SOUTH WALES PSC MENTAL HEALTH TRIAGE: SECOND EVALUATION

Evaluation Report: June 2019-December 2019

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Contents

Acknowledgments

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List of Abbreviations

BCU	Basic Command Unit
ED	Emergency Department
CMHS	Community Mental Health Service
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
HBPoS	Health Based Place of Safety
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services
MH	Mental Health
MHT	Mental Health Tagging
NICL	National Incident Category List
POS	Place of Safety
PCS	Public Service Centre
SWP	South Wales Police

Executive Summary

Background

The South Wales Police (SWP) Public Service Centre (PSC) Mental Health Triage service aims to provide vulnerable persons with a likely or known mental health (MH) concern the right support at first point of contact with the police. The triage pilot was a 'test and learn' exercise that was initially funded for 9 months (December 2018-September 2019); the overarching objective was to ensure such individuals are assessed by specialist MH professionals, and are signposted to appropriate services and pathways depending on the type and urgency of the response. Thus, the service was designed to help meet Welsh MH policy and legislation guidelines that emphasise the significance of early intervention to prevent crisis (i.e., National Assembly for Wales, 2018; Wales Crisis Care Concordat National Action Plan, 2019-2022). Further, the pilot was a response to the Police and Crime Act 2017, which outlined the responsibility of police to consult with appropriate professionals in their decision to detain individuals under S136 of the Mental Health Act. Funding for SWP triage was extended for three months, from 1st January 2020 – 31st March 2020, to allow for a further evaluation of the service.

An initial evaluation based on the first 5 months of the triage pilot (Broome & Davies, 2019) highlighted how the service had positively bridged an information-sharing gap between police and health, allowing specialist MH Nurses access to health data that could inform police decision making and support individuals in MH crisis and distress (the charity MIND defines a MH crisis as being at breaking point (i.e., suicidal feelings, extreme anxiety or psychotic episodes. Mental health distress is defined as frequent emotional stress that effects an individual's ability to think, feel and react (www.mind.org.uk)). Consequently, over the reporting period of the initial evaluation (January-May 2019), the police recorded an 86% decrease in repeat callers and a reduction in the use of S136 in areas where operational staff engaged with triage, thereby reducing demand on both police and health services. This was evidenced in a reduction of police time allocated per MH event (average reduced from 3.46hrs to 2.04hrs) and, as highlighted in interviews with officers, in reductions in deployment of ambulances and Emergency Department (ED) assessments when triage nurses assessed individuals over the phone. Staff across services valued the expertise of triage staff, and especially the support provided to officers to identify the most appropriate response that considered an individual's MH history and personal circumstances.

This second evaluation was commissioned to expand the findings of the initial evaluation and to address some of the limitations identified. This included expanding the evidence and understanding of the possible benefits of the service, and to begin to consider some of the social care impacts of the service and how triage might prevent escalation of MH needs and / or the police and other services responses.

Evaluation Objectives

This report builds upon the initial evaluation of South Wales Police MH triage pilot (Broome & Davies, 2019), to examine the ongoing 'need rate' of triage, S136 rates, demographic patterns and the main issues of concern for incidents into triage. In order to address some of the limitations noted in the previous evaluation, the current evaluation considered potential social and health benefits to triage, to examine how engagement in triage might reduce demand across services by preventing escalation of distress and crisis. This was explored from the perspective of triage service users (direct callers and carers of people experiencing MH concerns) and professionals (i.e., senior health, police and third sector staff). The data for this report covers the period following the first report (June-December 2019) unless otherwise stated.

Methods

The evaluation employed a mixed methods approach, analysing data from police systems (Control Works, Niche data, and National Incident Category List (NICL) outcomes) and health outcomes (S136 referral data and Cwm Taf Health Board Annual Review outcomes). Triage staff presented fifteen triage case examples to the evaluation team providing information on the journey of service users into triage and their outcomes immediately (24 hours) and 1 month after triage. Ten examples of areas of practice relating to assessments and referrals into services and signposting were also provided. Two focus groups were held during a Service Users Event; one for triage service users (direct callers and carers) and one with senior professionals (triage staff, police, Hafal and Swansea Bay University Health Board) to gather their views and experience of triage engagement.

Results

Mental health identification

Data indicates that the steep incline in MH tagging (i.e., an incident recorded as having a MH factor on the triage system) shown in the implementation period (January-May 2019) has stabilised during the current reporting period (June-December 2019). Whilst there was an increase of over 200% of MH tagging across all South Wales Police Basic Command Units (BCU) in December 2019 compared to initiation of triage (January 2019), engagement in all areas stabilised during the latter half of the year. This suggests that triage has overcome some of the implementation challenges identified in the pilot evaluation, including confidence in triage and data protection concerns (Broome & Davies, 2019). Current engagement trends might reflect the ongoing 'need rate' of triage as the service becomes embedded into police practice and services understand the objectives and impact of triage.

Reasons for triage use

Incidents tagged into triage principally reflected the main issue of being 'suicidal' (32%), followed by 'confused/strange behaviour' (21%) or a 'diagnosed MH condition' (17%). However, a notable number of incidents reflected issues that could be categorized as being social concerns (19%) i.e., relationship or housing concerns. Participants in the professionals' focus group discussed how triage has supported both the individual and officers in a number of calls where the core need presented concerned social issues (e.g., loneliness). Further, triage case examples show how triage signposts individuals with social concerns relating to, for example, drug use, money concerns and family issues, to community MH and third sector services to prevent escalation of further distress or crisis. Service users considered de-escalation in cases of distress or crisis to be a significant strength of the service, and felt having a MH professional listen to and believe them could de-escalate a situation. In such situations, triage might act as an intermediary to intervene with individuals who are experiencing distress from poor psychological wellbeing before escalation to crisis, thus reducing demand across other services. It was not possible to examine the potential financial impact of this across services, but the expertise of triage to divert people away from hospital/crisis admissions might lead to significant cost savings across both police and health. However, users identified problems accessing some services they had been signposted to due to community services not having the capacity to provide long-term support. Not being able

to access signposting services was considered to undermine aspects of triage and create distrust with the police, as support often ended following contact with triage.

The use of S136 of the Mental Health Act

The current evaluation identified several positive outcomes of triage engagement relating to S136 use, partnership working and triage service user outcomes. Since initiation of triage there has been a 21% overall reduction of S136 use across the force (comparing rates from 2018-2019). Time series analysis of percentage changes in S136 use in 2019 compared to 2018, showed a downward trend in S136 detentions during the current reporting period, with the greatest difference seen in December 2019; down 51% compared to December 2018. Western BCU (covering a similar footprint to Swansea Bay University Health Board i.e., Swansea, Neath and Port Talbot) had the greatest reduction, with a 36% decrease in 2019 compared to the previous year. Additionally, Northern (i.e., Rhondda, Merthyr, Cynon) and Eastern (i.e., Cardiff City Centre, Llanishen and Rumney) (both with footprints similar to Cwm Taf and Cardiff & Vale) had a decrease of 8% and 4% respectively; however, Central BCU (i.e., Maesteg, Bridgend and Vale of Glamorgan) (Cwm Taf) had a slight increase of 4% in S136 use in 2019. The decrease in S136 use in Western, Northern and Eastern led to an estimated £231,743 opportunity cost reduction in 2019 for activity within the police, the NHS, ambulance service and local authorities. The greatest saving was in Western (Swansea Bay: £174,624), whereas Central (Cwm Taf) had an estimated increase of £11,424 in 2019. The two areas with the highest and lowest engagement activity with triage respectively. Please see appendix A for the BCU boundaries, sectors wards and stations.

The total conservatively estimated opportunity cost savings from reduced S136 use (£220,303) across South Wales covers just over two thirds of the annual service cost for triage (£321,000). However, the true opportunity costs might be much higher as this is based on costs for S136 detentions lasting an average of 3-4 hours. Yet, the Independent Police Complaints Commission (IPCC) reports S136 detentions last an average of 9 hours. Thus, savings might be 3 times higher than those reported here, as is the view of Senior Management in South Wales Police. It was not possible to explore factors outside of triage that might have affected differences in S136 outcomes across the BCUs, such as sufficiency of provision, staff resources and provision for individuals who might be violent or intoxicated. However, the cost calculations show higher estimated savings in BCU areas

where front-line staff seek the expertise of triage staff. Thus, showing the potential savings triage engagement can have across police, health and local authorities by offering alternative strategies in the management of MH incidents beyond S136 use.

Triage outcomes

Professionals agreed that more robust approaches to measuring triage outcomes across service demands are needed, such as using distress ratings during calls, routine follow-up, and monitoring impacts on other services (e.g. where diversion of some sort takes place). For this to work there need to be in-built mechanisms across services and systems to follow up the outcomes of individuals referred to MH and third sector services. Whilst triage enables a multi-agency response in the management of individuals with MH concerns, assessment of multi-agency follow-up is essential to ensure triage outcomes, in terms of impact on both the individual and services, are measurable in the long-term.

Key Findings

- Triage is an opportunity to respond effectively to individuals with ongoing needs and promote partnership working across services to ensure preventative support is in place for the individual.
- There was an increase of over 200% of MH tagging across all South Wales Police Basic Command Units (BCU) in December 2019 compared to initiation of triage.
- Use of the triage service in all BCU areas stabilised during the latter half of the year (June-December 2019); these figures may represent the likely ongoing ‘need rate’ for the service.
- The main issue in a majority of calls was categorized as ‘suicidal’ (32%), followed by ‘confusion/strange behaviour’ (21%) or a ‘diagnosed MH condition (17%). However, 19% could be categorized as representing social or lifestyle concerns (i.e., housing or relationships).
- Triage might act as an intermediary to intervene with individuals who are experiencing distress from poor psychological wellbeing before escalation to crisis, thus reducing demand across services.
- There was a 21% decrease in S136 use across the force in 2019 compared to 2018 with a 51% decrease in December 2019, compared to December 2018.

- Decrease in S136 use in Western, Eastern and Northern has led to an estimated opportunity cost reduction of £231,743 in 2019 across police, the NHS, ambulance service and local authority. Overall, conservatively estimated costs savings from S136 use in 2019 compared to 2018 (£220,303) covers just over two third of the total service costs for triage (£321,000), showing how triage engagement can lead to potential cost savings across police and health.
- Triage provides control and front-line staff with education and learning opportunities in the alternative management of MH incidents, including services or strategies that service users might access to address their concerns/needs.
- The reduction in repeat calls shows that triage de-escalation and support practices are pro-active in identifying and responding to the root cause of repeat calling. It would be worth calculating the opportunity cost savings associated with this.
- An in-built mechanism across services is needed to assess the long-term impact of triage on individuals and service demand, including follow up to determine the impact of signposting to MH and third sector services.

The Minster for Health and Social Services proposes that a multi-agency response is necessary to ensure individuals receive the right support from MH specialists (National Assembly for Wales, 2019). MH triage is an example of joint working between the police and health in achieving this. Further, triage might ensure that better pathways for individuals experiencing MH concerns are in place to prevent escalation to crisis and increased demand across services, as prioritised in the South Wales Police & Crime Plan 2018-2021.

Context

The National Police Chiefs Council report an upward trajectory of MH related demand, with the police often being the first-point of contact for those suffering with mental ill health, even when a crime has not been committed (HMICFRS, 2018). A National Assembly for Wales Health, Social Care and Sport Committee short inquiry found that a number of stakeholders consider the police are positively responding to those in MH crisis (National Assembly for Wales, 2019). For example, the number of people in MH crisis that have been held in police custody has reduced in Wales, and where adults have been detained, MH provision has been good (National Assembly for Wales, 2019). However, little is known about the outcomes for these individuals (Senedd, 2020) and there are concerns that the correct professionals should be supporting those experiencing mental distress/crisis (National Assembly for Wales, 2019). For instance, the council report that the majority of individuals in contact with the police have health, welfare or social care concerns rather than being a case of immediate risk needing detention under S136 of the Mental Health Act, and question whether police are the best point of contact in such cases (HMICFRS, 2018). From a police perspective, McLean and Marshall (2010) report that the police often feel unsupported by MH services when referring people for assessments, and lack the necessary knowledge to support people with MH concerns. However, within Wales, the Minister for Health and Social Services has stated that police and health services need to work collaboratively to guide decision-making that is in the best interest of the individual involved (National Assembly for Wales, 2019). Mental health triage schemes are one example of this, in which Community Psychiatric Nurses (CPN) are based in police control rooms, or on the streets, to advise officers responding to MH calls. This is intended to directly overcome barriers to effective collaboration between police and health in supporting individuals with MH concern.

South Wales Police initiated a telephone triage service in December 2018, whereby CPNs provide advice to front-line officers and control room staff on the management of MH incidents. Triage staff can also speak directly to the individual to conduct over the phone assessments and provide appropriate support and advice. The service was developed in partnership with three University Health Boards, namely Cardiff & Vale, Cwm Taf and Swansea Bay (in April 2019, ABM University Health Board (UHB) was reconfigured with Bridgend based services moving to Cwm Taff UHB and Swansea and Neath services forming the new Swansea Bay UHB). South Wales Police funded this service from January-December 2019, and the health boards provided resources from the 1st January 2020 onwards. However,

the National Police Chiefs' Council has questioned the long-term sustainability of using police resources for this in light of diminished police funding. For South Wales Police, funding from the UK Government has reduced by 21% in cash terms (over 35% in real terms) since 2010, meaning innovative approaches to meeting policing priorities is needed (South Wales Police & Crime Plan, 2018-2021).

Independent evaluation of the first 6 months of the triage service found that, whilst the number of S136 detentions increased to 2,256 in Wales in 2018/19 compared to 1,955 in 2017/18 (Home Office, 2019), a decrease in detentions was shown in the areas that engaged with the triage service (Broome & Davies, 2019). Across the four Basic Command Units (BCU), Western BCU (co-terminus with Swansea Bay University Health Board) had the highest engagement with triage and the greatest reduction in S136 use in June 2019, compared to January 2019 (70% drop). Conversely, the greatest rise was in Central BCU (Cwm Taf) with the fewest MH tags (Broome & Davies, 2019). A tag indicates an incident has a MH factor and is recorded on the triage system. Whilst the evaluation could not consider other factors that might have contributed to the reduction in S136 use in Western, interviews with officers found they considered triage to be directly and positively shaping police response. This indicates that the South Wales Police triage model is meeting Welsh MH policy and legislation guidelines that emphasise the importance of early intervention to prevent crisis (i.e., National Assembly for Wales, 2018; Wales Crisis Care Concordat National Action Plan, 2019-2022). From the staff surveyed within the first evaluation, 84% (n=98) of police respondents and 77% (n=27) of crisis staff considered triage to be a valuable service, although some crisis staff considered it more valuable to police than health. This was discussed in the context of increased demand on crisis from inappropriate referrals, however this principally occurred when officers did not follow triage processes (Broome & Davies, 2019).

