Oldham Mental Health Phone Triage/RAID Pilot Project

Evaluation Report

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Reading the evaluation report

The report is produced in three parts. An **Executive Summary** is provided at the beginning of the report. This summarises the key findings and recommendations of the evaluation. **Part 1** outlines the purpose of the pilot; the aims and commissioning of the pilot. **Part 2** discusses mental health and policing, providing a national and local context to inform the findings and the final report. **Part 3** reports on the findings of the evaluation report. Comments from the authors are also included in the full text of the report. To assist the reader, figures and tables are included in the main body of the report for information. The **Appendix** includes additional documents and extracts relating to production of the report.

Background

In 2013, Greater Manchester Police (GMP) commissioned an independent evaluation of the Oldham Phone Triage/RAID Pilot Project. This evaluation report covers the period of the six month pilot from 02.12.2013 to 31.05.14.

Lord Adebowale's recent Independent Commission on Mental Health and Policing (2013) concluded that mental health represents one of the most significant and complex challenges for policing in the UK; addressing this matter is core business and should become a priority in all future service planning and delivery at a local level.

The Sainsbury Centre (2008) identified that nationally, 15% of all incidents dealt with by the police include the presence of significant mental health difficulties and problems. The report highlighted that police officers do not typically have ready access to sufficient additional information that would support their decision-making in these types of cases. Officers also felt that their training did not always adequately prepare them for this area of work.

In February 2014, a national Crisis Care Concordat was signed by more than 20 organisations in England in a bid to drive up standards of care for people in police custody. The Concordat, seeks to build on other announcements on mental health care, notably liaison and diversion schemes, street triage and the national Mental Health Action Plan (2014).

GMP and the Office of the Police and Crime Commissioner for Greater Manchester (PCCGM) have been instrumental in setting up a Mental Health Strategy Group to coordinate and improve mental health and policing across Greater Manchester. Mental health and the need to protect vulnerable people have been given major status in the Police and Crime Plan 2013-16 for Greater Manchester (PCCGM, 2013).

At a recent consultation event, Tony Lloyd (Police and Crime Commissioner for Greater Manchester) stated: 'People suffering mental health problems deserve the best service and the only way to achieve that is for the police, NHS and other agencies to pool resources and work together' (PCCGM, 2014: online).

The Oldham Mental Health Phone Triage/RAID Pilot and evaluation

In response to both national and local conditions, GMP in Oldham and Pennine Care NHS Foundation Trust jointly developed the Oldham Phone Triage/RAID Pilot Project to provide a service available to local police officers who attend incidents where an individual appears to be experiencing mental health problems. For the pilot, police officers were able to contact a dedicated 24-hour telephone number for professional advice and assistance from RAID (Rapid Assessment Interface and Discharge), the Trust's psychiatric liaison service. RAID is based in Royal Oldham Hospital, near its Accident & Emergency department. The RAID service consists of experienced trained mental health workers (working with hospital colleagues) who are available to support people with mental health and/or alcohol problems.

The pilot project was set up to improve police decision making and outcomes in circumstances where police officers attend incidents in the community and they believe a person requires professional mental health advice and assistance.

Aims of the evaluation

The purpose of the evaluation is to assess the impact of the Oldham Phone Triage/RAID Pilot Project in relation to:

1. Decision making, actions and outcomes from mental health referrals made by police officers to the Phone Triage Service.
2. Delivery of appropriate, timely and improved outcomes for individuals, families and communities.
3. Use and management of s.136 orders.
4. Broader learning from the pilot for the police service, in relation to improving complex and challenging decision making in the context of policing and mental health.

Findings and recommendations

The pilot has met its key objectives and demonstrated that there is extensive collective mental health expertise, skill and knowledge in Oldham to draw on and develop. The findings from the pilot should be shared in order to:

- build on the sound foundation of the pilot as a model for future police and mental health inter-agency working;
- widen future policing and mental health partnerships at a local level, incorporating other essential agencies into future projects (e.g. service user groups, carer groups, ambulance services, social care, specialist services, third sector organisations);
- inform future local service planning in order to respond effectively to the needs of vulnerable groups and communities.

Key points

- **The success of access to the RAID pilot – immediate, available and reliable**

  The value of using RAID is reflected across the period of the pilot and was a key theme emerging from interviews and consultations with police officers and others. The evaluation shows calls made by the police to the RAID pilot steadily increased over the

period of the project. Police officers themselves value RAID, describing the RAID resource as important and significant in managing mental health crises in the community. Of particular importance was the opportunity to be able to call RAID in 'real-time' at the scene of an incident, 24 hours a day, 7 days a week.

- **Police want to retain access to RAID**

  'If I lost RAID I'd lose a really good tool.' (police officer)

- **Improved communication - access to a dedicated RAID contact number**

  Access to a dedicated RAID contact number improved communication between police, psychiatric services and vulnerable members of the community.

- **Access to RAID improved effective use of police time**

  Records and comments from interviews and consultations with police officers strongly indicate that access to RAID during the pilot has significantly improved the amount of police time required to be allocated to dealing with mental health related calls.

- **The RAID pilot improved access to advice and support at key times**

  The RAID pilot has shown its value in improving access to professional advice and support during night time/early hours.

- **The RAID pilot contributed positively in helping to manage incidents of self-harm and threats of suicide.**

  Access to RAID was highly valued by police officers in the context of dealing with incidents which involved self-harm, threats of suicide, or overdose. Access through the RAID pilot to specialist professional advice and support was seen as a key asset in better managing challenging situations, informing decisions and co-ordinating actions to protect members of the public.

  Training in relation to mental health, responding to self-harm and threats of suicide was identified by officers as a specific need.

- **Repeat calls and supporting vulnerable individuals**

  The project supported improved delivery of appropriate, timely and improved outcomes for individuals, families and communities.

  Identification of individuals who frequently come into contact with services via the police was used to inform inter-agency responses and risk planning. Where this was utilised effectively, it was indicated that this helped reduce re-presentation and significantly supported more effective management of police time and resources.

  The pilot identified 115/673 (17.08%) calls to the police during the pilot period, regarding a small number of vulnerable individuals with legitimate and high level needs and who live in the community. This information could helpfully be used to further inform crisis/ safeguarding plans across all services.

- **Use of the RAID pilot supported the provision of appropriate specialist provision for vulnerable adults and young people in mental health crisis.**

  Access to RAID during police calls to incidents involving vulnerable adults and young people in crisis was identified as an asset in better managing incidents in the community, preparing for reception of individuals at RAID and then provision of appropriate in-patient care or follow up.

- **Access to RAID and use of s.136 – informing effective decision-making**

  Decisions to use s.136 were appropriate, proportionate and supported by the recorded evidence in all cases. The pilot positively facilitated support for police officers at the scene of an incident to immediately contact RAID and as a result speedily access professional mental health expertise and advice; share and exchange information; agree an appropriate course of action.

  The pilot positively facilitated support for police officers at the scene of an incident to immediately contact RAID and as a result speedily access professional mental health expertise and advice; share and exchange information; agree an appropriate course of action. By using the pilot, police officers were able to divert 35 possible s.136s to alternative 'least restrictive' services (a principle given emphasis in the Mental Health Act Code of Practice, 2008).

- **Mental health, poverty and social exclusion – identifying and meeting the needs of diverse communities and building on the pilot model**

  The pilot has identified concentrations of mental health demand within Oldham. Seven of the eight wards with the highest mental health needs are recognised as among the seven most economically and socially deprived wards in Oldham.

  The findings from the pilot should be shared to inform future local service planning; to build on the sound foundation of the pilot as a model for future police and mental health inter-agency working; to widen future policing and mental health services partnerships at a local level (e.g. with social care, specialist services, ambulance services, third sector organisations, service user groups) in order to respond effectively to local social needs, support vulnerable groups and communities. There is much collective expertise, strength, skill and knowledge in Oldham and Greater Manchester to draw on and develop (e.g. user-led self-help resources such as The Sanctuary).

  Detailed data about the specific mental health needs of BME heritage communities was limited. This should be given attention in future projects and schemes to ensure culturally appropriate and tailored service provision and delivery. The views of service users and carers across all communities should be incorporated into future service planning and development.

- **The RAID pilot has developed models for effective records keeping and information exchange.**

  National data gathering on mental health and use of s.136 is currently under review. Staff overseeing the administration of the pilot have built on good working relationships to develop new information systems, improve record keeping and knowledge exchange. This model and approach is to be commended and should be recognised as good practice. Staff should be encouraged to share their experiences of developing this approach with other police/NHS/mental health related projects.

- **Information about conveyance to hospital**

  Information about conveyance to hospital (by ambulance or police vehicle) was not readily available at the time of writing the report. However, this is important in relation to ensuring appropriate and safe service provision and practice. The inclusion of ambulance services in future projects should be utilised.

Conclusion

The pilot scheme has become established and valued by police staff in Oldham. The 24-hour dedicated phone line has been a key feature making it easily accessible. Police officers clearly value the advice and support that it offers. The main benefits in terms of service provision are the ways in which it allows officers to gain access to expert mental health support and advice, share appropriate information and agree a course of action. The scheme has also helped to foster improved joint-working by staff from the NHS and GMP. The pilot fits very well with the broader aims of the Mental Health Care Crisis Concordat to improve the standards of care provided to those experiencing any form of mental health distress.

The pilot has recently been extended. The evaluation findings support this decision. However, there is a need for further monitoring and research in this area. There is potential for this model of policing and mental health triage to be utilised across Greater Manchester and shared nationally.

Part 1

Context and background to the evaluation

PART 1 – Context and background to the evaluation

Introduction

Greater Manchester Police (GMP) commissioned an independent evaluation of the Oldham Phone Triage/RAID Pilot Project. This evaluation report covers the period of the six month pilot from 02.12.13 to 31.05.14.

Nationally, 15% of all incidents dealt with by the police include the presence of significant mental health difficulties and problems (The Sainsbury Centre, 2008). The report of Lord Adebowale's recent Independent Commission on Mental Health and Policing (2013) concluded that mental health represents one of the most significant and complex challenges for policing in the UK; addressing this matter is core business and should become a priority in all future service planning and delivery at a local level.

In February 2014, a national Crisis Care Concordat was signed by more than 20 organisations in England in a bid to drive up standards of care for people in police custody. The Concordat, seeks to build on other announcements on mental health care, notably liaison and diversion schemes, street triage and the national Mental Health Action Plan (2014). As College of Policing Chief Executive, Chief Constable Alex Marshall identified: 'The Concordat is a strong statement of intent of how the police, mental health services, social work services and ambulance professionals will work together to make sure that people who need immediate mental health support at a time of crisis get the right services when they need them.' (College of Policing, 2014: online).

GMP and the Office of the Police and Crime Commissioner for Greater Manchester (PCCGM) have been instrumental in setting up a Mental Health Strategy Group to coordinate and improve mental health and policing across Greater Manchester. Mental health and the need to protect vulnerable people has been given major status in the Police and Crime Plan 2013-16 for Greater Manchester (PCCGM, 2013).

At a recent consultation event in October 2014, Tony Lloyd (Police and Crime Commissioner for Greater Manchester) stated: 'People suffering mental health problems deserve the best service and the only way to achieve that is for the police, NHS and other agencies to pool resources and work together' (PCCGM, 2014: online). This evaluation report of the Oldham Phone Triage/RAID Pilot Project is intended to positively contribute to these initiatives.

The pilot and evaluation

In response to both national and local conditions, GMP in Oldham and Pennine Care NHS Foundation Trust jointly developed the Oldham Phone Triage/RAID Pilot Project in 2013 to provide a mental health phone triage service, available to local police officers who attend incidents where an individual appears to be experiencing mental health problems. In a briefing paper for the pilot, key drivers for its introduction were outlined:

> 'When we look across the spectrum of police incidents that Oldham officers have dealt with since 1st April 2013, over 900 have involved some level of mental health issue. Many of these individuals are repeat callers to the police and other public services.'

> ‘The Police and RAID teams rarely come into contact and do not share information. However, reducing budgets and increasing demand require that we pool resources and look to intervene much further upstream of an issue. The increased scrutiny on all public service means that our decisions are looked at by bodies such as the IPCC, the CQC, Coroners and the media. Our decision-making will be more robust if we have access to appropriate information and intelligence about an individual’s background.’
>
> (Mental Health/Police Phone Triage pilot - Briefing paper, 2013: 2)

The briefing paper outlined the proposed operation of the scheme:

> ‘If an officer is considering utilising their powers under section 136 Mental Health Act, a professional discussion will be had between the officer and RAID practitioner. This will include what both services know about the individual, previous mental health history, current care plans and how the person is presenting. A decision will be then be taken about the appropriate course of action and the decision recorded by both services. If the decision is to use s. 136, the RAID practitioner will meet the officer at the s.136 suite, A&E or custody.
>
> Officers will also be able to use the phone line for advice and signposting for any incidents where mental health is a factor.’
>
> (Mental Health/Police Phone Triage pilot - Briefing paper, 2013: 2)

For the pilot, GMP officers were able to contact a dedicated 24-hour telephone number for professional advice and assistance from the Trust’s psychiatric liaison service, RAID (Rapid Assessment Interface and Discharge) team. RAID is based in Oldham General Hospital , near its A&E department.

The Rapid Assessment Interface and Discharge (RAID) service consists of experienced trained mental health workers (working with hospital colleagues) who are available to support people with mental health and/or alcohol problems. Their role is to assess people who may require mental health or alcohol support; ensure they receive this support quickly and thereby reduce the risk of problems escalating. The team can also provide people with any additional practical, emotional and social support. RAID can also offer short-term follow up, treatment and support to individuals.

The pilot project seeks to improve police decision making and outcomes in circumstances where police officers attend incidents in the community where they believe a person requires professional mental health advice and assistance.

Aims of the evaluation

The purpose of the evaluation was to assess the impact of the Oldham Phone Triage/RAID Pilot Project in relation to:

1. Decision making, actions and outcomes from mental health referrals made by police officers to the Phone Triage Service.

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Evaluation methodology

Introduction

The evaluation used a modified mixed method approach (Cresswell and Plano Clark, 2011; Cresswell, 2007; Tashakkori and Teddlie, 2003) involving both qualitative and quantitative instruments. Case study approaches were also used in the evaluation (Thomas, 2010; Simons, 2009; Yin, 1994, 2009). The instruments used offered the opportunity for triangulation of the collected data and this provided added value to the evaluation.

Qualitative data collection and thematic analysis were applied, adopting a constant comparison method (Boeije, 2002). This helped to compare, explore and analyse participants' experiences and stakeholders' perspectives. This approach encouraged and synthesised discussion, facilitated collaboration and was used to improve the rigour and validity of the evaluation findings and final report.

Contextual review

As part of preliminary work for the evaluation, the research literature in relation to mental health and policing was reviewed. This was used to inform the design and delivery of the evaluation and report.

Consultation

Consultations and liaison were conducted throughout the period of the pilot as part of general information sharing and exchange, project management and quality assurance.

Quantitative data collection and analysis

An examination was undertaken of quantitative data collected over the period of the evaluation. The evaluation covered a six month period running from 12.12.13- 31.05.14.

Date	Dec 2013	Jan 2014	Feb 2014	Mar 2014	April 2014	May 2014	TOTAL
Mental health related calls to GMP (Oldham)	119	97	100	134	96	127	673
Calls to RAID	34	27	28	46	42	40	217

Table 01: Calls to RAID by month
Source: Pilot data

During the evaluation period 673 incidents were recorded which met the criteria for inclusion in the pilot and were used within the evaluation. Analysis of the figures are included in the Findings section of the evaluation report.

Criteria for inclusion of data in the pilot and evaluation

Data collected for monitoring the pilot and used in the evaluation was drawn from calls and referrals to the police. Calls from the public to GMP are routed to one of 3 GMP Operational Communications Rooms (OCR) across Greater. A call handler takes the details of each call, logs it and allocates each call or incident a unique Force Wide Incident Number (FWIN). Each call, incident or 'job' is recorded on the Greater Manchester Integrated Computer System (GMPICS), to which staff within different parts of the service may have access at different points and as appropriate.

Each FWIN is dated and ascribed an initial code (typically 1-3 codes) designated by the nature of the call or type of incident being reported (e.g. 'mental health', 'missing person'). FWINs are routed to the relevant geographical police division of which there are 12 across GMP. Oldham is designated as Q Division. Calls are graded and responded to locally within each division.

Further codes can be added to FWINs as events develop, further information emerges (e.g. G16, 'concern for safety') or are dealt with or closed (e.g. G36, s.136 Mental Health Act Detention').

In the pilot two main codes were used to filter calls ('jobs'). These were:

Primary call codes

G17 'Mental Health'

G16 'Concern for safety (18 and over)'

G36 's.136 Mental Health Detention'

Additional codes used in combination to the G17 ('Mental Health') and G36 ('s.136 Mental Health Detention') codes included:

Additional call codes, relating to mental health calls

G15 'General call'

G50 'Assistance to other public agency'

G60 'Missing person'

L17 'Drugs'

L15 'Alcohol'

G06 'Collapse Injury Illness Trapped'

D61 D62 D64 D65 'Domestics'

D93 'Neighbours'

D51 'Abandoned Call'

For the purposes of the pilot, data was extracted manually by police staff from the GMPICS computer system. The criteria for incidents to be included in the pilot were:

- locality (Division Q, Oldham);
- call and/or reported incident features a perceived mental health element;
- date of call;
- initial, secondary and subsequent coding of FWIN;
- actions, outcome and final FWIN coding;
- confirmation that the pilot service was used;
- a rationale, where a call and/or reported incident features a perceived mental health element but the pilot was not used.

Incidents identified for inclusion in the pilot, were monitored and followed-up by a designated police officer, clarifying or refining initial information, adding further information as incidents progressed or following up and adding missing details after incidents were closed. This follow-up significantly improved the quality of data available to the evaluation team.

