a national force the use of a vehicle would not be efficient. Therefore, the Street Triage model provides a telephone advice and follow-up service. The service is provided by BTP staff, and a Sergeant along with NHS nurses. • Psychiatric Liaison Nurses are available*9am-9pm Mon-Sun • Referrals are generated regarding incidents from police officers • Assist Officers & background assist the individual coming to notice • Provide rapid access to information in emergency situations to Officers 'on the ground' • Live time assistance such as Place of Safety details, Mental Health 'intelligence' pertaining to the individual etc • Follow up with crisis teams and individual in regards to engagement of services • Supporting Family and Relatives at risk due to Suicide • Activating the Samaritans referrals process; and other 3rd party organisations • Sign posting to further organisations • Liaison with hospitals/functional Mental Health teams CCGs, bed and AMP managers • Problem resolution to ensure processes and actions are correctly put in place. e.g. Officers spending excessive time with a patient, transport of patient issues • Engaging with communities by promoting the service offered by the team as well as to build up beneficial links between NHS facilities e.g. places of safety • Attending local events including a Mental Health Partnership meeting, meetings with local mental health charities (Papyrus) and meetings with local authority Social Services and Home Office Forces to discuss procedures. • Attend professional Meetings
KEY COMPONENT	• Dedicated (9am-9pm) telephone access for police referrals to NHS nurses • Daily Tasking Meeting • Clear and agreed referral pathways • Post Incident Follow-Up's

KEY SUCCESS	• Improved partnership working between the police and mental health services at a local level leading to efficiencies across the system • Improved sharing of information which allows the team to gain the background of a person to make a more informed decision as to the risk they pose of suicide and serious harm to themselves on the rail network leading to faster access to care and treatment for those in crisis • Improved user experience for those who come into the contact with the police and are in crisis and/or where a criminal offence is not the primary concern • Reduce risks to life and the distress that suicide attempts cause within the railway environment • Reduction in inappropriate detentions to both hospital and custody • Data captured and the outcomes of vulnerable persons who come to BTP's attention has improved considerably.
EVALUATION	• 6 month evaluation October 2014. Final evaluation will be conducted at the end of pilot – May / June 2015.

DEVON AND CORNWALL POLICE

START DATE	6 March 2014
FUNDING	DH funding - £200k
REGION	Telephone advice across Devon with ability to provide Face to Face support in Exeter and Plymouth
WORKFORCE	3 x band 6 Nurses
MODEL	9am – 5pm Monday to Friday 8pm – 6am Thursday to Sunday Mental Health Practitioners (MHP's) from Devon Liaison and Diversion (L&D) Team provide police officers with telephone advice relating to individuals who potentially may be detained under s136 Mental Health Act with the ability to provide on-site face to face support in the Exeter and Plymouth areas All MHP's have a combined role of day time Liaison and Diversion and night time Triage Pilot responsibilities. MHP's have the support of day time L&D colleagues to support signposting, administration business support etc.
KEY COMPONENT	• The 2 roles of L&D and Street Triage complement each other • Devon MHP's have a rota and have access to relevant information via local IT health care records and Police IT system • Clear and agreed referral pathways • Service embedded into crisis and liaison pathways.
KEY SUCCESS	• Decrease in S136 taken to custody • Improved partnership working between the police and mental health services at a local level leading to efficiencies across the system • Improved sharing of information processes leading to faster access to care and treatment for those in crisis • Improved user experience for those who come into the contact with the police and are in crisis and/or where a criminal offence is not the primary concern • Skills of team members have been enhanced • MH knowledge of Officers increased
EVALUATION	Force report to the DH re Pilot experience to be available from May 2015

