Appendix 2 – Partnership Initiatives undertaken with funding from the Police and Crime Commissioner

1. Mental Health Triage

1.1 The Mental Health Triage began operating on 1st December 2014 and is made up of a multi-agency team of police and mental health workers that operate between the hours of 5pm-2am, 7 days a week to provide a mental health triage assessment for members of the public coming into contact with the police where mental health issues are considered a factor in incidents. The team is based at Coventry Central Police Station and use a marked police vehicle to operate out of. Each response shift they operate to also has an identified sergeant acting as Single Point of Contact (SPOC). Out of hours clinical support is also provided via the crisis team, bleep holder and on call co-ordinator.

1.2 Calls are allocated to the service via police telephone operatives, however, calls for this service can also come via all police officers based in Coventry. The local Police Inspectors and Sergeants continue to maintain an awareness of incidents to ensure the service does not operate in isolation of neighbourhood policing duties. The Mental Health Team can offer advice on incidents and share relevant information whilst they are committed to attending other incidents.

1.3 The criteria for mental health used includes mild-moderate mental health issues, severe mental illness, personality disorder, dementia, substance misuse, learning disability, acquired brain injury, autistic spectrum disorders and emotional/behavioural difficulties.

1.4 The service is an all-age service and will attend incidents relating to children and young people, older adults as well as adults of working age. The service will prioritise incidents where s136 of the Mental Health Act is being considered, other priorities include incidents involving self-harm, suicide (including victims of crime) and where mental health is felt to be central to risk to others, crime and unusual behaviour.

1.5 The service is also reviewing areas of high demand from individuals and location to ensure multi-agency work is targeted to those who need it most.

1.6 All key clinical and police staff were identified through a volunteering process and resulted in a high level of interest with some 25 volunteers across 5 response teams being nominated. Initially 15 of the police officers, one sergeant (SPOC) from each response team and all of the mental health practitioners were trained and the remaining officers will be trained over the next 2 months which will allows cover for personnel changes, annual leave, training etc. The training provided incorporated mental health act, powers, hidden harm, physical health, roles and responsibilities, clinical assessment, mental health awareness, risk assessment/decision making, working together and safety. In addition, all response officers will have received bespoke mental health awareness by the end of March 2015.

1.7 An overview of performance to date, shows that a total of 225 incidents were responded to between 1st December 2014 and 28th February 2015. These incidents were broken down into the following categories:-

<u>Demographics</u>

- 54% were male
- The largest ethnic origin of individuals seen was White British (79%)
- 35% had previous convictions

- 46% were currently open to mental health services
- 30% had an active care plan (64% of those open to mental health services)
- 22% were previously known to mental health services
- 23% were known to substance misuse services

Reason for referral

- 8% were referred as missing persons
- 60% were referred due to risks to self
- 10% were referred due to risk to others
- 12% were referred due to intoxication
- 4% were referred due to violence
- 11% were referred due to other aggression
- 25% were referred due to unusual behaviour

Referrals

- 48% of incidents were attended by the triage service as the first/only unit to attend
- 66% of incidents were in a public place
- 79% were seen for a face to face assessment
- 29% of incidents were also attended by ambulance
- 76% of incidents was the first contact with triage car
- 21% of incidents the use of s136[1] was considered
  - considered in 62% of incidents attended in public place

1.8 Key Performance Indicators and Outcomes can be seen on the table below

	Target	Number Seen	Number Applicable	Number Offered	% Achieved
Percentage of individuals with a mental health issue who were not known to MH services and who want a referral, receive a referral	100%	225	63	63	100%
Percentage of individuals with a substance misuse issue who were not known to drug / alcohol treatment and who want a referral, receive a referral	100%	225	16	16	100%

	Target	Number Seen	Number Applicable	Number Diverted	% Achieved
Number of s136 detentions prevented and / or diverted (where s136 occurred within operational hours of the Street Triage service)	15%	225	81	48	59%

[1] s136 powers can only be utilised in a place that the public has access to

	Target	Number Seen	Number Prevented
Number of A&E conveyances / attendances prevented (NB Number prevented excludes incidents where conveyance to A &E was not appropriate or where Ambulance was already in attendance)	Baseline	220	73