Once an incident was selected as appropriate for inclusion in the pilot, additional information was collected. This included:

- whether anti-social behaviour was a feature;
- whether alcohol was a feature;
- whether a s.136 considered;
- whether the person was conveyed to hospital;
- the length of time officers spent with the person;
- the eventual outcome;
- whether the police National Decision Making Model was used;
- assessment of suitability of write-up;
- personal details of the individual.

For the purpose of the evaluation, anonymised statistical data from the pilot was made available for analysis. All personal details and identifying data were removed. To improve the accuracy of the overall data-set and analysis, the anonymised GMP quantitative data was cross referenced with anonymised quantitative data provided by Pennine Care NHS Foundation Trust. Comment on this is made within the body of the report.

Qualitative data collection and analysis (interviews and consultations)

Qualitative data collection took the form of a short series of semi-structured individual interviews and group interviews with police staff. These took place after initial analysis of quantitative data and were scheduled for the latter part of the pilot as the scheme became embedded and staff exposure to the pilot was more likely. Data collection focused on experiences of using the pilot, the strengths and deficits of the pilot, whether it had value and had achieved its aims; identifying areas for future development.

A purposive sample of respondents was used in the evaluation. Criteria included: police staff, involvement in the planning or use of the pilot, representation of views of key staff notably: Response Officers, Neighbourhood Officers, Community Support Officers across Grades 1-4, Management and Administration. The following ranks and positions were included: Chief Superintendent n=1, Inspectors n=2, Sergeants n=2, Police Constables n=6, Police Community Support Officers (neighbourhood) n=4, police graduate trainee n=1, performance manager n=1.

Group interviews made use of modified case study discussions, with participants identifying anonymised case examples of their experience and use of the pilot. Yin (2009) describes a well-crafted case study approach as containing elements of description, exploration and explanation with learning from cases being intrinsically valuable in theory building (Firestone, 1993; Yin, 1994, 2009). Stake (1995, 1998) argues that a goal of case study work should be production of intuitive and naturalistic conclusions which resonate

with the experiences of the participants and audience. This approach adds extra layers of analysis and rigour and also gives a 'real' dimension to the research by drawing directly on the unique views, reflections and reflexions of individuals and groups who can be acknowledged as 'experts' with regard to their particular experiences of policing and mental health.

Responses were analysed thematically using the constant comparative method and both across and between the different stakeholders (Boeije, 2002). Data collected was subjected to internal comparison, using open-coding. Comparisons were then made within each data set and then across data sets as part of triangulation of results; the intention being to compare data and then identify similarities and differences within and between the data sets and how these can be understood in relation to the study's overall aims and objectives.

Project management and reporting

For the period of the evaluation, liaison and meetings were conducted with GMP to monitor progress, troubleshoot and discuss work toward the production of the report. A draft of the final report was circulated for correction of factual errors.

Data protection

Both University of Salford and Manchester Metropolitan University have data collection polices which comply with the Data Protection Act (1998) Requirements.

Ethics

The evaluation has university ethical approval.

Part 2

Policing and mental health – national and local contexts

PART 2

Mental health law

This section is included to provide general background relating to the legislative and policy framework informing mental health provision in relation to mentally disordered persons found in public places and the role of the police, health professionals and others.

With regard to mental health and policing, sections 135 and 136 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) are particularly relevant. S.135 Mental Health Act 1983 allows the police to gain entry into private premises so that a Mental Health Act 1983 assessment can be carried out. The police require a warrant issued by a Magistrate. The warrant is issued following evidence from an Approved Mental Health Professional (AMHP) indicating the concerns that professionals have. The power allows for the patient to be removed to a Place of Safety. The police must be accompanied by an AMHP and a doctor. Section 135 (2) allows for the issuing of a warrant to a policeman to enter premises to return a detained patient who is absent without leave.

Section 136 of the Mental Health Act 1983, amended by the Mental Health Act 2007, allows a police constable to temporarily remove an apparently mentally disordered person from a public place to a 'Place of Safety' for up to 72 hours. The Place of Safety could be a police station, hospital or other agreed location. However, best practice is that a specially designated and designed "s.136 suite" should be provided and used as the recommended Place of Safety. The amended 1983 Act is presented below in its revised form and states:

> Mentally disordered persons found in public places
>
> 136- (1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a Place of Safety within the meaning of section 135 above.
>
> (2) A person removed to a Place of Safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional [1] and of making any necessary arrangements for his treatment or care.
>
> (3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (2) above, take a person detained in a Place of Safety under that subsection to one or more other places of safety.
>
> (4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the period of 72 hours mentioned in that subsection.[2]

Amendments

[1] Mental Health Act 2007 s.21 & sch. 2; Mental Health Act 2007 (Commencement No. 7 and Transitional Provisions) Order 2008 (England)

[2] Mental Health Act 2007 s.44; Mental Health Act 2007 (Commencement No. 5 and Transitional Provisions) Order 2008 (England)

Comment

The Mental Health Act 1983, as amended by the Mental Health Act 2007, is the legislation which can be used to compulsorily admit and detain a person to hospital for assessment and/or treatment for a mental illness. The police can use s.136 of the 1983 Act to take a person who appears to be suffering from mental disorder and in need of care from a public place to a 'Place of Safety.' The police do not need medical evidence before taking an individual to a Place of Safety. The police officer needs to reasonably believe the person is mentally ill and needs to be moved in the interests of themselves and/or other people.

A person removed to a Place of Safety under s.136 may be detained for a period not exceeding 72 hours for the purpose of enabling him/her to be examined by a registered medical practitioner; to be interviewed by an AMHP and if required to make appropriate and necessary arrangements for his/her treatment or care. A person cannot be forced to take medication or have any other treatment while under s.136. The 72 hours period runs from the time an individual is first detained in the designated Place of Safety. Once any necessary arrangements have been made and implemented for the detained person's care and/or treatment, detention under s.136 ceases to have effect.

Once it has been determined that the person requires assessment, best practice standards indicate that all Mental Health Act assessments will commence within four hours, and should be completed within six hours. Best practice also states Mental Health Act assessments should be undertaken jointly by an AMHP and a registered medical practitioner. A number of outcomes may result from this. The assessment will judge whether a person needs to be further compulsorily detained in hospital for assessment or treatment under mental health legislation; or, with the persons agreement, informally (voluntarily) admitted to hospital; or, offered community health or care services e.g. referred to a local Community Mental Health Team, General Practitioner or other service. Alternatively, the assessment may indicate an individual should be discharged from the s.136 order, released from detention and can leave the Place of Safety.

Rights

If detained under s.136, the hospital managers are required to make sure the detained person is given information to understand what the s.136 means and how mental health legislation applies to them. If the police take an individual to a police station, although they have committed no crime, their rights are the same as if they had been arrested under the Police and Criminal Evidence Act 1984. For an individual, this would include: telling someone where they are and what has happened to them; getting free legal advice from a solicitor; receiving medical treatment from an appropriate healthcare professional.

Mental Health Act Code of Practice (2008)

The Mental Health Act Code of Practice (2008) provides guidance to registered medical practitioners ("doctors"), approved clinicians, managers and staff of hospitals, and approved mental health professionals on how they should proceed when undertaking duties under the Act. The Code is also provided to be 'beneficial to the police and ambulance services and others in health and social services (including independent and voluntary sectors) involved in providing services to people who are, or may become, subject to compulsory measures under the Act.' (CoP, 2008: 2). It is also intended that the Code will be helpful to patients, their representatives, carers, families and friends and others who support them.

The Code notes that while the Act does not impose a legal duty to comply with the Code, the professional staff referred to in the Code must have regard to the Code and any departures from the Code could give rise to legal challenge.

Guiding principles of the Mental Health Act Code of Practice

The Code sets out five key principles. These are:

Purpose principle

1.2 Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm.

Least restriction principle

1.3 People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.

Respect principle

1.4 People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

Participation principle

1.5 Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

Effectiveness, efficiency and equity principle

1.6 People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

Using the principles

1.7 All decisions must, of course, be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998.

1.8 The principles inform decisions, they do not determine them. Although all the principles must inform every decision made under the Act, the weight given to each principle in reaching a particular decision will depend on the context.

1.9 That is not to say that in making a decision any of the principles should be disregarded. It is rather that the principles as a whole need to be balanced in different ways according to the particular circumstances of each individual decision.

(Mental Health Act Code of Practice, 2008: 5-6)

Mental Health Act Code of Practice - Chapter 10 Police powers and places of safety

The Mental Health Act Code of Practice (2008) emphasises that the Place of Safety should be a health facility and that a police station should only be used in exceptional circumstances. It is recognised that a general hospital A&E department is not an ideal environment for a patient who is experiencing acute mental distress (Clark et al, 2007). Best practice recommends dedicated hospital based s.136 suites be provided.

Chapter 10 of the Code deals with entry to premises under the Act (s.135 Mental Health Act 1983) and powers temporarily to remove people who appear to be suffering from a mental disorder, in a public place, to a Place of Safety (s.136 Mental Health Act 1983).

As the Code states in relation to s.136:

10.12 Section 136 allows for the removal to a Place of Safety of any person found in a place to which the public have access (by payment or otherwise) who appears to a police officer to be suffering from mental disorder and to be in immediate need of care or control.

10.13 Removal to a Place of Safety may take place if the police officer believes it necessary in the interests of that person, or for the protection of others.

10.14 The purpose of removing a person to a Place of Safety in these circumstances is only to enable the person to be examined by a doctor and interviewed by an AMHP, so that the necessary arrangements can be made

> for the person's care and treatment. It is not a substitute for an application for detention under the Act, even if it is thought that the person will need to be detained in hospital only for a short time. It is also not intended to substitute for or affect the use of other police powers.
>
> (Mental Health Act Code of Practice, 2008: 74)

The Code (2008) requires local social services authorities, the NHS and the local police authority to establish a clear policy for the use of the power to remove a person to a Place of Safety under s.136.

Local policy for s.136 - Oldham

GMP and Pennine Care NHS Foundation Trust have a policy and protocol in place relating to s.136. (Section 136 Mental Health Act 1983 - Removal to a Place of Safety, Version 4, CL21, 2014)

As the local policy states:

> **1 TRUST STATEMENT**
>
> 1.1 The purpose of this policy is to ensure that whenever section 136 of the Mental Health Act (MHA) 1983 is used the procedures that are followed comply with the Act and with the good practice guidance contained within the *MHA Code of Practice 2008 (Chapter 10).*
>
> **2 AIMS OF THE POLICY**
>
> 2.1 The aim of this policy is to provide staff with a process that promotes efficient and appropriate responses to section 136 detentions.
>
> 2.2 Staff and the external multi agencies that we liaise with whilst detaining and assessing a patient under section 136 should be supported by this policy and able to apply the processes contained within in their service areas.
>
> (GMP/Pennine Care NHS Foundation Trust, 2014: 6)

Designated s.136 Places of Safety for Oldham

The designated s.136 suite for Oldham is based at Parklands House Mental Health Unit, Oldham General Hospital. As the local policy states:

> 8 **PREFERRED PLACES OF SAFETY**
>
> 8.1 In general terms the choice of Place of Safety[1] will depend upon the condition, circumstances, behaviour and risk of the person in question, but should primarily fall within a healthcare setting. A police station must only be used as a Place of Safety on an exceptional basis.[2]
>
> 1 Section 135 (6) of MHA 1983 "in this section "a Place of Safety" means residential accommodation provided by a local social services authority under Part III of National Assistance Act 1948, a hospital as defined by this Act, a police, station, an independent hospital or care home for mentally disordered persons or any other suitable place (which could be the home of a relative or friend of the patient) the occupier of which is willing temporarily to receive the patient.
> 2 COP 10.21
>
> 8.2 A person should only be taken to the identified police station if they are-
>
> - Violent or likely to become violent and would therefore pose an unmanageably high risk to other patients, staff or users of the healthcare setting.
>
> - Under arrest for a criminal offence.
>
> In the circumstances outlined above this would be following a joint risk assessment with the police.
>
> In all other instances a person should be taken to the alternative Place of Safety that has been identified locally.
>
> If a person is unable to be assessed due to being intoxicated by alcohol or under the influence of illicit drugs, the level of intoxication should be carefully considered and not be used as an automatic refusal for the person's admission to a specific Place of Safety. People who are detained by police under section 136 who are believed to be under the influence of alcohol or drugs should initially be medically assessed. Once the person has been medically assessed, a mental health assessment may be delayed to allow time for the individual to be fit for the assessment. A joint risk assessment by police and health care staff should be undertaken to ascertain whether it is appropriate for police to remain with the person at the hospital at the time, and if so, the suitable place they are required to wait in.
>
> (GMP/Pennine Care NHS Foundation Trust, 2014: 8)

It is relevant to note the emphasis in the policy on joint working and this links to the Findings section of the evaluation report where this is discussed in relation to the RAID pilot and improved communication and collaboration.

The s.136 suite in Oldham General Hospital

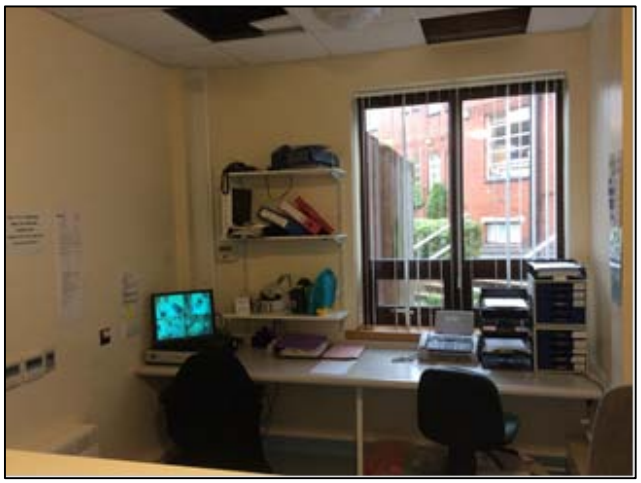
A purpose built designated s.136 suite is located in Parklands House Mental Health Unit at Oldham General Hospital. The suite is available 24 hours per day, 7 days per week. The suite is staffed and managed by the RAID team. Photographs of the suite are provided below.

The entrance to the s.136 suite from within Parklands House

The view of the s.136 suite from its entrance door

Facilities within the s.136 suite (basin and toilet)

Part of the RAID service offices next to the s.136 suite



Photograph(s) 1-6: s.135 Suite, Oldham General Hospital

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Research and literature relating to policing and mental health

Introduction

This section considers relevant law, policy and research that examine mental health work as a key part of the police role. The section concludes with an outline of specialist models of policing that have been developed to tackle these issues.

In Lord Adebolawe's (2013) recent report, he concludes that mental illness is 'core business' for the police. This report was commissioned following a number of deaths in custody. A recurring feature of these deaths was that the person suffered from a history of mental illness (IPCC, 2011). This analysis shows that the Metropolitan Police dealt with over 60,000 mental health related incidents in 2012. This is an average of 160 a day. In a survey carried out amongst officers, they indicated the nature of these 'daily or regular' contacts as follows: victims (39%), witnesses (23%) and suspects (48%) (Adebowale, 2013) In their responses, 66% of police officers indicated that they encountered unusual behaviour caused by street drugs or alcohol or a combination of the two (Adebowale, 2013).

Use of s.136

The quality of data for the use of s.136 is generally poor. However, it is accepted that the use of s.136 has generally increased since the mid-1990s. The majority of detentions take place outside of usual office hours when it is less likely that wider support services will be available (IPCC, 2008). This is addressed in the findings of this evaluation report. Research since the 1980s has consistently found that Black and Minority Ethnic groups are significantly over-represented in s.136 detentions (Rogers and Faulkner, 1987; Dunn, and Fahy, 1990; Bhui et al, 2003). As Keating and Robertson (2004) notes, a similar pattern of over-representation occurs across mental health services.

Her Majesty's Inspectorate of Constabulary study, *A Criminal Use of Police Cells? The use of police custody as a Place of Safety for people with mental health needs* (2013) examined 70 cases in detail. In 57 (81%) of cases, the reason for the use of the power was the perception of the level of risk that the patient would commit suicide or seriously harm themselves. Fahy (1989) and Borschmann (2010) indicate that the "typical" s.136 patient is a young, single working class male, with a past history of mental illness who is not registered with a General Practitioner. Other research studies (Mokhtar and Hogbin, 1993; Spence and McPhilips, 1995) highlight that a diagnosis of schizophrenia, personality disorder, mania or drug-induced psychosis featured in incidents where a s.136 order was used.

One of the recurring difficulties when examining the use of s.136 concerns outcomes. There is a tendency to argue that s.136 has only been used appropriately if the individual is admitted to hospital either as an informal patient or detained under the Mental Health Act 1983.

The HSCIC shows that the majority of s.136 orders in 2012/13 did not lead to formal compulsory admission to hospital under the Mental Health Act 1983 (HSCIC, 2013). This does not mean that the police use of the power was inappropriate. The test of s.136 is whether the police officer 'thinks it is necessary to do so in the interests of that person or for the protection of other persons' (MHA, 1983: s.136.1) In Borshmann's (2010) study of

the use s.136 by police in a South London Trust, of s.136 orders, 41.2 % did not lead to hospital admission, 23.1% led to an informal admission and 34.4% admission under the Mental Health Act 1983.

Use of police cells as a Place of Safety

In exceptional circumstances, a police cell can be used as a Place of Safety. Hampson (2011) defines 'exceptional' as a situation where the 'patient is too disturbed to be managed elsewhere' (p. 366). However, at present, it is estimated nationally 36% of all s.136 detentions are thought to involve police custody This figure varies between forces and areas depending on the alternative facilities available. A joint review led by HM Inspectorate of Constabulary (2013) found the most common reasons for the use of the police cell was that the person was drunk, violent, had a history of violence or there was inadequate alternative health-based provision. As the review notes, a person who is detained under s.136 and taken to a police cell is essentially treated like any other person in custody. They are searched and go through exactly the same booking in processes as someone who has been arrested.

Service-user perspectives

Jones and Mason (2002) carried out a study of the use of s.136 from a service-user's perspective. This study has very powerful messages for all services working in this area. In particular, this study emphasises that from the service-user perspective s.136 is a custodial rather than a therapeutic experience. In the study, service users felt that the police did not have their mental health needs at the forefront of decision making. It is interesting to note that it was felt that officers adopted a much more sympathetic approach in A&E departments.