DERBYSHIRE POLICE

START DATE	February 2014
FUNDING	DH funded pilot - £200k -predominantly spent on nurse wages. Police officer costs have been met by the Constabulary
REGION	D Division – Initially Derby City but after 2 months it was extended to also cover South Derbyshire and Erewash to match the geographical policing area
WORKFORCE	3 dedicated police officers / 3 Nurses on a rota basis from a pool of 7 nurses from the Criminal Justice Team
MODEL	Operating hours are 4pm to midnight 7 days per week. Nurse and police officer attend incidents as a secondary resource. The officer who initially attends the incident, requests Street Triage based on requirement. ST team also provide telephone advice to officers across the whole force area. Between 8am – 4pm, a police officer from the team is available for telephone advice only. The team only respond to police calls for service
KEY COMPONENT	Access to 3 databases – 2 police / 1 health Clear and agreed referral pathways Service embedded into crisis and liaison pathways
KEY SUCCESS	• Significant decrease in S136 through Derby custody suite • Significant reduction in S136 through A&E • Improved partnership working between the police and mental health services at a local level leading to efficiencies across the system • Improved sharing of information processes leading to faster access to care and treatment for those in crisis • Improved user experience for those who come into the contact with the police and are in crisis and/or where a criminal offence is not the primary concern • Review and implementation of new training inputs to Officers • Service is now embedded and will continue • Skills of team members have been enhanced • MH knowledge of Officers increased • Better management of repeat callers
EVALUATION	Service User feedback survey – Feb 2015. Final Pilot report to be available – March 2015

METROPOLITAN POLICE SERVICE (MPS)

START DATE	31 March 2014
FUNDING	DH Funded Pilot - £260k
REGION	London - in boroughs of Lambeth, Lewisham, Croydon and Southwark
WORKFORCE	• 4 Wte nurses based within a clinical bed management team working over a 24/7 providing telephone support including advice, information sharing and onward referral and face to face assessment where indicated.
MODEL	• 7 days per week 3pm – 12am • The service is managed within the crisis service line and is well integrated into the Trust's crisis care pathways. • Referrals are generated from direct calls to the triage team from front line police officers • Weekly operations meetings take place between local police officers and the triage team to build relationships and work out any snagging issues.

KEY COMPONENT	• Dedicated 24/7 telephone access for police referrals • Clear and agreed referral pathways • Nurse led service • Service embedded into crisis care pathways (inclusive of section 136) and Liaison Psychiatry • Active service user involvement in the delivery and design of the service • Particular focus on the experience of BME communities use of the service.
KEY SUCCESS	• No increase in the use of section 136 despite the overall increase of section 136 in London • Improved partnership working between the police and mental health services at a local level leading to efficiencies across the system • Improved sharing of information processes leading to faster access to care and treatment for those in crisis • Improved user experience for those who come into the contact with the police and are in crisis and/or where a criminal offence is not the primary concern.
EVALUATION	Force report to the DH re pilot experience to be available from May 2015

NORTH YORKSHIRE POLICE

START DATE	24 March 2014
FUNDING	DH funded - £198,895
REGION	Scarborough, Whitby and Ryedale
WORKFORCE	2.26 FTE Band 6 Nurses 2.24 FTE Band 3 Nurses
MODEL	• 7 days per week 10.30am – 10.30pm • Referrals are generated from direct calls to the triage team from front line police officers • Weekly operations meetings take place between local police officers and the triage team to build relationships and address any operational issues.
KEY COMPONENT	• Access to shared information where relevant Police / Health • Clear and agreed referral pathways • Service embedded into crisis and liaison pathways • Partnership agencies and service user's feedback used to develop pilot model.
KEY SUCCESS	• Significant decrease in S136 through custody suite (62%) • Reduction in S136 through A&E • Improved partnership working between the police and mental health services at a local level leading to efficiencies across the system • Improved sharing of information processes leading to faster access to care and treatment for those in crisis • Improved user experience for those who come into the contact with the police and are in crisis and/or where a criminal offence is not the primary concern • Success of Pilot led to implementation of additional scheme in York, funded by Local Authority and CCG.
EVALUATION	Local University to conduct evaluation at completion of pilot period. Force report to the Department of Health re Pilot experience to be available from May 2015