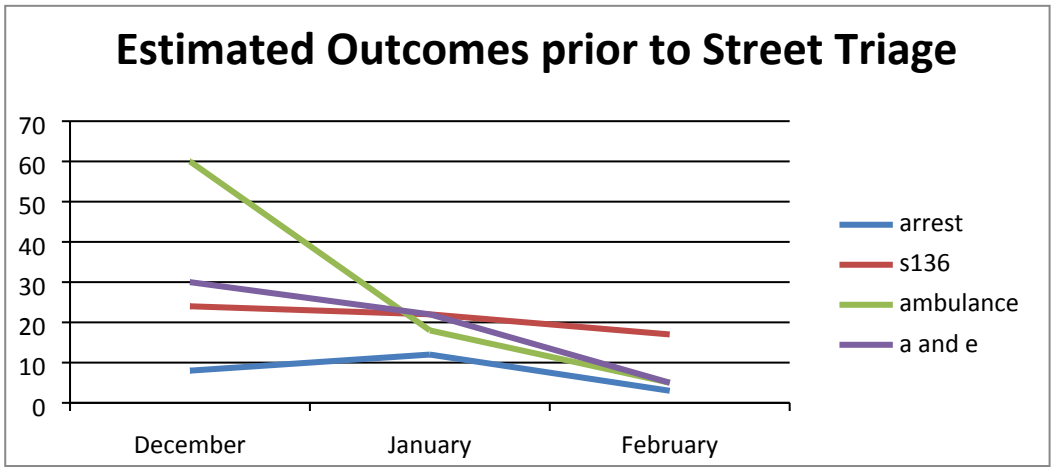
Conveyance

1.9 The Police and crime plan states that those experiencing mental health crisis should be conveyed in an appropriate vehicle not a police vehicle

- 35% of all incidents required some form of conveyance to a variety of locations (home, alternative accommodation, hospital)
- An ambulance was utilised in 53% of incidents requiring conveyance
- A police vehicle was utilised in 42% of incidents requiring conveyance e.g. conveyance to alternative accommodation
- A police vehicle was used to convey to a health facility on 10 occasions

1.10 It is interesting to note that the use of Police vehicles to convey has reduced and use of ambulance has increased. This is in line with the multi-agency policy on conveyance. This may reflect an increased understanding of the issues through training emphasising parity of esteem, dignity and conveyance policy.

- **Outcomes of Referrals**15% were detained on s136
- 8% were subsequently detained under the mental health act
- 4% were informally admitted to a mental health unit
- Police officers estimated that a total of 391 hours (approx. 44 shifts) were saved by providing a service closer to home and using alternative pathways
- Police officers reported that prior to the introduction of the triage car they would have used alternative outcomes in specific incidents
  - In 8% of incidents they would have arrested for an offence
  - In 21% of incidents they would have detained under s136
  - In 28% of incidents they would have requested an ambulance to attend
  - In 19% of incidents they believed admission to A and E was appropriate



1.11 The reductions in estimated use of ambulance and A and E may reflect that police officers are beginning to become more familiar with alternative pathways.

Case Examples

There were many examples where the triage team intervened when s136 was being considered in situations of self-harm, suicide or risk to others where the input of the triage team has diverted from s136, contributed to assessment of mental health and risk assessment and provided options for on-going pathways.

1. Joint work with Ambulance

Female reporting threats to self-harm and harm to others.. Originally ambulance were called, they were planning to take to ED or considering s136 with involvement of police. Following joint assessment of mental health and risk it was decided not to take to ED. Liaison with accommodation, support/strategies with managing difficult behaviour from both police and mental health.

2. Victim

Support was given to a victim of domestic violence, where police were concerned about her mental health. This intervention led to the victim receiving immediate support and access to other specialist support services.

3. Incident at private residential premises

Police call out to report of fire. Fire Officers confirmed that it was a small fire, female tenant confirmed fire was set in attempt to end her life. Joint approach from police, ambulance and mental health prevented situation from escalating, would have placed considerable demand on resources given suspected level of self-harm and aggression this may have caused. Underlying trigger was found to be fear of further domestic violence, referrals made through single point of contact for domestic violence safety, assistance from support worker given to attend and engage with referrals and to attend review with GP.