The experience in custody was characterised as extremely distressing. Riley (2011) carried out interviews with 18 people who had been detained in police custody under s.136. This study emphasised that there was general dissatisfaction with the whole process. In particular, it was felt that it made the individuals feel like criminals. Some detainees felt that their mental health had actually got worse because of their detention in police custody.

Police decision-making

The Assocation of Chief Police Officers (ACPO) has developed the National Decision Making (NDM) model 2012 (see Appendix) to inform all officers in the complex policing decisions they are required to make on a daily basis. At the centre of the model, the police values and mission statement commits the police to 'act with integrity, compassion, courtesy and patience, showing neither fear nor favour in what we do. We will be sensitive to the needs and dignity of victims and demonstrate respect for the human rights of all.' (ACPO, 2012: 3)

Officers are required to keep these principles at the centre of decision-making. The NDM model is applicable to all police work and appears particularly relevant to the context of police work where mental health issues are present.

Models of policing

This section of the report will explore models of policing that have been developed to address some of the challenges that working with mental health issues may create. These models have been developed as a result of national and local circumstances – often in response to a critical incident.

Lamb et al (2002) identify three possible models of police response. It should be noted that these models are essentially developed to respond to mental health crises that occur when officers are on patrol or called to an incident. This does not represent the totality of police work in the mental health field. Mental health crisis is a very broad term - it is not used in any clinical sense here. The models are:

- specialist trained officers;
- joint police and mental health teams;
- phone triage or a system that allows officers to access relevant health information and records.

Specialist police officers

The first and probably best known of these models is the Crisis Intervention Team (CIT) based in Memphis (Compton et al, 2008). This model was established in 1988 following an incident when the Memphis Police shot dead a man who was suffering from a psychotic illness. CIT officers deal with mental health emergencies but also act in a consultancy role to fellow officers. To become a CIT officer, personnel have to undergo intensive mental health awareness work as well as training in de-escalation techniques. CIT is a well-established model. In addition to the training of officers, one of the cornerstones of CIT is the fact that there is an agreement that the local hospital will accept all CIT referrals.
Franz and Borum (2011) suggest that this model continues to have a positive impact. In their study, the authors analysed 1539 calls between 2001 and 2005. They showed that the CIT model and approach only led to 52 arrests (an arrest rate of 3%) and strongly supported the potential of the model to support 'prevented arrest'. In an urban county of Florida where CIT had been used.

As Watson et al (2008) note, two key factors in the success of the CIT model are the increased police confidence in dealing with these situations and the 'no refusal policy' that is established with the local mental health units.

Joint police and mental health teams

There are a number of approaches to the provision of a joint police and mental health professional response. The most well-established of these models are to be found in the USA and Canada. Hails and Borum (2003) discuss the variations on the joint response that exist - either a joint team or specialist mental health support being made available. Reuland et al (2009) argue that both approaches have produced promising results in terms of both health care and more effective use of police resources. There is an organisational cultural issue that needs to be addressed here as the usual measures of police outcomes such as response times or arrest rates cannot be neatly applied to this issue, which is essentially a public health one. An example of a joint approach is Car 87 in Vancouver.
The Car 87 project is jointly funded between the police and local mental health services. In addition to a joint response it also provides a mental health phone triage service.

Triage

Triage is a well-established concept within general nursing and medicine. In this process, an early assessment allows for individuals at accident and emergency to be treated speedily in the most appropriate setting. This process also allows for the more efficient allocation of medical resources. It is also suggested that triage provides for more effective patient outcomes (Broadbent, 2002). Clarke et al (2007) argue mental health crises do not fit into the standard pattern of assessment at A&E departments. The mental health service-users interviewed for Clarke et al's study reported dissatisfaction with the service provided in A&E and the treatment they received. However, they felt that they 'had nowhere else to go' (2007: 128) when they were in crisis.

In the context of policing, mental health triage has come to be used as a short-hand for a number of models of joint services with mental health staff and policing. These systems share the same aims as triage in that they combine some element of assessment with a recognition that individuals need to access the most appropriate services in a timely fashion. In addition, these models of service provision seek to improve officers' confidence in decision making in the context of mental health.

In England and Wales, the Cleveland Street Triage team was established in 2012. This is also a joint health and police funded project that ensures that mental health nurses are available to carry out assessments when police are called to an incident.

The scheme has a broader remit as assessments also take place if there is a substance misuse problem or the individual has a learning disability. In the first year of the scheme, there were 371 assessments - only 12 (3%) resulted in s.136 assessments. Drug or alcohol related problems were the main presenting issues in 129 cases (35%). 205 individuals (55%) were regarded as not having any 'significant mental disorder'. 134 (36 %) were known to the local health trust. The majority of these cases may well not be psychiatric emergencies but they are representations of long-standing often deeply entrenched problems.

Studies of phone triage systems such as Sands et al (2013) have concentrated on the effective management of mental health crises within psychiatric services. These studies highlight the advantages of such approaches both in terms of clinical outcomes but also the more effective use of resources.

Conclusion

Policing requires officers to exercise a considerable amount of discretion and individual judgment. This is true in all areas of policing but seems particularly relevant in the area of mental health. Morabito (2007) argues that police decision making is even more complex. She argues that police decision-making is shaped by a number of variables. These are termed 'horizons of context' (2007: 1582). Variables that influence decision making are the nature of the incident, the available resources and the training and experience of the officers involved. It can be argued that Triage systems may increase the range of resources available to the police (and others) and are a means of confirming and developing individual skills and confidence in this field.

Profile of Oldham

Introduction

This section briefly describes and summarises details relating to general population trends, health and mental health in Oldham. This is provided for general background information and acknowledges argued links between health, mental health, social problems and inequalities.

Data for this part of the report is drawn from Public Health England Profile Oldham 2014, Public Health England Profile Oldham 2013, Community Mental Health Profiles 2013 Oldham (Public Health Observatories, 2013), Oldham Public Health Annual Report 2012-13, Public Health Observatories website, Office of National Statistics, census data.

Census data - key messages

Population

In 2011, the population of Oldham stood at 224,897. This was an increase of 6400 (2.9%) since 2001 (ONS, 2012). This level of change is significantly lower compared to regional and national population increases. Oldham has a younger age profile than England with under-16s making up 22.4% (50,459) of the local population. People aged 75 and over, make up 6.5% (14,673) of the population compared with 7.8% of England's population (Oldham Council, 2012).

Oldham has a diverse population, with established minority ethnic communities, primarily of 10.1%, Pakistani (22,686) and 7.3% of Bangladeshi heritage (16,310) (ONS Census, 2011: KS 201).

It is estimated the total population of Oldham will grow to grow to 241,100 by 2022.
Oldham's ward map and population by ward is provided below.

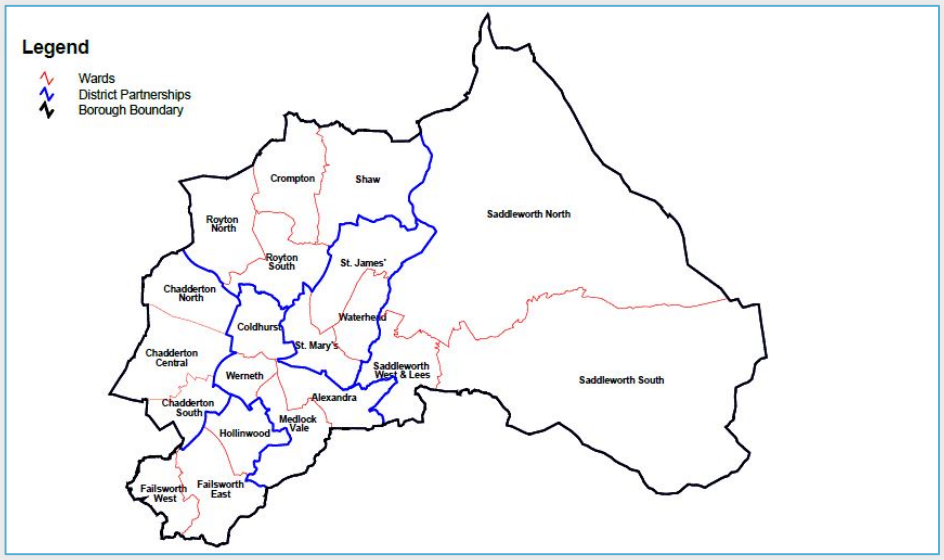


Figure 01: Map of Oldham by ward
Source: Oldham Council, 2014: online

Oldham by Ward	Population
Alexandra	11,830
Chadderton Central	10,454
Chadderton North	11,031
Chadderton South	11,019
Coldhurst	13,233
Crompton	10,581
Failsworth East	10,352
Failsworth West	10,397
Hollinwood	11,297
Medlock Vale	12,414
Royton North	10,283
Royton South	11,001
Saddleworth North	9,672
Saddleworth South	10,043
Saddleworth West and Lees	11,196
Shaw	10,501
St. James'	11,473
St. Mary's	13,944
Waterhead	12,027
Werneth	12,149
Oldham	**224,897**

Table 02: Oldham Population by ward
Source: ONS, Census: 2011

Referral numbers to RAID identified by ward will be discussed in the Findings section.

Economic and social deprivation

As the table below illustrates, Oldham has significant levels of economic and social deprivation, notably in its central districts. Oldham has higher levels of deprivation compared to the national average. Research examining experiences of common mental disorders (depression, anxiety) have found associations between mental ill-health and poverty (Knifton and Quinn, 2013; Butterworth et al, 2009; Jenkins et al, 2008: Weich and Lewis, 1998a, 1998b). Payne suggests, 'new research reveals an increased risk of poor mental health and suicide among groups experiencing different forms of social exclusion, including for example unemployment and poor social capital…' (Payne, 2012: 2)

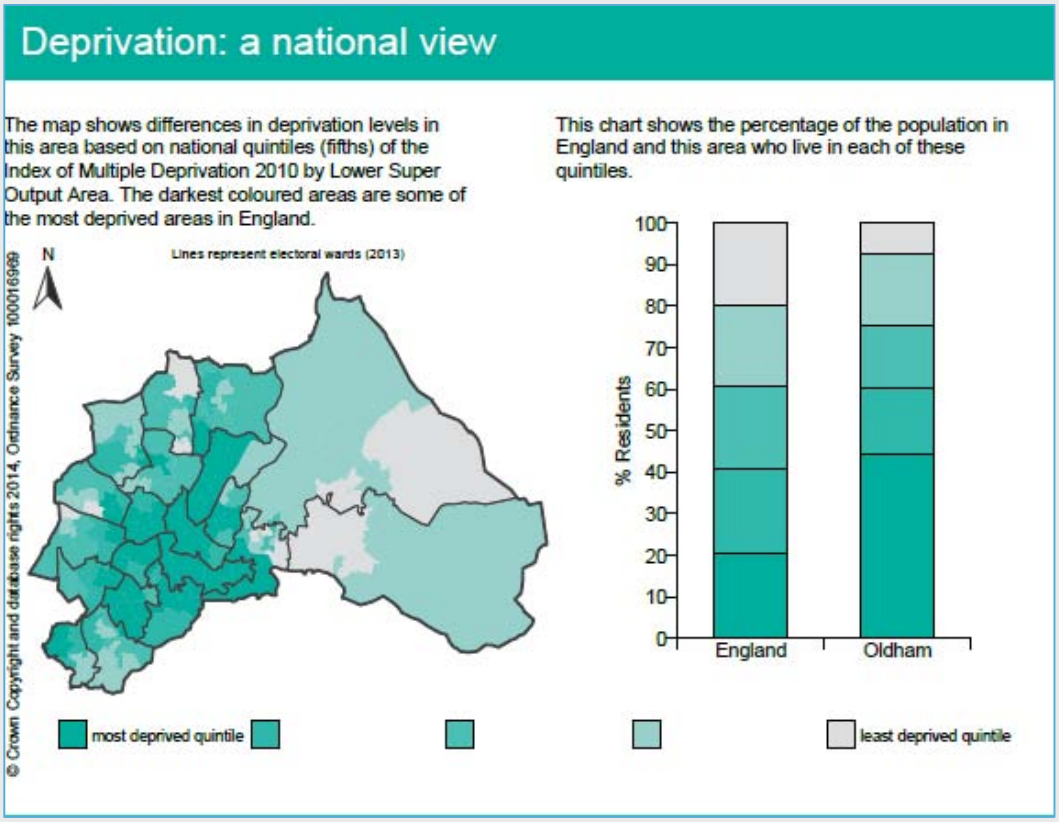


Figure 02: Differences in deprivation levels within Oldham
Source: Public Health England –Health Profile Oldham, 2014

Employment, sickness and disability

Oldham Council describe employment patterns in Oldham as being broadly in line with expectations from Department of Work and Pensions figures, with lower employment and higher unemployment compared to national figures. In Oldham, 5.8% (9.209) of the local population are classified as permanently sick or disabled. Oldham ranks 48th highest out of 348 local authorities in England and Wales in regard to sickness/disability levels. (Oldham Council, 2012: 7).

Health

According to Oldham Public Health Annual Report 2012/13, life expectancy in Oldham continues to increase, which it argues reflects improvements in factors which impact on health in a population. However, according to the report, aspects of Oldham's overall health profile, also give ongoing concern. According to Oldham Council (2012), the health of 6.9% (15,606) of its residents was reported as 'bad' or 'very bad' compared to the rest of England. Some individual wards (Alexandra, Werneth, Hollinwood and Coldhurst) are identified as being some of the most health deprived in the country.

Mental health and illness in Oldham

It is estimated that at any one time, approximately one in six of the general population will experience a serious mental health problem. The Oldham Public Health Annual Report (2012/13) estimated that there were approximately 33,000 adults in Oldham with 'symptoms of depression, anxiety and phobias' (OPHAR, 2013: 12). In the report it is stated: 'People with such problems represent a large proportion of demand on primary health care services, although perhaps only a quarter of people with problems actually present to health services. Admission rates to hospital for mental health problems are highest in Alexandra, Coldhurst and St Mary's wards' (OPHAR, 2013: 12). Seven of the eight wards with the highest mental health needs (indexed scoring) are recognized as among the seven most economically and socially deprived wards in Oldham (Ritchie, 2001). This distribution also corresponds to mental health related calls to RAID during the pilot.

Hospital admission rates for major mental health problems (depression, schizophrenia, Alzheimers and related forms of dementia) are all above national averages. Oldham also has higher numbers of people on the mental health Care Programme Approach (CPA) than the national average (OPHAR, 2013: 3).

Mental Health problems are interrelated with many aspects of social exclusion. Poverty, low educational achievement and employment, unemployment, fear of job loss, social inclusion and redundancy are some of the major risk factors for mental health. The link between poverty, mental health and inequality is complex and contested. However as Kelly (2005) makes clear, factors such as ethnicity, gender and socio-economic status limit life chances. This, in turn, impacts on mental health, recovery and wellbeing. The Marmot Review (2010) concluded that health and poverty are inextricably linked.

With regard to the impact of wider determinants of health the Community Mental Health Profiles 2103 – Oldham (PHO/DH, 2013) reports that in Oldham, youth and adult unemployment, levels of deprivation are 'significantly worse' than the England average. Rates of hospital admissions for alcohol attributable conditions are also 'significanlty worse.' (PHO/DH, 2013: 2).

Mental health admissions – England and Oldham

This section provides some general information on mental health admissions and is provided to help contextualise the later discussion of use of s.136 nationally and the introduction of the RAID pilot in Oldham.

Overview and trends of use of the Mental Health Act 1983- England

In the reporting year 2012/13 (HSCIC, 2013) there were a total of 50,408 detentions under the Mental Health Act (1983). This number was 1,777 (4%) greater than during the 2010/11 reporting period. The total number of people subject to detention under mental health legislation has remained similar to the number during 2011/12. However, in a longer period of comparison, the total number of detentions has increased by 13% over the past five years, albeit with some differing upward and downward trends. Over this period, the number of s.2 (Assessment Order) compulsory detentions has increased from 15,153 in 2008/9 to 22,477 in 2012/13. The number of s.3 (Treatment Order) compulsory detentions has decreased from 9,601 in 2008/9 to 7,776 in 2012/13.

Part II of the Mental Health Act 1983 allows a patient to be compulsorily admitted to hospital under the Act if he/she is suffering from mental disorder as defined in the Act and where this is necessary: in the interests of his/her own health; in the interests of his/her own safety; for the protection of other people. For information, Part III of the Act relates to people involved in criminal proceedings (these figures are not included here as they do not relate to the pilot or evaluation).

Under Part II of the Mental Health Act 1983, s.2 is used to admit a person to hospital for a mental health assessment and to provide any treatment deemed necessary. This Order lasts for up to 28 days. S.3 is used to admit a person to hospital for treatment which is deemed necessary and cannot be provided without detention in hospital. This lasts for up to 6 months and can be renewed. A s.3 detention may follow an initial detention on admission under s.2. To note, literature often uses the terms ‘formal’ and ‘compulsory’ interchangeably where compulsory detention to hospital is used; the terms ‘informal’ and ‘voluntary’ interchangeably to mean someone has entered hospital without a compulsory order being applied. Figures for detentions for the period 2008/9 to 2012/13 are shown below for information.