SUSSEX POLICE

START DATE	16 October 2013
FUNDING	DH funded - £191,241
REGION	Eastbourne
WORKFORCE	1 x Band 7 Nurse (1.2 wte) and 1 police officer to provide mobile triage response on identified days
MODEL	5 days per week / 4.30pm - 12mn Wednesday to Sunday 9am - 4pm Saturday and Sunday The Sussex Health and Criminal Justice Street Triage team consists of a mobile Police Constable and a psychiatric nurse providing response to reports of incidents from Police and members of the public regarding individuals who are in immediate need of support due to mental ill health. Together, they provide a mental health and criminal justice response to fast time calls, which would otherwise be dealt with solely by Sussex police officers. If there are any criminal offences disclosed then the Response Officer or other most appropriate Officer will assume responsibility, discretion will be used to decide whether the criminal justice matter can be dealt with once the health element has been addressed. The Street Triage team are not be the initial response to emergency or life threatening calls, as their vehicle is not fitted with blue lights and sirens. In these incidents Response Officers take the initial call until the Street Triage team arrive on scene.
KEY COMPONENT	• Access to shared information where relevant Police / Health • Clear and agreed referral pathways • Service embedded into crisis and liaison pathways • Partnership agencies and service user's feedback used to develop pilot model.
KEY SUCCESS	• Decrease in S136 through custody • Overall reduction in use of S136MHA • Improved partnership working between the police and mental health services at a local level leading to efficiencies across the system • Improved sharing of information processes leading to faster access to care and treatment for those in crisis, including Missing from Home and Police negotiation incidents • Improved user experience for those who come into the contact with the police and are in crisis and/or where a criminal offence is not the primary concern • Review and implementation of new training inputs to Officers • Service is now embedded and will continue • Skills of team members have been enhanced • MH knowledge of Officers increased • Better management of repeat callers.
EVALUATION	Force report to the Department of Health re Pilot experience to be available from April 2015

THAMES VALLEY POLICE

START DATE	31 December 2013
FUNDING	DH funded - £200k
REGION	Oxfordshire
WORKFORCE	2 x Band 6 Nurses : 1 x analyst
MODEL	• 7 days per week from 3pm to 1am in Oxfordshire

	• Mental Health Professional (MHP) and police officer providing a mobile response to Police reports of persons in Mental Health crisis • Face to Face Consultation (In Oxford City) with opportunity to provide telephone advice to the wider county area • 24 hour advice line for officers via the crisis team that simply provides information and advice about an individual to assist officers and the control room in decision making and potentially accessing pathways.
KEY COMPONENT	• Access to shared information where relevant Police / Health • Clear and agreed referral pathways • Service embedded into crisis and liaison pathways Partnership agencies and service user's feedback used to develop pilot model.
KEY SUCCESS	• Decrease in S136 through custody • Overall reduction in use of S136MHA • Improved partnership working between the police and mental health services at a local level leading to efficiencies across the system • Improved sharing of information processes leading to faster access to care and treatment for those in crisis, including Missing from Home • Improved user experience for those who come into the contact with the police and are in crisis • Skills of team members have been enhanced • MH knowledge of officers increased • Many high risk missing persons triaged once located to ensure suitable care pathways.
EVALUATION	Force report to the Department of Health re Pilot experience to be available from April 2015

WEST MIDLANDS POLICE

START DATE	10 January 2014
FUNDING	Funding initially received from DH - £265k On-going funding now obtained until April 2016 - £450K from CCGs • Black Country Pilot (£220k) funding form better care fund • Coventry Pilot (200k) from Public Health, Community Safety Partnership and Police and Crime Commissioner
REGION	Birmingham and Solihull – covers population of 1.2 million people, 1 MH Trust, 3 CCGs, 5 police areas and 2 Boroughs.
WORKFORCE	4 FTE (Band 6) MH Nurses, 3 FTE paramedics, 6 constables and 1 T/Sgt
MODEL	Triage car works from 10am to 2am 7 days per week. The team deploy in a plain ambulance with blue lights covertly fitted. Police officer, MH Nurse and Paramedic deploy together and are deployed via 999 through police or ambulance control room staff.
KEY COMPONENT	• Improved telephone access for police and ambulance information exchange • Vehicle is a plain ambulance providing a more dignified and respectful conveyance of al s136 and some s135 detainees • Paramedic supports local drive to reduce inappropriate attendance at A+E • Model provides an additional layer for the AMHP service to mobilise resources more appropriately

