HIP PROGRAMME REPORT

17th March 2021

Author: Devon HIP Team.

Version 1.0
Executive Summary

The High Intensity Partnership pilot (HIP) has been a twelve-month pilot in both Northern Devon and Plymouth since November 2019. The pilots use clinically approved governance as part of a national framework of award-winning Police and Mental Health collaboration called Serenity Integrated Mentoring (SIM). In 2016 SIM was adopted by NHS England for ‘national scale and spread’ (NHS Innovation Accelerator) and has since been recognised as good practice by both the National Police Chiefs Council and Her Majesty’s Inspectorate of Constabulary, Fire and Rescue. In 2018 the Academic Science Network chose SIM as a project to role out across their network. NHS innovation funding paid for the SIM network to provide the training and the framework portal for the HIP pilot.

Across the UK, emergency and healthcare services respond every minute to people in mental health crisis. Mental health crisis calls are consistently increasing each year. But there is also ‘a problem within this problem’ because in every community, up to 40% of this demand is caused by the same people; a small number of repeat callers who struggle to manage highly complex behavioural disorders and who, as a result place intensive operational demands upon police, ambulance, A&E departments and mental health teams.

Calling for help is wholly acceptable but some people in crisis ask for help repeatedly and then when offered help, are either unable or unwilling to positively respond to this support or even refuse to engage in that offer. There is a small but highly impactful cohort of emergency service callers with these behavioural patterns that exist in every community. Mental Health services help explain some of these individuals as engaging in a behavioural rather than an illness led reaction in these times of personal crisis. This not only impacts upon acute emergency services with increased and high-risk demand, but also hampers the individual’s ability to manage their distress in a way that is recovery focussed. Instead these ingrained negative patterns of behaviour, increases the risk of harm to the person and increases demand upon services for the future.

In addition to the financial costs that these repeat calls create, there are also other common problems associated with them. When in personal crisis, these high users of emergency services often demonstrate behaviours that put themselves and others around them at high risk of intentional or unintentional harm. They are more likely to die from accidental suicide because of the bigger risks taken in order to receive the response they have learnt to receive. They often have compromised social networks and in most cases have strained relationships with family members who have become frustrated by their repeated behaviour and in some cases have cut all contact with them. This is often why these people turn to the emergency services in order to gain a supportive response to their personal crisis.

Conservative estimates are that repeat callers of emergency services cost police, ambulance, emergency departments and mental health services a minimum costs at least £19,800 per service user per annum.

The High Intensity Partnership is a clinically led and prevention focused collaboration of mental health professionals (green) and police officers (blue). These teams work together in joint
mentoring teams providing compassionate, consistent, and resilient support to people struggling with complex, chaotic, and dysregulated behaviour.

Monthly High Intensity User Group meetings comprising of Community Mental Health Team, Liaison Psychiatry, Liaison and Diversion, SWAST and Police review existing cases and also any new referrals to determine if the threshold has been met for inclusion on what can be a very intrusive project.

HIP has intensively supported an identified group of individuals who were struggling to manage high frequency and high-risk crisis behaviours. This has been achieved by combining the clinical expertise of a mental health professional with the boundary setting skills of a police officer in a personal, relational and consistent approach. The pilot has demonstrated that those individuals who the pilot has engaged with, can start to change their key crisis decisions and consider healthier and safer responses to often highly complex emotions. The result was fewer 999 calls, fewer S136 detentions, fewer ED attendances and fewer hospital admissions.

HIP provides frontline emergency responders with very specific advice on decision making for different types of crisis through response plans co-written by the individual service user, Police and Mental Health Professionals. This helps the service user to understand the probable outcomes if they chose specific behaviours before they happen.

Front line staff within the partnership now provide consistent decision making evolving from a culture of fear to a culture of confidence. This is delivered through a programme of operational training for staff and dedicated joint police and clinical support to those individuals in need.

HIP officers are daily liaising with other partners to brief and advise on matters that affect operational demand and risk management. As a result, the pilot has demonstrated a reduction in call demand and unnecessary use of S136.

The data held by all partners involved in the project is shared utilising co-written and signed information sharing agreements. The data supports key decision making including when to accept clients onto the pilot where proportionate, justifiable, and if necessary without the consent of the client. The data is held on the High Intensity Network Portal and demonstrates progress and a developing picture of the journey of each client from the point of view of individual demand upon partner agencies.

The overall picture for the twelve months between November 2019 and November 2020 for each partner service has demonstrated a reduction in demand for service.

- Detentions under S136 MHA dropped by over 50% a saving of £8,000
- Unplanned hospital attendances at A&E dropped by 13% overall
- Admissions to an acute mental health ward dropped by 77% a saving of £61,000
- Overall calls to Police dropped by 19%
- Calls that the Police responded to in person dropped by 27%
· An overall cost saving of £50,458.
· Cost saving to police of £44,378
· Zero calls to AFRS to 108 calls post SIM increased cost of £864

(The intervention demand was translated into the service costs above using a national average cost per intervention.)

The above data is specifically in relation to those clients who have completed a full twelve months on the pilot although the data (contained within the portal) for the five months after the conclusion of the pilot continues to show a remarkable decline in demand.

The professional narrative in relation to the data will also demonstrate a shift from an inappropriate use of services (Police, SWAST, Accident and Emergency) to the most appropriate, efficient and cost effective use of the First Response Service; this in turn reduces the inappropriate use of S136 detentions.

This document and the HIP Portal also contains data and case studies for those who have not completed twelve months on the pilot nor met the inclusion criteria but nevertheless were provided with HIP support and interventions including jointly drafted response plans.

These additional case studies also demonstrate a clear:
· Reduction in demand for services
· Clients alternatively using the most appropriate and efficient service
· Clear, co-ordinated and consistent response to clients

The Pilot has nurtured and developed closer working relationships between partners which includes access to NHS data systems (Care Notes) for the HIP Police officer, this has enabled us to provide a better understanding of that person to inform Police tactical guidance, support and key information for dynamic and developing situations.

There has now been a cultural shift within Policing in North Devon leading to a more confident approach when faced with these challenging situations. There is now a recognition that on some occasions an arrest is the best outcome, custody is sometimes the right provision, it is in the public interest to prosecute and a better understanding and increased confidence in when to employ these approaches. This has taken time to embed and initially required interventions at managerial level but the positive results in the pilot has now increased confidence and the use of HIP.