Detentions on admission to NHS hospitals by section, and by reporting year

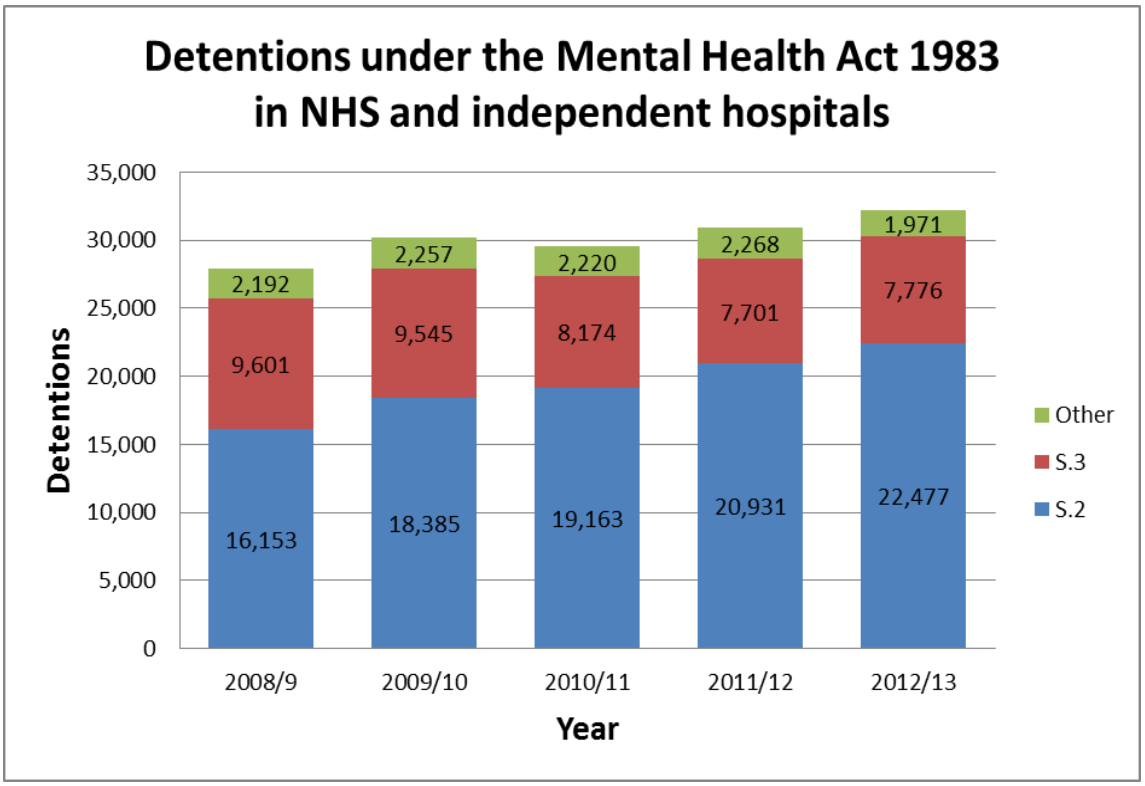


Figure 03: Detentions on admission to NHS hospitals by section, and by reporting year
Source: HSCIC, 2013: 14

Mental Health Act 1983 Detentions (by period 31/03-01/04)	2008/9	2009/10	2010/11	2011/12	2012/13
Total detentions on admission to hospital	**27,946**	**30,187**	**29,557**	**30,900**	**32,224**
s.2	16,153	18,385	19,163	20,931	22,477
s.3	9,601	9,545	8,174	7,701	7,776
Other parts of 1983 Act + other Acts	2,192	2,257	2,220	2,268	1,971

Table 03: Detentions under the Mental Health Act 1983 in NHS and independent hospitals by total number of detention and reporting year – numbers
Source: HSCIC, 2013

Overview of use of Mental Health Act 1983 - Oldham

The figure and table below outlines available figures for detention under the Mental Health Act 1983 in Oldham (to Oldham General Hospital). This is by calendar year. For illustration, we have limited detail to use of s.2 and s.3 of the Act between 2010-14. Oldham reflects the general national trend for use of Mental Health Act 1983 for annually rising numbers of compulsory detentions.

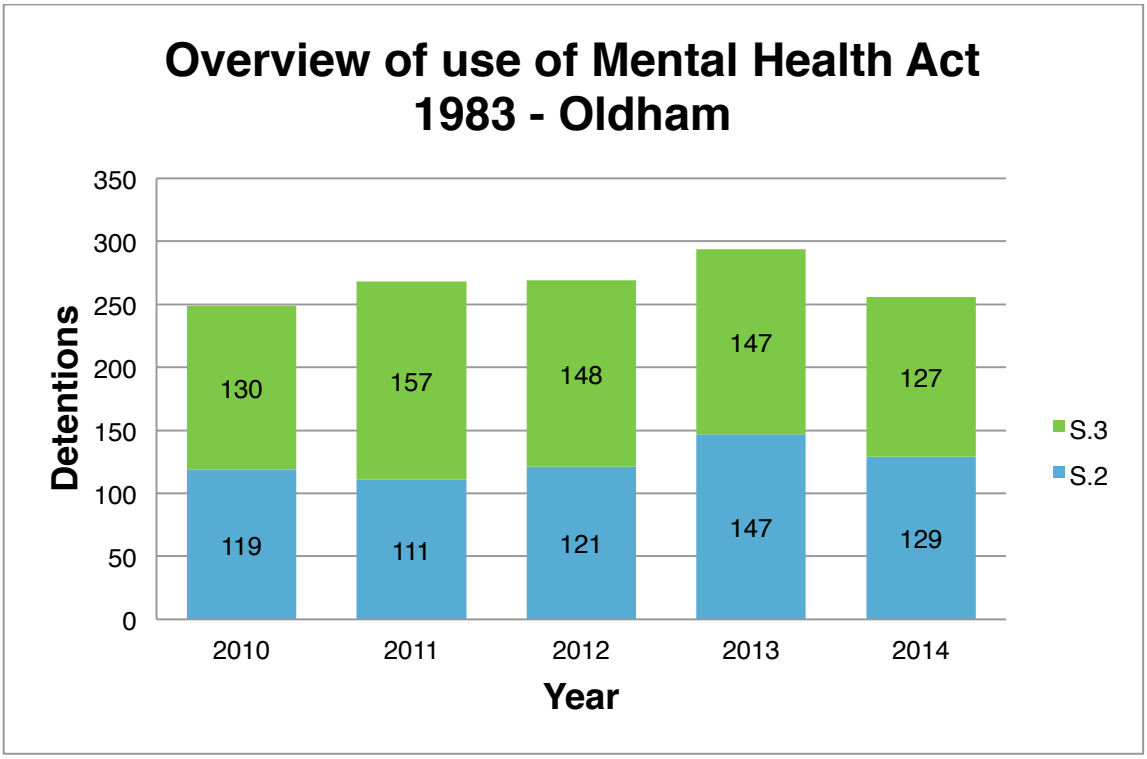


Figure 04: Oldham General Hospital and use of s.2 and s.3 of Mental Health Act 1983.
Source: Mental Health law Administrators office, Oldham Royal Hospital: 2014

Detentions (by calendar year)	2010	2011	2012	2013	2014*
Total	**378**	**381**	**393**	**419**	**397**
s.3	130	157	148	147	127
s.2	119	111	121	147	129

* 2014 (01/01/14 - 21/10/14)

Table 04: Oldham General Hospital and use of s.2 and s.3 of Mental Health Act 1983.
Source: Mental Health law Administrators office, Oldham Royal Hospital: 2014

Overview and trends of use of s.136 of the Mental Health Act 1983- England

As the HSCIC (2013) outlines, it is recommended in the Mental Health Act Code of Practice (2008) that the preferred Place of Safety for s.136 should be a health facility. A police station should only be used as a Place of Safety on an exceptional basis.

The table and figures below show a generally increasing trend in the use of s.136 in England between 2008/9 and 2012/13, with a slight decrease in its use between 2011/12 and 2012/13, the first reduction in five years.

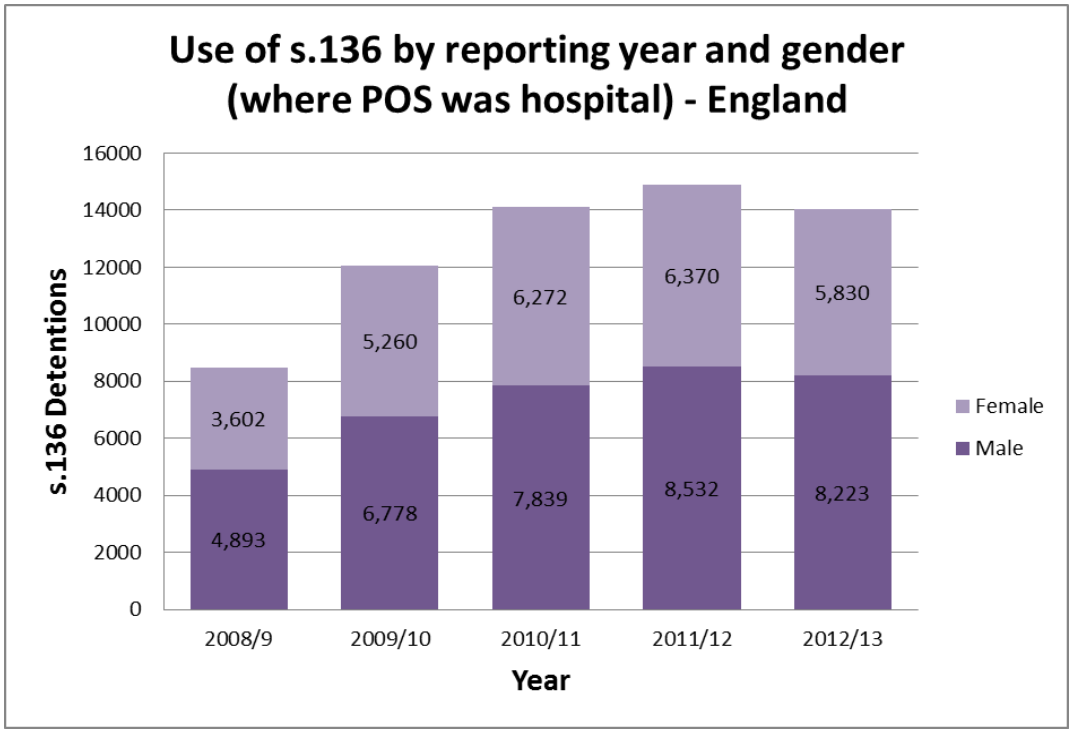


Figure 05: Use of s.136 by reporting year (where the Place of Safety was a hospital) – England
Source: Extract from HSCIC, 2013

Detentions - England (by period 31/03-01/04)	2008/9	2009/10	2010/11	2011/12	2012/13
Total s.136 orders	**8,495**	**12.038**	**14,111**	**14,902**	**14,053**
Male	4,893	6,778	7,839	8,532	8,223
Female	3,602	5,260	6,272	6,370	5,830

Table 05: Use of s.136 orders by reporting year with gender (where the Place of Safety was a hospital) – England
Source: Extracted and adapted from HSCIC, 2013

Use of s.136 - England

The table below shows that during 2012/13, 11, 849 (82%) of all s.136 orders did not result in further detention under s.2 (Assessment Order) or s.3 (Treatment Order) of the Mental Health Act 1983. This proportion has remained generally constant at over 80% since 2009/10. This trend corresponds to figures for s.136 orders in Oldham.

The number of detentions in NHS and independent hospitals following use of s.136 has decreased from 2,582 to 2,426 between the 2011/12 and 2012/13 reporting periods (a 6% fall). This is the first decrease in the period between 2008/9 and 2012/13.

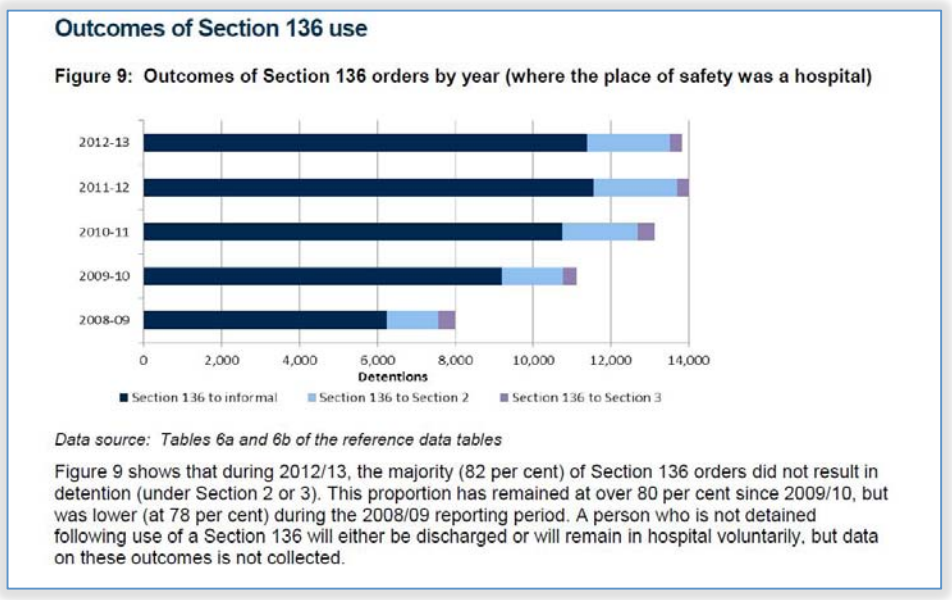


Figure 06: Outcomes of s.136 orders by year (where the designated Place of Safety was a hospital)
Source: Extract from HSCIC, 2013)

Outcomes and changes in s.136 legal status in NHS + independent facilities (by period 31/03-01/04)	2008/9	2009/10	2010/11	2011/12	2012/13
Total detentions on admission to hospital	**7,987**	**11,113**	**13,129**	**14,149**	**13,849**
s.136 to informal	6,236	9,211	10,753	11,567	11,393
s.136 changed to s.2	1,327	1,555	1,948	2,142	2,135
s.136 changed to s.3	426	367	428	440	291

Table 06: Outcomes and changes of legal status of s.136 usage in NHS and independent facilities
Source: CSCIC, 2013: Tables 6a and 6b

Use of s.136 - Oldham

Detentions under s.136 to Oldham General Hospital have been relatively even over the past five calendar years.

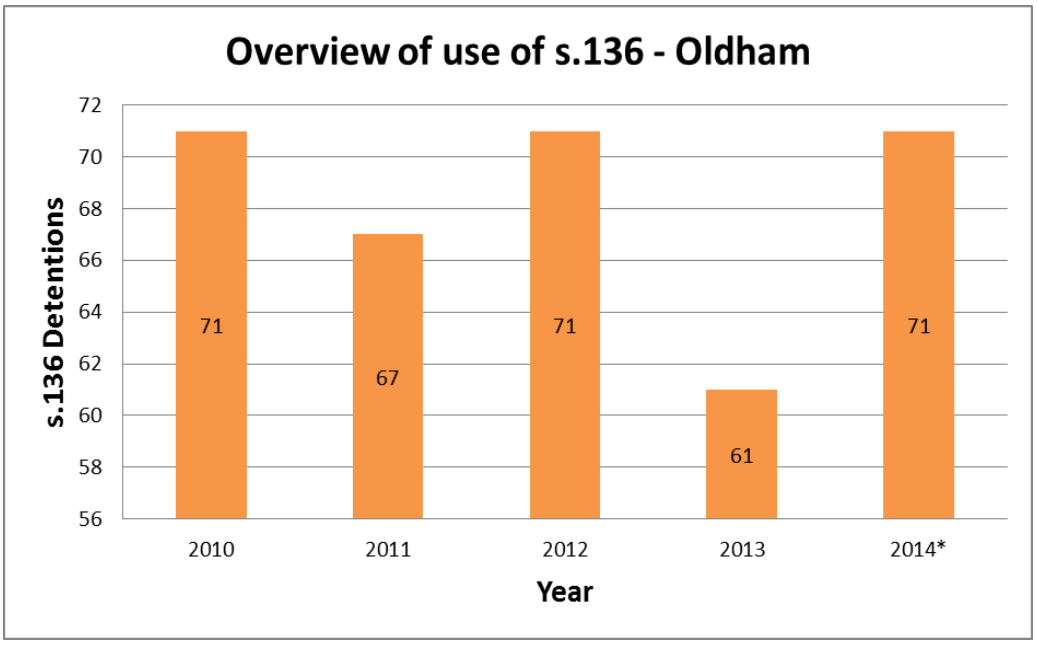


Figure 07: Overview of use of s.136 – Oldham
Source: Mental Health law Administrators office, Oldham Royal Hospital: 2014

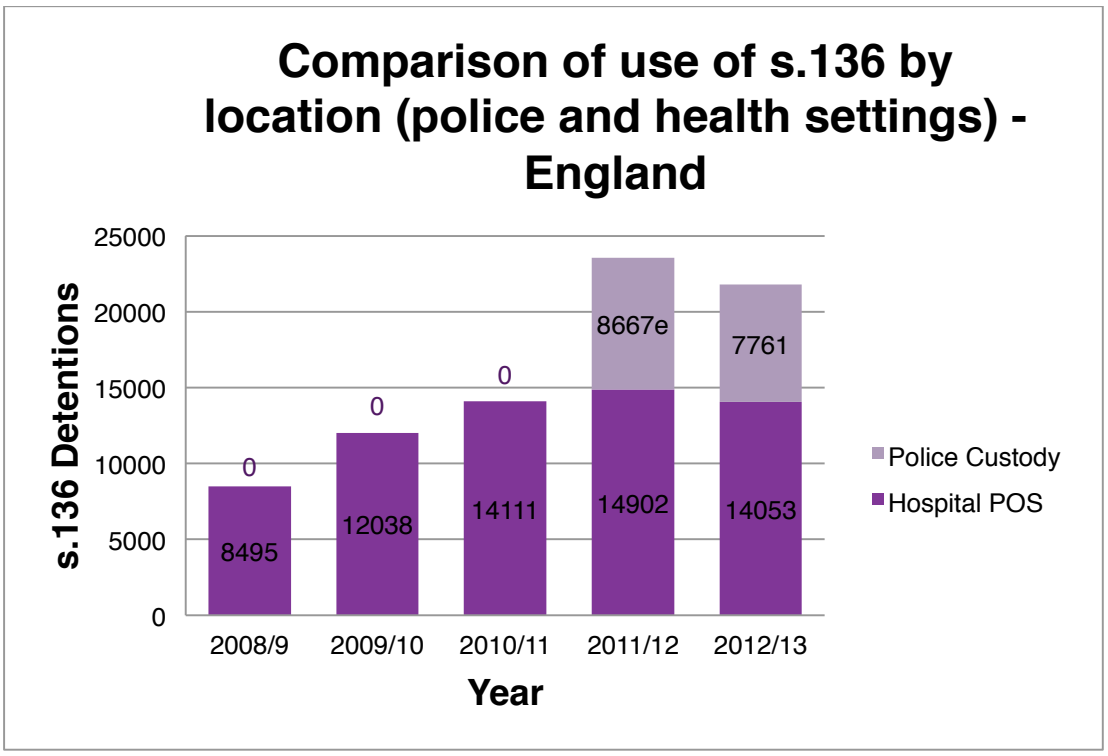
Oldham s.136 detentions (by calendar year)	2010	2011	2012	2013	2014*
Total	71	67	71	61	71

* 2014 (01/01/14 - 21/10/14)

Table 07: Overview of use of s.136 - Oldham
Source: Mental Health law Administrators office, Oldham Royal Hospital: 2014

Use of s.136 by location (police and health based Places of Safety) - England.

