



## Goldstein Awards 2015

### Trafford Mental Health Practitioner Project

#### Summary

This document presents a 12 month review of the above project.

#### Scanning

This submission an examination of the scale of the challenge faced by police and other service providers within Trafford, Greater Manchester, regarding repeat demand placed on resources by individuals suffering from mental illness and measures taken to address this challenge.

#### Analysis

Crime and incident analysis undertaken by Greater Manchester Police and partner agencies identified that one of the key drivers of demand for police resources on a daily basis was linked to a cohort of individuals with suspected or diagnosed mental health needs.

Their exhibited behaviour included:

- Being armed with knives intent on harming self or others
- Jumping from bridges causing significant personal injury
- Climbing to the roofs of buildings and threatening to jump
- Placing a ligature around own neck with suicidal intent
- Assaulting family members and emergency service personnel
- Racially abusing members of the public

#### Response

The principal element of this initiative has been the introduction of a mental health practitioner to operate within Trafford Police Station, working alongside police officers to triage emerging risk case, engaging with individuals presenting demands on services, and supporting the development of a multi-agency plan of care and intervention.

## Assessment

- (1) Impact evaluation
- (2) Cost benefit analysis  
(Fig1 and Fig 2 Appendix A)
- (3) Process evaluation – understanding of how the intervention works in practice.

Additionally the ability to draw on the advice, support and direction of an expert professional has increased confidence amongst police officers who have previously lacked an understanding of mental health services. It also allowed for the identification of critical success factors connected to this initiative.

### How the intervention works in practice:

The key ingredients of the Trafford initiative:

- Case management
- Intensive support based on outreach principles
- Focused problem solving complementing existing triage services

Above all the measurable outcomes of this initiative has been an overriding sense that it has reduced risk and produced better outcomes for service users.

A full assessment of the first seven months of this initiative is also attached  
“Appendix B”

## Scanning

The nature of the problem encountered was that a significant number of individuals within Trafford had regularly come to police attention, either via complaint from a third party or agency or by direct contact from the individual, with regard to their apparent mental illness and often the propensity of such persons to indicate their intention to cause harm to themselves and or others. Albeit measures would be taken under the mental health act to protect these individuals in the short term, such was the nature of their mental illness, that very often they would cause similar issues again within a short period of their release from any enforceable or voluntary care regime.

The problem was identified through the regular management review processes of police activity. This identified such incidents on a daily, weekly and monthly basis and attracted the attention of police managers due to their regularity and volume. The subsequent demand being placed on police resources was of concern as was the acute vulnerability of the persons concerned due to their mental illness.

In the first instance this issue was identified by police managers, who due to concerns regarding both demand and risk presented by the individuals involved, brought these matters to the attention of health and adult social care professionals.

Primarily, this issue was highlighted by police, due to the increasing risk that these individuals posed to themselves in terms of intended or accidental self-harm and the fact that a number of them were coming to police attention on a regular basis.

There was appreciation across a number of service providers that the level of care and control provided to this cohort of individuals could be improved and their health and social wellbeing enhanced.

Additionally the onset of existing and anticipated future financial austerity measures within the public sector, including the police service, mean the need to effectively manage demand on police resources is an ever increasing requirement.

Examples of the type of behaviour exhibited by the cohort are shown below.