Numerous feedbacks are contained within this review provided by front line practitioners from all HIP partners in both written and video testimonies. The overwhelming message is that HIP is a fantastic addition to the delivery of their service and should be sustained and made business as usual.

The HIP pilot has been a testimony to what can be achieved when a trauma informed, preventative, partnership approach is applied using supportive, clinically approved governance and the boundary setting of the criminal justice system.
Section One

PROGRAMME REPORT
Devon HIP Team.
Service User Feedback

Cath Courtney
Psychiatry Liaison

Richard was invited onto the HIP programme in November 2019. He began work with Laura Southall, Senior Mental Health Practitioner, Andy White Police and myself Cath Courtney.

(Psychiatry Liaison) Prior to starting HIP Richard completed a Core 10 on 2 September 2019 and scored 28, on retesting today he scored 14 which is a marked improvement. I asked Richard what he felt about the HIP programme and he said it was the help and support that it offered. He admits that in the early days it was difficult and he felt he had tested us. On exploring this a bit Richard acknowledged that this was probably about testing the validity of what we said i.e. that we are here to mentor you through this journey and we are not going anywhere, which is a message Richard had heard many times over the years but he was then let down or abandoned so testing would be a normal process with this context. He ways as a result of the HIP he is now a much healthier (both physically and mentally) and he is able to make reasoned decisions. He noted that previously his response to most situations was to pick up a drink and I noted that at these disinhibited times he would often also pick a fight which was leading him down the pathway of criminal justice. Richard reports that Crosscombe (the drug rehab he attended) has helped him but in some ways because this was sourced for him and he went there to have the help but also because he was homeless this was not a conscious choice he made. However he has now got in touch with Plymouth AA and is an active participant. He sought this out himself and finds real benefit from having made a healthy conscious decision. He is remorseful of his previous behaviour and is pleased that during a recent admission to have an appendectomy he was able to apologise and both security and the nurses; they reinforced the massive change he had made which helped to raise his self-esteem and maintain his commitment to his own recovery. Richard is reflective about past events and acknowledges the difficulties of landmarks and people where incidents occurred prior to HIP. In order to minimise the impact of this he would like to move to Plymouth and have a fresh start. He acknowledges the usefulness of the HIP plans safe place, safe person and safe routine that he can now instigate for himself. For example he is thinking about relationships in the future and if these become difficult having a plan already outlined of how to behave if things go wrong. Richard has made some huge changes. He is still awaiting the outcome of his assessment for autistic spectrum disorder which may open some avenues to him and help people find a way to stay alongside him. Andy and I both reflected on the huge changes Richard has made: Abstinent from alcohol since 24 December 2019. In accordance with support no interactions or inappropriate use of police/hospitals/SWAST for over 12 months. Richard is making positive decisions. He is aware of the ongoing need for support and is building this via his AA contacts. He is a reflective person now and able to make healthy measured choices. He is much less impulsive and reactive and has coped well even though some close friends, have been unable to maintain their recovery. I will ask Richard to read this and ensure it is a true reflection and then offer it as further evidence from a quantitative perspective of the impact of HIP. Richard responded with: Hi Cath this has put me in tears this is perfect thankyou I will keep going. I hope this shows the progression he has made with HIP.

The graph below shows the dramatic change in behaviour Richard experienced. It's also worth noting that the November 20 contact with A&E was a genuine physical ailment situation NOT driven by crisis behaviour response.
What we do.
Andrew White
Police Officer

HIP (High Intensity Partnership) is an award-winning mentoring programme for high intensity users of emergency services, who struggle to engage with mainstream services and can end up being detained under section 136 of the Mental Health Act or find themselves at risk of prosecution as a result of their behaviour at times of personal crisis.

SIM trains police officers in mental health high intensity behaviour, risk management and basic clinical theory. The officer is embedded in the local Community Mental Health teams to assist with the clinical and risk management of those under HIP. This multi-dimensional team, working intensively with the person, agree upon care and response plans and, over time, gradually help move away from high risk and high intensity behaviour. The plan enables the person to adopt more consistent and safer coping strategies to scenarios that would have brought them to the attention of emergency services.

With consistent support SIM can drastically reduce these crisis scenarios and other high risk events including police deployments, Ambulance callouts, Emergency Department attendances and Mental Health admissions. SIM helps people to engage with their local support services, moving away from high risk behaviours and avoiding potential criminal outcomes that these behaviours could have resulted in.

Why someone is referred to the High Intensity Partnership.

They may have been invited to be supported by The High Intensity Partnership for a number of reasons:

- A member of staff may have recommended that they be considered for The High Intensity Partnership to help them find better ways of coping that causes less risk to them or others.
- They may have been involved in a number of s136 detentions by the police, ambulance deployments or ED attendances. Or perhaps they have had multiple ward admissions.

The decision to offer them High Intensity mentoring has been made by a multi-disciplinary team consisting of representatives from Police, Ambulance, A&E and Mental Health called a High Intensity User Group that meets at least once a month in their area. This group will review how they are doing every month in the mentoring programme by talking to their mentors.

What are the objectives of the High Intensity Partnership team?

The High Intensity Partnership mentors support the person to find new ways of coping at times of personal crisis, improving their overall mental wellbeing and as result, moving away from behaviours that pose a risk to themselves or others.

Why is a Police Officer/Staff Member involved in the care?

It has been proven that a police officer can bring unique skills to this team that:

- Can help the person feel safer and better understood.
- Can help the person to identify clear, safe and achievable boundaries.
- Can help the person see the police service as an organisation that wants to help.
- Can help the person understand the consequences of unhealthy behavioural choices and to maximise the chances of avoiding the criminal justice system by supporting them.
with any behaviour(s) that maybe on the cusp of being criminal or anti-social.

- Can help other police officers to understand their personal needs when they are in crisis by writing detailed response plans.

A personalised plan of support and mentoring will be developed and discussed with the person during the mentoring meetings. At the end of the meeting it is hoped that they will have agreed with their mentors what their future goals and objectives are and what support they need to help them achieve them.

We encourage carer and family involvement in all aspects of the care and response planning, recognising that a person's goals and aspirations are more achievable with the support and understanding of those around them.

Personal progress on the programme is reviewed on a regular basis with the specific Response and Care plans being reviewed as frequently as required.