Figure 08 below provides a comparison of data showing uses of police and health based places of safety. The HSCIC notes this data has been a relatively new area of attention for analysis and it is not presently possible to collect data on persons taken to alternative places of safety (e.g. residential care homes or the homes of relatives or friends willing to accept them). To note here, figures for 2011/12 are estimated ('e'). The HSCIC (2013) states it intends to build on this area of work in future annual reports.



Note(s): 0 (zero) on the graph indicates no record available between 2008/9 and 2010/11.Numbers of s.136s in police custody suites are estimated ('e') for 2011/12 in the table.

Figure 08: Comparison of use of s.136 by location (police and health settings) –England
Source: HSCIC, 2013

Comparison of s.136 uses in police + health places of safety	2008/9	2009/10	2010/11	2011/12	2012/13
Total number of combined Place of Safety orders	**Not available**	**Not available**	**Not available**	**23,907e**	**22,057**
Where Place of Safety was a hospital	8,495	12.038	14,111	14,902	14,053
Where Place of Safety was police custody	**Not available**	**Not available**	**Not available**	8,667e	7,761

Note: Numbers of s.136s in police custody suites are estimated ('e') for 2011/12 in the table.

Table 08: Comparison of use of s.136 by location in relation to police and health based places of safety.
Source: HSCIC, 2013

The HSCIC comment on the figures relating to location of s.136 places of safety:

> In total, 22,057 Place of Safety (PoS) orders were made during 2012/13, and this figure is 1,512 lower than during 2011/12 (a 6 per cent decrease). Of these, 21,814 were Section 136 detentions and this figure represents a decrease of 7 per cent (1,755) since the previous

> reporting year. Information on uses of Section 136 for police based places of safety was extracted from local custody suite databases for each Force or Constabulary and represents people who went directly to a station, rather than those arrested for substantive offences and subsequently assessed. During 2012/13, 7,761 uses of Section 136 were recorded in police based places of safety, accounting for approximately 36 per cent of all uses of Section 136. This figure is 906 or 10 per cent lower than the estimated figure of 8,667 recorded during 2011/12 but we are confident that this represents a real decrease as qualitative data suggests that the previous figure was an undercount.
>
> (HSCIC, 2013: 20)

It is acknowledged that mental health statistics offer rich sources for data analysis. However, HSCIC also comments that data collection on use of s.136 requires development. The HSCIC include reference to work with the Association of Chief Police Officers on inclusion of new 'experimental analysis from police data' (HSCIC, 2013: 20-21) relating to policing and mental health with comments relevant to the RAID pilot. This work seeks to ensure police recorded s.136 figures will be consistently and accurately recorded across England. Attention is given to work to improve provision of information on the proportion of s.136 uses where the subject was under 18; where Child and Adolescent Mental Health Services are involved; information on individuals presenting who have learning difficulties; how persons under s.136 are transported to the Place of Safety (HSCIC, 2013)

Part 3

Findings

PART 3

Findings

Analysis of data from the pilot

All calls

There were 673 mental health related calls directed to Oldham Q Division of GMP over the duration of the RAID pilot project (02.12.13.-31.05.14). Over the course of the pilot, information was collected in relation to all calls to the police where a possible mental health issues was identified.

Mental health related calls made to Oldham police during the pilot – by month

Date	Dec 2013	Jan 2014	Feb 2014	Mar 2014	April 2014	May 2014	TOTAL
Mental health related calls to GMP - Oldham	119	97	100	**134**	96	127	**673**
Calls by police to RAID	34	27	28	**46**	42	40	**217**

Table 09: Mental health related calls made to Oldham police during the pilot – by month
Source: Pilot data

Mental health related calls made to Oldham police during the pilot – by ward

The 673 calls logged in the RAID pilot are identified by police beat, ward and ward population in the table below. Q1 police beats cover central Oldham and Q2 police beats cover the rest of the borough. The three wards with the highest rate of calls were: Coldhurst (73), Failsworth West (58) and Alexandra (42). Royton South, Shaw and St. Mary's were next with 35 each.

Oldham by Ward	Corresponding Police Beat Code	Population	Mental health related calls to GMP - Oldham
Alexandra	Q1 (H5)	11,830	**42**
Chadderton Central	Q2 (N5)	10,454	25
Chadderton North	Q2 (M5)	11,031	34
Chadderton South	Q2 (P5)	11,019	20
Coldhurst	Q1 (E5)	13,233	**73**
Crompton	Q2 (W5)	10,581	7
Failsworth East	Q2 (R5)	10,352	25
Failsworth West	Q2 (Q5)	10,397	**58**
Hollinwood	Q2 (S5)	11,297	20
Medlock Vale	Q1 (G5)	12,414	22
Royton North	Q2 (T5)	10,283	21
Royton South	Q2 (U5)	11,001	35
Saddleworth North	Q2 (Y5)	9,672	9
Saddleworth South	Q2 (X5)	10,043	9

Saddleworth West and Lees	Q2 (Z5)	11,196	33
Shaw	Q2 (V5)	10,501	35
St. James'	Q1 (L5)	11,473	22
St. Mary's	Q1 (J5)	13,944	35
Waterhead	Q1 (K5)	12,027	31
Werneth	Q1 (F5)	12,149	31
Oldham Town Centre	Q1J1	0	15
No record	-	-	71
TOTALS	**Q1 + Q2**	**224,897**	**673**

Table 10: Mental health related calls made to Oldham police during the pilot – by ward
Source: Pilot data

Mental health related calls made to Oldham police during the pilot – by police beat

Oldham	Police Beat Code	Population	Calls
'Central' Beats	Q1	87,689	240
'Borough' Beats	Q2	137,208	362
No record available	-	-	71
TOTALS		**224,897**	**673**

Table 11: Mental health related calls made to Oldham police during the pilot – by police beat
Source: Pilot data

Police use of the RAID pilot

The use of the pilot phone number by police officers became well-established early into the launch of the pilot. RAID was called on 217 (32%) occasions, indicating that officers not only value the resource but that it relates to a significant proportion of their work. Records show that 282 (41.9%) of all calls to RAID during the pilot, resulted in an individual attending hospital.

Category	Yes	No	Incomplete data
Use of RAID	217	451	5
S.136 considered	78	585	10
Conveyed to hospital	66	605	2
Write up Using NDM	282	389	2

Note: Detail of calls by month is contained in the Appendix.

Table 12: Use of the RAID pilot
Source: Pilot data

The evaluation shows calls made by the police to the RAID pilot steadily increased over the history of the project. This indicates the acceptance ('buy –in') of officers and the high value attached to being able to call RAID in 'real-time' at the scene of an incident, 24 hours a day, 7 days a week.

Recommendation

The success of access to the RAID pilot – immediate, available and reliable

The pilot succeeded in meeting one of its key aims. The value of using RAID is reflected across the period of the pilot and was a key theme emerging from interviews and consultations with police officers and others. Officers describe the RAID resource as important and significant in managing mental health crises in the community.

The pilot has identified concentrations of mental health demand within Oldham. As is noted in Part 2 of the evaluation report, seven of the eight wards with the highest mental health needs (indexed scoring) are recognised as among the seven most economically and socially deprived wards in Oldham (Ritchie, 2001). This distribution broadly corresponds to mental health related calls logged during the pilot. The data analysed in the pilot reflects research elsewhere linking mental health, poverty and social exclusion (Knifton and Quinn, 2013; Butterworth et al, 2009; Jenkins et al, 2008; Weich and Lewis, 1998a, 1998b).

Recommendation

Mental health, poverty and social exclusion – identifying and meeting the needs of diverse communities and building on the pilot model

The findings from the pilot should be shared to inform future local service planning; to build on the sound foundation of the pilot as a model for future police and mental health inter-agency working; to widen future policing and mental health services partnerships at a local level to include other essential agencies (e.g. social care, specialist services, third sector organisations, service user groups) in order respond effectively to local social needs, support vulnerable groups and communities. There is much collective expertise, strength, skill and knowledge in Oldham to draw on and develop.

Data on the mental health needs of BME heritage communities should be developed in future schemes.

It would not be appropriate for RAID to be consulted in all cases (451 cases did not result in a call to RAID). In a number of these cases, the police were able to draw on their local knowledge and own expertise, signpost individuals to other services without the need to phone RAID, health and social care professionals were at the scene of the incident so a call was not necessary, or officers were being requested to attend to support ambulance staff because of the nature of the incident.

Police officers called RAID 78 times when considering use of s.136. However, the number of s.136 orders during the pilot was 43.

Recommendation

Access to RAID and use of s.136 – informing decision-making, use of resources and outcomes

The pilot positively facilitated support for police officers at the scene of an incident to immediately contact RAID and as a result speedily access professional mental health expertise and advice; share and exchange information; agree an appropriate course of action. By using the pilot, police officers were able to divert 35 possible s.136s to alternative 'least restrictive' services (Mental Health Act Code of Practice, 2008)

The table indicates that the National Decision Making (NDM) model was only used in 66 (9.81%) of cases. This is slightly misleading as an analysis of the write-up shows that officers are actually following the NDM model and process but may not be formally identifying that they are doing so. Officers were also asked to record the 'length of time' they spent with an individual. 669 (99.4%) of calls were resolved within an hour.

Recommendation

Access to RAID significantly improved police resolution of calls and positively impacted on effective use of police time and resources.

Repeat calls and vulnerable individuals

11 individuals were identified who had repeatedly called or been the subject of repeat concerned calls raised about them by their family, neighbours or other agencies. Where an individual called or concerns were raised about them 5 times or more during the course of the pilot period then they were categorised for the purpose of the pilot as a 'frequent caller'.

In total 115 (17.08%) of all mental health related calls made to the police during the pilot involved repeat or frequent calls/callers. 3 individuals represented 70 (10.4%) of all such calls. The most frequent calls related to:

- Individual A - 34 calls (5.05%)
- Individual B - 22 calls (3.27%)
- Individual C -14 calls (2.08%)

Such calls typically featured repeat calls on the same day or periods where there were several calls over a week. Callers A and C were identified as having long-standing alcohol and/or personal issues. Incidents of self-harm and threats of suicide were also highlighted as present.

Recommendation

Repeat calls and supporting vulnerable individuals

The project supported improved delivery of appropriate, timely and improved outcomes for individuals, families and communities.

Identification of individuals who frequently come into contact with services via the police, can be used to establish agreed inter-agency responses and risk plans which are proactive and also less reactive to events. This approach, in turn may be used strategically to help reduce re-presentation and impact on police time and resources.

The pilot identified 115/673 (17.08%) calls to the police during the pilot period, regarding a small number of vulnerable individuals with legitimate and high level needs and who live in the community. This information could helpfully be used to further inform crisis/ safeguarding plans across all services.

Features of all mental health related calls during the pilot

Alcohol and/or drugs identified from calls to pilot

In taking or dealing with mental health related calls, police call staff and officers were asked to record if alcohol and/ or drugs were a presenting feature. it is apparent that alcohol was a factor, particularly in reporting cases of self-harm or threatened suicide. However, the 518 (76.96%) of cases where alcohol was not felt to be an issue is perhaps surprisingly high.

Category	Calls
Alcohol and/or drugs not identified	518
Alcohol and/or drugs identified as a feature	134
Alcohol and overdose identified as a feature	13
Overdose identified as a feature	13
No record	2

Table 13: Alcohol and/or drugs identified from calls to pilot
Source: Pilot data

Mental health presentations identified from calls to pilot

From call records the following categories were identified from logs, records and descriptions.

Category	Calls
Self-harm/ threats of suicide/ overdose	220
Mental health history identified	87
s.136 - Mental Health Act 1983	43
Police assistance - Mental Health Act 1983	18

Table 14: Mental health presentations identified from calls to pilot
Source: Pilot data

Self-harm/ threats of suicide

Some 220 (32.68%) of all calls received during the pilot involved an incident of self-harm, threatened suicide or overdose. Alcohol and drugs were often also identified as a contributing factor in these cases. The incidents were usually in response to an immediate personal crisis such as relationship breakdown, financial problems or similar concerns. Such calls were often prompted by either text messages sent to relatives indicating an intention to self-harm or by posting on social media sites. There were several examples were officers prevented individuals using ligatures to seriously harm themselves. As noted elsewhere, the police had a significant role in supporting the ambulance service.

Recommendation

The RAID pilot contributed positively in helping to manage incidents of self-harm and threats of suicide.

Access to RAID was particularly highly valued by police officers in the context of dealing with incidents which involved self-harm, threats of suicide, or overdose. Access through the RAID pilot to sound professional advice and support from health professionals was seen as a key asset in better managing challenging situations, informing decisions and co-ordinating further action.

Training in relation to better understanding mental health problems and responding to self-harm and threats of suicide was identified by officers as a specific need.

Mental health history identified

In 87(12.92%) calls, although the call indicated there was no immediate mental health issue or issue present requiring further action, the subject of the call was identified as having a history of mental health problems.

S.136 - Mental Health Act 1983

There were 43 (6.4%) uses of s.136 in the pilot period. This is covered in more detail later in the findings section.

Police assistance - Mental Health Act 1983

There were 18 (2.67%) calls where police were asked to assist in Mental Health Act assessments or locate person missing from hospital.

Concern for welfare

Concerns for welfare featured in 147 (21.84%) of all calls. These were typically calls where concerns had been raised about regarding the welfare of an individual or a family member. The majority of these callers were regarding vulnerable adults with a history of mental health problems. This category also included older people reported missing.

Adult safeguarding

There were 48 calls (7%) which were categorised as relating to adult safeguarding. The overwhelming majority of these fell into two main groups. The first were reports from family or neighbours reporting concerns regarding older relatives or friends. The police response was to organise a welfare check and/ or refer to appropriate services. The second group consisted of reports from care homes of relatively minor incidents – for example one resident pushing another. The police were informed because of the general requirements of safeguarding policies. However, the nature of the incidents meant that it would not be in the public interest to pursue any criminal matters.

No specific mental health issue identified in calls

In 67 (9.95%) calls, no obvious mental health issue was apparent from the records write-up.

Management and administration of the pilot

Overseeing data collection and monitoring across complex organisations such as the police and NHS is challenging. Staff administrating the pilot, in addition to their other duties worked with commitment and diligence to ensure data was collected in a timely way and reconciled.

Recommendation

The RAID pilot developed models for effective record keeping and information exchange.

Staff overseeing the administration of the pilot had built on good working relationships to maintain accurate records. This has led to identifying improvements in record keeping and knowledge exchange. This model and approach should be recognised as good practice and staff encouraged to share their experiences of developing this approach with other police/NHS/mental health projects.

Use of s.136 of the Mental Health Act 1983 during the pilot

There were 43 s.136 orders identified during the six month pilot period (02.12.13 to 31.05.14). For the purposes of this evaluation report, 40 s.136 orders were examined. Exclusion criteria were applied with regard to s.136s originating from out of area referrals and/or where sufficient matching information was not available at the time of writing the report.

Use of s.136 during pilot – by Gender

Of the 40 cases resulting in use of s.136, 24 were male and 16 female.

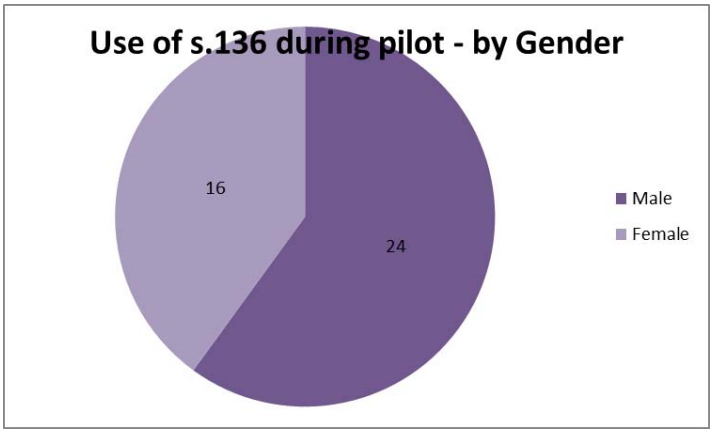


Figure 09: Use of s.136 during pilot – by Gender
Source: Pilot data

This distribution equates to the national profile of more males than females being subject to use of s.136.

Use of s.136 during pilot – by Age

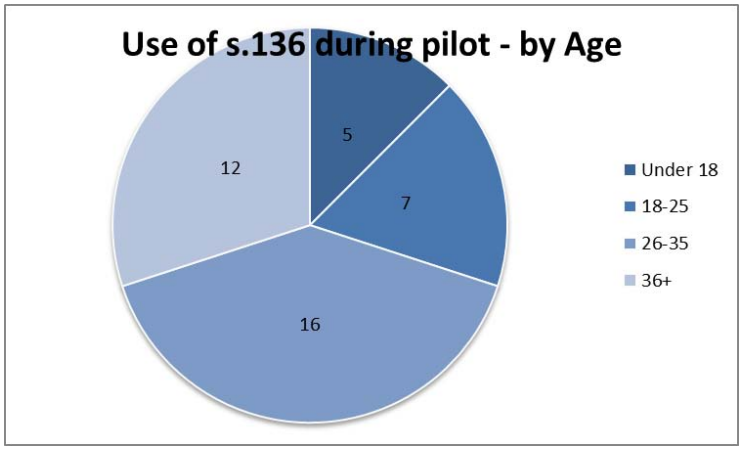


Figure 10: Use of s.136 during pilot – by Age
Source: Pilot data

Use of s.136 – by Age	Number
36+	12
26-35	16
18-25	7
Under 18	5

Table 15: Use of s.136 during pilot – by Age
Source: Pilot data

Note: It was agreed the evaluation report would not include further identifying details given the numbers involved.