In the first evaluation, it was not possible to explore the role of social stressors as a source of police call out and triage use, yet this is an important factor in determining how triage might prevent individuals escalating to crisis. Research shows that psychological suffering caused by social concerns (i.e., work, family and other personal circumstance) can lead to diagnosable mental disorders, poor social outcomes (i.e., aggressive or violent behaviour) and/or risky behaviour such as drug use or criminal activity (Suldo & Shaffer-Hudkins, 2008). Yet, the research is unclear about how police MH triage models might affect health and social outcomes and consequently service demand across police and health. Current

triage evaluations primarily focus on organizational and service-level outcomes, such as S136 detention rates, arrest rates, MH referrals, police time on MH related incidents and officer safety (Rodgers, Thomas, Dalton, Harden, & Eastwood, 2019). Yet, the impact of early intervention from triage to prevent escalation of MH distress or crisis from social and life factors have not been examined either from the perspective of triage users or from services. The increase in S136 detentions across Wales noted above might suggest that services are not acting early enough to prevent crisis (National Assembly, 2019), or that S136 is used when other options might be more suitable. Therefore, triage might act as an intermediary to intervene when individuals are experiencing poor psychological wellbeing and health before problems escalate, or provide additional options to the response officers on the scene. Thus, effective triage is likely to offer benefits directly to serve users and to organisations across police, health, social care and the third sector.

Background to the Evaluation

South Wales Police have experienced a steady increase in the number of MH related calls year on year since 2012 through both the Public Service Centre (PSC) and on the frontline, with an estimated 10% of policing incidents having a MH dimension (Senedd, 2020). A Mental Health Demand Day undertaken within the force in 2018 saw 200 MH incidents requiring police involvement recorded, represented 9.5% of all incidents that day. Developing better pathways for individuals experiencing mental distress or crisis was outlined as a priority in the South Wales Police & Crime Plan 2018-2021. This included providing individuals with early support to prevent escalation within the Criminal Justice System and ensuring non-custodial places of safety were utilized for individuals detained under S136. Essential to this is a focus on partnership working across policing, health and the third sector, with the potential for this to impact positively on those experiencing MH concerns, especially out-of-hours (National Welsh Assembly, 2018).

A report produced by the National Assembly for Wales entitled ‘Everybody’s business – A report on suicide prevention in Wales’ (2018) recommended that the Welsh Government develop an All-Wales triage model which would see community psychiatric nurses based in police control rooms with the aim to improve police management of crisis situations. The need for real time advice and clinical support from MH professionals in police control rooms was also noted as a core principle in the management of individuals in MH crisis in the Wales

Crisis Concordat National Action Plan 2019-22. In response to this, the South Wales Police Mental Health Triage Public Service Centre (PSC) Pilot is a 'test and learn' scheme with the aim to ensure persons in mental health crisis and/or distress are provided with the most professional and appropriate support and intervention at first point of contact, and that Section 136 of the Mental Health Act is used appropriately by officers. There have been two evaluations produced so far which have identified several benefits and positive outcomes to this service. The Public Protection Department within South Wales Police produced an evaluation of the first 12 weeks (14.01.19 to the 14.04.19), and identified the following key findings:

- In the first three months of operation, 1,700 incidents were directed to the triage team, with approximately half of these already known to mental health services.
- The force saw a reduction of two-thirds in the number of people with mental health issues in custody.
- The number of persons recorded as in crisis reduced from 50% to a low of 7%, averaging at 16%. This is predominately attributed to triage access to health information and developed relationships with CAMHs and other local mental health services.
- In 7.2% of contacts, triage prevented officer deployment and an average 34% of contacts with triage input/engagement resulted in no referral/no further input required, potentially reducing demand on services.
- When transport to A&E or crisis services by police was essential, triage contacted services leading to a reduction in waiting time.

A further independent evaluation of the first 6-months of the pilot was commissioned by South Wales Police and conducted by Swansea University (Broome & Davies, 2019). In addition to the earlier reported findings, the key outcomes were:

- Demand for triage is high and beyond initial expectations. There was a 191% increase in service use between January and May 2019 as the service became established.
- Police and health recognize that officers want additional support to manage MH concerns and regard triage as a supportive service that meets this demand.
- Officers surveyed stated that triage provided access to information and advice which meant they were less likely to detain under S136 or take individuals to the Emergency

Department (ED). Assessment and decision making by triage nurses over the phone was reported to have reduced the need for further deployment of officers or ambulances.

- Time spent on MH calls during the triage '4-week checkpoint' was compared with baseline data drawn from the 2017 Demand Day, identifying a significant reduction in the time allocated per MH event and the maximum time allocated to a single event. The average time per occurrence in 2017 was 3:46hrs compared to 2:04hrs four weeks after triage 'go live' date.

Aims and Objectives

Building on the initial evaluation (Broome & Davies, 2019), the current evaluation sought to examine engagement in the triage service and patterns of service use from June-December 2019. Specifically, the evaluation aimed to investigate:

- Frequencies of MH tagging across policing BCU areas.
- Demographic patterns (age group and gender of person experiencing distress/crisis)
- The main issues of concern for MH incidents into triage and S136 use.

Additionally, this evaluation begins the process of examining the potential social benefits of triage from the perspective of triage service users (direct callers and carers) and professionals (senior health, third sector and policing professionals). The aims were achieved by considering evidence against two key objectives:

Objective 1: To examine key outcomes (e.g. S136 detentions) from June – December 2019 to allow comparison with the findings from the first evaluation

Objective 2: To extend the scope of the first evaluation to consider:

a) The impact of triage on known repeat callers - including persistent callers
b) Evidence of successful signposting to, for example, the GP, charities and other third sector agencies and successful assessments and referrals to secondary services and crisis
c) Examples of users journey 6 months before triage / 24 hours and one month after engagement

The evaluation also considered future service developments and areas for further evaluation including working with the third sector and gathering wider health impacts and outcomes. Such findings might be used to inform data collection to enable on-going evaluation and to inform the case for future funding.

It is anticipated that findings from the current evaluation will be distributed and of use to the following primary organizations:

- South Wales Police
- Health boards (Cardiff and Vale University Health Board; Cwm Taff University Health Board; Swansea Bay University Health Board)
- Third sector organisations (i.e., Hafal)
- Welsh Government
- Welsh Ambulance Service NHS Trust

Other interested parties might include:

- Safeguarding Boards (Cardiff & Vale; Cwm Taff; Western Bay)
- Social services departments (Bridgend County Borough Council; City and County of Swansea; City of Cardiff Council; Merthyr Tydfil County Borough Council; Neath Port Talbot County Borough Council; Rhondda Cynon Taff County Borough Council; Vale of Glamorgan Council)
- NHS WCCIS (Welsh Community Care Information System)

Methods

This evaluation utilized a mixed-methods approach (Hanson, Creswell, Clark, Petska, & Creswell, 2005), in which quantitative and qualitative data collection and analysis approaches were employed to meet the objectives. Quantitative data were sourced from South Wales Police and health and included:

- Number of MH tags (extracted from the police Control Works system)
- MH occurrences from both crime and welfare (National Incident Category List - NICL data), police reported staffing numbers and population distributions across the BCUs

- S136 use (data populated by police and health, representing the S136 journey of the individual i.e., circumstances of detention and health outcomes. Data was extracted from Niche, which represents overall demand of MH in the police)
- Demographic and incident reporting data extracted from Cwm Taf Health Board Access Review. This data represents outcomes from the Cwm Taf area between December 2019 and January 2020 only.

Qualitative outcomes were measured from triage data to explore the potential social benefit of triage and how this might affect services. This was in the form of:

- Ten examples of areas of practice in relation to assessments and referrals
- Fifteen case examples of MH incidents across the BCUs, detailing the individuals' journey 6 months prior to triage, 24 hours and 1 month after triage.
- A Stakeholder Event, in which two focus groups were conducted to gather the thoughts and opinion of service users (direct callers and carers) and professionals (senior health, police and third sector (Hafal)).

Detailed below are the sources of data and form of analysis, considered against the evaluation objectives:

Objective 1: *To examine key outcomes (e.g. S136 detentions) from June – December 2019 to allow comparison with the findings from the first evaluation*

Data was drawn from the following services and data platforms:

- **Control Works (MHT code):** to capture number of 'Triage Tags' across the cycle of the service. Data covers January-December 2019, to allow for comparison of engagement in triage between the initial evaluation (January-May 2019) and the current reporting period (June-December 2019). This was reported graphically to provide a measure of 'service need' beyond the initial implementation stage. Trends across BCU areas were also compared to consider the impact of engagement on MH management in different areas.
- **Access Review for the Cwm Taf Health Board**: Data relating to who made contact, the gender and age group of the person experiencing MH distress/crisis, and reason

for call is presented graphically and narratively for 2,058 incidents that occurred during December 2019 and January 2020. This was the data period provided to the evaluation team from South Wales Police.

- **Niche and National Incident Category List (NICL) Code Data**: S136 data were extracted from for the whole of South Wales Police and are presented graphically to show trends over time. Niche data can provide information on the overall use of police resource by those with MH needs, including occurrences from crime and welfare. NICL data (representing all MH occurrences for crime and welfare), population estimates and staffing numbers were given to the evaluation team from South Wales Police. Data were also drawn from Health S136 assessment data following handover over of the service user from police to health. This is presented graphically for BCU areas, alongside percentage changes over time, comparing outcomes from 2018 and 2019. Frequencies of police custody and hospital places of safety are also graphically presented across the four areas as well as S136 outcomes.

Objective 2: *To extend the scope of the first evaluation to consider: Part A) Impact of triage on known repeat callers - including persistent callers; B) Evidence of successful signposting to, for example, the GP, charities and other third sector agencies and successful assessments and referrals to secondary services and crisis; C) Examples of users journey 6 months before triage / 24 hours and one month after engagement*

- **Triage Case Examples:** Fifteen triage case examples were presented to the evaluation team to include nurse reported data collected from triage and health systems across the four BCU areas. Structured information for each case was provided to include information on whether a person is care managed (a proxy for currently receiving support from MH services), a repeat caller, use of S136, and their journey 6 months prior to contact with triage, their journey 24 hours and one month after triage.
- **Example of Practices:** Ten examples of call-backs from triage to service users were also given to the evaluation team, demonstrating areas of practice in relation to assessments and referrals. A narrative summary of the cases and outcomes is presented.

- **Service User's Event**: Two focus groups were conducted: one with service users (direct callers = 4 and carers of individuals experiencing MH concerns = 2) and one with senior staff and experienced practitioners from a variety of stakeholder organisations (Cardiff and Vale University Health Board (Mental Health Triage Service; n = 2); Hafal (n = 2); South Wales Police (n = 1) and Swansea Bay University Health Board (Mental Health and Learning Disability Directorate; n = 1). Service users also completed a short survey (Appendix B) and both groups took part in a ballot to measure the overall value of the service (Appendix C). The objective of the event was to gather the opinions and thoughts of the service from the two perspectives. Independent focus groups were led by each of the evaluation team (service user group – LB; professional group - JD) to ensure that each group could provide an independent view. Group discussions were semi-structured with specific questions and topic areas used as a guide. Within this broad framework, participants were given the freedom to discuss their experiences and share their views. This allowed for debate and discussion of various perspectives within the group, with the aim to extract a collective view (Fontana & Frey, 2005; Ryan, Gandha, Culbertson, & Carlson, 2014). Appendix D contains a session plan and an outline of key questions / topics. South Wales Police invited users to the event (see Appendix E for invite letter) which was held in Hafal HQ in Swansea. For service user attendees, Hafal staff were available for safeguarding and support both during and after the event. An overview of triage use by the service user group (demographics, number of times engaged with and route into triage) is shown in table 1.

Table 1: *Demographics and triage use of service users focus group participants*

Triage Service Users Focus Group

	Age Group	**Gender**	**Times Engaged with triage**	**Route into triage**
SU1	35-46	Female	Unknown	Unknown
SU2	46-55	Male	2-4	Police
SU3	56-65	Female	1	101
SU4	56-65	Male	2-4	101 & 3rd party caller
SU5	66+	Female	1	Unknown
SU6	66+	Female	1	101

Results

Quantitative Outcomes

Triage Service use

There was a steep increase in MH tagging during the period January-May 2019, as might be expected for a new service as staff become more aware of its objectives (see figure 1). Engagement throughout the June – December 2019 reporting period has stabilized, possibly indicating that the service has become embedded in police practice and that the figures might represent the 'need rate' for triage (i.e., the likely on-going rate). The 298% increase in December compared to January 2019, might indicate that the police workforce has now gained confidence in the service (and thus engage with it), potentially addressing an implementation challenge noted in the first evaluation (Broome & Davies, 2019).

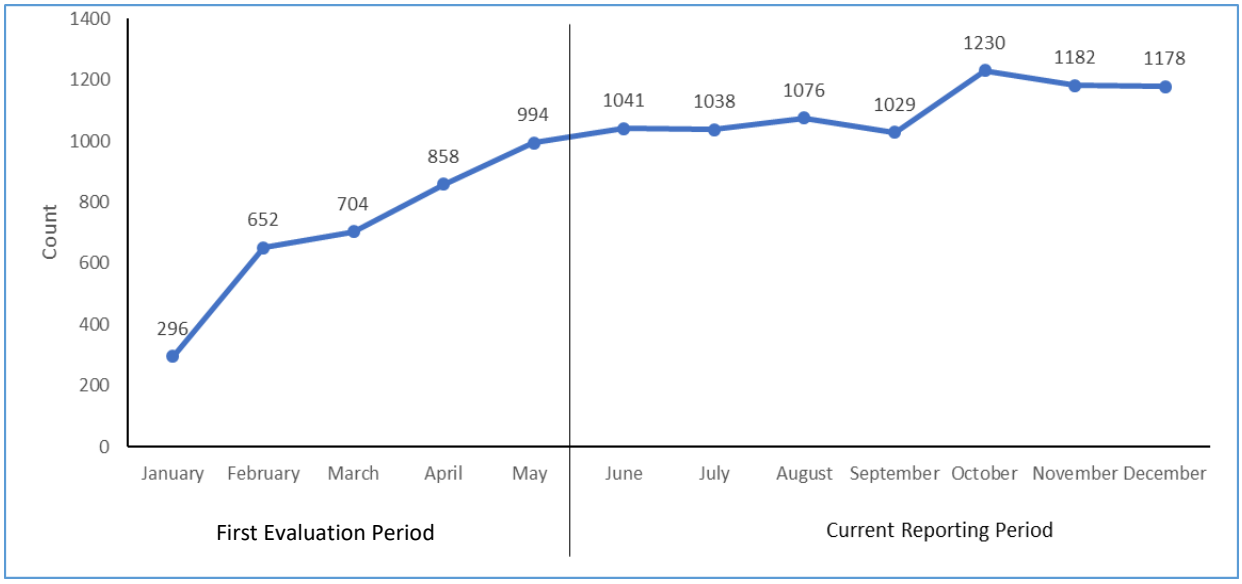


Figure 1: Total number of MH incidents tagged into triage for January-December 2019.

As seen in the first evaluation (Broome & Davies, 2019), Western BCU (Swansea Bay University Health Board) continues to be the area where the most MH tags are recorded, with Central (overlap between Cwm Taf and Cardiff & Vale) recording the least (figure 2). However, there continues to be an upward trend in engagement with the service across all areas, representing at least a threefold increase in tagging for each BCU.