- **Beverley** regularly calls mental health workers claiming to have taken an overdose. Mental Health workers then call police and she then goes missing resulting in a missing report and police hours spent locating her. She also attends or gets taken to A&E and leaves before she is seen, again resulting in a missing report. Beverley has been in possession of knives when police have attended and has refused to hand the knives over to police resulting in her being restrained.
- **Lucy** has made false allegations of sexual assault. She regularly calls the police and ambulance service stating that she is feeling suicidal.
- **Alex** regularly calls police & ambulance service when drunk reporting various issues. He is often unconscious through alcohol when police attend and officers have had to force entry in the past. His house is described as a health hazard with human waste, vomit and rotting food. The mental health worker is considering getting environmental health to do a deep clean of the address. Officers have to enter this environment due to the calls being made by Alex
- **Diane** is an alcoholic and in 2013 doctors believed that she had been drinking methylated spirits which has damaged her sight
- **Shelly** and her partner have made DV complaints about each other. Shelly was classified as a high risk victim in Dec 14. Shelly has made allegations of rape when under the influence of alcohol and has then retracted when sober.
- **Chelsea** has attended A&E numerous times due to self-harm. She has climbed on bridges and made threats to jump. On one occasion she jumped off a footbridge causing herself significant injury. She has committed assaults against police officers and hospital staff. She has forced her way into ex-partner's address and wrapped a cord around her own neck. She has answered the phone to police from within mental health unit and purported to be a member of staff.
- **Carl** called police and stated that he was suicidal. He was taken to hospital where he absconded resulting in a further call to police. A further call came in from the hospital stating that he climbed on top of a container and was self-harming. On a further occasion Carl climbed on the roof of building at the hospital and was demanding to be admitted to a certain unit. He was eventually talked down. He also climbed onto the hospital clock tower, threatened to jump and was eventually talked down by a PC who knew Carl and his interests (the PC also climbed up to get closer to him). Carl once cut into his forearm with a Stanley knife requiring stitches.
- **Lynette** is an alcoholic and assaulted her daughter (head butted) whilst drunk. Lynette received an adult caution for this.
- **Cathy** is an alcoholic and was charged with a racially aggravated public order committed whilst drunk in 2014.
- **Barbara** frequently reports domestic incidents committed by her parents and sister who also frequently call reporting domestic incidents against Barabara.

The scope of analysis appertaining to this problem was to identify incidents concerning individuals across Trafford during a 12 month period who were presenting to the police on a regular basis with apparent mental health issues. It also involved the identification of other relevant partner organisations from which these individuals were presenting an associated demand. This was seen as crucial to the development of a holistic approach to this problem.

## Analysis

Crime and incident analysis undertaken by Greater Manchester Police together with the Safer Trafford Partnership (STP) identified that one of the key drivers of demand for police resources on a daily basis was linked to individuals with suspected or diagnosed mental health needs. Part of the challenge identified related specifically to demand from individuals within existing recognised health care settings (both at the Accident and Emergency/ Urgent Care Centre (UCC) at the Trafford General Hospital (TGH), and the Moorside Mental Health Unit specifically). Further significant service demand was identified as being generated by individuals with mental health needs who were living in a community setting.

The analysis highlighted that this demand was affecting a range of local stakeholders, and related to individuals who were often repeatedly presenting with mental health needs and self-harming behaviour, but not meaningfully accessing support services. The overall key issue identified from the research was an apparent gap in meeting and managing the emotional and mental health needs of a small number of individuals - posing a significant resourcing challenge and a revolving cycle of service demand. This problem had been prevalent for a number of years

A broad partnership of stakeholder agencies e.g. police, health, adult social care, were closely involved in this issue. Additional to this professional involvement from both managers and practitioners, it was accepted that a vital component would be the views of the cohort members to ensure that the change in service delivery also led to an improvement in their personal experience of it.

Prior to this initiative incidents and individuals were dealt with in isolation with no holistic multi agency problem solving taking place

Examples of the harm resulting from the actions of the cohort membership range from causing or threatening to cause injury to themselves or others, causing distress and harassment to members of the local community and over monopolising finite emergency service provision to the detriment of other community members.

These examples include:

- Being armed with knives intent on harming self or others,
- Jumping from bridges causing significant personal injury,
- Climbing to the roofs of buildings and threatening to jump,
- Placing a ligature around own neck with suicidal intent,
- Assaulting family members and emergency service personnel,
- Racially abusing members of the public.



In addition to the potential and actual physical harm caused to the individual when they have thrown or threatened to throw themselves from motorway bridges, it is also recognised that the subsequent closure of that section of motorway to either negotiate their removal from the bridge or the recovery of the injured person from the roadway causes extreme traffic disruption, which is known to have a detrimental effect on the local community.

The analysis revealed that a relatively small number i.e. 16 individuals with suspected mental health needs, generated a total of 546 calls for Police service between January 2013 and March 2014. The majority of these incidents led to subsequent referral to a medical or psychological care providers.

The analysis confirmed the increasing prevalence of repeated calls to the Police by a small number of service users, exacerbating the cycle of inappropriately placing demand on police resources. More fundamental still, however, was the recognised complexity of the underlying issues, the vulnerability of the service users involved, and prime concerns in relation to risk management. This made a concerted dialogue with health partners and other stakeholders essential in determining potential joint action to improve the situation.

Liaison with local mental health services confirmed a range of issues in terms of classifying the service user demand being discussed:

- In many instances, individuals concerned were either ‘sub-threshold’ or their mental health needs were undiagnosed;
- In some cases, the mental health need was diagnosed, but the individuals concerned were not meaningfully accessing support services; and
- in further cases still, individuals concerned were diagnosed, were receiving care/treatment, but nevertheless were continuing to place significant demands on a number of services for a range of reasons.

In a number of cases the family or neighbours of the cohort member were the persons who contacted the police and or ambulance service in relation to the behaviour being exhibited by that individual. This was motivated by concerns for the mentally ill person or themselves. The improved management of the individuals within this initiative has led to a positive modification in behaviour and an appreciation of that fact by the community members.

The analysis identified a ‘core group’ of service users who represented the most significant cases of demand on police resources.

For the purposes of this initiative, project leads within identified partner agencies were requested to provide full profiling information in relation to a cohort of 10 service users who have been central to the work illustrated in this document.

This research and analysis showed that the cohort under examination has the following demographic profile:

- 4 female clients were open to Community Mental Health Teams: 1 had a diagnosed mental illness, 1 diagnosed personality Disorder, 1 dual diagnosis (alcohol and mental illness), and 1 was being managed as a vulnerable adult.
- 1 male was open to GMW's Crisis Response and Home Based Treatment Team, in connection with psychological problems and alcohol problems
- 1 female was open to the local Learning Disability Partnership Team
- 1 male was on a waiting list for alcohol Inpatient Detox – subsequently admitted in May (alcohol problems)

The remaining three members of the cohort (two females and one male) were not open to services. However, in each case there was a history of contact with A&E mental health Services, and problems with alcohol use.

Other profiling information: Features of complex dependency

A wider profile of the cohort identified problematic alcohol use as a particularly important issue, but also a number of additional challenges that often feature as presenting needs when examining and responding to complex dependency:

- Occupational status: None of the cohort recorded as having been in paid employment (going back 5 years). 1/10 (female) completed 15 hours of voluntary work per week. 3/10 were pensioners.
- Accommodation status: All recorded as resident in local authority or private rented accommodation. 1/10 owned their home.
- Children: 1/10 (female) had 2 children – though not custody of both children (supervised contact)
- Substance misuse: 6/10 recorded as having significant problems with alcohol use.
- Domestic abuse/adult safeguarding: 5 females recorded as being involved in intermittent relationships with history of domestic violence (safeguarding vulnerable adult assessments conducted).

## Response

The goals of this initiative were primarily to achieve the following:

- Reduction in incidents where vulnerable mentally ill individuals are at serious risk of harm from their own action or omission or where they place members of the public at such a risk.
- Reduction in the demand placed upon police and partner agency resources relating to the identified cohort of 10 service users. This was measured by the number of incidents generated by the cohort membership during the 12 month period..
- Reduction in costs – This was measured by establishing a stringent method of calculating the cost benefits derived from this activity.
- Improved patient processes –This was measured by capturing the views of project leads, practitioners and service users in particular, to ensure that this new way of working provided them with an enhanced level of service.

Although the initiative was originally devised as a key means of reducing demand on police resources, it has demonstrated a much wider potential to reduce demand on other emergency services

In considering possible responses to this issue it was recognised that the easiest response was for each agency to continue to operate in silos, each dealing with certain aspects of the individual's behaviour, each performing its core role, but at no point considering an overall multi agency strategy which offered the opportunity to actually address the underlying issues that manifested themselves in the person's behaviour.

Whilst this is seen as the easiest option it is also the least effective.

Conversely the most effective solution involving a number of stakeholder agencies is also never an easy process requiring agency professionals to appreciate both role and capabilities within partner organisations.

Holistic problem solving is always desirable, but rarely easy to achieve.



The analysis served to identify a cohort of problematic individuals. These were selected on the basis of their propensity to make repeat demands for service on the police. Further research revealed which other agencies were also involved with those individuals.

Additional profiling by partner agencies greatly enhanced the appreciation of the issues which were underlying their behaviour. This served to identify the most effective responses for each of the individuals.

There was a broad acceptance by stakeholder agencies that there was a genuine need to act in unison to address these issues underlying the behaviour of the cohort members. This positive reaction was further enhanced by existing and impending budget reductions facing those same partners and led to the application of public service reform principles to this issue.

A business case was developed proposing the introduction of a dedicated mental health worker to support the partnership in developing a problem-solving approach that would include a wider range of health professionals.

The initial response: Multi-agency action plan covering the following activity:

- Develop a formal strategic partnership examining the impact of mental health/vulnerability issues on police.
- Develop a menu of monitoring criteria.
- Develop an effective Tactical Partnership Delivery Group.
- Develop a process to focus on complex cases requiring higher degree of multi-agency intervention.
- Develop a system to identify repeat cases
- Develop an escalation process for problematic cases
- Review the management of voluntary patients and those who have authorised leave
- Review the roles and responsibilities of the Home Based Treatment Team (HBTT) and GMW staff regarding response to missing patients
- Conduct a review of security at the Moorside Mental Health Unit.
- Deliver an on-going series of joint partnership training inputs
- Organise awareness sessions for staff regarding policies and protocols amongst all agencies.
- Include this issue as an agenda item at the Trafford Adult Safeguarding Board & Trafford Health and Well-Being Board
- Develop a partnership survey to capture blockages in current systems and ideas for service improvement moving forward.

The collaborative multi agency actions were implemented at a strategic level by senior managers from:

- Trafford Police
- GMW
- Trafford Clinical Commissioning Group (CCG)
- Trafford Council
- Acute Services (Central Manchester Central Manchester University Hospitals NHS Foundation Trust (CMFT))

A number of factors were considered in deciding potential responses. These were:

- Section 1 Human Rights Act 1988 requires all government agencies to protect human life.
- The sworn duty of all police officers together with the requirements of this act directly influenced the activity pursued with regard to the cohort membership.
- Professional experience of the various agencies was fully utilised to identify the most effective means by which this could be achieved.

These were supported and endorsed by the moral responsibility and ethos to do all that was feasible and reasonable to lessen the continued risk of harm.

These methods of working were selected on this basis and secondly as they represented a corresponding reduction in costs across a number of agencies

Dedicated resources directed to the problem consisted of one full time Mental Health Specialist Practitioner and a Support Time and Recovery Worker (STR worker, 0.6 FTE). It was appreciated that an earlier appointment to this latter post would have increased effectiveness.

A wider profile of the cohort identified a number of issues including problematic alcohol use as a particularly important issue. These individuals also had several additional challenges and dependencies which proved to be an added difficulty.

These included:

- **Occupational status:** None of the cohort had been in paid employment (last 5 years). 1/10 (female) completed 15 hours of voluntary work per week. 3/10 were pensioners.
- **Accommodation status:** All recorded as resident in local authority or private rented accommodation. 1/10 owned their home.
- **Children:** 1/10 (female) had 2 children – though not custody of both children (supervised contact).
- **Substance misuse:** 6/10 recorded as having significant problems with alcohol use.
- **Domestic abuse/adult safeguarding:** 5 females recorded as being involved in intermittent relationships with history of domestic violence.

## Assessment

The following were the intended goals of this response:

- Reduction in incidents where vulnerable mentally ill individuals are at serious risk of harm from their own action or omission or where they place members of the public at such a risk.
- Incident Reduction
- Cost Reduction
- Improved patient processes

The 12 month evaluation indicates that these goals were clearly achieved with no transference to other adverse behaviour.

This is supported by statistical findings regarding the impact of the initiative, results from the Cost Benefit Analysis, and wider evaluation findings on the initiative outcomes to date.

Outcome analysis has been based on a detailed examination of case files and management information relating to the 10 service users.

(n.b. Albeit the capacity of the cohort was 15 service users only 10 have remained with the project for the full 12 month period and it is changes in their behaviour which has been used to calculate demand and cost savings.)

In addition to the statistical reduction of incidents reported, there has also been a reduction in the severity of such incidents and the potential harm posed to the individual and or others.

The impact of the responses led to a reduction in the demand placed upon police and partner agency resources. This produced a reduction in costs and improved patient processes.

These results were measured both quantitatively and qualitatively as detailed below:

**Demand** - on various stakeholder services over the 12 months of the initiative (April 2014 – March 2015) have been compared with a baseline period of equivalent length immediately before the intervention began (April 2013 – March 2014)

#### 22.30% reduction in Police demand

- The ten members of the cohort generated 530 police incidents in the 12 months prior to this initiative and 412 police incidents in the 12 months of the initiative. This is a reduction of 22.30% (118 police incidents).
- NB, if the data from two cohort individuals who displayed particularly complex and challenging behaviour, were removed, then a cohort of 8 individuals would have generated 170 fewer police incidents – a reduction of 36.6% (170 incidents).
- The type of calls received by the Police has also changed with calls made by the cohort becoming less resource-intensive and complex.
- 341 calls to NWS before the initiative and 283 calls during the initiative. This represents a 17% reduction.
- A&E Acute presentations have reduced from 490 to 281, which is a reduction of 76%.
- 76.6% reduction in hospital in-patient admissions relating to the cohort. Admissions were reduced from 214 to 50 in-patient bed days.
- The Home Based Treatment Team is an alternative to hospital admission for persons in psychiatric crisis. Incidents reduced from 336 to 111 (-67%), - success in moving from crisis care to planned and more upstream intervention at the earliest opportunity.

#### Costs Reduction

The cost savings associated with decreases in service demand across a number of agencies is compared to the annual expenditure associated with this work. The annual financial net gain is shown as being £89,540

Reference text – Refer to Fig 1 & 2 Appendix A

#### Improved Processes

The below are considered to be the critical success factors associated with this initiative.

1. High-calibre candidate in the central role
2. Strategic leadership and buy-in
3. Co-location
4. Manageable cohort of 10-15 service users
5. Flexible approach to selection and de-selection criteria

The need to find efficiencies was a clear driver of this initiative, however, also considered to be of fundamental importance, was the need to achieve better patient outcomes – morally therefore this was “the right thing to do”.

Several members of the cohort provided their views on the new way of working. These themes are:

“The personal relationship is valued”

“Frequency of contact is welcomed”

“The recovery focus of the intervention is evident”

This feedback tallies with that of the Specialist Mental Health Practitioner and of wider project leads.

Many of the cohort membership are socially isolated, and the ‘whole person’ approach has been an important part of its success.

### **Practitioner Perspectives**

The recurring themes that have been made known during the evaluation are broadly as follows:

- Practical brokerage role between agencies. - Introduction of a dedicated post has achieved significant demand reductions
- Significant added value through the brokerage role - Offered by the Specialist Mental Health Practitioner
- Improvements to information sharing - Multiple practitioners have highlighted improvements to information sharing as a major benefit of the project.
- Strategic collaboration and culture of joint working. - Largely unintended consequence of the project has been its role in bringing together senior management teams



The impact evaluation and accompanying Cost Benefit Analysis has not, at this stage, factored in the potentially significant impact of the intervention in the longer-term, and therefore a range of further benefits and savings are not quantified at present. e.g. worklessness, child safeguarding, tackling domestic abuse, alcohol dependency

It is expected that a further comprehensive assessment in a further twelve months' time would be able to build upon the impact analysis conducted here, and cement the wider links to Public Service Reform and better outcomes from service users.

This would be in similar detail to that produced by Lucy Evans, Trafford Police Crime Analyst, David Ottiwell and Britta Berger Voigt, New Economy, Greater Manchester, This document contained within "Appendix B"

This initiative is fundamentally a delivery model grounded in the principles of Public Service Reform. It is focused on multi-agency problem-solving, addressing complex need at the earliest opportunity, and is centred on the application of a tailored case management approach.