Young people and s.136 outcomes

Of the 5 individual's under 18, 3 were age between 16 and 17, and 2 were under 16. Officers commented in interviews that where a young person presented as mentally unwell and distressed, the use of mental health legislation, including s.136, was particularly emotionally challenging. Contact with RAID through the pilot was important here in accessing professional advice and support in order to make more effective decisions. This also facilitated the provision of age appropriate services where s.136 was used. In the cases examined, this included informal admission to a paediatric ward, follow up by Children and Adolescent Mental Health Services (CAMHS) and learning disability services.

Recommendation

Use of the RAID pilot supported the provision of appropriate specialist provision for young people in mental health crisis.

Coding of calls made to the police during pilot, resulting in use of s.136

As discussed earlier in the report, calls from the public to GMP are routed to one of 3 GMP Operational Communications Rooms (OCR). A call handler takes the details of each call, logs it and allocates each call or incident a unique Force Wide Incident Number (FWIN). Each FWIN is dated and ascribed an initial code (typically 1-3 codes) designated by the nature of the call or type of incident being reported (e.g. G17, 'mental health'; G60, 'missing person'). Further codes can be added to FWINs as events develop, further information emerges (e.g. G16, 'concern for safety – 18 and over') or are dealt with or closed (e.g. G36, s.136 Mental Health Act Detention'). Mental health related calls identifying potential for risk and harm to self or others are responded to as a priority.

Analysis of police data in relation to calls to RAID during the pilot which resulted in a s.136 order, found initial coding of mental health related calls to be consistently and accurately classified. The main coding categories were as follows:

- G17 'mental health'
- G16 'concern for safety – 18 and over'
- G15 'general call'
- G50 'assistance to other public agency'

Less frequent, but also present, the code G60 ‘missing person’ appeared in records.

Recommendation

The RAID pilot demonstrated good practice in the coding and prioritising of mental health related calls to the police.

The accuracy of coding suggests examples of good practice in managing calls received, improving opportunities to identify and prioritise calls made to the police, increasing the likelihood of timely responses to mental health emergencies. This should be acknowledged, shared and developed in future training and developmental work.

Calls by the police to RAID during the pilot, resulting in use of s.136

The use of a s.136 order under the Mental Health Act 1983 requires officers to make professional judgments in dealing with individuals experiencing a mental health crisis, typically involving situations where risk and the potential for harm to self and/or others is assessed as high and an individual’s actions or threats of actions indicate the need for urgent intervention.

During the pilot evaluation period, in the context of use of s.136, police officers contacted RAID on 31 of 40 (77.5%) occasions as part of their assessment process. Only on 3 occasions were RAID not called. In 2 of these cases, mental health professionals were already at the scene. On 1 occasion, the RAID number was called but not answered.

Where s.136 was used, police officers had consistently sought to access RAID to liaise, seek further information and used the call to seek advice and support regarding decision-making and actions. The frequency of calls to RAID suggests high value was attached to RAID as a key resource.

Mental health crises and use of s.136 - presentation, assessment and decision-making by police officers

Examination of police records and summaries provided of health records indicate that in the context of use of s.136, police officers consistently exercised sound professional judgment. In all cases, descriptive records of incidents indicated high risk, the clear potential for harm to self and/or others and the need for urgent intervention. Typical presentations featured reports of mental distress, disturbed or erratic behaviour, threats of suicide, actual or threatened self-harm, threatening behaviour. This was often accompanied by physical actions or threats of actions by individuals which required immediate intervention (e.g. individuals acting to threatening to jump from a bridge, roof or other high place; crossing moving traffic).

Police records and health summaries identified that threats of suicide and self-harm featured regularly in presentations and accounted for 24 (60%) of all calls resulting in use of s.136. In 80 (20%) cases of use of s.136, individuals were described as being agitated, erratic and/ or unsettled. In 4 (10%) cases 'paranoia' or 'psychosis' was used to describe presentations at the s.136 suite. Presentations of mental health crisis typically required urgent action and intervention.

Recommendation

Access to RAID by police officers better informed use of s.136

Decisions to use s.136 were appropriate, proportionate and supported by the recorded evidence in all cases. In findings from interviews and consultations with police officers RAID was highly valued as a resource for information, advice and guidance. RAID was also attributed as supporting more timely and better co-ordinated access to appropriate services.

S.136 and presence of alcohol and drugs

The presence of alcohol and drugs in the context of policing and mental health complicates assessment and adds to the complexity of working with individuals in mental health crisis.

Police records and health summaries identified alcohol and/or drugs as an additional component of individual presentations and incidents in approximately 10 (25%) of s.136 cases.

Prior contact with health and social care services

Interestingly in only 5 (12.5%) cases were individuals identified as being linked to the mental health Care Programme Approach (CPA). In cases where individuals were made subject to s.136, 30 (75%) had been previously known to secondary health or social care services (services identified here included specialist mental health services, drug and/or

alcohol services, child and adolescent mental health services, learning difficulties services).

Outcomes of s.136 orders - Oldham

Outcomes were analysed in relation to outcomes of the s.136 orders used by the police during the pilot. Figures are set out below.

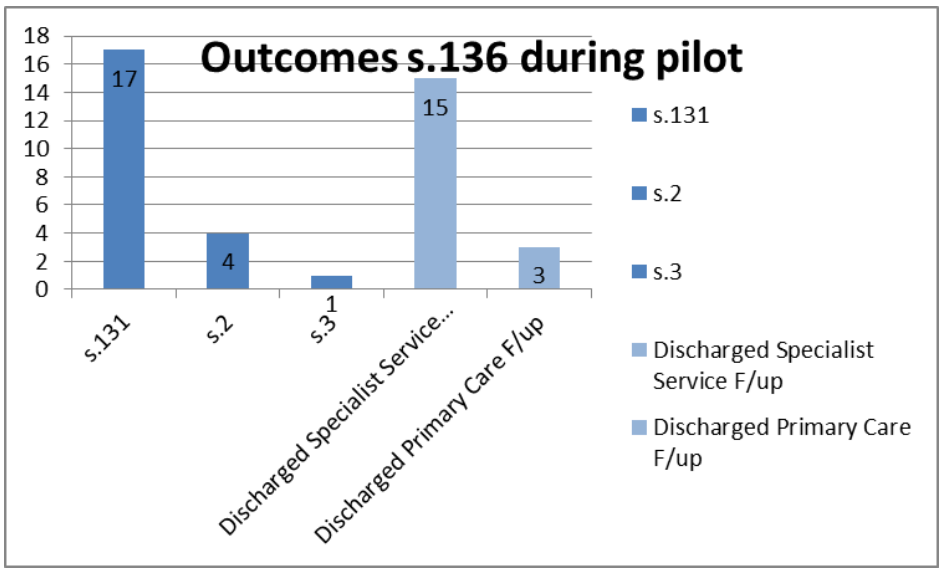


Figure 11: Outcomes of s.136 orders- Oldham
Source: Pilot data

Outcomes of s.136 during pilot *(n=40)*	Number
s.136 converted to s.131 'informal' (i.e. voluntary/non-compulsory) admission to hospital	17
s.136 converted to s.2 (Assessment Order) compulsory detention to hospital lasting up to 28 days	4
s.136 converted to s.3 (Treatment Order) compulsory detention to hospital lasting up to 6 months (with the possibility of renewal)	1
s.136 completed. 'Discharge' with follow-up from specialist services	15
s.136 completed. 'Discharge' home (with primary care follow up or no further action indicated)	3
TOTAL	40

Table 16: Outcomes of s.136 orders- Oldham
Source: Pilot data

These figures indicate that 22 (55%) of s.136s identified during the pilot period resulted in admission to hospital, with 17 (42.5%) being admitted to hospital under s.131 (voluntary/ informal admissions), 5 (12.5%) admitted to hospital under s.2 or s.3 (compulsory/ formal admissions). In 18 (45%) cases, individuals were discharged home, with 15/40 (37.5%) discharged with specialist services follow up and only 3 (7.5%) discharged home with primary care follow up.

With regard to specialist services follow-up, services identified included: RAID follow-up, home treatment service, community mental health services, drug/alcohol services, Children and Adolescent Mental Health Services (CAMHS), Learning Disability services.

S.136, the s.136 suite and use of police cells as the designated Place of Safety

During the pilot, in relation to use of s.136, of the 40 cases considered, police cells were used as Place of Safety on only 3 occasions. This is positive and perhaps indicates the skills levels and willingness of RAID staff to manage individuals in the s.136 suite with significantly high levels of challenging behaviours. Police offered to remain in attendance at the hospital based s.136 suite as requested.

Recommendation

Access to RAID facilitated discussion about the preferred and appropriate Place of Safety.

This supports the key principles outlined in the Mental Health Act Code of Practice 2008 to use compulsory detention as a last resort and to always seek the 'least restrictive alternative.'

Recommendation

Information about conveyance to hospital

Information about conveyance to hospital (by ambulance or police vehicle) was not readily available at the time of writing the report. However, this is important in relation to ensuring appropriate and safe service provision and practice. Planning of future policing and mental health pilots and schemes should ensure inclusion of ambulance services.

Completion of s.136 process – police time and resources

Analysis of police time spent with individuals subject to s.136 indicates that calls were responded to promptly (see below) and seen through to a point where officers could be released back to other duties. Of the 40 cases examined, in 30 (75%) cases officers were able to resume other duties within 60 minutes. In 5 cases (12.5%), delays of 4+ hours were identified, typically where police attendance at the s.136 suite was requested/ required or a person was transferred to a hospital out of the immediate, local area.

Recommendation

Access to RAID improved effective use of police time

Records and comment from interviews and consultations with police officers strongly indicate that access to RAID during the pilot has significantly improved police time required to be allocated to dealing with mental health related calls.

Presentation and completion of s.136 process – by time of day

Of the 40 s.136 cases examined, in relation to time of day of presentation: 23 (57.5%) of cases presented between 08.00- 20.00 hours and 17 cases (42.5%) between 20.01 -17.59 hours.

Recommendation

The RAID pilot improved access to advice and support at key times

The RAID pilot has shown its value in improving access to professional advice and support during night time/early hours.

Improving delivery of services

Comment from interviews and consultations with police officers strongly indicate that access to RAID during the pilot improved communication; co-ordination of police-RAID work; the timeliness of interventions; completion of assessments within satisfactory timescales. All these would indicate improved service delivery for individuals, families and communities. This links to completion times of s.136 assessments, which are set out below.

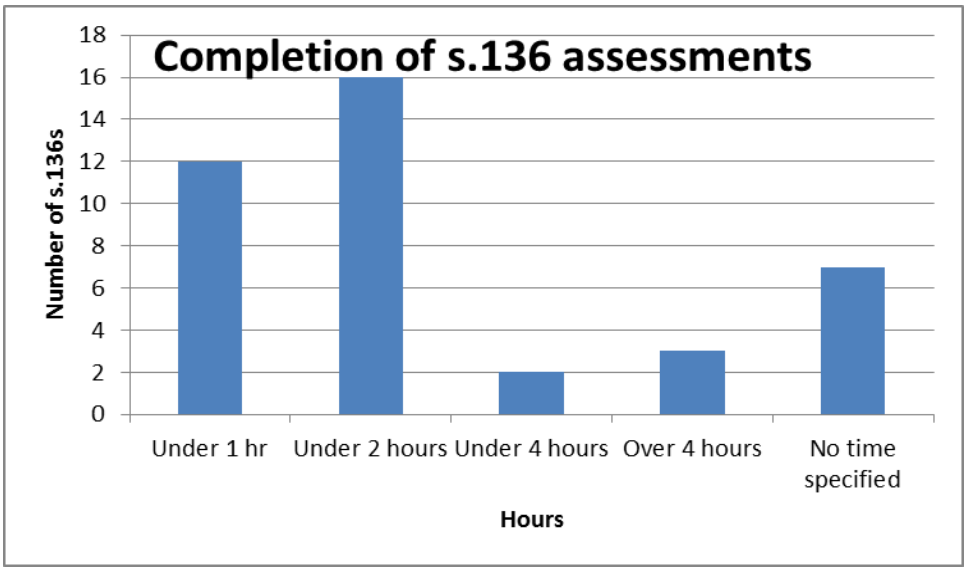


Figure 12: Presentation and completion of s.136 process - by time
Source: Pilot data

Completion of s.136 assessments – by time	Number
Under 1 hour	12
Under 2 hours	16
Under 4 hours	2
Over 4 hours	3
No time specified	7
TOTAL	40

Table 17: Presentation and completion of s.136 process- by time
Source: Pilot data

Recommendation

The RAID pilot improved duration and delivery of assessments under s.136.

Impact of the pilot on s.136 - Oldham

Detentions under s.136 to Oldham General Hospital have been relatively consistent over the past five calendar years. From the data analysed in the pilot, s.136 was considered for use on 78 occasions during the pilot period. Table 18 below shows that of these, only 43 s.136s were used. This figure, if projected forward, suggests the pilot may have a nominal or modest impact on the number of s.136s in Oldham. However, it is important to note that national trends in use of s.136 are moving upwards. 2102/13 figures (14,053) for use of s.136 are 39% higher than in 2008/9 (8,495).

It is clear from the evaluation that of the 40 s.136s analysed, that in all cases, decisions to use s.136 were appropriate.

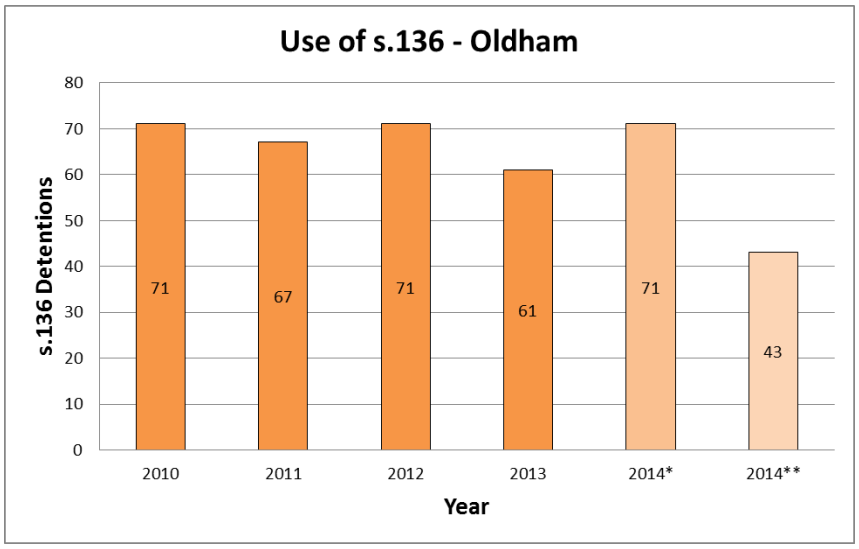


Figure 13: Use of s.136 - Oldham
Source: Pilot data

s.136 detentions (by calendar year)	2010	2011	2012	2013	2014*	Pilot period
Total	71	67	71	61	71	43

* 2014 (01/01/14 - 21/10/14)

** Pilot period (02/12/13 – 31/05/14)

Table18: Use of s.136 - Oldham
Source: Pilot data

Recommendation

The RAID pilot supported appropriate use of s.136.

Report of consultations and interviews with police officers and others about the pilot

This section of the report focuses on the consultations with police and health staff that took place across the period of the pilot and the semi-structured individual interviews and group interviews that took place with police staff during the latter part of the evaluation. As mentioned in an earlier section of the report, interviews were carried out after initial analysis of quantitative data covering the first quarter of the evaluation period and were mainly scheduled for the latter part of the pilot. During this phase, the scheme had become more embedded and staff exposure to the pilot was more likely. Data collection in this context focused on respondents experiences of using the pilot, the strengths and deficits of the pilot, whether it had merit and the extent to which it had achieved its aims; areas for future development. Responses were analysed thematically and the summary below represents the views and experiences of police staff who had knowledge and experience of the RAID pilot.

Views on the contemporary context of policing and mental health

With regard to policing involving responding to calls where mental health issues were identified as a feature of 'jobs', longer serving officers (with 5-10 years+ service) reflected that '*the job has certainly changed a lot*…' over the period of their police service. Notably, with regard to the increasing range and complexity of contemporary policing, the need to operate within stretched resources and the stress and pressure of '*frontline work*' on staff. All staff, irrespective of experience, acknowledged that encountering vulnerable members of the local community is now a frequent and recurrent feature of their day-to-day work. Typical responses included:

> '*When I joined the service, you didn't come across this sort of job as often…definitely not.' (*Police officer*)*

Officers expressed empathy and concern for individuals who had severe mental health difficulties. However, the pressure such calls placed on their work also caused frustration at what they felt was the apparent absence of specialist services to help vulnerable individuals. This feeling also manifested itself in concerns about how to be effective in dealing with incidents where mental health difficulties were present and awareness of public concern and scrutiny about police management of challenging mental health issues, encapsulated in one response from a police officer as '*doing the right things and doing things right'.*

These views combined with a certain amount of "pilot project fatigue" (police felt pilots and temporary schemes seemed to be a recurring feature of their workplace) impacted on how

police generally viewed pilot schemes and informed how they responded to the RAID pilot as a specific programme. However, police staff appeared to have no reservations about speaking candidly and plainly, which was viewed as an asset for the evaluation. This is worth noting as feedback on the RAID pilot was consistently and overwhelmingly positive.