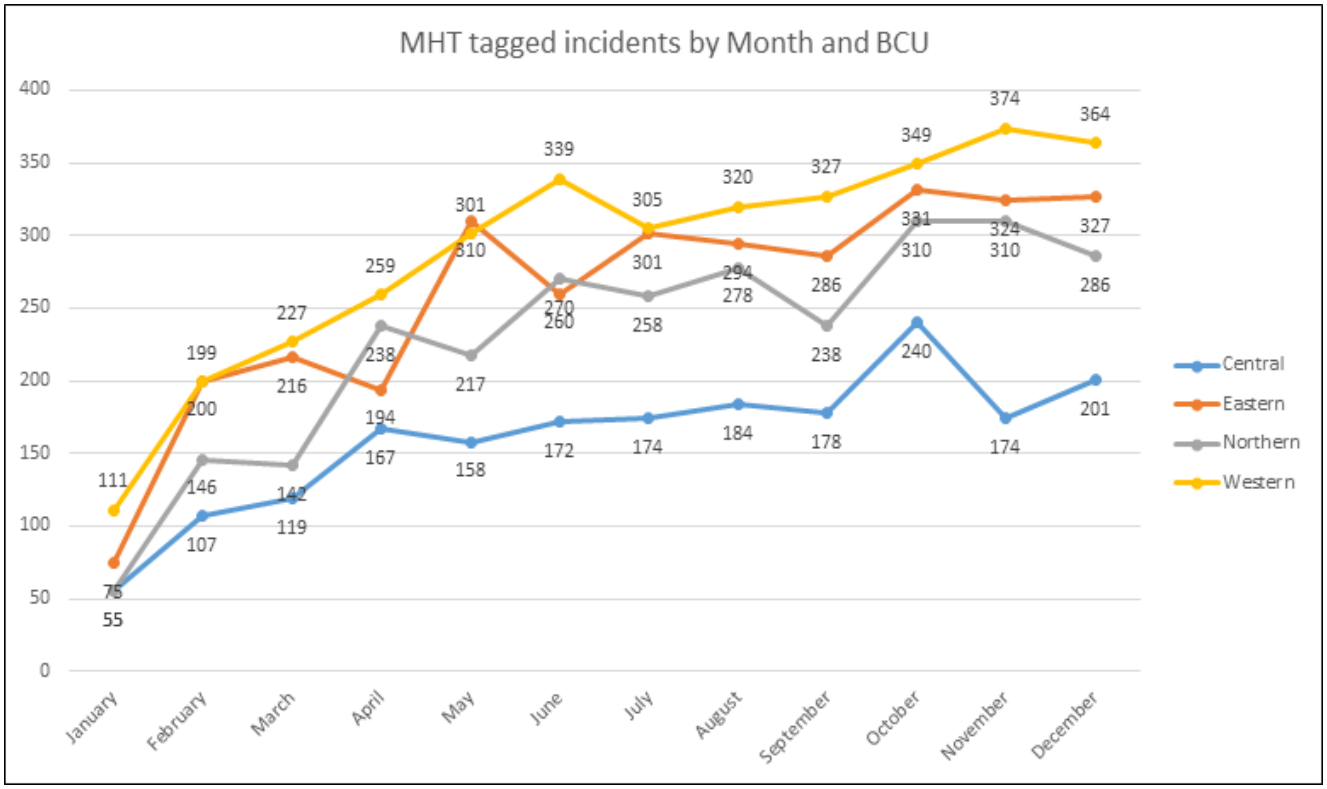


Figure 2: Total number of MH incidents tagged into triage across the four BCUs for January-December 2019.

To understand the use of the service across the different BCUs it is important to be able to put the tag data into context. As can be seen in table 2, Western BCU, have a higher number of front-line response staff (n = 246) and population compared to the other areas. Consequently, this table also shows the MH tag rate in relation to staffing and population. This reveals that the tag rate (and by inference the engagement rate in triage) is high in the Western area using both these reference points. In the context of population estimates, table 2 shows Northern BCU also have high levels of engagement with triage.

Table 2: *MH occurrences and population estimates per thousand across the BCUs.*

	MH tags (Dec 19)	*Front line staff*	*Popn '000s*	*MH tags (Dec 19) per 100,000*	*Ratio MH tags: staff*
Western	364	246	390	93	1.48:1
Central	201	169	278	72	1.19:1
Eastern	327	282	366	89	1.16:1
Northern	286	211	301	95	1.36:1

During December 2019 and January 2020, 2,058 incidents were reviewed as part of the Access Review for the Cwm Taf Health Board. Each of these incidents were added into the Mental Health Triage control group on Control Works and shows activity for the Cwm Taf area only. Figure 3 shows that a large majority of incidents in Cwm Taf (34%) were reported by the person with the mental health issue themselves or by a professional (i.e., GP, nurse, mental health nurse, ambulance and multi-agency safeguarding hub) (24%). The other 42% were from a range of sources including members of the public, ex-partners, strangers, family, friends and neighbours.

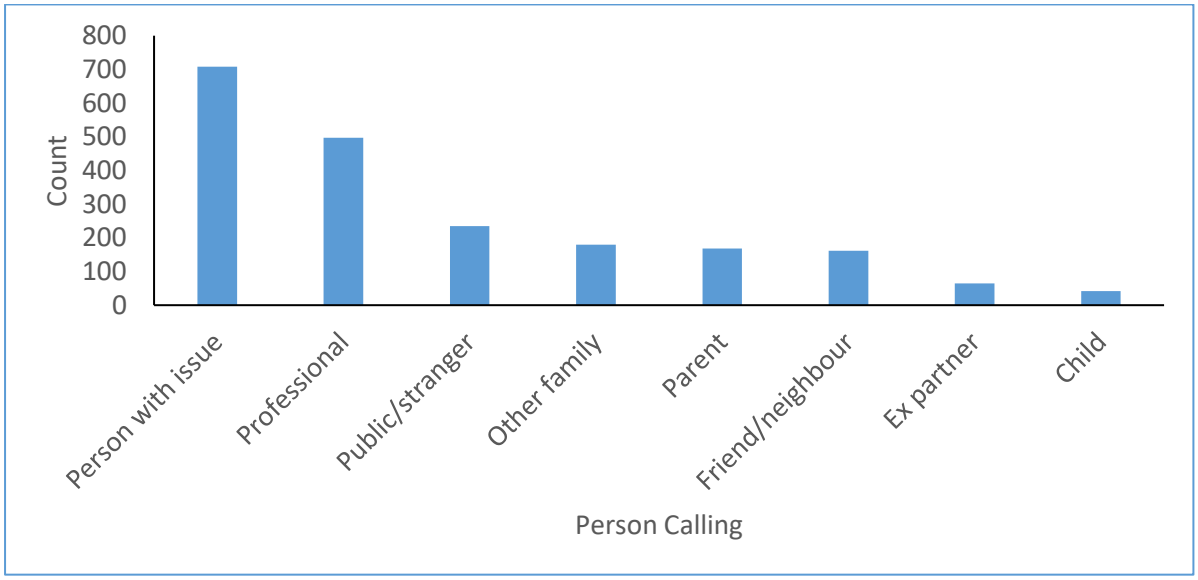


Figure 3: Person making the call to the police with a MH concern.

There was a relatively equal number of reported incidents from males (54%) and females (46%), with a majority of cases relating to those aged 30-39 (24%) and 18-29 (23%) (figures 4 and 5). The rates by age broadly reflect population demographics across South Wales (https://statswales.gov.wales).

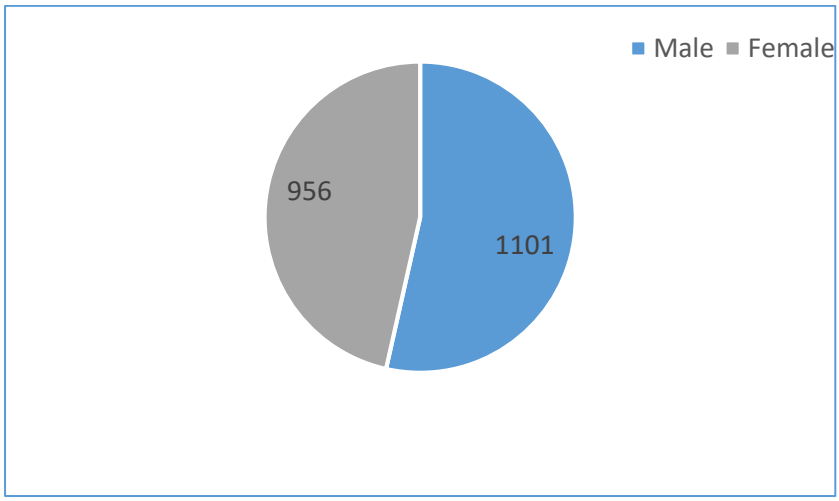


Figure 4: Gender distribution of the person experiencing a MH concern.

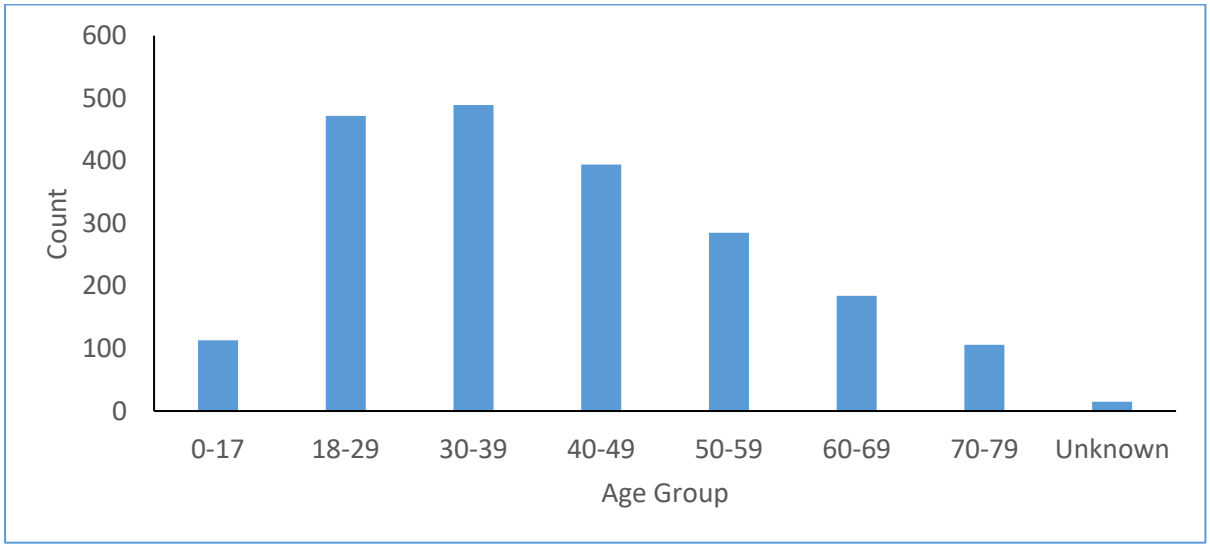


Figure 5: Age range of person experiencing a MH concern.

In this two-month period, a large majority of calls were identified with the main issue being 'suicidal' (32%), demonstrating 'confusion/strange behaviour' (21%) or 'diagnosed MH condition' (17%) (figure 6). Two hundred and five individuals called more than once during this period, with one person living in Eastern BCU, calling 28 times (recorded as demonstrating confusion/strange behaviour). Almost a fifth of calls (19%) had the main issue categorised as representing social or lifestyle concerns, including housing, domestic abuse and relationship problems. However, it is important to note the data has been categorised in a way that considers factors such as low mood/depression and stress/anxiety/panic together rather than as discrete concerns. Low mood and stress might represent wider psychological wellbeing which could reasonably be addressed through signposting to support services, in contrast to a depression or anxiety disorder, which could include conditions attracting a formal diagnosis. Indeed, 'diagnosable mental health' was recorded as 'other issues' for 238 cases where the main issue was categorised otherwise. In order to enable a more precise picture of the need presented, the categories used (and their descriptions) should be reviewed to inform future data collection.

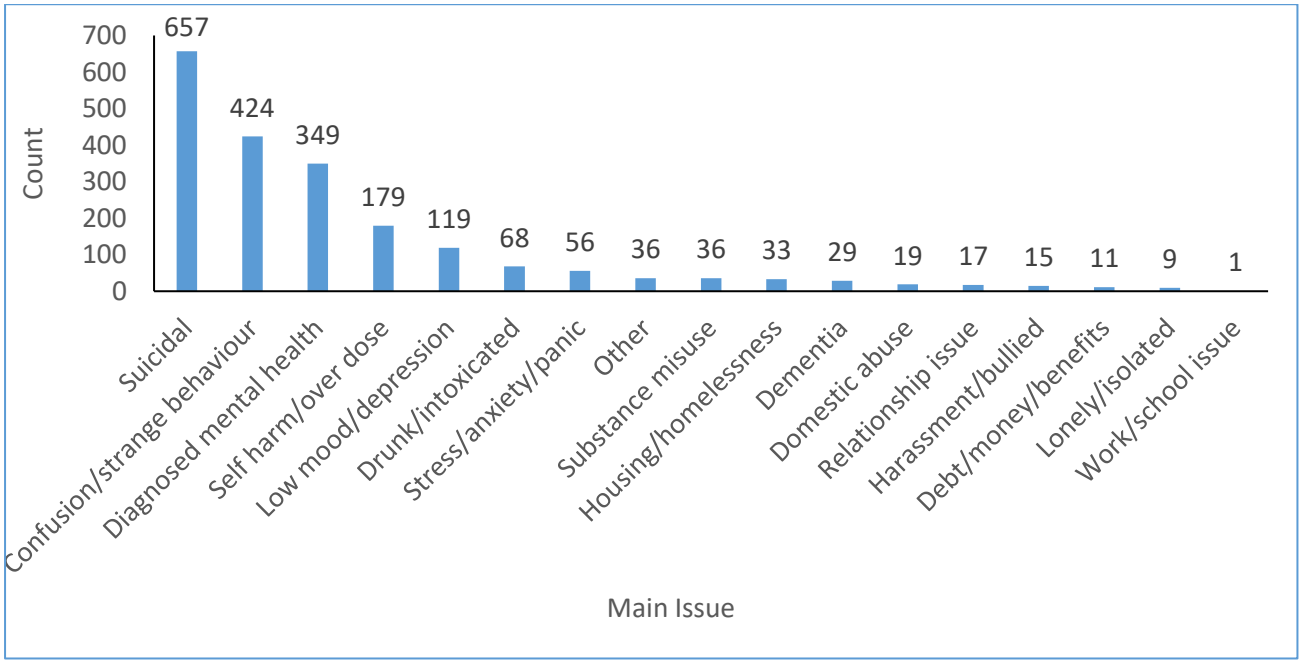
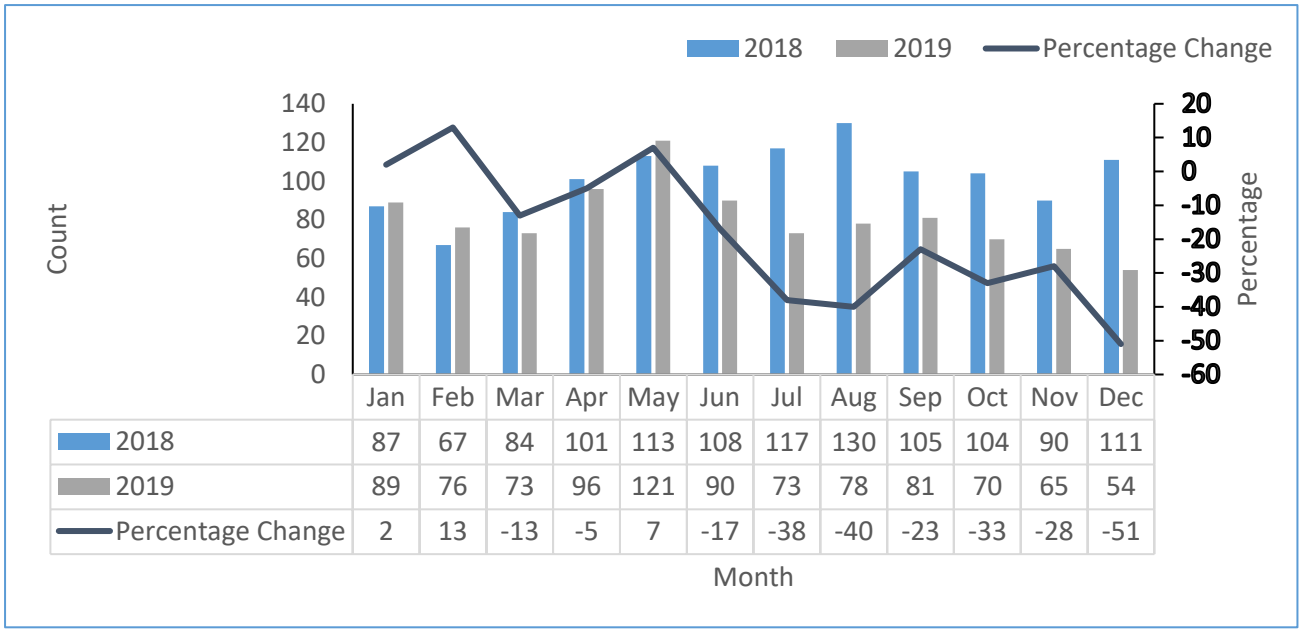


Figure 6: Main issue of person experiencing a MH concern.

Analysis of S136 Data

Data from S136 forms on Niche for the whole of South Wales Police shows a downward trend in S136 use in 2019 compared to 2018, with an overall decrease of 21% in 2019 (figure 7). During the period of the first report (January-May 2019), the rates of S136 use were relatively stable when making month by month comparisons between 2018 and 2019. However, there is a clear downward trend in S136 use between June-December 2019 compared to the same months in 2018. The greatest decrease is at the end of the current data period in December 2019, down 51% from December the previous year. Whilst it has not been possible to consider other factors to this reduction outside of triage, in view of the increase in MH tagging across the year shown in figure 1, triage may be a significant factor in this change. For example, findings from the first evaluation, found that triage provided officers with alternative approaches for the management of MH incidents which, in some cases, prevented further escalation and the use of S136 (Broome & Davies, 2019).



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2018	87	67	84	101	113	108	117	130	105	104	90	111
2019	89	76	73	96	121	90	73	78	81	70	65	54
Percentage Change	2	13	-13	-5	7	-17	-38	-40	-23	-33	-28	-51

Figure 7: Rates of S136 use across South Wales Police in 2018 and 2019.

Separating the S136 data into BCUs, the greatest reduction has been seen in Western BCU with a reduction of 36% in 2019 compared to the previous year (figure 8). Northern and Eastern have seen a slight decrease of 8% and 7% respectively, and Central has seen a slight

increase of 4% in 2019 compared to 2018. As was seen in the first evaluation (Broome & Davies, 2019), Western continues to have the greatest engagement in triage from officers alongside the greatest reduction in S136 use, and central has the lowest engagement with little change in S136 use. A more detailed case study analysis of policing approaches to MH and the use of triage in Western would be useful to examine practice, facilitate information sharing and consider factors outside of triage that might be influencing decision-making.

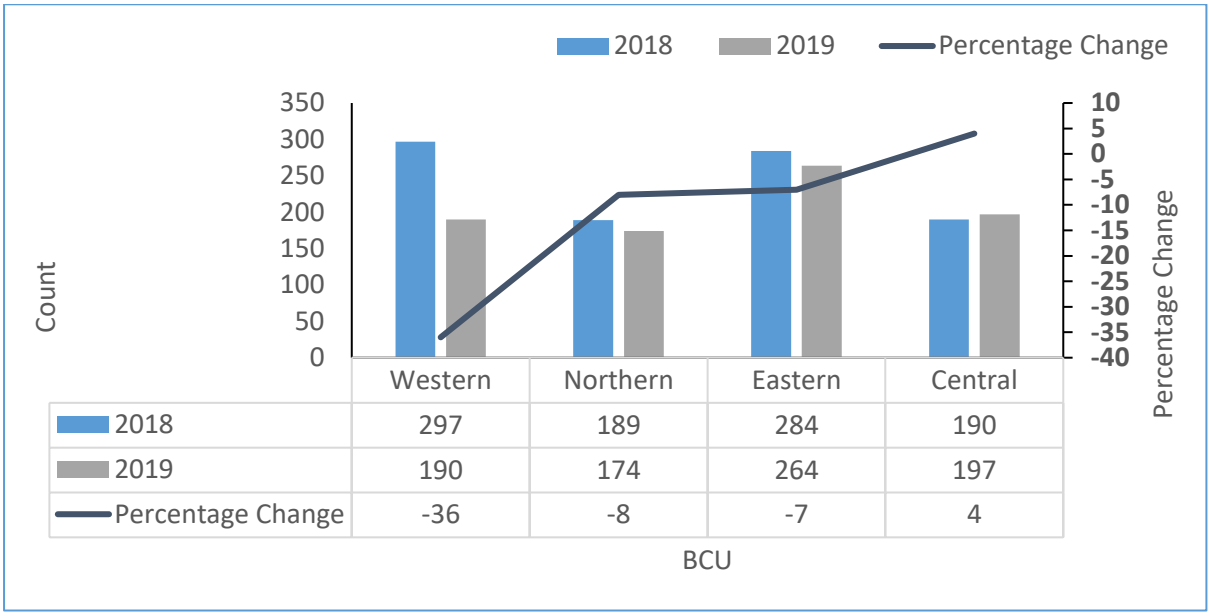


Figure 8: Rates of S136 use across the four BCU areas in 2018 and 2019.

Places of Safety and S136 Outcomes

Figure 9 shows that in almost all S136 cases, people are brought to a health based Place of Safety (PoS) across the four BCUs. Both Central and Western BCU decreased their use of a police custody PoS in 2019 compared to 2018 with a slight increase in Eastern and Northern. However, for all units, the number of individuals taken to a custody PoS is very low (<5). It has not been possible determine the factors which may influence a decision to use a custody PoS, and specifically which individuals might be taken to a custody based PoS.

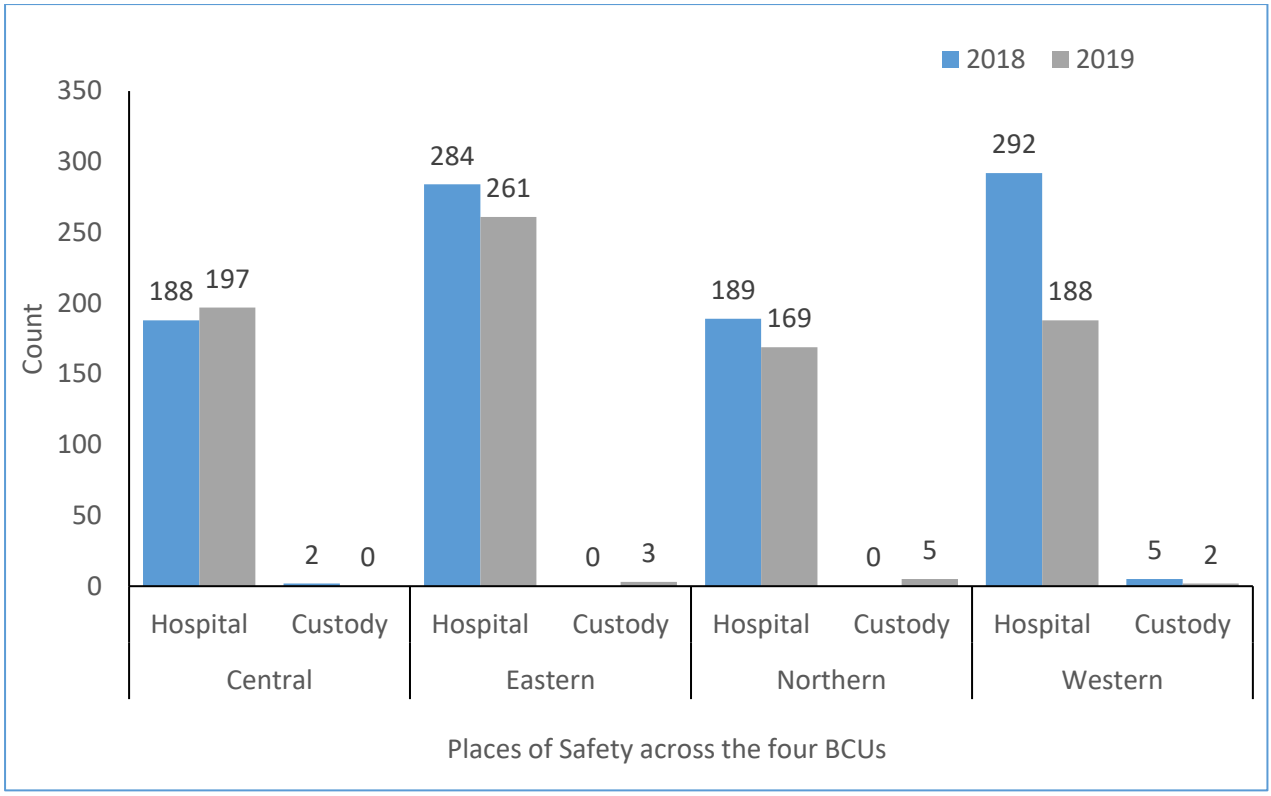


Figure 9: Rates of hospital and custody being used as a PoS across the BCUs.

As can be seen in figure 10, the assessment outcome following S136 detention includes several options. The number of people being admitted to hospital on Section 2 of the Mental Health Act, accepting admission informally or being admitted in some other way remains largely consistent between 2018 and 2019, however slightly fewer people were referred to other services and notably fewer were discharged in 2019 compared with 2018. Whilst the reason for the 31% decrease in those discharged following assessment is not recorded, by linking this reduction to other data in this report (and the consistent rate in S136 – admission) it would be reasonable to suggest that more judicious use of S136 may account for this. Specifically, it may be that those subject to S136 who would be discharged following a formal MH assessment in a PoS are now being diverted as a result of triage input. When the BCU level data is reviewed (figure 11) it is possible to see that rates are broadly consistent across years for Northern and Eastern BCU. Central has seen an increase in referrals to outpatient MH services and a decrease in discharges. In Western, both the number referred to outpatient MH services and those discharged has reduced. This adds further weight to the possible impact of Triage on ensuring that S136 is used to target those most likely to require inpatient care following an assessment.

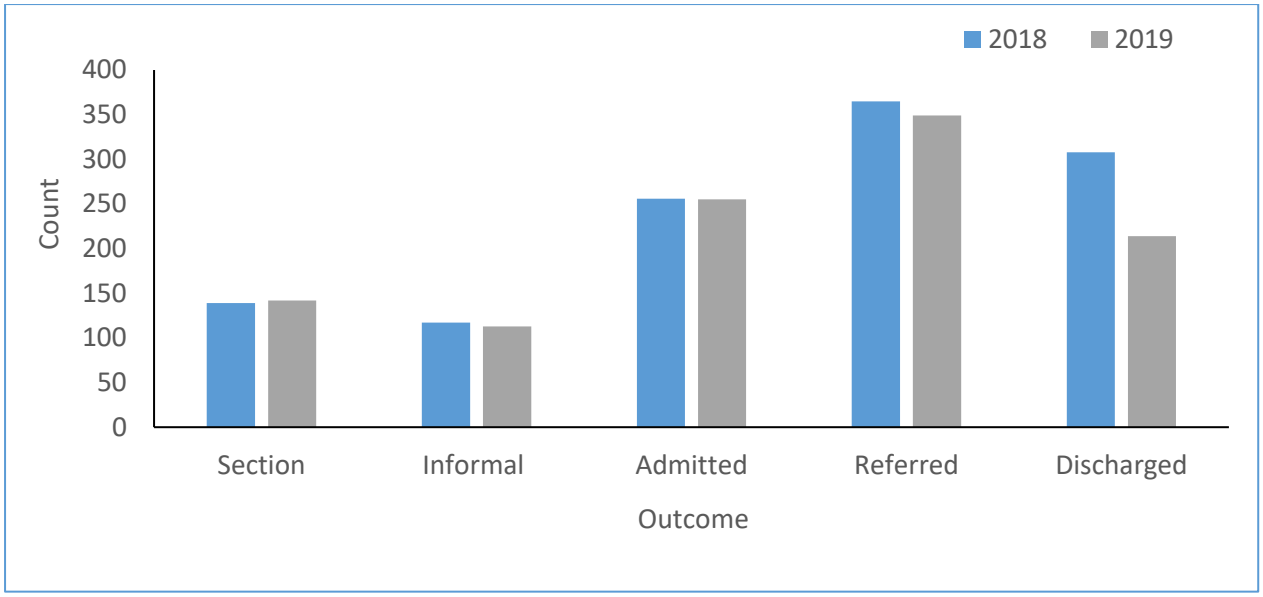


Figure 10: Process and outcomes of S136 in 2018 and 2019.

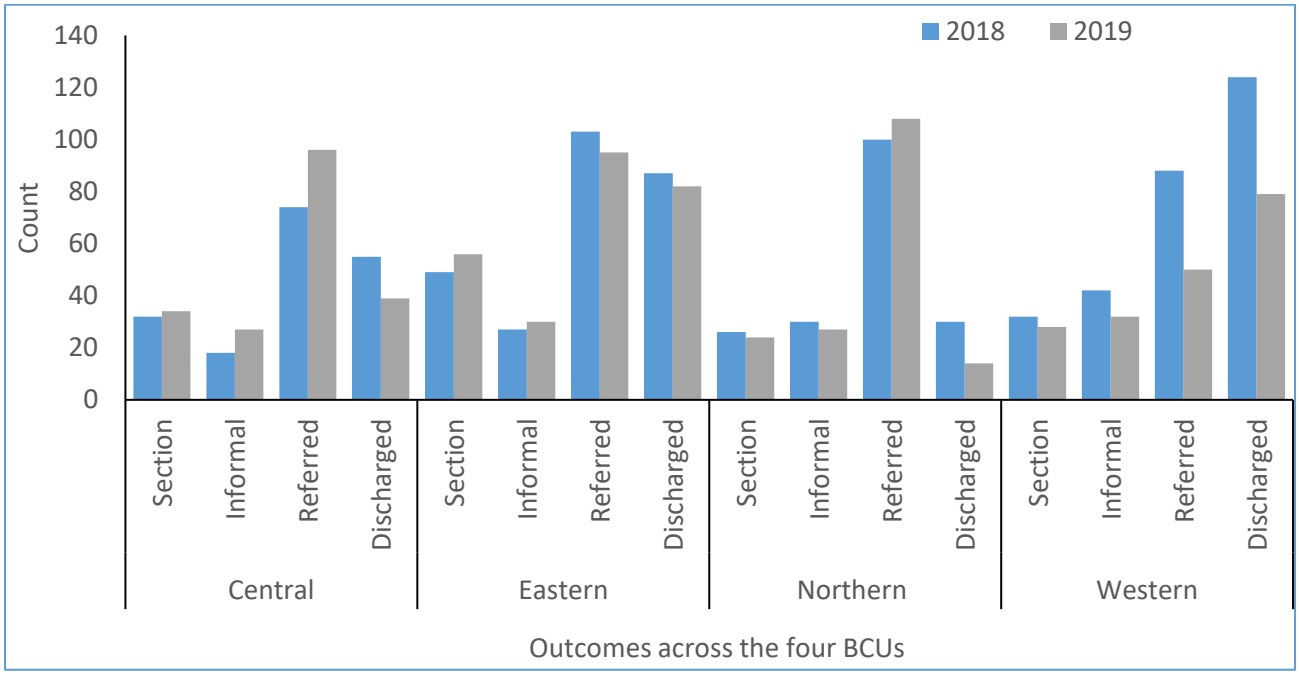


Figure 11: Process and outcomes of S136 in 2018 and 2019 across the BCUs.

Western BCU recorded the greatest reduction in repeat use of S136 for the same person in 2019 compared to 2018 (64%), followed by Northern, who experienced a 60% decrease (figure 12). These two areas have seen the greatest engagement with Triage as indexed by the number of MH tags per 100,000 people (table 2). Central, which has the fewest MH tags, did

not see a reduction in S136 repeats across the two years. It would be useful for further specific data to be collected by police and health to determine how triage (or other factors) have influenced these figures.

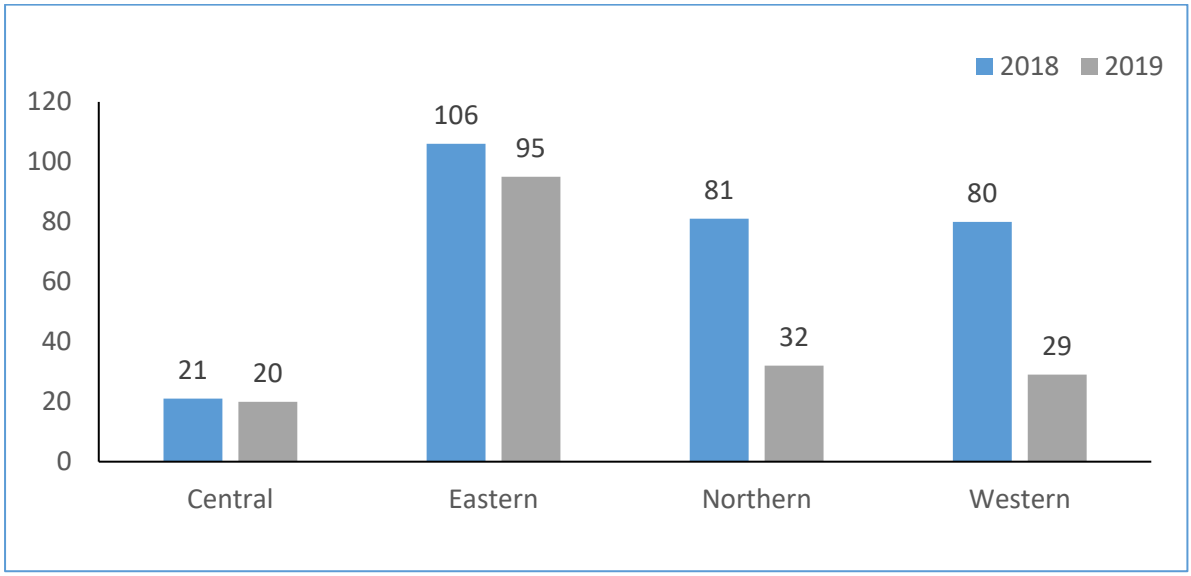


Figure 12: S136 repeat rates for all BCUs in 2018 and 2019.

S136 Estimated Opportunity Cost Reduction Across Police, Health and Local Authorities

It was not the objective of the current evaluation to consider how triage might lead to explicit costs reductions across services; however, the reduction in S136 use reported above can be used to provide one indication of the 'unseen' opportunity costs across police, health and local authorities (i.e., potential cost reductions for activities across services). Keown et al. (2016) report the estimated unit cost of S136 assessments for police, the NHS, local authorities and ambulance services is £1,632, with such assessments lasting an average of 3-4 hours. Based on these figures there has been an estimated £231,743 opportunity cost reduction based on less S136 use across Western, Northern and Eastern BCUs since the initiation of triage. Table 3 shows that Western (Swansea Bay) had the greatest estimated saving in 2019 of £174,624, however Central (Cwm Taf / Cardiff & Vale) experienced an increase of £11,424. Considering outcomes against rates of MH tagging in these areas, where tagging is highest in Western and lowest in Central, engagement in triage indicates potential savings across the services.

Table 3: *Estimated S136 opportunity cost reduction across BCUs since initiation of triage*

	S136 use		*Estimated Cost*[1]		*Estimated Savings*
	2018	2019	2018	2019	
Western (Swansea Bay)	297	190	£484,704	£310,080	**£174,624**
Eastern (Cardiff & Vale)	284	264	£463,488	£430,848	**£32,624**
Northern (Cwm Taf)	189	174	£308,448	£283,969	**£24,479**
Central (Cwm Taf / Cardiff & Vale)	190	194`	£310,080	£321,504	**£-11,424**
Total	960	822	1,566,760	1,346,401	**£220,303**

Note: [1] Based on estimated cost of £1632 per unit, across police, NHS, ambulance and local authority

The costs to run triage from 1st April 2020 to 31st March 2021 are forecasted to be £321,000. This is based on The South Wales Police triage operating model of 6 CPNs (Community Psychiatric Nurse Practitioners) and one CPN Supervisor working between 09.00hrs to 01.00hrs (16hrs) over 7 days per week. The estimated opportunity cost savings from the decrease in S136 detentions from initiation of triage covers just over two thirds of these costs, and if the reduction of S136 use across policing areas continues, this would indicate further potential savings across all sectors. However, it is important to recognise that these figures are likely to be a significant under estimation and should therefore be considered cautiously. A report from the Independent Police Complaints Commission (IPCC), suggests that the average length of S136 detention / MH assessment is much higher [Than our data or from Keown et al., 2016] at 9 hours and 36 minutes (IPCC, 2008). Thus, using IPCC as a reference point, the estimated costs savings might be three times as much than is presented here. This would be consistent with the view of Senior Management in South Wales Police, who suggest cost savings to the police alone are potentially higher than those figures presented in table 3, this is without consideration of health and local authority costing. For example, an arrest is estimated to cost the police an average of £1,780 (Dean, 2018). Should that arrest lead to the individual needing MH intervention the costs will escalate to include costs of police time up to the point of hospital admission (or discharge from S136). Detailed local costings should be addressed in future evaluations. Additionally, it has not been possible to consider the potential savings when triage has reduced demand on health by signposting or referring individuals into appropriate third sector services. It is therefore highly likely that the

potential opportunity cost saving of triage might be much higher for police, health and local authorities, and future research should examine these potential savings further.

Qualitative Outcomes

Stakeholder Event

The subsequent findings relate to data collected at a Service Users Event, hosted at Hafal HQ in Swansea. The event aimed to capture the opinions of triage service users and professionals to explore strengths, weaknesses and potential improvements of the service from the two perspectives. Two focus groups were conducted during the event, one with service users / carers and the other with professionals. Six individuals who had engaged with triage as users formed the service user's focus group; 4 who had direct contact with triage and 2 carers who contacted triage on behalf of a loved one with ongoing MH concerns. Three users had contact with triage once, and 2 had engaged with service 2-4 times. Hafal staff (who were not part of the service user focus group) were available to provide support to service users during the focus groups, however no service user made use of this. The second focus group consisted of six professionals from various agencies namely health (a senior manager and triage staff representing 2 different health boards), police and third sector (Hafal). The two focus groups were semi-structured, with a set of questions / themes used to guide discussions (see Appendix C for session plan and questions). Participants were free to discuss what they considered important from their own personal experiences (Fontana & Frey, 2005; Ryan, Gandha, Culbertson, & Carlson, 2014). Sessions were not audio recorded but written notes were made by the facilitators during the discussions. The event explored several areas:

- How triage might help people with MH concerns.
- If incidents might have escalated if triage did not exist.
- If improvements have been seen in police responses to MH incidents.
- What difference, if any, triage might make on society.
- How triage might improve the way police and health support people with MH concerns.

In addition to the group discussions, individuals were asked to rate their agreement with the statement: '*triage is a valuable service that provides support and advice to people with*

mental health concerns'. A majority of respondents in both groups strongly agreed that triage is a valuable service (figure 13). Triage service users were also asked to rate the extent to which contact with the service had been helpful (figure 14).

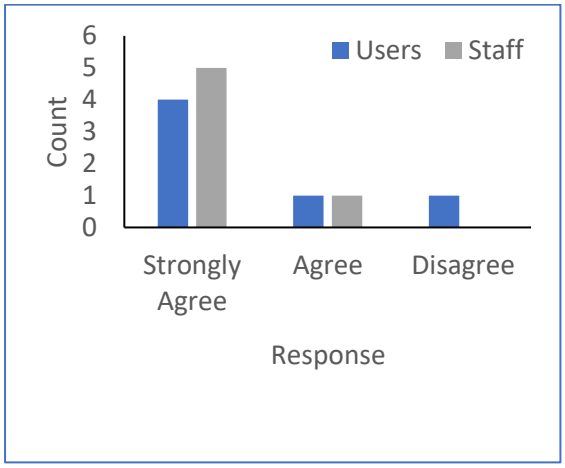


Figure 13: Number of triage service users who consider triage to be valuable

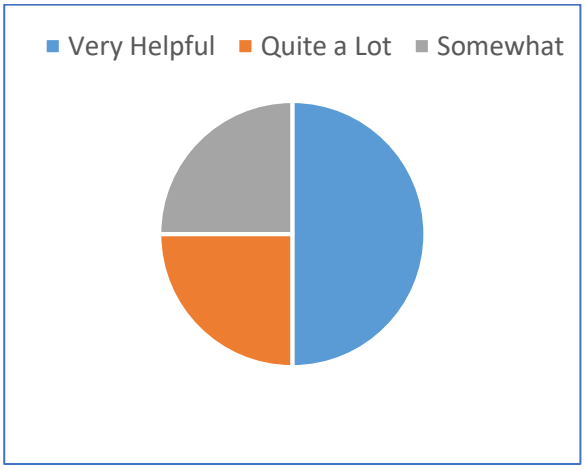


Figure 14: Number of triage service users who found the service helpful
Note: no respondents considered the service unhelpful

Service User Focus Group Outcomes

Three recurring themes were identified from the service user's discussion addressing: *de-escalation of MH distress/crisis, lack of follow up, and triage and carer trauma.* These themes are summarised below:

De-escalation of MH distress/crisis

There was general agreement within the group that triage is a supportive service that fills a gap when community MH and GPs services are closed. Users explained having a sense of fear, especially out-of-office-hours, which can escalate and lead to increased distress or crisis. One user said: "*when you're ill you can't trust yourself* [to make decisions]." Users found that having reassurance from a specialist MH professional, who *"listens and believes you,"* could de-escalate a situation. Linked to this, users found it helpful when triage liaised with services on their behalf, removing the stress and fear of continuously explaining their needs to multiple services.

De-escalation in cases of crisis was considered a significant advantage of triage, which was regarded as having improved police response to MH incidents by users. Consequently, users felt the police often have 'better techniques' than crisis teams and were more likely to believe them. For example, one carer described that long waiting times for support from crisis services can result in a person de-escalating by the time they are seen. They might then be sent home without assessment, making them feel as though they had not been believed. Service users felt this sometimes led to further escalation that required a police response. Overall, triage was said to have led to *"more understanding and highlighted mental health problems, but it's opened a can of worms – where do people go after?"*

Lack of Follow Up

The most significant problem with triage reported by the group was being able to follow up with or access services that users had been signposted to. Access to follow on care was identified as a wider service challenge due to cutbacks in community services. However, it was felt that this could undermine triage and create distrust with the police, even in situations outside of police control. One person explained *"the police can de-escalate a situation, then triage signposts you, nothing happens, then you escalate again causing further distrust,"* another said, *"It looks like the police are lying."* Linked to this, users suggested that triage might need to manage expectations from users. For example, user's initial expectations were that triage would follow up and offer long term support in the absence of community services. As one person explained *'there's a false sense of security that you'll get* [long-term] *support, but you don't and there's no* [other] *help."* The concern amongst service users was that triage might show a 'need' and offer initial help but that support could end when the phone call ended.

Triage and Carer Trauma

Carers of people with mental ill health described the trauma of witnessing a loved one in distress or crisis, and triage was considered to act as a 'middle service' for families who might need to contact the police about the behaviour of a loved one. One person explained, *"Phoning the police for a loved one is the worst feeling, knowing a MH professional is there* [on the phone] *makes you feel better."* Carers also discussed how triage and police officers supported, not only the person experiencing distress/crisis, but also their families, with triage

offering *"competent and understanding words."* This might support carers in de-escalating an incident enough to get through the night and access services when they open or to feel more confident they are '*doing the right thing'*. The group emphasised the need for police and health to recognise that carers experience trauma when a loved one is in crisis and distress; as one person asked, *"Who looks after a carer in a mental health crisis?"*

The development of a regular 'service users forum' was proposed in which users, police, health and third sector community services would come together to share knowledge and reflect upon their experiences. One specific contribution users felt they could bring was consideration of some of the language (phrasing) used by police and triage: *"sometimes the police use the word 'referral' when they mean public protection order, but you would assume that means referral to services."*

Professionals' Focus Group Outcomes

The professionals' focus group included senior staff and experienced practitioners from a variety of stakeholder organisations namely: Cardiff and Vale University Health Board (Mental Health Triage Service; n=2); Hafal (n=2); South Wales Police (n=1) and Swansea Bay University Health Board (Mental Health and Learning Disability Directorate; n=1). The professionals group represented those with both a service user and service delivery focus. The themes from the discussions are presented below and represent *service functions and perceived impacts; lessons learned and areas for further work; challenges and concerns.*

Service functions and perceived impacts.

The service functions and inputs were noted to include decision-making (e.g. in relation to use of s136); education (e.g. providing information to control room and front-line staff) and advice (e.g. of services or strategies that service users might access or use to address their concerns or needs). It was reported that these functions were made possible through access to multiple systems by triage staff and their training in working with people in crisis. There was discussion of problem solving and of triage staff supporting front line police colleagues to respond to unfamiliar and challenging situations. In many cases, this included supporting assessment to determine next steps and providing strategies and techniques to help de-escalate a crisis. This skilled 'back-up' to officers with limited training and experience in working with those with MH and related difficulties was considered to have consequently

improved trust between police and MH services. It was also reported that there were several specific police situations where triage may have a unique role to play. Firstly, in missing person cases, assess to MH data along with liaison with MH services could provide critical information in relation to the current MH (and treatment) of an individual, the presence of current relevant stressors, recent (life) events and support / social networks. Such information could assist the police in decision-making, search strategy and other key actions. Secondly, the group gave examples of supporting police negotiators by providing information and advice based on individual specific and general MH knowledge. Again, this was used to inform the strategy and approach taken by those at the scene.