1.12 Future Developments include:

- Reviewing the operational model to ensure that the triage service is being utilised for all appropriate incidents and during the hours when it can be most effective.
- Review the pathway between mental health street triage and West Midlands Ambulance Service/NHS 111.
- Engaging with those individuals and locations that are using wider services and supporting services to understand the needs and meet these as appropriate.
- Monitoring delivery of Key Performance Indicators and Clinical Outcomes
- Building on existing working arrangements with third sector, Secondary Care Mental Health Services e.g. Community Integrated Police Units, Crisis Team, Place of Safety and Children and Adolescent Mental; Health Services (CAMHS) to focus on pathways.
- Establishing Service User feedback, experience and satisfaction measures.
- Mapping local training needs for Coventry and Warwickshire Partnership Trust, local Police and other key stakeholders.

2. Coventry Criminal Justice Liaison and Diversion Trial Scheme (June 2014-December 2014)

1.1 The scheme began operating in June 2014 with the overall aim being to improve the appropriateness and timeliness of information sharing across agencies and for lawful purposes in preventing and minimising risk of harm crime and nuisance through:

- Information that assists with decisions in relation to charging and sentencing within the criminal justice system.
- Assessment which are undertaken and fed back to custody and/or investigating officers with consent from the individual with which to inform decisions in respect of charging.
- Decisions regarding sentencing are mainly being informed by contributing to pre-sentence reports. Support, supervision, consultancy and training
- Informal advice and support provided in respect of the nature of health and social vulnerabilities is facilitated by being co-located in the youth offending, police and probation services.
- To inform additional training needs
- Improved risk management
- Joint agency professional meetings are attended to discuss risk management and attendances at Multi-Agency Public Protection Arrangements, Multi-Agency Risk Assessment Conference to discuss the health and social care needs of those who have offended or who are likely to reoffend.

1.2 The service operates during the hours of 0730-2000, 7 days a week with flexibility to work beyond the extended hours where a planned need arises. The scheme has integrated well within Police and Probation and is further developing integration with Youth Offending Service.

1.3 Briefing sessions were held for magistrates and the service stared working within the magistrates and crown court on 1st October, court work is also being identified through liaison with Probation Court Team and Pre-Sentence Report Writers.

1.4 Early Identification is key to providing services and interventions to support individuals with health and social care vulnerabilities at the earliest opportunity and so a rolling programme of briefings to all Neighbourhood Team Sergeants, Adult and Child Public Protection Unit teams, Police Force CID and Response Team Sergeants is being scheduled. Within this programme of briefings there will be a focus on identifying young people coming into contact with the criminal justice system including those suspected of offences, or attending voluntary interviews and community resolutions. This will ensure that young people attending for voluntary interviews will receive the same level of access to services as those detained in police custody currently do.