'If I lost RAID I'd lose a really good tool'

The RAID pilot came to be valued quickly by local officers and was seen as a considerable asset and support to the delivery of more effective, safer and speedier police interventions. In interviews and through the consultation period, RAID was seen as a direct and practical help.

> '*You ring, you get straight through…no wait, no forms*.' (Police Officer- Neighbourhood Team)
>
> '*It's a solution to a problem and a real help. If I'd had RAID before, I know I would have been able to do my job better and be more effective....'* (Police Officer- Response Team)
>
> '*If I lost RAID I'd lose a really good tool*.' (Police Officer- Response Team)
>
> *'Mental health is interesting to me and trying to help people get the help they need is now a bigger and important part of our work…it's much more part of the job now than when I first started. Our job is protecting the public…and to do this we have to use our time and resources as effectively as we can…We can manage major incidents but dealing with vulnerable people is a challenging area of work for all of us. Stress is definitely something you have to deal with as a police officer but this doesn't mean you feel equipped to help people who are very distressed or ill… or behaving unpredictably… Dealing with this can take staff out for a full shift…so anything which helps us do the right thing and get jobs completed quicker has to be good. The feedback I've had has been very, very positive.' (Police Inspector)*
>
> *'My officers really like it and see it as a useful resource…officers see value in it… they just wouldn't use it otherwise.'* (Police Inspector)

Recommendation

Police want to retain access to RAID

'If I lost RAID I'd lose a really good tool' (police officer).

Improved communication and access between police, psychiatric services and vulnerable members of the community

Access to RAID was viewed as important in terms of improving contact, access to expert advice, speed of response and managing risk. Communication with RAID was '*uncomplicated and easy to use'*. Frequent comments included '*good contact*', and a '*quick'* and *'prompt response*' to telephone calls. Respondents drew attention to the value of rapid access to RAID in helping to build professional relationships between police and psychiatric services. Typical comments mentioned '*improved liaison and bridge building'* and that '*you can get on better with people as you get to know them…'*

Respondents commented on existing working relationships between the police and emergency services (notably, the ambulance and fire services) describing a mutually supportive approach to dealing with calls.

> *'We are all out there trying to do the job and get it done right… we know each other well, we rely on each other and support each other…the jobs hard enough* (and although) *…there are pressure times when it can get sticky you have to just keep things moving…we are all against the clock' (*Police Officer – Neighbourhood Team)

> *'Yes, that's right…everyone's under pressure so you try to keep things focused, make a decision, get sorted, do something*…(and) *sort things out after if there's a problem…people tell it as it is and you just move on…'*(Police Officer – Neighbourhood Team*)*

However, in relation to responding to calls where mental health problems are present or become apparent, prior to the existence of the RAID pilot, officers felt less assured about how to proceed and less supported by services. While frontline officers often felt their professional instincts prompted them to action rather than inaction, how to proceed presented challenges and trying to '*not do the wrong thing and make things worse'* was a concern for several officers. As one frontline officer commented:

> *'…having someone to speak to quickly is a great help. You want to help, but sometimes they're* (the individual who is the subject of a call*) really out of it. before I joined the force I'd never come across people who were like this… wound up, pacing around and not able to stand still…you want to get them help* (but) *you don't want to escalate the situation…you don't know how people are going to react, even if they are regulars…'* (Police Officer – Neighbourhood Team)

Communication with RAID, its immediacy and rapid access to professional psychiatric advice and support was highly valued. Prior to the pilot experience of trying to access emergency psychiatric services was described as lengthy and frustrating. Frontline officers contrasted their experience of using the RAID pilot to the situation where there was no such resource, *'…sometimes you could be on the phone for hours… you get passed from pillar to post…' (*Police Officer – Neighbourhood Team*)*

On limited occasions officers commented that they could not access RAID as the line was engaged or not answered this but this was generally the exception and became less frequent over the final period of the pilot.

A direct dedicated RAID line was seen as offering a preferred route by which to by-pass switch boards, non –emergency services and talk to a trained individual who had access to health records, quite often knew or knew of the person who was the subject of the call, could respond and advise quickly. Staff also commented that access to RAID improved information giving and exchange and that having direct contact meant '*things get done quicker and we can get back to our (*other work*)'*.

Officers noted that a real asset of the RAID phone service was that whilst it was possible for officers to speak to RAID staff directly, where appropriate officers could pass their mobile phone to the individual who was the subject of the call and they could also talk to RAID staff. This often improved immediate management of the situation in at least one of four ways:

- the distressed person could talk directly and immediately to a trained health professional and this tended to calm situations
- the opportunity to access RAID via the police demonstrated that the views of the person and difficulties of their circumstances were being taken seriously by officers
- the response of police officers was seen as more welfare oriented than responding to criminal or public order issues
- officers felt they were more frequently trusted by members of the public who were distressed and that proposed plans to take people to hospital were seen to be more believable.

Communication with RAID could be made using police radio sets or mobile phones. However, to note here, there were some issues identified in relation to the use of radio sets. This is discussed at the end of this section.

Recommendation

Access to a dedicated RAID contact number improved communication between police, psychiatric services and vulnerable members of the community.

Effective use of time and resources

Officers felt that access to RAID has speeded up police time when responding to and dealing with calls where mental health challenges were present. This was particularly the case where an individual required hospital assistance.

> *'Before RAID, time after time you would literally be stuck in A&E for hours…a full shift wasn't unusual. It's frustrating because you can hear*

calls coming in on the radio and you can't attend…you feel bad…Time stops still in the hospital…' (Police Officer- Neighbourhood Team)

The value of the RAID pilot, as a means of saving time and making better use of resources was voiced strongly in comments from frontline officers. Many officers commented that prior to the RAID pilot, calls involving mental health problems often took up considerable time and resources. In particular, prior to the RAID pilot, where s.136 was used to compulsorily remove an individual to a designated Place of Safety (typically, an Accident and Emergency Department) officers would have to wait a considerable time until a medical doctor and social worker would be available to make an assessment and decision.

Officers felt the RAID pilot had made a positive impact on time and resource management. Having initiated s.136, a person could now more quickly be moved to the designated Place of Safety. The RAID team could be contacted prior to arrival and staff co-ordinated to be present when police arrived. Handovers were thus seen to be improved in terms of risk and potential harm being better managed and assessments completed more speedily. Importantly, for officers, they could return to other urgent calls and duties without undue delay.

Knowledge, decision-making and confidence building

Frontline officers who had used the RAID pilot consistently and positively commented on how this service had significantly helped to improve their own knowledge and confidence in assessing situations, in managing incidents and making decisions.

Officers commented that prior to the pilot, they had typically had to rely on personal knowledge of mental illness and health to guide them in situations where mental health was a presenting issue. Some officers could recall previous training on basic mental health or had accessed other information and reading, but felt this was of mixed or limited value or had not been retained, developed or updated as part of their professional development.

*'You are expected to do lots of courses as part of your early training and I think mental health gets covered but only really briefly and it's all pretty general…some's useful and some not...it doesn't really prepare you properly…and in any case, after all said and done, this isn't our job, we aren't doctors are we…' (*Police Officer*)*

Officers felt they were generally good at observation and assessment of how individuals present. This was part of their training and a key element of their operational work. However, they did not feel this equipped them sufficiently to make decisions about risk and potential harm in the context of mental health. A deficit of knowledge about mental health issues, notably in relation to major psychoses and managing threats of self-harm and suicide, caused concern.

Using the RAID pilot, the opportunity to talk to a trained mental health professional gave officers insights into the sort of information health professionals required and valued in making assessments and the types of questions it was appropriate and helpful to ask.

Officers expressed improved confidence in decision-making as a result of using the RAID pilot, as they were offered immediate reliable information, including summaries about an individual's current circumstances; information on access to services and care planning; guidance and advice on options and alternatives available on the day; advice about how to proceed. As one officer commented:

> *'The really good thing about RAID is you get information straightaway that's just about the person in front of you, so you know right off what's been happening…who's involved and what you can do…after all they need specialist help, not us, the police…'* (Police Officer- Neighbourhood Team)

Finally, officers reflected that access to the RAID pilot had improved reciprocal awareness and mutual respect between police and psychiatric health staff of each other's professional knowledge, skills and work pressures. Officers commented on having gained increased awareness and respect for the high level skills and knowledge of staff in psychiatric services and in turn felt more recognised and valued by health staff. This bridge building work was given consistently strong feedback regarding 'softer' benefits of the pilot.

Recommendation

Access to RAID significantly improved inter-professional awareness, shared knowledge and respect between police and mental health staff.

Access to RAID, the use of s.136 powers and compulsion

Officers reflected that external public scrutiny by the press and media and the presence of the IPCC compounded the need for officers to be risk aware in the context of mental health but also led them to be more risk averse.

> *'Sometimes using s.136 is the only option to cover yourself*…' (Police Officer)

Frontline officers reflected on the consideration and use of s.136 in the context of the RAID pilot. Overall, officers suggested they were now felt better informed in making decisions; they felt a reduced need to resort to immediate use of s.136; they had increased access to alternative services and resources. Access to RAID by phone also helped to inform and confirm decisions about when to use s.136 and promoted defensible decision-making where they were not sure how to proceed.

However, officers did clearly comment that decisions about the use of s.136 had to be led by an individual's immediate presentation and actions, the level of distress or high risk behaviour present and assessment of viable alternatives to compulsion e.g. information of forthcoming regular medical appointments, information sharing about care plans and contingencies for crisis care, advice about what to do and where to go.

Officers suggested access to RAID informed their decisions to use s.136 and helped them to '*target use of s.136 to people in need'*. For individuals who were the subject of repeat

calls to the police, access to RAID seemed especially valued, as officers felt they could build on their previous experiences and respond quicker to a situation.

Access to RAID in the context of the National Decision Making model

Officers acknowledged their obligations to use the police National Decision Making Model (NDM). No clear explanation for use or non-use of the NDM emerged during the course of the evaluation. However, where officers who used NDM did comment they suggested access to RAID had helped inform their decisions and decision making, assisting them to construct a rationale for action.

> '(Using RAID)…*supports the effectiveness of police officers and the national Decision-Making Model…this has merit…'* (Police Officer)

This merits further consideration.

Difficulties, challenges and issues relating to the pilot

Although endorsement of the RAID pilot was very positive overall, a number of difficulties and problems were identified during the evaluation.

Technical issues impacting on communication

Calls not answered

On a relatively small number of occasions calls to RAID were not answered. Technical problems were acknowledged by RAID with regard to the quality of mobile phones they held and signal strength in certain locations e.g. parts of the Accident and Emergency department. A new model of mobile phone is due to be trialled in the near future. If this is not successful use of a bleep system is being considered as a possible alternative or additional option.

Use of radio sets and mobile phones to access RAID

Police radio sets are expensive items of police equipment and the responsibility of individual officers to maintain and keep. As a protection for officers, radio sets are always on and tuned to the main police frequency. Officers make and receive calls through this secure police network. If officers need assistance they use their radio sets to call for immediate help. To access RAID using a mobile network via the radio set, the radio set has to be in effect disconnected from the police network for the period of the call. Officers were very reluctant for safety reasons to disconnect their radio sets from police networks as this meant they could not call for help if urgently required and could not respond to calls for immediate assistance from colleagues.

As the radio sets also relied on listening to mobile phone calls with an ear piece, officers expressed reluctance to share what they considered a personal item of equipment and essentially felt sharing earpieces was not hygienic.

As an alternative to using a radio set, officers seemed to frequently rely on the use of personal mobile phones. Carrying personal phones appears common custom and practice

for officers out on beats, patrols and calls. Officers suggested that using their personal phones in this way was preferable to using their radio sets, for the reasons outlined above. In addition, the RAID phone number is not a public access number, so passing on the dedicated number to members of the public is not an option.

In addition, carrying a mobile phone as well as a radio set was viewed as advantageous by some officers, but not all, as they were sometimes willing to allow the person they were dealing with to use the phone being carried by the officer. This practise was not uniformly applied.

This did present a dilemma for some officers in terms of whether using a personally owned private mobile phone to call RAID was appropriate or a reasonable expectation. This merits further exploration.

RAID, time and the preferred and agreed Place of Safety

In the view of both the police and health staff, the RAID pilot had genuinely improved communication and information, management of risk, the coordination of s.136 decisions and custody and transfer to hospital under s.136. However, staff did comment that there were still occasions where disagreement about the appropriate designated Place of Safety had significantly impeded and delayed the progress of assessments and ultimately satisfactory, safe and timely resolution. This seemed particularly the case where alcohol, drugs and/or risk of violent behaviour were significant and there was disagreement about the level of risk presented and the appropriate setting for a person to be located. This seemed to mainly focus on whether a person should be in a Custody Suite, the RAID Suite or managed in a local or more secure psychiatric unit. It is probably fair to say these points of disagreement are possibly outside the remit of the RAID pilot and more directly relevant to interpretation and operationalisation of local GMP-Trust protocols.

Conclusion

The pilot scheme has become established and valued by police staff in Oldham. The 24 hour dedicated phone line has been a key feature making it easily accessible. Police officers clearly value the advice and support that it offers. The main benefits in terms of service provision are the ways that it allows officers to gain access to expert mental health support and advice, share appropriate information and agree a course of action. The scheme has also helped to foster joint working by staff from the NHS and GMP. The pilot fits very well with the broader aims of the Mental Health Care Crisis Concordat to improve the standards of care provided to those experiencing any form of mental health distress.

The pilot has recently been extended. The evaluation findings support this decision. There is potential for this model of policing and mental health triage to be utilised across Greater Manchester and shared nationally. There is a need for further monitoring and research in this area.

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Appendix

1: RAID Project Monthly Analysis (Ian Cummins)

RAID PROJECT MONTHLY ANALYSIS: PROJECT SUMMARY

2/12/13 -31/5/14

Total number of calls: **673**

Section 136: **42**

Category	*Yes*	*No*	*Incomplete info*
Use of RAID	**217**	**451**	**5**
Section 136 considered	**78**	**585**	**10**
Write up Using NDM	**66**	**605**	**2**
Conveyed to hospital	**282**	**389**	**2**

Category	*Number of calls*
Alcohol/drugs not identified	**518**
Alcohol/drugs a factor	**134**
Not recorded	**2**
Alcohol + O/D	**13**
O/D	**5**
Epilepsy	**1**

Category	*Number of calls*
Self-harm/suicide/OD	**220**
MH history identified	**87**
Concerns – e.g MFH	**147**
Other – no clear MH issue identified	**67**
Delusional/Bizarre ideas outlined	**44**
Adult safeguarding	**48**
MHA – S.136	**42**
MHA – support for assessment etc	**18**

Beat codes	*Number of calls*
Q1	**264**
Q2	**304**
Address given	**105**

RAID PROJECT MONTLY ANALYSIS

Month: *December 2013*

Total: 119

Section 136 MHA: 5

Category	*Yes*	*No*	*Incomplete info*
Use of RAID	**34**	**82**	**3**
Section 136 considered	**13**	**98**	**8**
Write up Using NDM	**15**	**104**	
Conveyed to hospital	**65**	**54**	

Category	*Number of calls*
Alcohol/drugs not identified	**68**
Alcohol/drugs a factor	**43**
Not recorded	**0**
Alcohol + O/D	**5**
O/D	**2**
Epilepsy	**1**

Category	*Number of calls*
Self-harm/suicide/OD	**47**
MH history identified	**27**
Concerns – e.g MFH	**17**
Other – no clear MH issue identified	**10**
Delusional/Bizarre ideas outlined	**8**
Adult safeguarding	**4**
MHA – S.136	**5**
MHA – support for assessment etc	**1**

Beat codes	*Number of calls*
Q1	**39**
Q2	**58**
Q3	**1**
Address given	**21**

RAID PROJECT MONTLY ANALYSIS

Month: *January 2014*

Total: 97

Section 136*:* 4

Category	*Yes*	*No*	*Incomplete info*
Use of RAID	**27**	**70**	
Section 136 considered	**17**	**80**	
Write up Using NDM	**13**	**84**	
Conveyed to hospital	**32**	**65**	

Category	*Number of calls*
Alcohol/drugs not identified	**88**
Alcohol/drugs a factor	**9**
Not recorded	**0**
Alcohol + O/D	**0**
O/D	**0**
Epilepsy	**0**

Category	*Number of calls*
Self-harm/suicide/OD	**28**
MH history identified	**19**
Concerns – e.g MFH	**16**
Other – no clear MH issue identified	**11**
Delusional/Bizarre ideas outlined	**6**
Adult safeguarding	**9**
MHA – S.136	**4**
MHA – support for assessment etc	**4**

Beat codes	*Number of calls*
Q1	**46**
Q2	**43**
Q3	**0**
Address given	**8**

RAID PROJECT MONTLY ANALYSIS

Month: *February 2014*

Total: 100

Section 136: 4

Category	*Yes*	*No*	*Incomplete info*
Use of RAID	**28**	**72**	
Section 136 considered	**1**	**99**	
Write up Using NDM	**16**	**84**	
Conveyed to hospital	**35**	**65**	

Category	*Number of calls*
Alcohol/drugs not identified	**79**
Alcohol/drugs a factor	**19**
Not recorded	**0**
Alcohol + O/D	**1**
O/D	**1**
Epilepsy	**0**

Category	*Number of calls*
Self-harm/suicide/OD	**28**
MH history identified	**11**
Concerns – e.g MFH	**30**
Other – no clear MH issue identified	**13**
Delusional/Bizarre ideas outlined	**3**
Adult safeguarding	**7**
MHA – S.136	**4**
MHA – support for assessment etc	**4**

Beat codes	*Number of calls*
Q1	**37**
Q2	**52**
Q3	**0**
Address given	**11**

RAID PROJECT MONTLY ANALYSIS

Month: *March 2014*

Total: 134

Section 136 MHA : 11

Category	*Yes*	*No*	*Incomplete info*
Use of RAID	**46**	**88**	
Section 136 considered	**12**	**122**	
Write up Using NDM	**12**	**122**	
Conveyed to hospital	**58**	**76**	