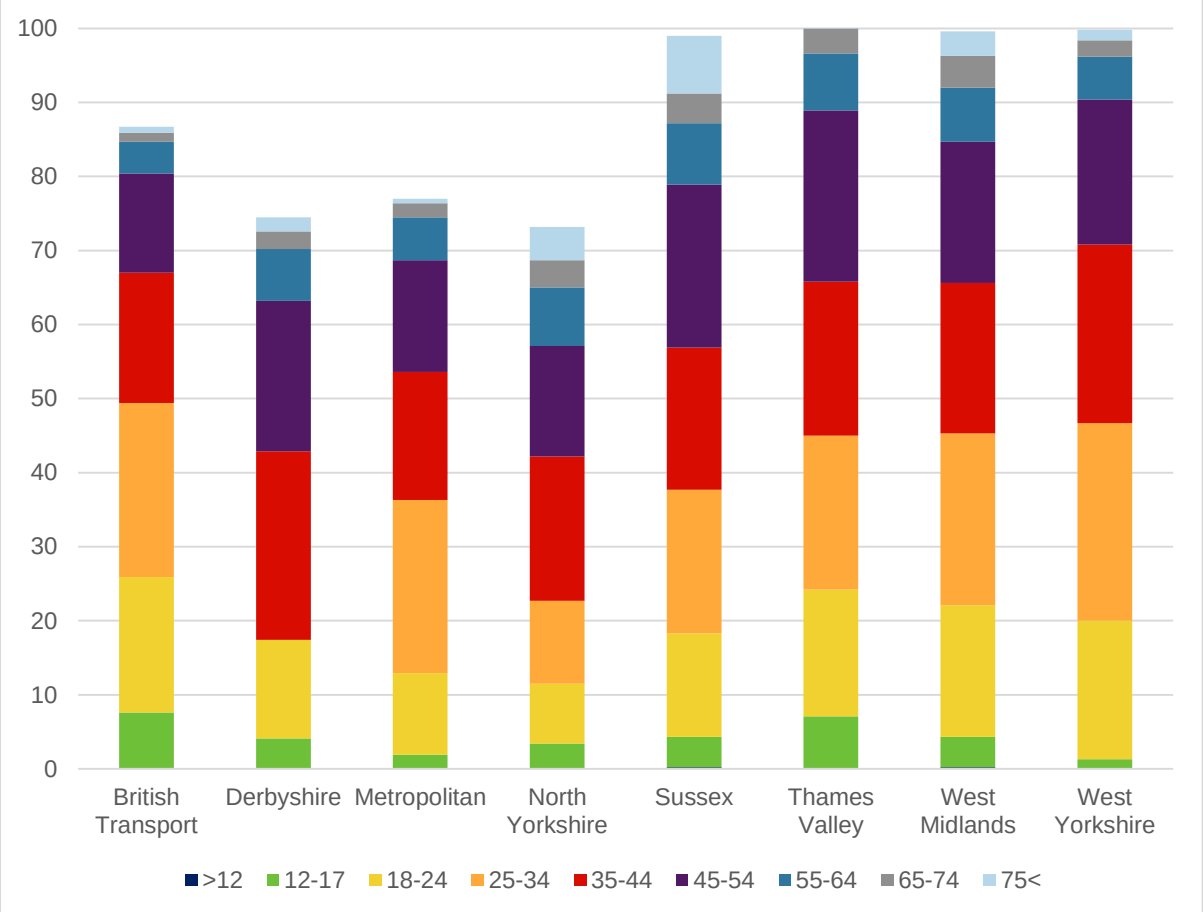
	• clear and agreed referral pathways including 3rd sector, substance misuse and RSLs in a psycho-social model of intervention • tripartite led service – risk based model by which all staff on car sign off pathways intervention • particular focus on the experience of BME communities use of the service with Critical friend sitting on the Governance board • Active engagement with 'Time to Change' 300 voices project • Governance structure includes all key stakeholders (CCG, Local Authority, Mental Health Trust, Police and Ambulance.
KEY SUCCESS	• First 11 months (2356 incidents) – Attended 1756 incidents to conduct face to face assessments – S136 detentions x 301 (previous 636) – (57% reduction) – Incidents on street - 884 – Incidents in private premises - 1472 – Interactions on street where the use of s136 was a consideration by police officers or paramedics - 539 – Physical health assessment where A&E attendance would have previously occurred x 601 – Conveyance of persons in Street Triage car to Place of safety instead of using an ambulance x 266 • Created a solution to private premise interventions • Commissioning now extended through CCG's • Only 5 people taken into police custody using s136 across whole West Midlands Police area in last 12 months • Significant number of positive letters and cards and reduction in s136 complaints seen by West Midlands Police • Delivered training to over 1000 individuals across agencies • Evidence has allowed model to be rolled out across the 4 black Country police areas and a hybrid model in Coventry.
EVALUATION	Local evaluation available from March 2015

WEST YORKSHIRE POLICE

START DATE	1st December 2013-30 Nov 2014 **Extended Pilot** – 1st December 2014 to date
FUNDING	**Initial Pilot** – DH funded - £200k **Extended Pilot –** NW Leeds CCG
REGION	West Yorkshire Police – Leeds District North West Leeds Clinical Commissioning Group Leeds & York NHS Partnership Foundation Trust
WORKFORCE	**Initial Pilot –** 4.3 WTE (2 x Band 6 Nurses / 2 x Band 3 Nurses) **Extended Pilot –** 10.22 WTE
MODEL	**Initial Pilot** – Street Triage staff were based within the Crisis Assessment Service. Referrals were taken between 3pm -1am from front line police Response Officers to a dedicated Street Triage telephone. Street Triage staff consisted of 1 band 6 Mental Health Clinician (Nurse, AMHP, and Occupational Therapist) and a band 3 Health Support Worker. Initial triage telephone information gathering was conducted to ascertain whether face to face assessment was required. If required the Street Triage team aimed to be on scene within 45 minutes and if not required Street Triage intervention would be conducted over the telephone.

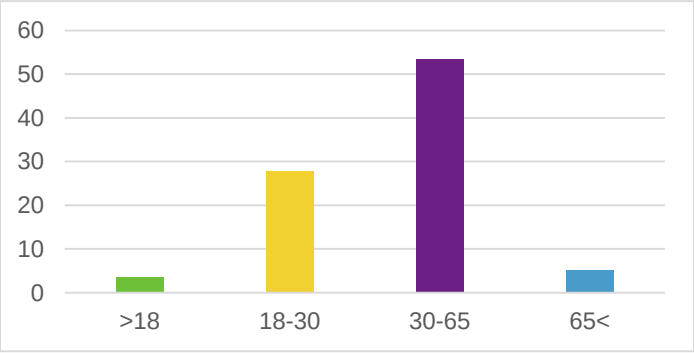
	Extended Pilot - Street Triage has been renamed as Mental Health Crisis Triage (MHCT). Staff continue to be based within the Crisis Assessment Service. Referrals are now accepted 24 hours a day/7 days a week from front line police officers to a dedicated MHC Triage telephone. The pathway has now been opened up to BTP and Yorkshire Ambulance Service. The Triage staff consists of 1 band 6 Mental Health Clinician (Nurse, AMHP, and Occupational Therapist) and either a band 5 clinician or a band 3 Health Support Worker. Initial triage telephone information gathering is conducted to ascertain whether face-to-face assessment is required. If required the MHCT team aim to be on scene within 45 minutes, if not required Triage intervention will be conducted over the telephone.
KEY COMPONENTS	• dedicated 24/7 telephone access for police referrals • clear and agreed referral pathways • Non medic mental health profession led service (predominantly nurses however service also has AMHPs and Occupational therapists that work in a generic crisis role). • Service embedded into crisis care pathways (inclusive of section 136). • Partnership agencies and service user's feedback used to develop extended pilot.
KEY SUCCESS	• Decrease in Section 136 detention. • Improved partnership working between the police and mental health services at a local level leading to efficiencies across the system • Improved sharing of information processes leading to faster access to care and treatment for those in crisis • Improved user experience for those who come into the contact with the police and are in crisis and/or where a criminal offence is not the primary concern.
EVALUATION	**Initial Pilot evaluation shows*:*** 32% decrease in Section 136 detention 53% increase in overall mental health contacts. It is believed that one factor influencing this increase is the identification of previously unmet need. 72% increase in onward referrals to various forms of mental health care. Approximately 60% of Street Triage intervention took place in as private place (service user residence/other) 33% increase in admissions following police referral in comparison to previous 12 months – would indicate the correct people are being detained under S136. Pilot review document available March 2015

11. Appendix D: Age Distribution of Street Triage Contacts



Note. Where data do not reach 100% the remaining data are missing.

Figure 4. Age distribution (percentage) of contacts in eight Street Triage schemes.



Note. 10% missing data.

Figure 5. Age distribution (percentage) of Street Triage contacts in Devon and Cornwall.