There were several impacts noted by the group, some of which require further research / data collection to quantify the extent of the effect:

- An increased sense of partnership between police and mental health services
- Triage providing MH education and learning opportunities for control room and front-line staff
- Improved responses to repeat callers resulting in a reduction in emergency calls from this group and pathways of care to support where needed
- Reductions in service user frustration with inappropriate signposting
- Improved liaison with, and referrals to crisis services
- Increased trust between triage and MH / other services associated with improved / streamlined access in some cases
- More accurate police information available in real time (e.g. out-dated markers on Niche being removed and new ones added as appropriate)

Lessons learned and areas for further work

In considering what had been learned to date, what would be done differently if starting again and areas for further development the responses from the professional group broadly related to organisational / systems factors and practice factors.

At a systems level, the group noted the importance of systems access, governance and quality, and the staffing resource. Access to the multiple health and social care systems was

an ongoing area of learning and development. This involved both having agreements in place for information sharing (e.g. a Memorandum of Understanding as have already been agreed in some areas) and having real time system access. The different systems and permissions used by the various organisations meant that information was not always available or could only be accessed by calling services over the phone (and therefore only possible if the other service was open).

Governance factors covered a range of key processes (e.g. rules for accessing systems; confidentiality; note keeping; adhering to data sharing principles) and the ways in which these were monitored and best practice maintained. Staff described the evolving nature of this work as new systems were added and procedures developed. To support the wider governance (and development) of the service, the group identified the importance of regular meetings between multiple agencies (police, health, social care and third sector) and for this to include stakeholders not currently involved in the pilot.

Maintaining / enhancing service quality was seen as a key aspect of on-going service development. The group discussed the need to develop more robust ways to measure inputs and outcomes, including ways to a) use distress ratings during calls (to examine immediate impact); b) engage in routine follow up to understand both actions taken and the impact of these (e.g. in relation to signposting) and c) through monitoring impacts on other services (reductions in or more appropriate use). Whilst the first 2 developments could be actioned by the triage team (resources permitting) the service impacts data would need access to a range of systems (e.g. GP, A&E, crisis teams, CMHT, social care, ambulance call data) and possibly changes to the ways information is recorded on other systems. At present there remain no readily available sources of information relating to self-care, third sector or social care outcomes. This is important as the group noted that police attend a number of call where social issues (including loneliness) appear to be the main precipitant of the call to the police.

Embedding the service with the appropriate staffing resource was seen as critical to moving from a pilot to a sustainable service. Ways to organise working patterns and the numbers of staff potentially needed were discussed by the group along with ways to ‘mainstream’ the service to avoid ‘silo’ working and staff burnout / loss of other skills and knowledge. The need for the service to be able to provide 24-hour input was noted along with ensuring the staffing model includes sufficient time for recording and follow up as needed. It was noted that on-going consideration needs to be given to the best use of resources (e.g. shift patterns)

and to ways to pre-emptively manage stress and burnout and ensure staff able to take leave. One suggestion was for the service to link with specific existing health board services (e.g. crisis response / intervention teams or hospital psychiatric liaison teams) allowing staff to rotate into triage work more routinely and to enable the service to be part of a wider collective reducing its vulnerability to absence through leave or sickness. The group also discussed the professional groups of the triage staff and whether this would benefit from including staff with AMHP training (or direct access for consultation to such individuals). The optimum staffing configuration should be considered as part of the ongoing development of the service.

Several practice factors identified by the group related to issues that were unforeseen and for which there were not easily transferable existing protocols or guidelines. For example, the ways in which third party callers are engaged with is an on-going area of development. These callers include both family, carers and friends as well as members of the public. The group discussed the need to consider ways to respond when the views of the family are different to the views of the individual and considered this an area where closer links to crisis intervention teams might be beneficial. As a starting point to better understand third party involvement, the group suggested collecting further information on the 'sources' of calls and the inputs / outcomes. Another important practice factor identified was access to services and supports, especially for social and more general mental health needs. Use of 'service directories' such as the Dewis Cymru resource and various helplines provide one avenue. Signposting to social care 'one stop shop' services where these exist and other community resources (e.g. citizen's advice) were also seen to be potentially helpful. However, the group noted that more work is needed, especially in relation to the outcomes of such signposting and the responses of service users to this form of resolution.

Challenges/Problems/Concerns

Whilst having some overlap with lessons learned and areas for on-going development, this theme contained the comments and areas of discussion that do not currently have a clear action plan or route to resolution. These are presented below as a list of points:

- Using this service as a pilot, the group agreed that it would have been helpful to have a longer period for induction and to ensure that systems and agreements between agencies were agreed and in place (including data collection). It was agreed that if the

service was to be replicated elsewhere, the induction for the triage staff could be enhanced and that many of the areas listed above should be in place prior to the service 'going live'

- Accessing information though timely access to systems presents an on-going challenge. Understandably, timely access to information must be seen within the context of assurance that information will be used sensitively, appropriately and will operate within data management, governance and confidentiality parameters. Whilst this has already been noted above, the group considered this a potential area for significant difficulty given the 'system by system' agreements and accesses that needed to be negotiated.

- The nature of the service needs to be regularly reinforced to avoid drift from the primary aims of triage. Recognising (and accepting) the service as triage rather than a general MH resource is important along with being clear about the boundaries between services and the different roles services might play. For example, it is important to recognise that in many instances, agencies are being notified (provided information) rather than a formal referral being made. This needs to be clearly communicated to the service user, other agencies and recorded on the systems. In addition, the two-way pathway between triage and the police (e.g. call handler / front line officer directs to triage, triage acts then directs back) was seems as an important principle.

- Some service users had reported concern and frustration when they felt 'turned away' from crisis intervention and the group considered how the triage service might help to shape expectations and options. This is an area for further work. This issue could be compounded by the differences in some processes across the Health Boards. It was generally considered that processes were smoother / easier in those areas where open access (self-referral) to MH assessment is available. Single points of access with health boards (e.g. through crisis intervention services and CMHTs where an individual is currently receiving care), and social care services were generally felt to be helpful especially where this included other services (e.g. the one stop shop idea). However, ways to develop closer integration with statutory and third sector stakeholders requires more work.

Service Users Journey

Triage outcomes from a variety of context were explored to examine the service user's journey through the triage system, including signposting or referral to other MH and third sector services. The evaluation team requested case examples for:

- Known repeat callers
- Assessments and referrals into secondary services and crisis
- S136 detentions
- Signposting to services such as GP, charities and other third sector agencies

To consider the users journey into triage and outcomes following engagement, information was requested for engagement in services 6 months prior to triage and outcomes 24 hours and one month after triage for each case example. Additionally, information on whether the person was care managed (as an index of their access to secondary MH services), a repeat caller or had been detained under S136 was provided for each case. Fifteen triage case examples were provided to the evaluation team; 8 for Northern (Cwm Taf), 3 for Eastern (Cardiff & Vale), 2 from Western (Swansea Bay) and 2 for Central (Cwm Taf, Bridgend). The evaluation team received 1 additional case example from Cwm Taf (Bridgend), however it was not possible to determine outcomes from the information provided and the case was excluded. As can be seen from table 4, the case studies represent an equal ratio of those known and not-known to MH health services, with a high frequency of known repeat callers and S136 use. The case studies are grouped into themes namely: *support and signposting to services, assessments and referrals, information sharing* and *S136 use.* A case example for each theme is presented here and further examples can be found in Appendix F.

Table 4: *Triage case example outcomes for known to MH services, repeat callers and use of S136.*

BCU	Known to MH Services[1]		Repeat Callers		S136 Used	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
Northern (Cwm Taf)	3	5	5	3	1	7
Eastern (Cardiff and Vale)	2	1	3	0	1[2]	2
Western (Swansea Bay)	1	1	2	0	0	2
Central (Cwm Taf (Bridgend)	2	0	2	0	1[3]	1

Note: [1] Also includes those awaiting allocation; [2] prior to triage; [3] not under the advice of triage

Support and Signposting to Services: This theme includes examples where triage have signposted individuals to secondary and third sector services for further support and specialist advice (i.e., to CMHT, drug services etc.)

Case 1 Example: Eastern BCU (Cardiff and Vale)

6 months prior to triage: Regular input from CMHT and support received for domestic violence issues from Women's Aid.

Triage involvement: PCSO's had contact with the service user who was considered to have mental health issues. Officers attended and requested support from triage who conducted an over the phone assessment. As a result, the service user was signposted to GP/CMHT for further support.

24 hours after triage: No contact.

1 month after triage: Remained open to CMHT for one month after triage. Care package was still in place from the local authority and receiving support from women's aid. Although open to these services and despite being vulnerable, this individual was reported to not be suffering from a serious mental illness. Several calls, both direct and 3rd party, were made to South Wales Police and WAST due to overdoses, intoxication, and to report bizarre behaviour. Refusal to be assessed in all cases and individual was considered to have capacity to refuse. CMHT made contact with individual via telecom; they identified no immediate risk or concerns and reminded her of an upcoming review with the consultant psychiatrist.

Outcomes: Seventeen concern for safety calls and 2 public safety/welfare calls are recorded for January-December 2019. This person is open to CMHT, has social worker and consultant psychiatrist input, triage assessed the individual, and decided S136 was not appropriate. Successfully signposted back to the GP and CMHT, removing the need for a mental health assessment.

Assessments and Referrals: This theme comprises examples of cases where triage assessed individuals and provided advice to police in the management of incident involving crisis or distress. Incidents might also include referral into secondary and third sector services.

Case 2 Example: Northern BCU (Cwm Taff)

6 months prior to triage: Assessed by the MHLT and taken to hospital by police due to concerns. Assessed and signposted to drug and alcohol services and crisis service details given.

Triage involvement: Two third party calls received, no risks identified and referred to local CMHT for assessment. Police called to property due to concerns in behaviour and taken to ED by police following advice from triage. Further assessment from MHLT who contacted police due to individual running off. Police contacted triage for advice who advised them to utilize the capacity act to remove the individual from the property and return to hospital. MH assessment arranged, after which the individual was admitted on Section 2 of the MH Act.

24 hours after triage: Remained on Section 2 of the MH Act.

1 month after triage: Discharged from MH Unit one month after contact with triage, however family raised concerns in her presentation and she was placed under the home treatment team.

Outcomes: Eight concern for safety notes are recorded for this individual between January and December 2019. The person was able to access support from hospital following detention on Section 2.

Information Sharing: This theme focused on examples where triage have liaised with services to facilitate support for an individual in crisis or distress, i.e., GPs, community MH teams or ED etc.

Case 3 Example: Western BCU (Swansea Bay)

6 months prior to triage: Receiving support from MH services including monthly medication monitoring. Regular Public Protection Notices (PPN) being raised due to safeguarding concerns.

Triage involvement: Individual was signposted to crisis services but declined telephone support. Triage staff requested a welfare check, which was declined by the area Sergeant. The individual was later seen by Ambulance but refused to engage.

24 hours after triage: No further contact.

1 month after triage: Three calls to services were made, during which the individual was reported to be demonstrating strange behaviour. The individual was reviewed by triage who liaised with the crisis team. Crisis agreed for the calls to be discussed during an outpatient appointment the following week.

Outcomes: Thirty 'concern for safety' calls and 3 public/welfare calls are recorded. Triage signposted the individual to a Mental Health Liaison Officer, Community Psychiatric Nurse and Anti-Social Behaviour Coordinator, who visited the individual at home and discussed his repeat contact to emergency services. Following communication between triage and MH services it was proposed that the individual writes down incidents of concern rather than ringing the police, however it is unclear from the data what affect, if any, this had on the number of calls made to (all) services.

Use of S136 under the Mental Health Act: This theme contains triage examples where S136 had been utilised by officers, both under advice from triage and in cases where officers did not engage with triage leading to potential escalation.

Case 4 Example: Northern BCU (Cwm Taff)

6 months prior to triage: Assessed by crisis and referred into primary care services. Signposted to CALL helpline (MH helpline) and information was given for third sector organizations. Changes made to medication.

Triage involvement: Use of triage due to concerns for safety, no risk identified and individual did not wish to engage with MH services and left with family. Police called again

in the same day due to escalating behaviour. Individual would not engage with triage and risk increased. Police utilized S136 upon advice from triage.

24 hours after triage: Individual subsequently assessed but discharged and returned home with family.

1 month after triage: Continued direct and 3rd party contact with crisis, however no further assessment was conducted. Referred to secondary services, however family did not consider this appropriate.

Outcomes: This person was not known to services and was not categorized as a repeat caller. There were 2 concern for safety calls and 1 missing person's report from January-December 2019. A S136 was used on the first day of triage and the individual was signposted to CALL helpline (for emotional support and information on MH), crisis team and GP.

Call Backs: Areas of Practice

The impact of triage on an individual's journey into MH services was further explored through examples of areas of practice from triage. Ten cases involving call-backs to individuals who had engaged with triage were presented to the evaluation team, relating to triage assessments and referrals. Cases are presented below, demonstrating how engagement with triage has facilitated: *referrals into services, de-escalation and support* and *information sharing / partnership working.*

Referrals into Services

1. **Nature of Call:** Third party caller had received a message saying that an ex-partner is at home self-harming. Images posted on social media.

   Triage Process: Triage spoke to individual who has a long history of emotional dysregulation and self-harm. Denied any suicidal intent. Triage identified use of distraction techniques as coping mechanism. Referred to Primary Care mental health services.

   Outcome: Call back found individual more settled and individual was happy that triage had referred them to talking therapy and provided telephone numbers for charitable organizations.

2. **Nature of Call:** Individual contacted 999, voicing thoughts of people breaking into his property. Reported that when police attend the alleged perpetrators leave.

   Triage Process: Heath information showed a history of alcohol withdrawal and impulsive overdose. Death of mother several months previous. Triage referred to CMHT and adult social services.

   Outcome: At point of call back individual had continued to abstain from alcohol. Triage advised him to contact alcohol services which they declined. Contact numbers provided for bereavement services.

De-escalation and Support

3. **Nature of Call:** Third party caller. Individual contacted 101 concerned that their ex-partner had voiced suicidal intent whilst their son is away.

   Triage Process: Contact with individual – inconsistencies in suicidal intent i.e., future planning regarding birth of grandchild and GP appointment to discuss referral to MH service. Caller assured triage that they had no intent of harming themselves. Protective factors and plans for the weekend discussed.

   Outcome: Triage called back as arranged, individual was more settled and had been shopping on the weekend for 'future' grandchild.

4. **Nature of Call:** Individual contacted 101 distressed that bailiffs were attending their property, and distressed at lack of financial support. Individual complained of suicidal thoughts because of current distress.

   Triage Process: No history noted and no current risks.

   Outcome: Triage called back later that day and arranged for PCSO to support in the community. Citizens Advice Bureau appointment made and individual agreed that family members would support.

5. **Nature of the Call:** Third party caller, concerned that adult child was driving erratically and having mental health issues.

Triage Process: Health notes indicated that individual had been seen by community liaison following overdose and sees a private psychotherapist every other week. Has marital problems, a volatile home environment and feels a loss of purpose. Triage contacted individual who reported an argument whilst they had been in the car.

Outcome: Female thanked triage for their time and discussed distraction techniques. Called back, no reply therefore literature sent for self- help.

6. **Nature of Call:** Third party caller, concerned individual was voicing suicidal thoughts due to a consumer dispute.
   Triage Process: Triage contacted individual who was at work. Individual spoke of stressors regarding a dispute with purchasing a mobile phone and feeling that no one was listening. No risks identified. Triage discussed stressors and looked at other options with the aim of seeking more constructive help. Further discussed a safety plan, where triage was reassured she had no plans on harming herself and was willing to accept support. It was agreed that triage would contact trading standards for consumer advice.

   Outcome: Triage phoned individual back that evening with update of information from trading standards, individual was thankful for the support and advice.

7. **Nature of Call:** Support worker called to report concerns about an individual (client) who had witnessed a neighbour committing suicide by jumping from an apartment block. Individual had self-harmed due to witnessing this.

   Triage Process: Notes revealed a history of substance misuse and contact with CMHT re: low mood related to trauma experienced and childhood sexual abuse. Previous attempted hanging and self-harm. Individual denied current suicidal intent; wounds had been seen medically and dressed. Individual did not wish to fully engage with triage whilst with the support worker and declined additional input from MH services. Individual will make contact their GP, has helpline numbers and number for crisis team - will contact them if mood changes.

Outcome: Call back as arranged; individual had been to GP and discussed stressors.

8. **Nature of Call:** Individual currently receiving MH service input contacted police seeming confused. Individual not happy with care team or of being removed from own home.

   Triage Process: Notes revealed individual receiving input from Social Worker in CMHT. Individual didn't want to leave own property; feels social worker isn't helping. No current risk. Individual lives alone with very little social contact. Individual had become a frequent caller to the police seemingly to orchestrate contact with triage. Permission given by Triage supervisor for triage to proactively phone individual on a planned basis once a week.

   Outcome: Individual reports speaking to triage helpful; uses calls to reflect on the past. Regular, limited contact has significantly reduced individual's calls to police.

Information Sharing / Partnership Working

9. **Nature of the Call**: Third party caller. Individual reported feeling low and having suicidal thoughts.

   Triage Process: Notes indicate individual receiving input from CMHT; diagnosed with depression and OCD. Feels isolated in current address and wants to move to be more socially active. No current risk. Triage liaised with CMHT to log the conversation and the concerns, and request a planned appointment be brought forward. Triage also explored if CMHT could refer him for support to engage in more activity.

   Outcomes: Call back to provide an update; individual has telephone details for the CMHT.

10. **Nature of the Call:** Third party caller concerned individual had engaged in self-harm and was voicing suicidal thoughts. Officers attended scene (home address), assessed risk and arranged for triage to contact before leaving.

Triage Process: Notes report discharge from crisis following assessment. Individual reported high stress due to no income and no access to food banks. Reported feeling let down by others and feeling ignored. No support network. Long history of self-harm through cutting. Reported having drunk bleach 4 days previously and assured triage they would seek medical help. With consent, triage contacted previous GP, who advised on how individual could register with a local GP and access support services.

Outcomes: Call back to provide instructions to individual to register with GP. Subsequent call (later that day) – individual had registered with a GP surgery and made an appointment for the following morning. Individual reported feeling more positive and that help is finally being obtained. Due to individual's poor literacy, triage contacted GP to request referral to primary care MH services, and to third sector services.

Conclusions

The current report presents the findings from a second evaluation of the South Wales Police PCS Mental Health Triage Service (data period: June-December 2019), to measure the potential ongoing 'need rate' of triage in terms of staff engagement and S136 use. Extending outcomes from evaluation of the implementation period (Broome & Davies, 2019), the current evaluation considered some of the potential social (care) benefits of triage, exploring the service user's journey in and out of triage and by capturing the value of triage from both service users and relevant professionals. This was achieved through analysis of: police and health data, triage case examples, areas of triage practice and outcomes from a Stake Holders event in which focus groups with triage service users (direct callers and carers) and relevant professionals (senior police, health and third sector staff) were held. Detailed below are outcomes relating to the current evaluations key objectives.

Objective 1: To examine key outcomes (e.g. S136 detentions) from June – December 2019 to allow comparison with the findings from the first evaluation

Overall, there has been a 21% reduction in S136 use across the force since initiation of triage (2018 vs 2019 detentions), leading to an estimated £231,743 of cost avoidance across

Western, Northern and Eastern BCUs. Trend analysis for the current reporting period (June-December 2019) show a significant decrease in S136 use across the latter half of 2019 (compared to 2018), with a 51% reduction in December 2019 compared to the previous year. As seen in the first evaluation (Broome & Davies, 2019), the largest reduction is seen in Western BCU (Swansea Bay), with a reduction of 36% in 2019 compared to 2018. Leading to an estimated £174,624 opportunity cost reduction for S136 use in this area.

The cost avoidance across the police, NHS, ambulance service and local authorities associated with changes to S136 use alone covers just over two thirds of the total annual service costs for triage (£321,000).It has not been possible to quantify the full cost effectiveness of triage on services, however the expertise of triage staff in diverting people from hospital/crisis admissions and offering police alternative approaches to MH management, might lead to significant costs saving across services. On this basis, it is likely that there are many other potential cost savings / cost avoidance as well as improved outcomes which are more difficult to explicitly quantify.

Engagement in triage has grown across all four BCUs, with an overall 298% increase in MH tagging across the South Wales Police area at the end of the reporting period (December 2019). Data during the first evaluation showed a steep growth in MH tags from January to May 2019, with data for the current reporting period (June-December 2019) revealing that tagging rates have stabilized. This might be expected as triage becomes embedded into service practice, and is also evidence that triage has overcome the early implementation challenges identified in the first evaluation, including a lack of confidence from officers in triage expertise and concerns surrounding data protection (Broome & Davies, 2019). Tagging rates during the latter half of the year might therefore indicate the likely longer-term service need of triage.

Western (co-terminus with Swansea Bay University Health Board) has the greatest engagement in triage, however, further research is needed to consider the various factors that may facilitate or hamper S136 use and engagement with and benefits from the triage service. For example, the role of geographical and force differences, proficiency of services, rates of MH occurrences, incident types, numbers of staff and population factors may all be important to understand. Further data is also needed in relation to S136 outcomes and how this might be affected by triage engagement. For example, it is important to be mindful that discharge from S136 is not always due to inappropriate use of the Mental Health Act. Mind Cymru suggest

that individuals can be discharged after S136 assessments due to being under the influence of alcohol or other substances and experiencing high levels of distress (National Assembly of Wales, 2019). This would require cross agency data collection to assess the role triage might have in reducing a potential 'revolving door' situation, in which individuals are discharged and signposted to their GP, only to escalate and again be detained under S136.

Objective 2: Part A) Impact of triage on known repeat callers - including persistent callers; B) Evidence of successful signposting to, for example, the GP, charities and other third sector agencies and successful assessments and referrals to secondary services and crisis; C) Examples of users journey 6 months before triage / 24 hours and one month after engagement

It was not possible to quantitatively examine the impact of triage on repeat callers (i.e., those who persistently and regularly contact 999 emergency services); however, a majority of the triage case examples relate to repeat callers and demonstrate the work of triage in the management of these individuals; including providing alternative strategies to managing concerns and being pro-active in identifying the root cause of repeat calling. Future evaluations should consider the long-term implications of this and data is needed to fully examine the impact of triage in supporting repeat callers and reducing demand on services.

Triage service users valued a service that listened and facilitated support during times of crisis and distress. However, there are significant challenges in accessing follow-on care from services signposted by triage. The absence of follow-on care following MH crisis has been raised by both Samaritans and Barnardo's, with an individual being particularly vulnerable the following seven-days after a MH incident. The Samaritans said: *"If someone's attended A&E due to self-harm or a suicide attempt, the following seven days is the period where there's the highest risk of suicide. So, if they're not given follow-up support, within those seven days, suicide attempts or ideation is increased. It's crucial that support is given to them as soon as possible"* (National Assembly for Wales, 2018). Triage might act as an intermediary service in the management of such individuals, particularly during out-of-hours when individuals might feel vulnerable and scared. Thus, providing an opportunity to capture individuals with ongoing needs and promote partnership working across services to ensure preventative support is in place for the individual.

Triage is a positive example of joined up working across health and police that aims to ensure individuals experiencing MH distress or crisis are appropriately supported. Thus, addressing the South Wales Police & Crime Plan (2018-2021) priority of developing better pathways for individuals experiencing MH concerns. However, currently there is no 'built-in mechanism' whereby multi-agency reviews are triggered to support individuals who have been referred into MH or third sector services from police (Royal College of Nursing, 2019). Until services (i.e., health, third sector, police) work together to release data on referrals into services, outcomes following discharge of S136 or after signposting into services, it will be difficult for service evaluations to fully explore the long-term impact of triage on individuals and service demands.

Limitations

The current evaluation was limited in respect to available health data, which was primarily sourced from the Cwm Taf Health Board Access Review and only captured outcomes from December 2019-January 2020. Further, data collection represents activity from the Cwm Taf area only and should be considered cautiously when generalised to BCU areas co-terminus to Swansea Bay and Cardiff & Vale University Health Boards. Data across all relevant health boards is needed to examine differences in outcomes across areas, and a wider data reporting period should be considered for future evaluations. Access to health data was also a significant limitation to the initial evaluation (Broome & Davies, 2019) and police and health should continue working together to ensure access to and the availability of high quality health data. This should include non-mental health services such as A&E, GP and ambulance data.

Triage case examples showed that triage is being pro-active in the management of repeat callers, including developing individual plans and working with MH services to address the root cause of this behaviour. However, it was not possible to report on the long-term impacts of these approaches and the potential benefit to individuals and service demand. Future research should examine quantitative changes in repeat, frequent callers to explore the long-term impact of triage's management of such callers. The triage case examples were selected by triage staff and may therefore be seen as biased in some way. Nevertheless, the case examples contain themes echoed elsewhere in this report and the previous evaluation and from the service users who engaged in the focus group.

The cost-avoidance estimates of S136 detentions were based on figures presented by Keown et al (2016) and represent calculations from the North-East of England. Additionally, it is unclear how the estimate of £1,632 was calculated, which is important to enable calculations of S136 costs in South Wales by the respective services. A cost analysis of the SWP triage model would overcome this limitation and enable further estimations of the potential savings across organisations for triage interventions (c.f. mobile crisis team costs impact: Lancaster, 2016).

One of the primary objectives of the current evaluation was to begin to understand the nature of social concerns and the demand for resources and services in respect of these. Social and lifestyle concerns accounted for a notable number of incidents (19%), however the categorization of the caller's main issue was unclear. For example, some categories overlapped with psychological wellbeing and a diagnosable MH condition (i.e., low mood/depression and stress/anxiety/panic). Further, a 'diagnosable mental health' issue was recorded as 'other issues' for 238 cases where the main issue was categorised otherwise. Triage should consider having discrete categories for diagnosable MH conditions and wellbeing/lifestyle factors to enable future evaluation of the demand on services from social concerns. Further, engagement with social care and third sector services is essential to help determine the long-term impact of triage. Examining how triage might have prevented further escalation of distress and consequent MH problems for those experiencing poor psychological wellbeing (i.e., loneliness, debt, bereavement etc.). This might also be an alternative approach to measure the potential costs savings to services when triage have intervened.

Future Work / Recommendations

In addition to the points already presented, attention should be made to the following:

1) Continued in-house, routine evaluation of the ongoing service demands.
2) Should this model of triage be rolled out across other forces in Wales, a detailed multi-force/agency evaluation is needed focusing on: lessons learned from the pilot, multi-agency outcomes, detailed cost estimation across services and the long-term impact on users of the service (both direct and 3rd party users).
3) Consider alternative approaches to measure the impact triage might have on service activity, which might include cost-avoidance and savings across services when triage

has diverted people from hospital/crisis admissions by signposting and referring into appropriate services.

4) Collaboration with police, primary and secondary services and third sector agencies to measure the long-term impacts on service user outcomes and service demands. This is needed to ensure data across all sectors is available to evaluation teams to overcome the limitations of both the first and current evaluations. Continued working partnerships between services is vital and secondment of CPN into the police will ensure appropriate data sharing is maintained.
5) Follow the service user journey into MH services and the third sector, to measure how triage has facilitated multi-agency support of individuals with MH concerns. This requires a 'built-in mechanism' whereby multi-agency reviews are triggered when an individual has been referred into services by triage.
6) Multi-agency partnerships are needed to consider the challenges experienced in accessing follow-on support from triage. Addressing recommendations 3 and 4 might facilitate this process by enabling triage to review support already in place for an individual, ensuring appropriate and relevant signposting advice is given. Regular meetings between agencies to identify best practice, consider the data to be collected and reported and to develop (refine) appropriate frameworks for partnership working (e.g. through Memorandum of Understanding) should be ongoing.
7) Exploration of confounding factors that might have contributed to S136 variations across BCUs. This might include geographical differences, population estimations and demographics, arrest rates, staff concerns (i.e., staff resources or management structures) or policing processes.
8) Sufficiency of provisions for PoS across BCUs, including management of intoxicated or violent individuals.
9) S136 discharge outcomes from health boards, to enable future evaluations to consider levels of appropriate and inappropriate detention rates.
10) Case study analysis of Western BCU to explore triage engagement in this area. This might facilitate information sharing and allow future evaluations to consider factors outside of triage that might be influencing decision making.
11) Development of a Service User Forum to facilitate information sharing between triage service users, professionals and stakeholders.
12) Consider additional measures to examine triage impact, including but not limited to: distress ratings during calls; routine follow up to understand both impact and actions;

and monitoring impacts on other services. For this to be achieved access to a range of system would need to be facilitated (e.g. GP, A&E, crisis teams, CMHT, social care, ambulance call data).

13) Consider triage staffing processes and working patterns to prevent burnout and maintain levels of expertise. For example, link triage with specific existing health board services (e.g. crisis response / intervention teams or hospital psychiatric liaison teams), allowing staff to rotate into triage work more routinely.

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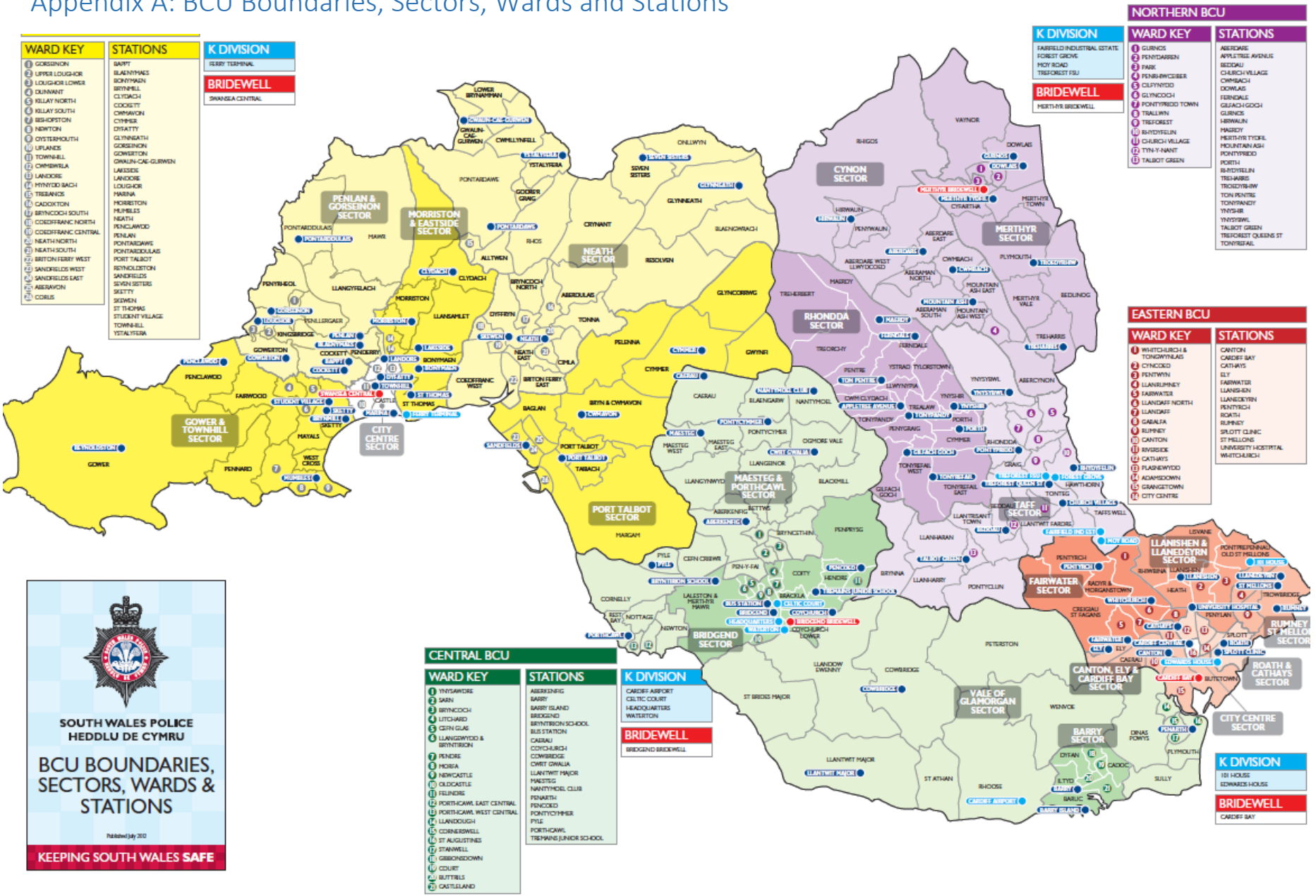
Appendix A: BCU Boundaries, Sectors, Wards and Stations



Mental Health Triage User Survey

Appendix B: Service Users Survey

Swansea University
Prifysgol Abertawe

Objectives of the survey:

To gather your thoughts and opinions on the South Wales Police Mental Health Triage. Survey outcomes will be used alongside today's activities to help us understand the impact of Triage on users and to consider ways in which it might be improved.

1. What is your gender?

☐ Male ☐ Female ☐ Other ☐ Prefer not to say

2. What is your age group?

☐ 18-25 ☐ 26-35 ☐ 36-45 ☐ 46-55 ☐ 56-65 ☐ 66+

☐ Prefer not to say

3. How many times have you engaged with the Triage service?

☐ Once ☐ 2-4 ☐ 5+

4. What was your route into Triage? Please tick.

☐ I called 999 ☐ I called 101 ☐ Someone called 999/101 on my behalf ☐ Via a police officer

5. On a scale of 1-5, how helpful was this contact? Please circle your answer.

1	2	3	4	5
Not helpful	A little	Somewhat	Quite a lot	Very helpful

6. Before engagement with Triage had you received support for your mental health from other agencies?

☐ Yes ☐ No

7. Did Triage help you find the support you needed?

☐ Yes ☐ No ☐ Unsure

8. If you answered 'yes' to question 7, how this was achieved? Please tick those relevant.

☐	☐	☐	☐
New referral to MH team	Signposting to another service	Referral to A&E	Communicated with MH teams on my behalf

☐ Other. Please provide details: _____

9. On a scale of 1-5, how much do you agree with the following statement? Please circle your answer.

Without Triage I would not have received the support I needed.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Additional Comments

Thank you very much for taking the time to complete this survey. Your feedback is valued and very much appreciated!

Appendix C: Triage Ballot Vote

South Wales Police Mental Health Triage Ballot

How much do you agree with the following statement? Vote by placing a cross in the box next to your choice.

'Triage is a valuable service that provides support and advice to people with mental health concerns.'

Strongly Agree	☐	Neutral	☐
Agree	☐	Disagree	☐

Appendix D: Service Users Event Schedule and Probing Questions

	Activity	Timing
	PART 1	**50 minutes**
1	• Welcome / users to complete short survey on arrival **Introduction to session and who's who** • Introduce the aim of session (i.e., what we're doing, focus on thoughts & feelings towards triage not disclosure of personal circumstances / support available if anyone is affected by discussion / police available for specific questions on triage at the end of the session etc.) • Each person to introduce themselves (names only) **Icebreaker – Word Bank Task** • Ask users to think of as many words as they can when they think of Triage, write each word on a postit. Can relate to anything i.e. who might use it, feelings, etc. Throw postits in a box in the centre of the group • Ask users to pick one out and read to the group, what are peoples thoughts?	17.00 - 17.10 17.10 - 17.20
2	**Group discussion (split into two groups; triage service users and professionals - Laura and Jason to then lead one each)** • Probing questions 1. In what way, if any, do you think Triage helps people? 2. Without disclosing any personal information, do you think your situation might have escalated if Triage didn't exist? 3. Have you experienced any improvements in how police officers respond to MH concerns since Triage has been introduced? 4. What difference can a service like Triage make on society? 5. How might Triage improve the way the police and health support people with MH concerns?	17.20 – 17.50
	BREAK	**30 minutes**

	PART 2	45 minutes, plus time for questions
3	**Free listing task (completed as separate groups)** • Discussion around strengths, weaknesses, improvements of triage. Ask users to list their thoughts on each domain • Discussion around answers	18.20 – 18.35
4	**Wishing task group discussion** • If there were no restrictions to budgets, services etc, when it comes to MH support what would be the ideal? • Discuss from the perspective of police initially, then the health service**.**	18.50 – 19.05
5	**Anonymous vote** • Users to compete a voting ballet as below, place response in box 'Triage is a valuable service that provides support and advice to people with MH concerns.' Strongly Agree Agree Neutral Disagree Strongly Disagree	
6	**User questions and close** • Specific questions about this research / Triage? • Would you be willing to be contacted again in the future to help support our research?	

Appendix E: Service Users Event Invite Letter

CADW DE CYMRU'N DDIOGEL • KEEPING SOUTH WALES SAFE

Dear

Invitation to Service User Event – 9th January 2020

South Wales Police have experienced a steady increase in the number of mental health related calls year on year since 2012 through both our call centre (Public Service Centre) and on the frontline. This places officers in a difficult position, as they do not have the level of expertise to determine the best outcome for an individual with mental health crisis. Therefore in January 2019, South Wales Police invited Mental Health Professionals to work within our force call centre alongside call handlers and police officers to provide advice and support to mental health related incidents.

We want to learn from the experience of the service user so that we can reflect and improve our service to those suffering with mental health issues. Therefore, we are holding an event on 9th January 2020 at 17:30hrs, which will provide service users an opportunity to speak to us and other professionals regarding the service received. Our records show that you have had contact with the Mental Health Professionals based within our Police Headquarters this year and we would like to give you the opportunity to help us shape our service for the future by reflecting on your experience and making improvements for the future.

The event will be informal and will be attended by Health Services, Mental Health Professionals, Hafal who are the leading charity for people with serious mental illness and South Wales Police representatives. There will also be refreshments provided.

The address details for the event are below:

Hafal Headquarters, Unit B3
Lakeside Technology Park, Phoenix Way
Llansamlet, Swansea
SA7 9FE

If you are interested in attending this event or would like further information, please contact Detective Inspector Chris Grey by email at Christopher.Grey@south-wales.pnn.police.uk. If you are in receipt of benefits, you will be entitled to claim back any travelling expenses so please keep any receipts.

Appendix F: Triage Case Examples: Triage Users Journey

Support and Signposting to Services

Case 5 Example: Western BCU (Swansea Bay)

6 months prior to contact: Four calls were made in January 2019, the outcomes of which included assessment in custody, being placed on Section 2 of the Mental Health Act and an ED admission due to a reported overdose. Triage attempted to contact this person on two occasions but were unsuccessful. Five further calls were made in July 2019, concerning reported self-harm, hearing voices and feeling suicidal. Again, triage attempted to make contact but were unsuccessful and officers transported the individual to hospital for assessment. The service user was signposted to crisis services, the out of hours GP and other services (i.e. WCADA (drug and alcohol service), CALL helpline.)

24 hours after triage: A further 4 calls were made including direct contact from the individual and 2 third party calls from the fire service. The triage team gave the individual signposting advice (to contact their GP).

1 month after triage: Eight further calls were made relating to intoxication, suicidal thoughts, hearing voices and self-harm. Triage signposted to GP, WCADA, and Mind and advised to await Out Patients Appointment (OPA).

> **Outcome**: This individual had 18 concern for safety calls and had contact with the police a total of 9 times in the six months leading up to contact with triage, demonstrating MH concerns in all calls. Triage staff attempted to contact this individual on several occasions 6 months prior to triage and signposted the individual to the crisis team, their GP, the out of hours GP and drug and alcohol services for support, leading to a MH diagnosed and they are now on medication.

Case 6 Example: Northern BCU (Cwm Taff)

6 months prior to triage: The service user was care managed by a Community Psychiatric Nurse and had entered the triage service multiple times. Each time, despite being 'suicidal', assessment suggested vague plans, a lack of intent and evidence of future planning. Following each assessment the service user has remained at home and been advised to

contact the CPN or the appropriate crisis team with triage also providing an update to the CMHT following each call.

24 hours after triage: No further contact.

1 month after triage: Continues to be care managed by the CMHT.

> **Outcomes**: This person is a repeat caller, with 25 concern for safety calls between January-December 2019. There was no use of S136 in this case, with the person being signposted to CPN and CMHT duty desk. Triage contacted the CPN to facilitate support.

Case 7 Example: Northern BCU (Cwm Taff)

6 months prior to triage: Seen by Primary Care Services and placed on waiting list to see psychiatrist. Also assessed by crisis and advised to continue input with primary care. Medication changed made.

Police attended home following concerns raised by doctor in Primary Care. Triage advised officers of recent contact with services and the advice that had been given. As there was no change in presentation since those contacts, the individual was told to continue with previous advice. Signposted to drug and alcohol services.

24 hours after triage: No further contact.

1 month after triage: No further contact with triage or police – disengaged with Primary Care services. Did not engage with drug and alcohol services.

> **Outcomes:** Despite not being categorized as a repeat caller, five concern for safety calls were made between January-December 2019. The individual was signposted to appropriate services but did not engage.

Case 8 Example: Northern BCU (Cwm Taff)

6 months prior to triage: Discharged by secondary care services to the care of GP. Officers had concerns for the individual's mental health, however when the officer liaised with triage the individual was calm and engaging. It was decided that a triage assessment was not appropriate at that time although the individual was offered an assessment with the crisis

team but refused. It was felt that the individual had capacity to refuse and as there were no immediate concerns or risks the individual was advised to self-refer to the community mental health team the following day if required.

24 hours after triage: No further contact.

1 month after triage: No further contact.

> **Outcomes:** Four concern for safety calls and 6 abandoned calls were made between January-December 2019. Triage signposted individual to CMHT, no further contact with services was made 1 month after triage.

Assessments and Referrals

Case 9 Example: Northern BCU (Cwm Taff)

6 months prior to triage: Individual had previously received Primary Care Mental Health Support Services. Two previous assessments were conducted with the crisis team, due to voluntary referrals. Discharged on both occasions with advice to engage with Primary Care, however engagement was sporadic.

24 hours after triage: Triage involved due to self-harm and conveyed to ED to be treated and assessed. No further input from MH services and given contact for crisis team.

1 month after triage: Two more assessments by crisis as well as multiple phone contacts made by individual to crisis.

> **Outcomes:** Nineteen concern for safety calls made between January-December 2019. No S136 was used and triage signposted to the ED and MHLT.

Case 10 Example: Northern BCU (Cwm Taff)

6 months prior to triage: Unknown.

24 hours after triage: Taken to ED by ambulance but was not assessed by mental health services. She was in contact via telephone with the crisis team the next day.

1 month after triage: Continued to have contact with CMHT and crisis.

Outcomes: This person is a repeat caller, with 17 concern for safety calls between January-December 2019. Triage referred to ED and she was put in contact with crisis. This individual is now awaiting allocation of CPN.

Information Sharing

Case 11 Example: Eastern BCU (Cardiff and Vale)

6 months prior to triage: Individual was assessed by the CMHT and referred for Floating Support and First Point of Contact (FPoC). Further assessment conducted by crisis and informal admission offered, but refused. CPN support was offered but numerous telephone calls were made and unanswered. A welfare check was requested, however crisis team made a home visit and no immediate concerns were raised. Third party call from Hafod received as individual was expressing suicidal thoughts. Triage assessment found no immediate concerns. Ambulance was later called; no immediate concerns and she was discharged from secondary MH.

During the incident, triage contacted the individual's GP who spoke directly to them to offer an appointment which was refused. Individual also refused to attend the ED (superficial self-harm and under the influence of alcohol).

24 hours after triage: No further contact.

1 month after triage: No further contact.

Outcomes: Thirty-nine concern for safety calls and 1 public safety/welfare call were recorded between January – December 2019. S136 was not used and triage signposted back to the GP for support.

Case 12 Example: Northern BCU (Cwm Taff)

6 months prior to triage: Under the care of the CMHT, however engagement was poor.

24 hours after triage: Triage contact care team to make them aware of the call.

1 month after triage: Joint visit with CMHT and social worker at home. MH considered poor and individual was admitted into hospital.

Outcomes: There were 24 concern for safety calls and 29 reports of anti-social behaviour between January-December 2019. S136 was not utilized in this case but triage contacted the individuals care team to inform them of contact.

Use of S136 under the Mental Health Act

Case 13 Example: Central BCU (Cwm Taff, Bridgend)

6 months prior to triage: Three admissions to MH ward.

24 hours after triage: Advised to stay at friend's house and use his medication. Was later placed on S136 without engagement from triage. Discharged home with signposting advice.

1 month after triage: Attended outpatient's appointment, 3 presentations to ED and discharged home, admitted to MH ward following assessment in custody, assessed as a voluntary patient, self-presentation to crisis and discharged home.

Outcomes: This individual made 18 concern for safety calls between January and December 2019. Officers detained under S136 without engagement with triage. Following S136 assessment, he was discharged home with signposting information. Engagement with triage might have prevented escalation to S136 use.

Case 14 Example: Eastern (Cardiff & Vale)

6 months prior to triage: Between January and May 2019, the integrated Autism Service saw this individual and they were reviewed by the Community Mental Health Team and Cynnwys. The CPN attended several home visits, but the individual frequently refused telephone support, visits and appointments. Several visits to the ED were also made with officers and WAST, resulting in assessment and discharge back to CMHT for follow up. Crisis was contacted and signposting advice given. This individual was placed on a S136 without contact to triage, she was discharged following assessment.

24 hours after triage: Triage completed. Given advice and signposted back to her CMHT.

1 month after triage: Individual did not attend appointment with CMHT, they were seen by WAST and a call to crisis was made and advice given. Second engagement with triage who

advised she remain home with her parents, a few days later she was informally taken to hospital for crisis assessment and was discharged.

Outcomes: From January - December 2019, there were 52 concern for safety recorded for this individual. Officers detained this individual under S136 without contacting triage. She was discharged after assessment with signposting advice back to the CMHT. Engagement with triage might have prevented escalation to S136 use.