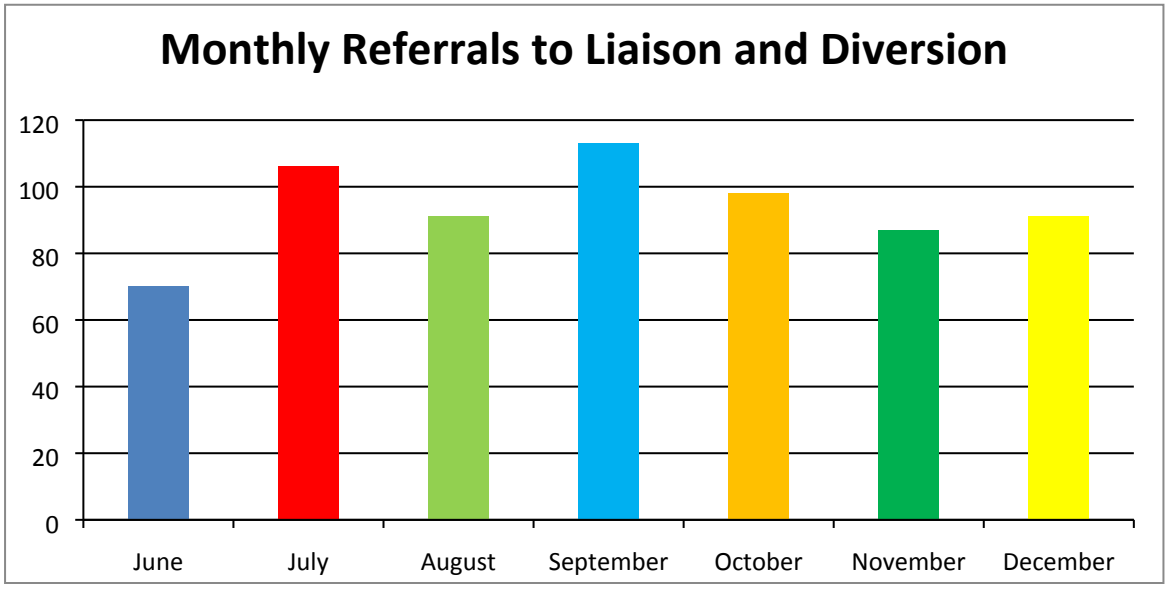
1.5 The age of individuals benefiting from the scheme varies considerably with the youngest being 10 years old and the oldest being 76. The average age is 35.

1.6 Physical health needs were identified in 14% of individuals referred, Mental Health needs in 61%, Learning Disability needs in 6%, Social and Communication needs in 6%, Alcohol related needs in 35%, Substance Misuse related needs in 33%, Accommodation needs in 17% and Financial needs in 8%.

1.7 The physical needs of Children and Young People were identified in 0% of individuals referred, Mental Health needs in 65%, Learning Disability needs in 6%, Social and Communication needs in 15%, Speech and Language needs 6%, Alcohol related needs in 18%, Substance Misuse related needs in 24%, Accommodation needs in 12%, Financial needs in 3%, Employment, Education and training needs 26%, Gang related Involvement 6%, CSE, 9% and Bullying 6%

Referrals

1.8 Assessments undertaken between June and December 2014 resulted in 656 referrals, an average of 94 referrals per month.



- 82% of referrals came from police and 13% from probation.
- For urgent referrals 79% were seen within 30 minutes, 90% within one hour, 96% within 2 hours, 98% within 3 hours. The longest wait was 6.75 hours.
- Non-urgent referrals were seen within 2-31 days, average 7.6 days, lengthier delays were usually at the request of the professional involved.

On-going Engagement of individuals

1.9 The operational model highlights the importance of following up referrals to other agencies and providing brief interventions. 1,186 were offered follow up support, 93 (14%) of these however did not take this up/attend follow up appointments (On average 2.2 contacts were offered per referral), however all non-attendances were followed up by officers making contact with the individual or the services working with the individual.

1.10 During the months of October-December 2014, 44% of the adults referred were previously known to Mental Health services (this includes referrals with no further action), 16% were previously known to Substance Misuse services, 4% to Learning Disability services, 2% to Autism services and 8% to Social Services.

1.11 20% of the individuals referred were currently open to Mental Health Services, 11% open to Substance Misuse Services, 3% to Learning Disability Services, 3% to Autism Services and 8% to Social Services.

1.12 For all individuals where a Mental Health, Learning Disability, Social/Communication, Alcohol related, Substance Misuse and Financial needs were identified and a referral was agreed to, this was followed up with intervention (e.g. advice, brief intervention, liaison with current service, referral) with the exception of Physical 4% and Accommodation needs where 10% did not receive an intervention when a current need had been identified.

1.13 During July-December 2014, 41% of the children and young people referred had also been previously known to Mental Health services (this includes referrals with no further action), 3% were previously known to Substance Misuse services, 3% to Learning Disability services, 0% to Autism services, 0% to Speech and Language Services and 0% to Social Services.

1.14 12% of the individuals referred were currently known to Mental Health services (this includes referrals with no further action), 12% were previously known to Substance Misuse services, 0% to Learning Disability services, 0% to Autism services, 0% to Speech and Language Services and 30% to Social Services.