Some of the interventions that can be provided by the High Intensity Partnership team are;

- Self-help skills, i.e. anxiety management, emotional coping skills
- Low level psychological interventions
- Supporting the person to prevent or manage mental health crisis
- Supporting the person to maintain their own safety
- Signposting the person to appropriate support from other agencies, charities and third sector organisations
- Health and wellbeing guidance and support
- Support in seeking and securing voluntary work in the community
- Advice in forming an agreed weekly plan

**What are the expected outcomes of the High Intensity Partnership?**

We are confident, that with consistent support that many of the following outcomes can be achieved (the range of outcomes achieved will vary from case to case):

Their outcomes may include:

- A reduction in reliance on mental health admission to cope and increased confidence in community support
- A reduction in harm to self and others
- An improved quality of life and more feelings of optimism
- Improved relationships with family and friends with more confidence to ask for help
- A more stable and structured home life
- Improved self-esteem and wellbeing
- Improved emotional coping skills
- Regular voluntary work

- Better understanding of the link between mental health and physical health
Section Two
QUANTITATIVE DATA ANALYSIS
DEMAND & COST:
All Teams | All Data Types

Summary

30 people were referred to HIP over the past year, out of those people 12 were suitable to come under the pilot. Of those 12 people only 5 had reportable activity data 12 months prior to their engagement with HIP and during the 12 months of the pilot. The above graph shows these five people’s demand upon the services involved in the HIP pilot denoted by different colours; shades of blue are the differing types of demand on the Police service, shades of green are the demand upon the Ambulance service, yellow is demand upon the Hospital service and pink on Mental Health Services.

Of those further 7 people who have engaged with HIP, activity data has been gathered but as this data does not span the 24 months required, does form part of this report. These people continue to be engaged with HIP and of those 18 people considered not appropriate at time of referral, some have been engaged with as preventative work to ensure that they are not disadvantaged by not meeting the pilot’s criteria.

The referral criteria for HIP is such people are unlikely to experience a change in long-standing, learnt behavioural responses in a short period of time. It can certainly be seen that Police contact, SWAST contact, hospital attendances and admissions all continued their upward trend in the first days of the project, the overall trend over the following 10 months was a gradual reduction in all of these.

Detentions under s136 MHA dropped by over 50%
Unplanned hospital attendances at A&E dropped by 13% overall
Admissions to an acute mental health ward dropped by 77%
Overall calls to Police dropped by 19%
Calls that the Police responded in person to dropped by 27%
The area of ‘offending behaviour’ denoted by dark blue in the graph under Police demand dropped by 13%. However we do recognise that there was a significant under-recording of crime in the previous year for at least one of the individuals but the reproduceable figures show 13% reduction even discounting this potential under-recording.

Admissions to a mental health ward shown as pink on the graph dropped by 77%. It is important to recognise that this is offset by one individual being admitted to an out of area Tier 4 placement shown as dark purple in the graph, even with this included the total ward admission rate dropped by 16%.

Contacts with the Assessment and First Response Service (AFRS) which is represented by light pink in the graph, quickly grew for almost no activity to 108 calls and provided a vital support at times of personal crisis to those on the pilot. This is the first line of support we would typically expect and encourage those in mental health crisis to use as an alternative to acute response services. It would therefore be expected that calls to AFRS would increase during the life of the pilot as contact with acute or emergency services decreased. Reflecting a move away from high risk behaviours and the subsequent emergency service response towards a more appropriate avenue of support via the commissioned mental health service.

### Summary

The above graph highlights the difference in service costs across Devon & Cornwall Police, South West Ambulance Service Trust, Devon Partnership Trust and Northern Devon Healthcare Trust.

A saving of £50,458.

The intervention demand was translated into the service costs above using a national average cost per intervention and has been broken down per service below.
Summary

Both the demand and cost graphs show a clear correlation with the other services in the report. The patterns of behaviour learnt over time and used successfully by service users are not changed overnight and testing of the new team is to be expected. This is evidenced in the continuing high level and even rise of behaviours and demand in the early weeks post acceptance onto the programme.

Gradually as the team build relationships with the service users, plans are devised, agencies are briefed, support put in place and the process settles into a rhythm. The behaviours can be seen to gradually reduce. This is shown on the graph as the gradual reduction over the twelve-month period in all the measured metrics. In real terms, this means the service user is taking less risks and becoming safer. Whilst not in the scope of the report this trend continues in months 13, 14 and 15 also.
The Police see less occurrences where they exercise the section 136 MHA powers. These are shown across the group as a reduction from 21 to 10 incidents.

The volume of calls from, or about the 5 service users reduced from 237 to 192. This comes about as a result of both the changing behavioural responses from the service user but also the Police, other agencies and the people around the service user having stronger protocols and knowledge to assist the service user when in times of distress.

The number of those calls that were subsequently resourced fell from 171 to 124. This reflects the changing nature of the response to the demand. Where historically Police ‘just went anyway’ they applied boundaries to their own responses. Radio operators and call handlers had clear guidance on the expected response to certain behaviours. Duty Sergeants understood why and what the service user was doing and the expected response to it. Where the individual committed offences, they were dealt with consistently. Where the service user was better served by telephone support from a mental health practitioner, this became the response they got.

Offences committed across the 5 dropped from 47 to 40. This despite there being routine under-recording of offences in the twelve months prior to them being accepted onto the programme. (This is expected because the scrutiny their interactions face once they come onto the programme and the clear guidance officers have when dealing with the service user mean committed crimes are not missed.)

Both the reduced volume of demand but also the changed nature of the responses meant the cost of supporting these service users also fell over the year. The average cost reduction across the 5 was £10k per person.

It should also be noted the work done with other service users during the pilot that do not have the full twelve month post project data show similar trends to those witnessed in the graphs.
**DEMAND & COST:**

**All Teams | Ambulance Data Types**

**Summary**

Both the demand and cost graphs show a clear correlation with the other services in the report. The patterns of behaviour learnt over time and used successfully by service users are not changed overnight with testing of the new team involved in their care and support to be expected.

This is evidenced in the continuing high level and even rise of behaviours and demand in the early weeks post acceptance onto the programme. However, gradually as the team build relationships with the service users, plans are devised, agencies are briefed, support put in place and consistency across agencies is established, the behaviours are shown to gradually reduce. This is shown on the graph with gradual reduction over the twelve-month period in all the measured metrics. In real terms, this means the service user is taking less risks and becoming safer. Whilst a large emphasis is put on the cost saving element of this project, it is more important to note these graphs show that service users are being made safer and receiving more appropriate patient...
centred support. This also means that emergency service resources are being kept available for the wider public.

