The model has been designed specifically for people struggling with highly intensive patterns of trauma, mental health problems and behavioural disorders. Mental Health services are designed to manage mental health crisis but with this cohort the crisis is normally a behavioural response to safety seeking which can’t be managed by health alone (green) as we are unable to reinforce boundaries whereas the police (blue) can support green to do this this.

The team adhere to the following model of care to:

- Support crisis patients struggling with the most complex and challenging behaviour to write their own care plans, whilst simultaneously empowering them towards safer and healthier lives.
- Help patients reduce risk and harm to both themselves and others.
- Reduce the chance of patients having contact with the criminal justice system (but being highly supportive if they do).
- Provide urgent care teams with high quality clinical and behavioural information, allowing them to make more clinically accurate, less reactive and more consistent decisions.
- Bring hope to patients who are struggling to see a positive future.

There are 4 key components:

1. This intervention is designed to work with service users who have behavioural disturbance which they have capacity to change, so normally Emotionally Unstable or Anti-Social Personality Disorder would be the diagnosis.

2. To reinforce the boundaries the Blue are required to work alongside Green. As the work will involve clinical decision making you would never have Blue without Green.

3. You would never take away anything without giving something back for example if you wanted them to stop attending the bridge you would replace that with an alternative safe place, safe person and safe routine.

4. The more engagement and authoring of the tools that are completed by the service user the more empowering and robust they will be.

SOP

Referrals:

Referrals can be made by any of the partner agencies including police, SWAST and DPT. All referrals will require a referral form for presentation to the Panel. This will allow the Panel time to apply due diligence before making a decision. To this end we would not be able to accept a referral to that months Panel in the 7 days leading up to Panel.
If the referral has come from DPT we would expect the referrer to also present via Teams their rationale for referral and what has already been tried.

Referrals can be accepted by the Panel or they may be rejected in which case we would feedback the rationale. There may also some referrals that we may want to hold for a few months to see what develops or they may require a SOP but not be suitable e.g. diagnostic exclusion. In the latter case The Liaison Police Officer can support the local force to write and implement the SOP.

The Panel

The Panel is made up of 3 police officers, the Sergeant who chairs the Panel, The Liaison Officer and an officer supporting the project. The Lead for DPT Community Services in North provides the senior input from DPT and the Service Manager and Practice Lead from Liaison provide clinical opinion and assist with the data collection from a health perspective. SWAST are also represented as this client group can also affect them.

Once the referral has arrived the group need to have all referral forms e-mailed at a minimum of 7 days before Panel so they can apply due diligence in advance of the Panel sitting.

For the Clinical response this will be interrogation of Carenotes and possibly GP summary so we can give a robust clinical response.

For the Liaison Officer this will be interrogation of police records, logs etc.

For SWAST this will be to check frequency and any associated issues to their address.

The Panel will then hear from the DPT designated worker within the meeting. If there is no worker the panel will need to discuss the referral and if they fulfil the criteria the Panel would recommend who could be approached to provide the Green response-until this is established and the worker is aware of the potential protracted involvement the referral cannot be accepted on to the program.

The clinical voice on the Panel has to overrule the other Panel members as the ethos is to support Green in providing boundaries and if Green think they don’t meet the criteria the Panel will accept this.

The intervention

Green and Blue will arrange to meet with the person and at the beginning while explaining the intervention, building rapport and beginning the crafting of the co-authored plans and SOP this is usually weekly.

If the person attends then this process is followed until there is a response established to each difficult behaviour. Sticking to the ethos this needs to provide something in exchange for the behaviour by way of a safe place, safe person and safe routine that is completely individual to that person.

These meetings would then continue and may expand if the person begins to move forward for example job centre, other supports such as NA or AA, The Moorings etc.

Once the behaviours abate Green and Blue would work towards discharge from the program.
However if the person referred will not attend this does not exclude them from the project. In this case appointments would continue to be offered but if still not accepted then Green and Blue craft the plans and SOP and then let the individual see these. If they want to make changes they can again be offered appointments to discuss this but the plans will be implemented regardless.

Again once the behaviours abate Green and Blue would work towards discharge from the program.

**Outcome measures**

We do not have any standard outcome measures although we have used Core 10 on some of those on the program. As part of the SOP development this is an area of consideration.

**Data**

The service clearly needs to keep robust data to evidence its validity which is currently being held by the Liaison Officer.

**Information Sharing**

Under review by [redacted]
### Referral source
Delete as needed

<table>
<thead>
<tr>
<th>Police</th>
<th>Health</th>
<th>SWAST</th>
<th>Other</th>
</tr>
</thead>
</table>

Person being referred with name and DOB and any other identifiers available.

<table>
<thead>
<tr>
<th>Referrer</th>
<th>Name</th>
</tr>
</thead>
</table>

Do they have a DPT worker?
Name if they do
* 

If yes is the DPT worker aware of the referral?
* 

<table>
<thead>
<tr>
<th>Behaviours of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description of nature, frequency and level of risk perceived.</td>
</tr>
</tbody>
</table>

What has already been tried?

<table>
<thead>
<tr>
<th>Is the client aware of the referral?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

If yes how have they reacted?

<table>
<thead>
<tr>
<th>Are they known to Criminal Justice?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

Delete as needed
* For non DPT referrals only