1.15 A total of 803 contacts were made with other professionals in order to share information of which on average 1.3 contacts/sharing of information took place for each referral.

1.16 Future Developments:

- The scheme now needs prioritise the focus on the needs of children and young people and those individuals that present to the scheme voluntarily.
- On-going training to police and provision of training and awareness to key partners is being considered.
- Further work to obtain service user feedback on their experience and satisfaction of the service provided through this initiative is being progressed and work to strengthen links with the Mental Health Street Triage Team, CAMHS and voluntary sector to ensure that clear pathways exist between all services and between CWPT and the police.
- The Liaison and Diversion Service has grown considerably since April 2014 and is well established and integrated within police, probation and youth offending services. It has assisted in developing our understanding of mental health for those who are suspected, charged or convicted of an offence in order to ensure the most appropriate treatment and outcome is achieved and significant improvements to information sharing and joint working of agencies to support the individuals with most need

3. Work with female offenders and their families to prevent reoffending

1.1 The Springboard initiative is the Community Rehabilitation Company's (CRC's) partnership with Fry Housing Trust to provide a bespoke intervention for women, which incorporates Surestart to address the priorities of empowering female offenders, reducing their reoffending whilst working with their children to assist with a more stable, supportive start for them.

1.2 Springboard carry out group sessions in community based venues such as Hillfields Community Hub and Tesco (Ricoh) Community Space**.** The location is extremely important to the women involved as they can see us in their community and that they see Springboard as part of their wider community also. Being community based empowers the women to access our services in an environment where they feel safe and comfortable. Additionally, the women often access other services and support that are also being run from the community venues. Since using the Hillfields Community Hub the number of women attending our group sessions has shown a dramatic increase, this proves that working in the communities has a positive impact on the women we work with and improves their support network.

1.3 Current and planned work with Springboard clients includes:-

- **Women in Theatre** - W&T offer women the opportunity to express themselves in a variety of creative ways. The workshops they provide have presented many of our women with the opportunity to enhance their learning experiences building upon their emotional, social, physical and cognitive development. The effect their work has had on our women's self-confidence and ability to work successfully within teams is profound. W&T embrace all levels of talent regardless of ability.

- **Power to Change** - Delivered by Valley House - The support groups are based on the Power to Change programme which was devised by Women's Aid. The Power to Change is an educational self-help programme that provides education and support to women in a group setting who have experienced domestic abuse. Many women who have experienced domestic abuse suffer with low self-esteem and loss of confidence, the Power to Change programme is based on the two key principles of building self-esteem and empowerment. The support group aims to:
  - Help the women to develop their awareness of DVA
  - Promote positive change in their lives
  - Prevent them from returning to DVA relationships
  - Understand the impact of DVA on their children
  - Build on confidence, self-esteem and empowerment

- **Sorted Project** – This project supports women with financial assistance and debt advice, focussing on managing your bills at home.

- **CRISIS Skylight** - Offer a variety of programmes to improve the women's skills in a range of areas including: IT, DIY and repairs around the home, as well as this they will be doing cooking and arts and crafts groups. Many of the women that have accessed support via Springboard have gone on to access CRISIS Skylight timetable which offers a range of courses at various locations across the city, including sustaining tenancies/accommodation, criminal convictions and disclosure and improving health, confidence and self-esteem.

- **Changing Lives** - Changing Lives run group sessions for Springboard clients, focussing on self- esteem and confidence building.
- **1st Aid Training** - First Aid training delivered by The British Red Cross to support women with skills in basic first aid and preservation of life.

- **Planned 121 Support and drop in sessions weekly**-Much of our support is carried out on a 121 basis this can be pre-planned appointments at either of our community centres and home visits. We also offer a weekly drop in for women to attend without an appointment.

1.4 Since the scheme started in July 2012 it has had 109 women referred in total. To date 86 have been provided with a support package and of which over 40 have been also been supported through Social Care interventions.

1.5 Due to its success, Springboard is considered a reputable and robust sentencing option to the courts and by the very least is always considered as an option for female offenders in Coventry.