It has proven to have significant potential when measured in the most direct of terms ie its ability to reduce the demand placed upon blue-light and healthcare services when complex service users are in crisis, and when that crisis cyclically recurs.

A key message from this evaluation is that this intervention can certainly be replicated, but should be considered as a discrete intervention. The key ingredients of the Trafford initiative – case management, intensive support based on outreach principles, and problem solving – can complement the existing focus on triage and navigation services, but neither intervention is a substitute for the other.

Most importantly it has also shown that it is vital to keep patient outcomes 'front-and-centre' in an evaluation of the intervention. In that respect, all the agency stakeholders feel confident that the intervention plays a vital role from a risk management perspective. In simple terms this means fewer Trafford residents taking overdoses, fewer Trafford residents being intent on self-harm and fewer Police calls to reports of people threatening suicide on bridges, roofs of buildings, and railway lines.

It reduces risk and makes vulnerable people safer. It also costs less.

**Word Count 3996**

## Agency and Officer Information

### Key Project Team Members

**Superintendent James Liggett** – Divisional Superintendent, Trafford, Greater Manchester Police

**Inspector Vincent R Jones** – HUB Manager, Trafford Division, Greater Manchester Police.

**Catherine Mudzingwa** - Specialist Mental Health Practitioner, Integrated Safer Community Team.

**Helen Cutts** – Assistant Director of Clinical Services, Greater Manchester West Mental Health NHS Foundation Trust

**Paul Mitchell** - Project Lead, Criminal Justice Liaison and Training Project, Greater Manchester West Mental Health NHS Foundation Trust

**Claire Fraser** – Senior Manager, Moorside Mental Health Unit, Trafford General Hospital.

**Brian Clarke** – Senior Information Analyst, Greater Manchester West Mental Health Foundation Trust.

**Lucy Evans** – Intelligence Analyst, Trafford Division, Greater Manchester Police.

**David Ottiwell** – Principal, Public Protection Research Unit, New Economy, Greater Manchester

**Britta Berger-Voigt** - Public Protection Research Unit, New Economy, Greater Manchester

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## Appendix A

Fig 1

Headline benefits (demand reduction) attributed to the New Delivery Model  
Outcome

Outcome	Gross Fiscal Saving	% Total
Police demand (-22.3% reduction)	£16,513.02	8.4%
999 calls to NWAS (-17% reduction)	£12,539.75	6.4%
A&E attendances (-42.7% reduction)	£18,467	9.4%
Hospital admissions (-76.6% reduction)	£94,316.40	44.8%
Home Based Treatment Team calls (-67% reduction)	£54,371	27.7%
	<b>£196,207.42</b>	

Fig 2

All costs associated with the New Delivery Model

Cost category	Annual cost	% Total
<b>Direct/salary costs</b>		
GMW Mental Health Practitioner - Staff Salary & On Costs (1 FTE)	£48,670	45.6%
GMW Support Time and Recovery Worker - Staff Resource/Time (0.6 FTE)	£12,775	12.0%
<b>Administration and resource support</b>		
GMW Mental Health Practitioner -Admin, Supervision, and IT (including travel cost)	£4,745	4.4%
Project overheads -Office space/office equipment	£936	0.9%
Project coordination and governance	£1,692	1.6%
Police Officers' Resource/Time - Service User Support	£456	0.4%
Police Officers' Resource/Time - Officer shadowing / learning exchange	£129*	0.1%
Police triage training	£5,382*	5.0%
<b>Voluntary and community sector contribution</b>		
Voluntary sector support–Thrive/ blueSCI	£2,685	2.5%
<b>Other teams/agencies referral costs</b>		
A&E Mental Health Team	£29,198	27.4%
	<b>£106,667</b>	

## Appendix B



# Home Office Innovation Fund Specialist Mental Health Practitioner Pilot

## Project Evaluation and Cost Benefit Analysis

David Ottiwell  
Lucy Evans  
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