Category	*Number of calls*
Alcohol/drugs not identified	**100**
Alcohol/drugs a factor	**34**
Not recorded	**0**
Alcohol + O/D	**0**
O/D	**0**
Epilepsy	**0**

Category	*Number of calls*
Self-harm/suicide/OD	**45**
MH history identified	**8**
Concerns – e.g MFH	**30**
Other – no clear MH issue identified	**14**
Delusional/Bizarre ideas outlined	**13**
Adult safeguarding	**9**
MHA – S.136	**11**
MHA – support for assessment etc	**4**

Beat codes	*Number of calls*
Q1	**49**
Q2	**57**
Q3	**0**
Address given	**28**

RAID PROJECT MONTLY ANALYSIS

Month: *April 2014*

Total: 96

Section 136 MHA: 9

Category	*Yes*	*No*	*Incomplete info*
Use of RAID	**42**	**52**	**2**
Section 136 considered	**21**	**73**	**2**
Write up Using NDM	**6**	**88**	**2**
Conveyed to hospital	**40**	**54**	**2**

Category	*Number of calls*
Alcohol/drugs not identified	**79**
Alcohol/drugs a factor	**9**
Not recorded	**2**
Alcohol + O/D	**4**
O/D	**2**
Epilepsy	**0**

Category	*Number of calls*
Self-harm/suicide/OD	**34**
MH history identified	**8**
Concerns – e.g MFH	**25**
Other – no clear MH issue identified	**8**
Delusional/Bizarre ideas outlined	**5**
Adult safeguarding	**5**
MHA – S.136	**9**
MHA – support for assessment etc	**2**

Beat codes	*Number of calls*
Q1	**41**
Q2	**35**
Q3	**0**
Address given	**20**

RAID PROJECT MONTLY ANALYSIS

Month: *May 2014*

Total: 127

Section 136 MHA: 9

Category	*Yes*	*No*	*Incomplete info*
Use of RAID	**40**	**87**	
Section 136 considered	**14**	**113**	
Write up Using NDM	**4**	**123**	
Conveyed to hospital	**52**	**75**	

Category	*Number of calls*
Alcohol/drugs not identified	**104**
Alcohol/drugs a factor	**20**
Not recorded	**0**
Alcohol + O/D	**3**
O/D	**0**
Epilepsy	**0**

Category	*Number of calls*
Self-harm/suicide/OD	**38**
MH history identified	**14**
Concerns – e.g MFH	**29**
Other – no clear MH issue identified	**11**
Delusional/Bizarre ideas outlined	**9**
Adult safeguarding	**14**
MHA – S.136	**9**
MHA – support for assessment etc	**3**

Beat codes	*Number of calls*
Q1	**52**
Q2	**59**
Q3	**0**
Address given	**16**

Mental Health/Police Phone Triage pilot Briefing paper

Oldham Borough Mental Health Services, Pennine Care NHS Foundation Trust & Greater Manchester Police, Oldham Division

2nd December 2013

The Status Quo

Currently, when a police officer or PCSO initially find themselves dealing with an individual with mental ill health issues, whether in crisis or as an underlying part of an incident, they do so in isolation of information from other services. This is not a criticism; simply the way service provision has evolved over many years.

The RAID team are currently based in A&E at Royal Oldham hospital. When an individual presents at A&E with medical and mental health crisis, the RAID team provide a frontline assessment of their mental wellbeing and decide on the best course of further action.

The Police and RAID teams rarely come into contact and do not share information. However, reducing budgets and increasing demand require that we pool resources and look to intervene much further upstream of an issue. The increased scrutiny on all public service means that our decisions are looked at by bodies such as the IPCC, the CQC, Coroners and the media. Our decision-making will be more robust if we have access to appropriate information and intelligence about an individual's background.

Background Data

Since 1st April 2013, Oldham division have used their powers under section 136 Mental Health Act 38 times to protect vulnerable individuals in crisis. As a general rule, only around 20-25% of these individuals are sectioned under the Mental Health Act. Some are admitted informally for a short period, some are given follow-up care, others are assessed as having no mental health issues.

When we look across the spectrum of police incidents that Oldham officers have dealt with since 1st April 2013, over 900 have involved some level of mental health issue. Many of these individuals are repeat callers to the police and other public services.

The Pilot

As of 2 December 2013, the current RAID team will be appropriately staffed on a 24/7 basis to provide a service to officers who are dealing with individuals in crisis and with underlying mental health issues.

If an officer is considering utilising their powers under section 136 Mental Health Act, a professional discussion will be had between the officer and RAID practitioner. This will include what both services know about the individual, previous mental health history, current care plans and how the person is presenting. A decision will be then be taken about the appropriate course of action and the decision recorded by both services. If the decision is to use section 136, the RAID practitioner will meet the officer at the s136 suite, A&E or custody.

Officers will also be able to use the phone line for advice and signposting for any incidents where mental health is a factor.

The project will run for an initial three month pilot period with an agreed data collection set to support the pilot process and evaluation.

Intended Outcomes

- More appropriate and dignified treatment for the individual in crisis
- Reduction in demand of frequent callers due to mental health issues being addressed
- Reduction in police time dealing with inappropriate s136 cases
- Reduction in Oldham Borough Mental Health team time dealing with inappropriate s136 cases
- More robust decision-making at incidents where mental health is a factor
- To provide an evidence base for future phone triage models

We are hopeful of an independent evaluation, subject to funding being agreed.

3: National Decision Model

ASSOCIATION OF
CHIEF POLICE OFFICERS

The National Decision Model

Introduction

1. The Association of Chief Police Officers (ACPO) has approved the adoption of a single National Decision Model (NDM) for the Police Service. The ACPO Ethics Portfolio and the National Risk Coordination Group have developed this values-based tool to provide a simple, logical and evidence-based approach to making policing decisions.

2. Ever since its creation the police service has been making good decisions. Police decision making, however, is often complex; decisions are required in difficult circumstances and they are open to challenge. We must improve our decision making, and where the outcome is not what we wanted, we have to learn. Adopting the NDM is part of a concerted drive to ensure a greater focus on delivering the mission of policing, acting in accordance with our values, enhancing the use of discretion, reducing risk aversion and supporting the appropriate allocation of limited policing resources as the demand for them increases.

3. Understanding and practising the NDM will help police officers and staff develop the professional judgement necessary to make effective policing decisions. It will also help them learn from decisions that have a successful outcomes, as well as the small proportion that do not.

4. Decision makers will receive the support of their organisation in all instances where they can demonstrate that their decisions were assessed and managed reasonably in the circumstances existing at the time. This applies even where harm results from their decisions and actions.

Application

5. The NDM is suitable for all decisions. It can be applied to spontaneous incidents or planned operations, by an individual or teams of people, and to both operational and non-operational situations. Decision makers can use it to structure a rationale of what they did during an incident and why. Managers and others can use it to review decisions and actions taken. The inherent flexibility of the NDM means that it can easily be expanded for specialist areas of policing. In every case, the model stays the same, but users decide for themselves what questions and considerations they apply at each stage.

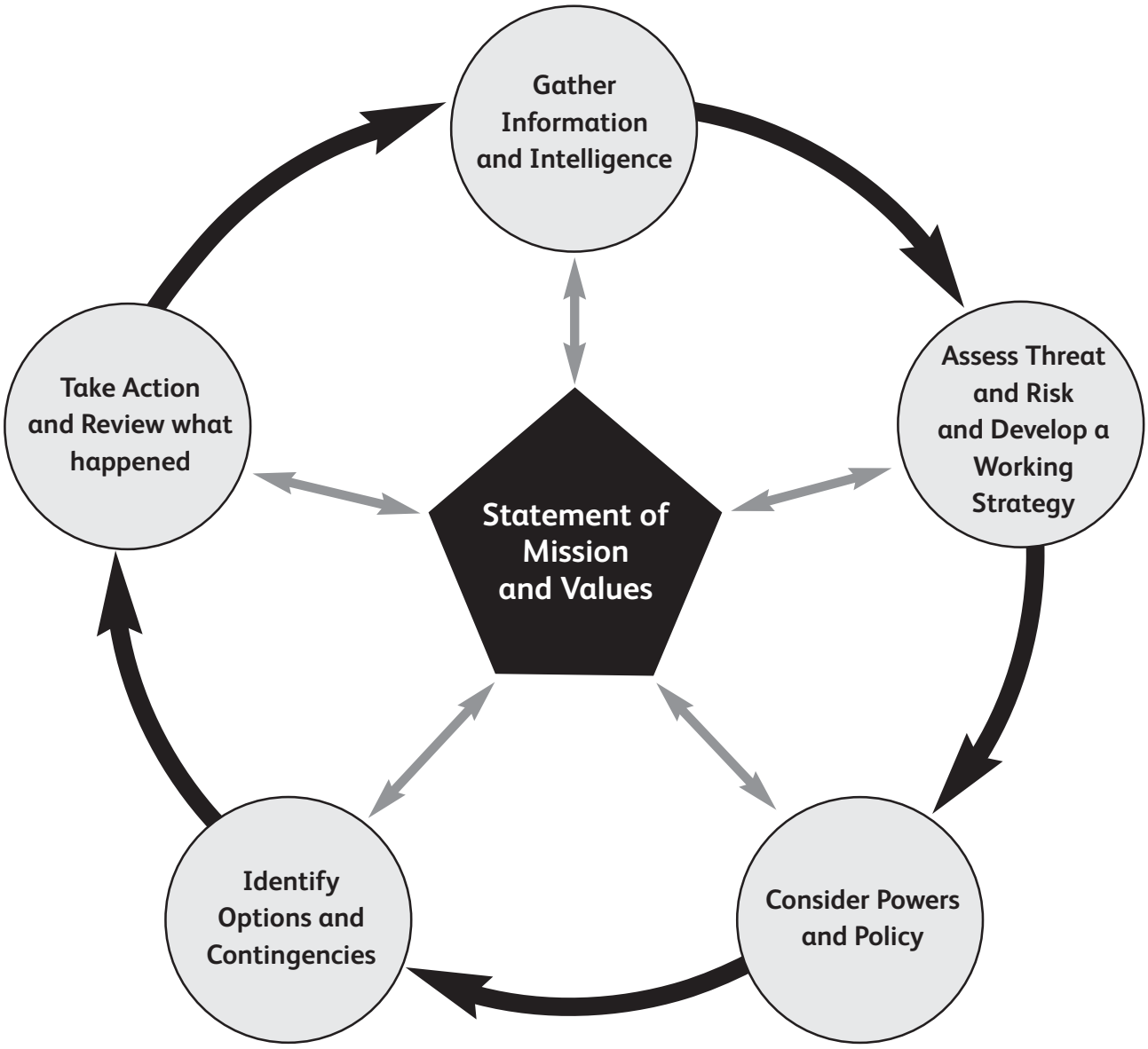
6. In a fast-moving incident, the Police Service recognises that it may not always be possible to segregate thinking or response according to each phase of the model. In such cases, the main priority of decision makers is to keep in mind their overarching mission.

The Model

7. The National Decision Model has six key elements. Each component provides the user with an area for focus and consideration (see **Figure 1**).

The National Decision Model

Figure 1: The National Decision Model



The National Decision Model

8. The pentagon at the centre of the NDM contains the **Statement of Mission and Values** (ACPO, July 2011) for the Police Service.

> The mission of the police is to make communities safer by upholding the law fairly and firmly; preventing crime and antisocial behaviour; keeping the peace; protecting and reassuring communities; investigating crime and bringing offenders to justice.
>
> We will act with integrity, compassion, courtesy and patience, showing neither fear nor favour in what we do. We will be sensitive to the needs and dignity of victims and demonstrate respect for the human rights of all.
>
> We will use discretion, professional judgement and common sense to guide us and will be accountable for our decisions and actions. We will respond to well-founded criticism with a willingness to learn and change.
>
> We will work with communities and partners, listening to their views, building their trust and confidence, making every effort to understand and meet their needs.
>
> We will not be distracted from our mission through fear of being criticised. In identifying and managing risk, we will seek to achieve successful outcomes and to reduce the risk of harm to individuals and communities.
>
> In the face of violence we will be professional, calm and restrained and will apply only that force which is necessary to accomplish our lawful duty.
>
> Our commitment is to deliver a service that we and those we serve can be proud of and which keeps our communities safe.

9. It is the need to keep this statement of mission and values – with its integral recognition of the necessity to take risks and protect human rights – at the heart of every decision that differentiates the NDM from other decision-making models. This is also why it now replaces all models previously used by the Police Service, including the Conflict Management Model (CMM).

10. The corners of the values pentagon connect to and support the five stages of the decision-making process. One step logically follows another, but the model allows for continual re-assessment of a situation and the return to former steps when necessary.

Explaining the NDM

11. The pentagon at the centre of the NDM reminds police officers and staff to keep the police mission and values at the heart of the decision-making process.

12. The following table gives examples of the types of questions and considerations that decision makers should think about, but they are not the only ones for every situation. They are a prompt or aid only. It would not be helpful to be more specific; decision makers must be free to interpret the NDM for themselves, reasonably and according to the circumstances facing them at any given time.

The National Decision Model

Central Pentagon: VALUES **Statement of Mission and Values**

Throughout the situation, you could ask yourself:

- Is what I'm considering consistent with the Statement of Mission and Values?
  (You are wanting to ensure that decisions reflect an understanding of the police duty to act with integrity, be willing to take risks and protect the human rights of all.)
- What would the Police Service expect of me in this situation?
- What would any victim(s), the affected community and the wider public expect of me in this situation?

Stage 1: INFORMATION **Gather Information and Intelligence**

During this stage the decision maker defines the situation (ie, defines what is happening or has happened) and clarifies matters relating to any initial information and intelligence.

- What is happening?
- What do I know so far?
- What further information (or intelligence) do I want/need?

Stage 2: ASSESSMENT **Assess Threat and Risk and Develop a Working Strategy**

This stage involves assessing the situation, including any specific threat, the risk of harm and the potential for benefits.

- Do I need to take action immediately?
- Do I need to seek more information?
- What could go wrong? (and what could go well?)
- How probable is the risk of harm?
- How serious would it be?
- Is that level of risk acceptable?
- Is this a situation for the police alone to deal with?
- Am I the appropriate person to deal with this?

Develop a **working strategy** to guide subsequent stages by asking yourself:

- What am I trying to achieve?
  (Amongst other things consider discrimination, good relations and equal opportunities.)

Stage 3: POWERS AND POLICY **Consider Policy and Powers**

This stage involves considering what powers, policies and legislation might be applicable in this particular situation.

- What police powers might be required?
- Is there any national guidance covering this type of situation?
- Do any local organisational policies or guidelines apply?
- What legislation might apply?

As long as there is a good rationale for doing so, it may be reasonable to act outside policy.

The National Decision Model

Stage 4: OPTIONS **Identify Options and Contingencies**

This stage involves considering the different ways to make a particular decision (or resolve a situation) with the least risk of harm.

Options

- What options are open to me? Consider the immediacy of any threat; the limits of information to hand; the amount of time available; available resources and support; your own knowledge, experience and skills; the impact of potential actions on the situation and the public.

If you have to account for your decision, will you be able to say it was:

- Proportionate, legitimate, necessary and ethical?
- Reasonable in the circumstances facing you at the time?

Contingencies

- What will I do if things do not happen as I anticipate?

Stage 5: ACTION and REVIEW **Take Action and Review What Happened**

This stage requires decision makers to make and implement appropriate decisions. It also requires decision makers, once an incident is over, to review what happened.

Action

Respond
- Implement the option you have selected;
- Does anyone else need to know what you have decided?

Record:
- If you think it appropriate, record what you did and why.

Monitor:
- What happened as a result of your decision?
- Was it what you wanted or expected to happen?

If the incident is continuing, go through the NDM again as necessary

Review

If the incident is over, review your decisions, using the NDM

- What lessons can you take from how things turned out?
- What might you do differently next time?

Recording What Was Done and Why

13. Decision-makers are accountable for their decisions and must be prepared to provide a rationale for what they did and why. In some circumstances the need to document decisions is prescribed by statute, required by organisational strategies, policies or local practices, or left to the decision-maker's discretion.

14. Whatever the circumstances, the Police Service recognises that it is impossible to record every single decision and that not all decisions need to be recorded. In most instances professional judgement should guide whether or not to record the rationale, as well as the nature and extent of any explanation. The record should be proportionate to the seriousness of the situation or incident, particularly if this involves a risk of harm to a person.

15. In addition to using the NDM to determine their actions, decision makers may also find it useful for structuring the rationale behind their decisions.

The National Decision Model

The mnemonic VIAPOAR will help users remember the key elements of the NDM.

V	**V**alues
I	**I**nformation
A	**A**ssessment
P	**P**owers and policy
O	**O**ptions
A	**A**ction
R	**R**eview

REVIEWS/DEBRIEFS

The NDM is ideal for examining decisions made and action taken, whether by a supervisor, an informal investigation or a formal inquiry. Examples of questions and considerations are:

Values

- How were the police mission and values, risk, and the protection of human rights kept in mind during the situation?

Information

- What information/intelligence was available?

Assessment

- What factors (potential benefits and harms) were assessed?
- What threat assessment methods were used (if any)?
- Was a working strategy implemented? Was it appropriate?

Powers and policy

- Were there any powers, policies and legislation that should have been considered?
- If policy was not followed, was this reasonable in the circumstances?

Options

- How were feasible options identified and assessed?

Action and Review

- Were decisions proportionate, legitimate, necessary and ethical?
- Were decisions reasonable in the circumstances facing the decision maker?
- Were decisions communicated effectively?
- Were decisions and the rationale for them recorded as appropriate?
- Were decisions monitored and reassessed where necessary?
- What lessons can be taken from the outcomes and how the decisions were made?

For Supervisors

- Did you recognise and acknowledge instances of initiative or good decisions (were they passed to managers where appropriate)?
- Did you recognise and challenge instances of poor decisions?

Even where the outcome was not what was hoped for, if the decision taken by your staff was reasonable given the circumstances, they deserve your support and that of the organisation.

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