Case Study

C was referred to Springboard in April 2014. She has 4 children who live with her. C has suffered Domestic Violence previously and spent some time living in a women's refuge with them.

As C started Springboard the family moved into rented accommodation and used this as a fresh start with which to change her lifestyle and social circle. She had realised that her friendships were not always genuine as they often asked for money and to stay at her house. In doing so her life became less stressful and she was able to manage her money more effectively and she had more time for her children.

With this new positive outlook on life and her future she engaged really well with Springboard attending group and one to one sessions with her children. During these sessions she recognised how happy her children became through play and the importance of this in their lives. This had been difficult for her previously as two of her 4 children are much older and so it is challenging for her to divide her time and arranging suitable activities that cater for all her children's ages.

C learnt to interact with her children through play which helped with parenting back in the family home. C really benefited from the sessions herself and enjoyed meeting with the other Mums also attending.

As C came to the end of her sessions with Springboard she had a clear vision about what she wanted to gain in the future and how she wanted to achieve this including some voluntary work when her youngest child starts nursery. She has a particular passion to help women who are in or have experienced Domestic Violence & Abuse relationships and so Springboard are supporting this to take up volunteering with a provider of such services.

4. Youth Offending out of court disposals, early intervention, substance misuse for young people and parenting services

1.1 Out of Court Disposals (OOCDs) are a range of pre court interventions that were introduced by The Legal Aid Sentencing and Punishment of Offenders Act in April 2013. There are three statutory options which are, on the first occasion, Police only decisions. Subsequent disposals are agreed with CYOS. The options are Community Resolution which is a Police only decision for low gravity offences, Youth Cautions and Youth Conditional Cautions (offences with a final gravity score of 2 or 3).

1.2 The Coventry Youth Offending Service (CYOS) delivers interventions for Enhanced Community Resolution (ECR) with support from our local Police and Crime Board. An ECR is a local good practice disposal which means that young people are assessed and receive an intervention from CYOS. This includes a health screening and mental health assessment (if appropriate), substance and alcohol misuse assessment , causal links specific to offending which includes parenting assessments and their victim is contacted and offered restorative services. This is an early intervention which routinely means the young person does not receive a criminal record but relevant services can be accessed to prevent further offending and to meet identified welfare needs. Working with this cohort of young people has identified mental health needs both in the young people and their parents , triggered child protection referrals and identified domestic violence and abuse issues. It is a service that would not be offered without PCC Board support.

1.3 In the first 12 months April 2013 to March 2014 a total of 107 OOCDs were delivered. This was 60 in the first six months (April to September) and 47 in the second six months October to March.

1.4 In the first six months of 2014 (April to September) there have been 79 OOCD, an increase of 19 cases or 32% compared to the same period of 2013.

1.5 Looking at the 9 month period April to December 2014 there were 114 OOCD compared to 81 in the same period of 2013. This is an increase of 33 cases or 41%. Given this continued increase it is anticipated that the number for twelve months will be about 150.

1.6 The number of out of court disposals in that 9 month period is broken down as follows.

- Enhanced Community Resolution (ECR) x 80
- Youth Caution (YC) x 19
- Youth Conditional Caution (YCC) x 5
- Joint Decisions (JD) x 10

1.7 Parenting activities are also provided by YOS using this funding and is delivered by 2 support officers for all out of court cases. This includes a parenting assessment, and interventions are determined by need identified in the assessment. The types of interventions include referrals to Social Care, Youth Service Vulnerable person team, Triple P parenting Programmes, one to one work on boundaries and relationships, addressing anti-social behaviour and support for parents with mental health issues.

1.8 The partnership funding has also contributed to having a dedicated worker from COMPASS working in YOS one day per week, to undertake substance use assessments for any young person who scores 2 or more on an overall assessment. Following assessment, interventions are provided including treatment services. Provision of a Compass worker, ensures that YOS staff can arrange assessment slots in line with the young person's statutory appointments and therefore significantly increases the likelihood of attendance. The case worker can support/introduce the young person, and prevents the need for them to go to another service

site to be seen. The Compass worker also contributes to training YOS staff, and provides support to any member of YOS staff working with a family where there are substance issues.