Whilst it is not in the scope of the report, this trend continues in months 13, 14 and 15 also.
Summary

From a health perspective we have long recognised the difficulties with engaging with this client group. Their underlying fear of being abandoned which leads them into intense attachments that are often unhealthy and serve to push loved ones away is often a block to engagement. Splitting is also a symptom of the diagnosis which can additionally make engagement difficult.

Given these difficulties this client group will often want to test the personnel bringing any new intervention into play. As a result there will often be an initial escalation in behaviour to test the team. I think the graphs reflect this with an initial spike in A&E attendances in month one.

There are also patients in this cohort who due to previous behaviour or pre-existing comorbidities may need to attend A&E for unrelated physical health issues, for example one patient has had an appendectomy is being put on the HIP program.
I also think the graphs need to be viewed as part of a wider picture across the community resources and costings, as this gives a truer reflection of the intervention.
DEMAND & COST
All Teams | Mental Health Data Types

Summary

The graph above shows a reduction of operational costs across Mental Health Services in the first 8 months of the pilot, this was achieved by engaging people at the point of personal crisis through out of hours telephone support and moving away from only engaging people through Mental Health Act Assessments following s136 MHA detention and subsequent admission.

During the 9th month of the pilot one of those engaging with HIP moved to a Tier 4 placement, this admission contributed £61,000 to the costs between month 9 and month 12.

Including the cost of the Tier 4 placement saw an overall cost reduction of £8k across Mental Health Services, without the Tier 4 placement costs the reduction is £69,000. This cost reduction can be further explained by,

s136 MHA detentions were reduced by 50% a saving of £8,000
Acute MH Bed days were reduced by 77% a saving of £61,000

Zero calls to AFRS to 108 calls post SIM increased cost of £864

Overall the reduction of s136 MHA detentions and acute admissions, highlights the main achievement of the pilot. That is to support people to move away from high-risk behaviours that ultimately could result in significant harm to themselves or others, and to instead feel able to engage with community services and out of hours telephone support in order to manage their personal crisis. This approach allows the practitioners involved in that person's treatment and support to engage with them in a more stable and consistent manner.
Section Three
QUALITATIVE DATA ANALYSIS
**Feedback**

ℹ️ **Author:** | Third Sector Support Worker

His entrenched behaviour has become a regular occurrence with repeated police & ambulance attendance as HIP is well aware however having now seen him come out of the other side with the solid boundaries & foundations that HIP established with him it is clear that the intensive work & consistence delivery of service from police & MH, in relation to the plans that were co-authored with XXXXXX for when incidents did occur have been the difference to him now being able to lead a more productive, positive & happy life.

His trauma will always be there but he is able to manage himself much differently now he has been given the opportunity to accept, reflect & be supported regardless & always in an agreed safe way. I know he has moved away now but I would love it if I was to bump into him again sometime in the future & see more of his life that HIP has enabled him to have now.

💬 **Author:** | n/a | Service User

"Thank you and XXXX for everything you both are doing with me. I'm so grateful."

┆**Author:** | Paramedic |

This has undoubtedly saved the ambulance service a large sum of money but has also increased the safety to the community through both phone lines not being engaged, an increase in ambulance availability and a reduction in unnecessary blue light responses.

Paramedic, frequent caller team. SWAST

▋**Author:** | Police | Response Sgt
I'm a massive fan of the HIP scheme. I only add that I think it would be of massive benefit in the West as well, so if we can push for that it would be great!
I like the fact there is structure to how people should be dealt with and it helps officers establish what is possible “attention seeking behaviour” and what may be a real need. It also helps assist when it comes to being robust with other agencies. I would argue that it helps when it comes to the Courts as well, because it can be clearly evidenced the help and support available.
Response Sgt. Police

Author: N/A | Service User

"I'm so grateful to not be a strain on resources, that's amazing on it's own."
Service User.

Author: | Emergency Department Consultant

My experience of HIP member’s involvement in our frequent attenders MDT has been that it’s really helpful and useful in getting the bigger picture of the unmet needs of the patient. This works in both directions – via XXXXX we’ve been able to get a message to D&C police around bringing a patient in (potentially under s136) for alleged paracetamol overdose, and in ED we’ve been able to get a feel for the context the police are working in with certain patients. In ED we haven’t used the HIP care plans directly, as we write our own for the MDT to use, but there are a couple of patients where the HIP care plan was appended to ours for awareness or what the police were acting on in the community. This was helpful.
Mostly it was just really, really helpful to get different -but – related teams working together to care in our respective ways for these most complex patients. Insights have been shared and much closer working relationships forged. Our similarities have been shown to be greater than our differences – we often all share the same or related challenges.
Hospital Emergency Department Consultant.

Author: | Community Consultant Psychiatrist.

“very useful service and has made all the difference for a couple of my patients, allowing us new, different solutions and approaches to previously intractable problem situations. I
can only imagine it has also saved a lot of system-wide resource”. - Community Consultant Psychiatrist

Author: Community Mental Health Team Manager

“Mixed success for me, initial teething problems. Benefits- that both services worked closer and got a better understanding of each other’s worlds. Hard work by both parties helped bridge the gaps in their joint working so well done XXXXX and all the other guys who were involved. Initial pieces of work labour intensive particularly for CMHT clinicians due to their workloads but benefitted by reduced workload in the end and clear, safe response from both services to patient.

In my view it worked better with CMHT clinician and HIP blue clear message and plan, no confusion. Clinicians have enjoyed the work and want it to continue and have identified patients who they feel would benefit from this response. So CMHT say “it’s a yes from us!”

- CMHT Team Manager

Author: Police | Response Sgt

I am a supporter of the HIP setup, it has been very useful to me when dealing with at least two regular callers in our area, and has provided me with some evidence in which to back up my decision making, and risk assess; No1: At her worst, she was calling us multiple times each night. These were always of a suicidal threatening nature. I can recall one particular bleak evening covering XXXXXXX whereby our section must have had in excess of 6 calls from or about her. We were desperate not to 136 her that night as it was just playing into her behaviour and wishes. Using the HIP to rationalise my decision making (along with the NDM) I was able to hold off the first 5 calls, before sadly being over-ruled by my Inspector to attend and deal with her.

Dare I say it, I haven’t heard XXXXXXX’s name mentioned in police circles for a number of weeks now. No2 Earlier in the summer, we received a number of calls from and about XXXXXXXX, who was drunk and agitated in XXXXX, intoxicated. She was eventually located, and I used the information from her HIP as justification to pass my Code G PACE test to get her into custody, past a reluctant custody sergeant. Again, this wouldn’t have been possible without the HIP.

Response Sgt, Police
Author: Community Mental Health Clinician

I personally have found the HIP programme effective in reducing or shifting individuals' behaviours. I feel that having a boundary approach and consequences to their behaviour which is not related to their mental health has been successful.
I hope the programme continues.
Community Mental Health Team Clinician.

Author: Police | Response Sgt

Overall, I can say that the implementation of the HIP programme has been overwhelmingly positive.
I think it has been beneficial in identifying those high intensity users, has been great to have that collaboration with our partners around that individual and the plans being in place which are readily available to access have given me the ability to make decisions based on the input of professionals who know that individual and are working alongside that individual. In short, it's enabled me to robustly deal with the individuals in question and our partner agencies by building my rationale around the HIP plan.
The only concern that I would have around the HIP plan is that we are treating individuals differently in regards their criminality purely based on the fact that they are on HIP. I am more than happy to arrest these individuals (who are aware of their actions) for substantive offences such as public order, drunk in a highway, assault etc. but as you know I feel that in some cases we have crimed/prosecuted individuals for matters that would invariably not be in the public interest had they been committed by anyone else – this sits uncomfortably with me, because it goes against my own values.
If you are asking me for my opinion as to whether HIP has been worthwhile, beneficial to us as an organisation and whether it should continue, my answer would be a resounding yes. As you know we have fully implemented the HIIP plan on D Section and have right from the off and we will continue to support this initiative.
Response Sgt, Police

Author: Police | Response Sgt

"The HIP thing and the knowledge of that I felt empowered me in the following ways:- It meant that we didn’t S136 him which is definitely what he wanted and he was arrested for committing offences. It meant I was able to say to Custody that there was a plan in place, that XXXXX had behaviour issues, not mental health issues, so there was no requirement
for him to go to hospital and that to do so unnecessarily or just in case would be going against the plan."
Response Sgt, Police

Author: Hospital Mental Health Team |

"Overall I am very impressed with the change in him. Well done! HIP seems to be working wonders with him."
Mental Health Team, Hospital.

Author: Police | Response Sgt

"Certainly for me having the plans has been useful more often than not especially making dynamic decisions when attending logs. In particular though I feel it has been your way of explaining the needs of these individuals and approaches that has been very beneficial."
Response Sgt, Police

Author: Community Mental Health Clinician | Senior Mental Health Practitioner

“I feel the HIP model needs to become an integral part of mental health care. The feedback received from the individual I support on the pilot is positive – they have reported that without the boundaries and structure of the plan they would not have felt empowered to change the unhelpful pattern of behaviour. It has also opened up the lines of communication between different services that have been hugely beneficial in supporting individuals and providing consistent responses to repeat presentations.” – Senior Mental Health Practitioner, CMHT

Author: Nurse, Drug and Alcohol Services |

I am a great believer in the benefits of joint working, and I believe the HIP promotes not only joint working between the police and mental health, but between all services that are
supporting the client, and this can only benefit the client in the long term. From the results that I am aware of, the HIP approach has certainly had a positive impact on the clients that have chosen to engage, they are at the centre of the care planning and allows them to make choices that they feel are achievable to them. The HIP has reduced both hospital admissions and police time/involvement for that client which will also be cost saving in the longer term.

Nurse, Drug and Alcohol services.

Author: Police | Response Sgt

Certainly for me having the plans has been useful more often than not especially making dynamic decisions when attending logs. In particular though I feel it has been your way of explaining the needs of these individuals and approaches that has been very beneficial. Building the file for XXXXXXX and being able to approach you for up to date information regarding his progress on the HIP plan, meant that I could include this in the submission to court. They in turn have considered all of this and we can all work together for a useful sentence. To actually improve lives. Much better than just a criminal process.

Response Sgt, Police

Author: Advanced Practitioner, Homeless Team | Mental health Practitioner

“I worked with the HIP programme with a very complex individual. The robustness of the programme combined with the Multi-agency approach meant that the individual was very well supported using a boundaried method that was tailored to their individual needs. It was very successful, I have since seen the individual who has completely turned their life around. This demonstrates multi-agency work at its very best!” – Advanced Practitioner, Homeless Team

Author: Police | Inspector

I initially became involved in the HIP programme in my previous role as Force Contact Centre Inspector. I attended a training day with which was delivered by the High Intensity Network founder Paul Jennings. The training was genuinely compelling, and whilst the purpose of my attendance was to embed the Contact Centre and Control Room reporting
processes with the delivery of individual HIP management plans, it also served to make me believe in the evidence base to support the project and its capacity for success. Having delivered the project within Contact Services and now assumed a role as a Sector Inspector, the value and trajectory for Trauma led policing seems clear, but aside from undertaking training we must actually resource this issue to deliver results.

In terms of results, I have seen the same data you will see demonstrating the clear success HIP has delivered in demand reduction, and also the improvement to individual lives. The evidence seems to speak for itself. HIP is the ideal format to deal with the really high demand individuals with complex Psychiatric diagnosis and needs, but in my view we must do more.

Policing has a long and occasionally difficult relationship with Mental health partners. HIP provides a platform for bottom up change to this relationship based on growing relationships between practitioners. In our own geography, PC Andy White has been a real driving force for this. As an aside, Andy’s involvement has made it clear how important it is for Police Officers who genuinely believe in and care about the project to make it work, as with an inappropriate candidate this would have been an abject failure.

Andy’s involvement in the project has meant his abstraction from our Local Policing team. In a small team is not without its impact. However, as an indication of the extent to which I continue to support this, I also have an ongoing tasking for a Neighbourhood Beat Manager to take an evidence based problem solving approach to reducing demand led by repeat residential callers data. This has led to Barnstaple Sector being really effective in reducing problematic and repeat callers, and therefore a reduction in demand for our Response officers, which is an enabler of proactivity. Our embedded HIP practitioners have been on hand for specialist advise to support this, which has been invaluable.

As in so many tragic cases, it’s a reputational risk for us to have all of the data to demonstrate a problem exists, but to fail to respond to those risks as priorities. Our area of greatest risk are where this relates to incident types which to not individually garner attention, but together build a troubling picture. Repeat demand and the assessment of associated threat and risk is a clear means of identifying the potential for harm, and cases where we can and should work in a more focussed way with partners to address underlying issues. My concern is that as an organisation we do not therefore go far enough to forego resourcing events which have already happened (but where little ongoing risk is identified), and instead get upstream of demand to reduce risk and prevent harm. I see this as a driver of achieving World Class Sustainable Policing. The continuation of the HIP, and potential for us to expand our response to repeat demand alongside this are in my view key to improving the service we provide to the public, the identification of risk, and maintenance of public safety.
Video Interviews

HIP Team: Plymouth

HIP Team: North Devon

Service User - Richard
HIP Service User Richard
from High Intensity Network

HIP Service User Rachel
from High Intensity Network

Service User - Rachel

HIP Service User Rachel
from High Intensity Network

Service User - Kirstien
Devon & Cornwall Police: Police Response Sgt

HIP - Patrol Sgt - Sgt Donna Money
from High Intensity Network

13:41

Devon & Cornwall Police: Police Community Safety Sgt

HIP Service User Kirstien
from High Intensity Network

36:30
SW Ambulance Service: Frequent Caller Team

HIP - SW Amb - Thomas Cowland
from High Intensity Network

24:23

University Hospitals Plymouth NHS Trust: A&E Psych-Liaison Team
University Hospitals Plymouth NHS Trust: A&E Lead Nurse

HIP - A&E Nurse - Fiona Veale

Devon Partnership NHS Trust: Mental Health Service Manager
HIP MH Clinical Development Lead - Jake Moore
from High Intensity Network

LIVEWELL Southwest: Consultant Psychiatrist
HIP Consultant Psychiatrist LIVEWELL
from High Intensity Network

HM Prison and Probation Service: Plymouth
Probation Officer
Case Studies
Frequent caller to Police with suicidal ideation and actions.

Case Intensity

The service user, a 21 year old female diagnosed with emotionally unstable personality disorder, abandonment issues and on the autistic spectrum was making regular calls to Police expressing suicidal intentions or disclosing active self-harm including actions like inserting foreign bodies, swallowing batteries and ligaturing. They would also attend high places and state their intention to end their life.

The Police response would routinely require multiple officers, numerous but clinically unhelpful section 136 detentions and no attempts to put a boundary around the behaviours because they were misunderstood.

The service user refused to make use of either the in house support or external statutory agency support but routinely created a large impact on the Police and Ambulance services.

SIM Team Intervention
The team worked to build a therapeutic relationship with the service user. A dedicated 24x7 care pathway was clearly explained and documented. A crisis response plan was built in conjunction with the service user and the agencies supporting them. Regular meetings were held to review and edit the crisis response plan as required or as behaviours changed.

Multi-agency meetings were held regularly to ensure all parties understood how best to respond to the service user and to ensure a united and agreed response was delivered in each circumstance.

Clear information sharing between agencies helped to ensure responses were considered based on best information and best interest rather than perception of circumstances, inaccurate reporting or agencies each being given different information by the service user.

**Result of SIM Intervention**

Every Police, SWAST and health interaction was known to the team and all parties worked hard to ensure responses were both clinically guided but also that opportunities for boundary setting, evidence gathering, support and understanding of behavioural responses were not missed.

Support was ensured when they were a victim of crime but also prosecution was utilised whenever appropriate.

There was clear clinical guidance provided by our partners in health for the health related aspects of her responses but also clear guidance to assist in determining whether offences were suitable for prosecution or should be used as part of the therapeutic response.

Clinically unhelpful section 136 detentions were reduced significantly whilst officers were provided with a toolkit of other options to consider.

Whilst their safety was improved and their vulnerability reduced in the early days of the intervention the Covid pandemic removed all of the community support options we had been engaging them with. This saw a gradual re-escalation of the hard won ground but the good working relationship continued and resulted in better engagement with mental health services.

(The new pink sections of the graph)

Whilst the demand would appear to have increased the nature of the demand changed from almost daily Police and Ambulance attendances to notification of incidents and diversion to mental health support services for their mental health condition.

The improved engagement with mental health services meant a long term, out of area therapeutic placement was offered. They are now safer than they were, more engaged with their clinical team than before and are more likely to have a future in the community than before we worked with them.

**Intervention duration:** 9 months

**Crisis demand:** Stopped

**Likelihood of re-offending:** Low

**Likelihood of Custodial Sentence:** Low

**Mental Health Service Status:** Open - admitted to specialist placement.
Frequent caller to Police with delusional disorder.

Case Intensity

The service user, an elderly person diagnosed with a delusional disorder, was making frequent and repeated calls to Police as a result of their illness. The individual lacked insight into their illness and would not engage with the health-based support services available to them, but they routinely contacted the Police for support. This led to frequent Police attendance at the home address for what was ultimately a health-based matter.

SIM Team Intervention

By applying our rigorous multi-agency assessment process, it was recognised that this was a behavioural response that was rooted in illness. This meant the individual did not meet the normal criteria for inclusion on the programme. We recognised this was an opportunity to work in an advisory capacity and provide guidance on a solution that would assist in decreasing the demand whilst supporting the individual and making them less vulnerable.

We worked with our partners in health to understand the nature of the illness and crafted a considered response that would support the individual but pass the contact created by them to the team best equipped and staffed to support them. It was recognised by all parties that this was not the Police. The SIM team contacted the service user and explained why the new approach was required and the content and implications of this new approach.
Result of SIM Intervention

HIP team intervention was more akin to that of a tactics advisor. Through use of the national SARA model we identified an approach and crafted a considered and professional response with the key clinicians involved in the person’s care. This resulted in a clearly documented plan to follow in the control room. It had strong clinical guidance and gave clear direction to the call handler what was required and why. This helped them to understand the need to follow the actions that were in the individuals best clinical interest, but which also reduced the demand on and deployment of Police resources. This service users on going management enquiry was then passed to the local Neighbourhood Policing Team to monitor and ensure the protocol was being followed. Prior to this work the average number of days between contact was 18. At the time of writing we are on 69.

Inappropriate contact with Police has currently stopped and this is reported by the service user to health as being a deliberate action on their behalf.

**Intervention duration:** 2 weeks

**Crisis demand:** Stopped

**Likelihood of re-offending:** Low

**Likelihood of Custodial Sentence:** Low

**Mental Health Service Status:** Open
Frequent caller to Police engaged in drunken expression of suicidal ideation and possession of a bladed article.

Case Intensity

This service user engaged in routine drunken calls to Police whilst expressing suicidal ideation and having possession of a blade for self-harm purposes. Previous Police responses had unwittingly fed into the needs-based behaviours of the service user who had escalated their volume of contact due to the nature of the Police responses. The individual represented a foreseeable risk not only to themselves but a clear risk to both Emergency responders and secondary health care professionals due to drunken aggression and possession of weapons.

SIM Team Intervention

The HIP team instigated clear and consistent boundaries whilst crafting and offering a 24x7 support pathway. Regular support was offered, and clear guidance given around actions involving criminality and inappropriate behaviour. Statutory and third sector counselling and support was offered. A bespoke crisis response plan was crafted with them to cover each of their behaviours and this set not only a clear pathway for them when they were in distress but also an expectation on them to use the very services that were there to support them when they felt that way. They were also made aware of the implications of engaging in the criminal high risk behaviours.

Result of SIM Intervention
As a result of HIP team intervention there was clear information sharing across agencies to maintain safety of staff. The service user had a clear and full understanding of what was expected of them and what they could expect as a response when exhibiting those behaviours. Offences were rigorously pursued when committed. These resulted in court appearances and a suspended prison sentence.

As can be seen on the graph, The behavioural responses changed rapidly seeing a switch from predominantly using Police and SWAST to inappropriately manage distress across to the Access First Response Team who were available whenever needed to support them.

Offending reduced and engagement with recovery focussed support options improved. Their ability to manage distress improved. The risk was reduced to both them and the public and inappropriate demand on the Police service was almost completely eliminated. They are less vulnerable than previously. Less likely to commit offences and less likely to engage in behaviours that resulted in hospital admissions.

**Intervention duration:** 7 months  
**Crisis demand:** lowered  
**Likelihood of re-offending:** Low  
**Likelihood of Custodial Sentence:** Medium if they re-offend due to offending hisotry  
**Mental Health Service Status:** Open
Frequent caller to Police expressing suicidal ideation, taking overdoses of medication and attending bridges.

Case Intensity

This service user engaged in high-risk, high impact behaviours resulting in calls to Police at road bridges where they would express suicidal ideation before running off or they would tell people they had taken an overdose of medication before running off from the home address. This caused a large impact on the local community when the bridge was closed to facilitate safe intervention and resulted routinely in high-risk missing person episodes. Police activity was focused almost entirely on response to incidents and little activity occurred of a preventative nature. As can be seen on the left hand graph the resourcing impact on Police and SWAST was significant.

SIM Team Intervention

The HIP team tried to work with the service user, but they would not engage in the traditional sense. Whilst co-production is very much the preferred method of interaction, the risk to them and the wider community was such that a response needed to be created without co-authorship to mitigate the risk to the service user and the wider public. Multi-agency information sharing, and multi-disciplinary management meetings ensured both clinical oversight but also clear understanding and a consensus of approach from all agencies in how to manage the risk around this individual.

The service user when engaging would routinely disclose they were taking overdoses of prescription medication because they were seeking the feelings of intoxication that went with this.
Clear self-rescuing behaviour was being exhibited whilst they were refusing to voluntarily use the help and support that their behaviour was obtaining anyway.

**Result of SIM Intervention**

HIP team intervention meant the GP was informed of the way the prescribed medication was being misused. A new prescription regime was put in place that removed the ability to overdose on large quantities of medication because access was restricted to low quantities. Clear information was provided to the service user around the likelihood of criminal justice activity for misusing emergency services and wasting Police time. They received a clear understanding that there would be a consistent and robust boundary around the behaviours that our partners in health were telling us was a choice on their part and not a consequence of serious mental illness. Everybody had a copy of the same crisis response plan. This included the service user, so everybody knew what to expect, what to do and why.

Criminality was pursued to ensure the boundaries for behavioural responses were maintained whilst support was repeatedly offered. The right hand graph shows the inappropriate reliance on Police and Ambulance services reduced significantly over the twelve-month period as the service user was encouraged to make use of the Access First Response Service. (pink columns)

By engaging them with the mental health team to help them manage their distress they were assisted to become safer, less vulnerable and became more recovery focused.

Their engagement with mental health support services improved as did their distress management.

**Intervention duration:** 12 months  
**Crisis demand:** Eliminated  
**Likelihood of re-offending:** Low  
**Likelihood of Custodial Sentence:** Low  
**Mental Health Service Status:** Closed
Frequent High Risk Missing Person

Case Intensity

This individual diagnosed with dissociative amnesia routinely responds to trigger events by dissociating and going missing from their home address or other locations. The Police response was to routinely make them a high-risk missing person with the significant associated impact on both the Police service and the wider community due to the high level and high cost resourcing requirements of a high-risk missing person episode. Whilst recognised as a problem pre-HIP no tangible activity had occurred to address the situation.

SIM Team Intervention

The multi-agency panel agreed that the fact the service user had no control over when they dissociated meant they didn’t fit the normal criteria for inclusion on the programme. It was agreed that we could fulfil a tactical and delivery role by crafting a multi-agency response based on an understanding of the actual, rather than perceived risk around this service user.

Research across multiple forces, close work with our partners in the community mental health team and the G.P. helped us to understand the nature of the condition and likely triggers. In understanding the condition, we learnt the risk to the service user was significantly lower than we would have thought.

We discovered our previous responses had inadvertently been making the situation worse not better, therapeutically our response needed to change.

The team worked with the family and the service user. A dedicated SOP was drafted to assist CIM’s in understanding the true risk around the missing episodes and the need to balance that risk...
against the therapeutic advantage of a much lower level response.

A Police enquiry holding detailed research and updates was opened to provide further guidance and background to the crafting of the SOP and held the evidence base to support the new response. The response teams were all briefed on not only the response needed to this person’s episodes but also why. This helped drive compliance with the protocol and empowered them to challenge managers or radio operators that had not read the protocol but were trying to deploy units inappropriately.

Whilst the new Police response was embedded the team worked with the service user to understand the trigger events and come up with ways to mitigate these in an effort to reduce the frequency and severity of them. No longer just responding to incidents but actively working to prevent them happening.

Result of SIM Intervention

Whilst this is very early in the cycle of intervention, the level, volume and cost of the Police response has been cut dramatically. We no longer incorrectly record this person as a high-risk missing person as a matter of course. We no longer deploy multiple response units, dog unit and NPAS. We now know that this is normally unhelpful for them therapeutically and it creates a response that has a high impact on our ability to deliver a service to the wider community that is not justified.

The individual is seeing their long-term therapeutic recovery balanced appropriately against the risk of harm to them that is actually present. They report an improved and more compassionate response from Police which is likely to lead to less episodes in the future and gives health the space and time to intervene without the Police response inadvertently becoming a barrier to this.

They are now actively engaged in both statutory agency therapeutic activity and third-party support organisations.

A longer term plan for recovery is being crafted.

**Intervention duration:** 3 months  
**Crisis demand:** Lowered  
**Likelihood of re-offending:** Low  
**Likelihood of Custodial Sentence:** Low  
**Mental Health Service Status:** Open
Frequent drunken malicious caller to Police and SWAST.

Case Intensity

Over the previous three years the service user would routinely get drunk in public places and then call Police or SWAST intimating suicidal feelings. They were routinely put in Police cars or Ambulances and driven back to their supported living accommodation with no consequence for their behaviour. They ‘learnt’ they could behave this way and get a free ‘Police Taxi’ or ‘Ambulance Taxi’ home with no penalty for the behaviour. As a result, the Police contact figures escalated by 50% year on year for three years running. SWAST saw similar. Crimes went unrecorded and opportunities to provide a boundary to the behaviour we’re missed or ignored.

SIM Team Intervention

The HIP team immediately crafted a care pathway available to the service user 24x7. A crisis response plan was developed to cover each of the service users chosen behavioural responses to situations with what they could and should do as an alternative. Where criminal offences were committed, it was explained how the criminal justice process would be used to manage the situation and that things would not be like they were before. The plan was made available to the service user and the entire professional team surrounding them. Any Police officer at any time of day or night could access the latest version of the plan. Everyone knew what was expected of them. The HIP team ensured responses matched those detailed in the plan. Crimes were recorded accurately and investigated effectively. Anti-social behaviour legislation was used where appropriate and ultimately a restraining order was issued that was breached within days. The service user was sentenced to a short period of imprisonment. (This shows as grey on the right...
hand graph) Whilst the service user is still not effectively engaging with their team, the team continue to work with them, the GP, the local Neighbourhood Policing Team and the Community Mental Health Team to ensure all parties have the latest information and all are pulling in the same direction. The nature of the behaviour post criminal justice sanction can be seen to the right of the grey section of graph.

**Result of SIM Intervention**

As a result of intervention, the impact this service user has had on SWAST and the Police has been reduced gradually over the 12-month evaluation period. Now a further three months later there has been almost no contact in three months. Inappropriate calls to Police and SWAST have stopped.

This service user has taken many years to get to this point and with their diagnosis and complex trauma history it is unrealistic to think they can be completely resolved in just twelve months however they are safer than they were 15 months ago. They are less vulnerable than they were 15 months ago. They are less likely to commit crime than they were 15 months ago. Their impact, both from a demand and financial aspect is significantly reduced compared to 15 months ago and this appears set to continue.

**Intervention duration:** 12 months  
**Crisis demand:** Lowered  
**Likelihood of re-offending:** Low  
**Likelihood of Custodial Sentence:** Medium if they re-offend due to offending hisotry  
**Mental Health Service Status:** Open
Frequent contact due to individual taking overdoses of medication, leaving the home address and attending bridges/high places.

Case Intensity

The service user diagnosed with Emotionally Unstable Personality Disorder struggled to manage their distress in relation to trigger events. They would routinely state they had taken an overdose of medication and leave the home address when things became 'too much' but would refuse to use those support services available to them. Other scenarios that required an emergency response did not involve an overdose on medication, but the service user would instead attend bridges/high places and make statements of intent to harm themselves that resulted in the use of section 136 detentions. They were fully aware their phone was being tracked by family and they rarely prevented emergency services from finding them. They demonstrated clear self-rescuing behaviour but refused to use any of the support options in the lead up to the crisis behaviour. They appeared to be actively seeking an alternative to the distress caused by the situation at home that appeared to be triggering the behaviours.

SIM Team Intervention

The HIP team worked with the service user each week to build a therapeutic relationship. A crisis response plan was co-authored and the team helped mentor them in the use of coping techniques and accessing support services. Multi-disciplinary team management meetings helped share information and ensure everybody understood what it was felt was going on. Understanding the dynamics of domestic violence, the different stories parts of the family knew and therefore why
certain pressures existed and childhood autism within the family unit were part of working on understanding the background circumstances that led to the triggers and stressors that caused the behavioural responses. Support services and advice was offered around each of the areas that contributed to the behaviours.

**Result of SIM Intervention**

The HIP team worked with the service user to understand how and why they should engage with the support network and why there needed to be consequences for the behavioural choices they were making. They helped co-author a plan around these behaviours and whilst they did not agree with the decision, fully understood when they were arrested for attending a bridge intimating suicidal intent having just been discharged from a place of safety.

They confirmed themselves that whilst they didn’t like the fact it was there, the boundary set by Police meant they were less likely to engage in the unhelpful behaviours. They have now started to use the very support services and techniques we have been encouraging them to engage with for the last twelve months. Whilst the graph shows the 12 month period post intervention, there have been none of the previous behaviours over months thirteen and fourteen. Whilst the shown demand may not appear dramatically different the NATURE of the demand is. Distress management through inappropriate behaviours and use of Police/SWAST has been replaced by contacting the mental health services. The costs of section 136 detentions, emergency responders and investigations have been replaced by them using the very service that is there to help them when they are struggling. They are safer, they are less vulnerable, they are more focussed upon their recovery.

**Intervention duration:** 12 months  
**Crisis demand:** Stopped  
**Likelihood of re-offending:** Low  
**Likelihood of Custodial Sentence:** Low  
**Mental Health Service Status:** Open