Case study 1:
A is a 16 year old boy currently on an out of court disposal due to damage he caused within the family home. He was referred to the health specialist for a health assessment and initially engaged well and began to disclose what he described as strange thoughts that he was experiencing. Further officer exploration of this discovered that he had become increasingly more paranoid feeling that he was being controlled by people through both his laptop and phone and this was confirmed by his mother who advised that her son had become increasingly agitated at home. A described how over recent months given distress within his family relationships he has increasingly used cannabis alongside peers.

The health specialist with A's consent undertook a subsequent joint session him and his mother to obtain an in-depth developmental history which through this process established a significant mental health history within the family. A further joint assessment with psychiatric services took place to determine medication required that would compliment Cognitive Behaviour Therapy. A joint support plan to include this and substance misuse was agreed with all agencies involved with A which over subsequent weeks has shown an improvement in his thinking and behaviour and he is now looking to reunify his relationship with his father

Case Study 2 – demonstrating complexity of cases
J is a 17 year old female who is also subject to an Out of Court Disposal. During a routine health screening appointment she disclosed a long-standing history of misusing various illicit substances and admitted to current, frequent heroin use. Already open to COMPASS, J had met with her Substance Misuse Worker two days prior and denied any current drug use.

During the health screening, it became apparent that there were also outstanding issues relating to J's mental and emotional wellbeing and so the opportunity was taken to conduct a more thorough mental health assessment there and then, with J's consent. A traumatic event in the previous year had triggered deterioration in J's mental state and she was displaying objective symptoms of depression. There was a previous referral to adult mental health services which she was pending an appointment for an initial assessment with them. A clinical nurse specialist remained engaged with her in the interim. However during that time J's drug use increased, her mental state deteriorated further and her engagement with professional services reduced significantly. J was also known to social services as a "Child in Need" due to issues of domestic violence at home. The clinical nurse continued to attend professional meetings, shared information, supported family in a collaborative approach with J's COMPASS worker and continued to reschedule missed appointments with J despite her reluctance. This then led to conducting outreach appointments and has included accompanying her to health appointments, following-up referrals on her behalf, visiting her at neutral locations within the community and making frequent 'safe and well' contact in various ways.

J is a socially isolated young woman with unmet health needs. She has limited support – both personally and professionally – and is at risk of harm in the sense that she is vulnerable to being exploited by others, due to her drug-taking behaviour. Additionally, she has a history of suicidal ideation and along with her risk-taking behaviour; she is at risk of accidental harm.

J's mood and mental state continues to be monitored and assessed currently by the Clinical Nurse Specialist, in conjunction with the COMPASS worker, until such a time that adult mental health services can provide the initial assessment that J is still awaiting.

Case Study 3: Health Specialist role in detecting undiagnosed mental health issues in parents of young offenders (hidden harms)

G is a 12 year old boy also currently on an Out of Court Disposal and was initially referred to the Health Specialist due to concerns regarding obesity and increasing behavioural difficulties at school. As a result of the initial assessment and liaison with an allocated social worker, it was as he and his siblings were also subject to child protection plan. Of great concern from social care was the non- compliance of parents to the plan and the parents' hostility towards social care staff, especially when home visits were undertaken.
From the Health Specialist's perspective, although there were concerns in relation to G, the main concern was the impact of the previously undetected mental health difficulties to the mother's persona and engagement. Following a joint home visit with the YOS case manager, it became apparent the priority was the need to address this, in order to progress any meaningful intervention. As well as meeting with G, the Health Specialist has undertaken individual meeting with mother to understand her personal mental health issues. With consent, a referral has now been submitted to adult mental health services (via SPE) and she is now receiving specialist adult mental health support.

5. Victim Support services for victims of serious crimes and harms

1.1 Additional funding was provided by the Police & Crime Commissioner with which to enable local victim support services to build capacity in their organisation with which to support increasing numbers of victims.

1.2 With the support of Voluntary Action Council the Partnership Board were able to identify local victim services that support our most vulnerable victims and survivors domestic and sexual violence.

1.3 The local services undertook extensive work to achieve the additional capacity required. A summary of this can be found on Appendix 3: