East of England

Ref no	Trust	SIM Yes Yes - adapted Yes – stopped Yes – adapted then stopped No	Fidelity to national model	Evaluation (inc SU involvement)	Withholding treatment/use of sanctions	Data sharing	Police role
1	North Suffolk	Closed 31/7/21	Joint Engagement Team based on SIM. 2 High Intensity Liaison Officers employed by Suffolk Police with joint contracts with NSFT. Model commenced 2019. 27 people accessed service.	Received some complaints. None were escalated to safeguarding. On the whole received positive feedback from interviews undertaken by clinical lead. Most interviewees remarked that if there were greater support from recovery workers there would b no need for this additional support. Also held 2 public engagement events – received far greater negativity from users who were unaware of the model and who were responding to things they had read online or from other areas. Staff positive about the model. Case studies… "with one particular patient it has led to smoother/calmer admissions without the need for restraint as they have followed the care plan" Review: in line with LTP, NICE, patient confidentiality and data-sharing and human rights. (case study provided see next slide)	No criminal sanctions issued. Some people given verbal warning re anti-social behaviour. No one at any time refused support from a health professional.	Information sharing agreement between agencies in place and ensured consent was given from service users open to JET.	Officers attended SIM training but I need to be really clear this was in addition to psychological intervention and support from recovering worker. HIOs acted as mentors and facilitators.
2	Herts & West Essex	Herts West Essex	Herts no longer using SIM. Have a clinical PD pathway and remodelled Crisis Resolution Home Treatment Service	Service users and carers co-designed PD pathway	No behavioural contracts that seek to withhold care		

East of England	
Trust ref: 1 North Norfolk Case study	[Service user] initially came to JET displaying high risk behaviours including lying on or near the A14, this involved risk of causing serious danger of death to themselves, other road users and emergency responders. [Service user is] After intensive intervention and liaison from a member of the JET team the service user initial high-risk behaviour of going to A14 has stopped completely. Crisis still exists but less frequent and lower risk.

East of England

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3	Cambridgeshire & Peterborough	 SIM piloted for one year. Ended July 2021. 3 SUs on caseload.		No complaints until an informal complaint re service ending. Data demonstrates a change through reduction in presentations and the nature of presentations. Qualitative data also suggests progress made with all participants on a variety of levels eg [ ]. Informal feedback over year has been positive. Concerns raised by Rethink – assurance given that time taken to develop the consensual model.	[ ]	Service offered on basis of consent from SU	"It has helped to create an interface to support and educate other police officers in how to respond to mental health issues by creating more options to respond to service user needs."
4	Mid and South Essex and NE Essex	 Mid-Essex  Southend – uses SHIFT	Started 2018. 13 service users. Stopped since removal of police input in June 2021.	One complaint from SU unhappy that referred to Team. Subsequent to starting review one formal complaint from a SIM client via their solicitor – appears to be part of wider enquiry on use of SIM models. Service User outcome data (all quantitative) show a marked reduction in crisis presentations to A&E, use of ambulance, contracts with police, number of S136s, and inpatient bed days.	No SHIFT or SIM clients prosecuted for any behaviour relating to access services. No plans that deny emergency care.		"Clients valued the joint police/mental health role."

East of England

Ref no	Trust	SIM Yes Yes - adapted Yes – stopped Yes – adapted then stopped No	Fidelity to national model	Evaluation (inc SU involvement)	Withholding treatment/use of sanctions	Data sharing	Police role
5	BLMK		High fidelity to national SIM model. 8 people supported by the team.	No complaints. Number of self-reported compliments: "Afternoon, just wanted to let you wonderful people know that I have had a successful Xmas so far. I've had no police interaction or any emergency services involvement whatsoever. Been feeling really low in mood but have used my coping strategy really well and I'm so proud of myself." "It's been a year today since my accident and I just wanted t thank you for all of your support this year and with helping me get back on my feet quite literally. You guys saved me from multiple disasters and I will be forever grateful for that." There is recognition across the system that there is a need for a comprehensive service to support people with complex needs. The future work is to build on the learning and experience of this programme to develop a model of care which delivers clear measurable outcomes that support people with complex needs t access the right services appropriately.	2 people sanctioned. Neither involved any direction to reduce access to patient care. One given repeated warnings about inappropriate use of 999 and was eventually prosecuted and issued with a treatment order. One was a public order issue for causing a nuisance in the community by walking in front of cars and putting the public in danger as well as themselves.		Police not involved in mental care of patient. However, it could be said at times that there was a blurring of roles.

London

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6	West London	 Prior to 2020 SIM model only taken forward in Hounslow *(post 2020?)*. 20 patients supported by model, 3 active when concerns raised.	SIM model locally did not use coercion. Only patients who were able to, and did, provide consent were included.	Lack of evaluation of patient experience of the model hampered its further development, assurance about it, and further learning. Trust Ethics Committee – recommend a co-produced evaluation of SIM in Hounslow and subsequent co-produced service development of the model going forward. SIM nomenclature not appropriate going forward.	No evidence that model led to withholding of life-saving treatment. No evidence model took an approach to criminalising mental illness. On the contrary, appropriate sharing of information was felt to have reduced restrictive practice and arrests.	Intention and practice of information sharing does not appear to have been disproportionate or unethical, there are aspects of the governance of information flow between police and mental health services which require more rigorous oversight.	Transparency of process/model is necessary to allow duty of candour eg communicating that police are providing a mentoring role, that information is shared with police.
7,8,9	Joint response from: SLAM, Oxleas & SWL and St George's	 Not clear from response whether SIM is still in place or stopped		Trusts' review extensive and covered such themes as compliance with NICE guidance, governance, data sharing, service user and staff experience. Provided us with assurance that in the main experience of SIM by staff and service users was positive. Recommendations: Multi-agency agreements should be supported by adequate Data Sharing Agreements between agencies. Any new model should be co-produced with service user and carer representatives and should also consider guidance of RCN and RCPsych and must be designed to respect the human rights of the individual. New approach to multi-agency working should have clearly defined scope and purpose and outcome; and should be accompanied by the commissioning and completion of an independent evaluation. Relationship between mental health trusts and AHSN needs to be defined.		In 2020 our Trusts had already started to address issues associated with data sharing arrangements with High Intensity Network Ltd and general governance of SIM	

East of England

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10	BEH Trust	Launched in Enfield in September 2019. Stopped in 2020 following letter from National Medical Director. Caseload of 9.	No further information provided.				
11	ELFT	Halted referrals to SIM while carried out a review into pilot in Newham. Decided to discontinue.		Working with service users to co-produce a service which previously met the needs of service users referred to SIM.			
12	Camden & Islington	SIM ran from 2018. Paused in Jan 2021 when SIM MH Nurse left and stood down in April 2021 pending a review		Partnership between mental health nurse and police officer provide effective in improving the clinical care of frequent users of emergency and mental health crisis services and in reducing unhelpful contact with these services. (detailed notes from interview with one service user, see next slide)	The aim of all Trust services, including SIM, is to support people to use services in the most helpful way possible. Crisis plans developed by the SIM Team in collaboration with service-users and their community mental health team Case Managers routinely included advice on whether Hospital admissions or Police call-outs had been found to be helpful. They also advised emergency services and mental health crisis services on the most helpful way to respond to individual service-users, based on the Trust's understanding of an individual's mental health needs. The C&I SIM Team never used punishment in an attempt to shape a service-user's behaviour. This would be against the ethos and values of the Trust and the SIM Project. One service user was issued with a Community Protection Notice re acting in an anti-social manner by City of London Police regarding their presentations on bridges. This letter was not initiated by the SIM team.		1 police officer and 1 MH nurse worked with a caseload of 7 -10 service users Future model we would like to implement would be similar to SIM but with important differences. Helpful to reinstate role of MH practitioner to work with a small caseload of high intensity service users in a more intensive way than current community mental health case managers are able to. .

London

Ref no	Trust	Evaluation (inc SU involvement)
12	Camden and Islington continued	The service-user overall had a *''very positive experience''* of the SIM Project. They understood that they had been referred to SIM by City of London police because they believed they needed more support than they were getting. When asked about their experience with the SIM team, they replied: *''The police side of things tried to understand what was happening with me, to learn how to best help me, and to educate their colleagues on how to help me. I noticed the police were far less aggressive than they were in the beginning. They are now very gentle, they don't hassle me, they use the crisis plan. They kind of educated themselves on the police side.* *When I'm unwell I don't recognise people or see faces, but I can hear people. I felt the police were then sending people who had dealt with me before and who knew how to deal with me. They knew not to be aggressive, to be as gentle as possible. It's very rare now that I have a bad experience with the police, whereas before I had a lot of bad experiences. I think it's because they educated themselves and trying to understand me.''* The service-user further elaborated on their experiences with three different police officers who had occupied the role as part of the SIM Project, stating that they felt able to talk honestly and openly with them. In regard to the police, they said: *''At the beginning they didn't know how to handle me, the police weren't as gentle as they are now. If they hadn't been educated through SIM, and had no crisis plan, then they would be the same.''* The crisis plan was a specific aspect of the SIM Project that the service-user identified as being extremely helpful, and noticeably different to crisis plans designed for them previously. They said: *''The crisis plan, all parties put a lot of work into it. The crisis plan is way, way better than the crisis plan we had pre-SIM. Much more functional and practical as I'm non-verbal when in crisis. When they look at the back of my phone they get all of the information. The crisis plan pre-SIM wasn't as detailed. For the SIM crisis plan it goes through all triggers that I have, all the things that I do to myself, and how emergency services should deal with whatever I do. For instance, if I self-harm then I don't necessarily need to be taken to A&E, it can be handled one way.''* Regarding A&E and any other emergency services, the service-user was asked whether they felt that had access to all such services during their time with the SIM Project. They responded: *''Yes, I felt able to access whatever I needed, any services I needed''.* When asked about if they had any concerns about information being shared between the Police and Mental Health services, the service-user said they had no issues with this, and that they don't see *''the police as a disciplinarian body. I can see that they are helping, and they are there to help.''* As the service-user was known to Mental Health services prior to their engagement with the SIM project, they were asked what their experience was like before and after SIM. They said the SIM team: *''spent the time understanding me first. They saw me as I am, with the problem that I have first, rather than the diagnosis.''* *The service-user went on to elaborate, stating:* *The SIM structure gave you the time to get to know me and that made a whole lot of difference.''* At the end of the interview, the service-user was asked if they had anything further they wanted to discuss. The service-user finished by giving their overall thoughts on the SIM Project and their experience, stating: *''Overall I had a very positive experience. I have progressed a lot with the help of SIM. I'm nowhere near where I was like a year ago.''*

Midlands

Ref no	Trust	SIM Yes Yes - adapted Yes – stopped Yes – adapted then stopped No	Fidelity to national model	Evaluation (inc SU involvement)	Withholding treatment/use of sanctions	Data sharing	Police role
13	Leicestershire Partnership	? Joint health/police working with service users outside of crisis similar to SIM. 12-week limit on PAVE team support not similar.	Local service called PAVE. Designed to work with individuals who have complex needs and present to police on a regular basis. Team will work with an individual intensively to ensure that the correct criminal justice, health and social care pathways are accessed and utilised appropriately. Three-tier MDT outcome plan.	No complaints/safeguarding issues. Team are reviewing discharge pathways to assess if service users engage with services they are referred to.			2 MH practitioners, 2 police officers, 0.8 Turning Point
14	Derby	Known locally as JET model. Supported 8 patients. Following national concerns and withdrawal of local partners from project, only 2 patients open to service.		No concerns or complaints logged and there have been 23 compliments since January 2019. All JET patients will be contacted with a view to attending a focus group with feedback independent of the Trust. Derbyshire Health United which provides primary care out of hours emergency care and EMAS (ambulance service) have withdrawn from the JET service model and will be no longer using its care plans due to the adverse national publicity and concerns that have been raised. This could potentially increase the risk to these already high risk service users. Staff have been concerned that adverse national criticism impugns their professionalism and compassionate approach to patient care. They have been reassured that this is not the case.	"The JET model helps the patient reflect on their mode of seeking help from care and emergency services particularly if they are using increasingly risky behaviours to elicit a response. The approach requires discipline and effort from the patient to slowly develop the skills, resilience and coping mechanisms required for a healthier life. The aim is to enhance personal and public safety and prevent crime and disorder by people exhibiting crisis behaviour. A conditional approach to care could be perceived and/or experienced by the patient as coercive but this is not the intention and safe care cannot be established unless there is mutual respect of appropriate boundaries."		RMN plus police officer

Midlands

Ref no	Trust	SIM Yes Yes - adapted Yes – stopped Yes – adapted then stopped No	Fidelity to national model	Evaluation (inc SU involvement)	Withholding treatment/use of sanctions	Data sharing	Police role
15	Nottinghamshire Healthcare		Not applicable. Trust piloted a High Intensity User model with a band 6 nurse for a 3-month period. Intention it to move to substantive recruitment.				No police role outside police officers using S136 of mental health act. Police officers seek a clinical perspective from Street Triage clinicians and clinical staff in CRHT or HBPS prior to using a S136, a least restrictive option is always considered.
16	Herefordshire and Worcestershire		Not applicable. Usual pathway includes Crisis Team contact/support, 136 assessments, liaison assessments if present at the acute hospitals. CENS are collecting outcomes data (both qualitative and quantitative) but currently no data available.		Patients admitted to the wards displaying challenging or aggressive/illicit drug use or suspected dealing behaviour have had police involvement – occasionally charged but usually no sanctions.		

Midlands

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17	Lincolnshire Partnership		Not applicable. Pre- COViD High Intensity Model developed and subject to piloting, iteration and evaluation. Programme put on hold in 2020 due to COVID pandemic response.				Range of partnership initiatives which have improved the combined response to vulnerable people with mental health problems with a focus on shared learning, decreasing number of people requiring detention in the Section 136 suite.

North East and Yorkshire

Ref no	Trust	SIM Yes Yes - adapted Yes – stopped Yes – adapted then stopped No	Fidelity to national model	Evaluation (inc SU involvement)	Withholding treatment/use of sanctions	Data sharing	Police role
18	Cumbria, Northumberland, Tyne and Wear	 N.Cumbria In North Cumbria only Freedom to Fly project set up as part of national SIM project. However, following initial training by SIM team, it was decided a local model would be developed. Instead, Enhanced Risk Management Core Team model set up to support an identified group of five high risk/frequent contact people in a more co-ordinated, preventative, proactive and consistent way. Based on Integrated Motivational Volitional model.	Not applicable. Did not take up offer of model due to concerns about ethos and governance. Have good and innovative practice in place to allow us to decide this wasn't needed: clinical police liaison lead; work closely with police negotiator team on those presenting in high risk situations; street triage team; criminal justice liaison team in Northumbria Custody/Courts.	No recorded complaints against Freedom to Fly project. "*The F2F project is an amazing service with friendly staff. Gives time to do positive stuff and to be able to talk. The daytime can be hard, so it is nice to know that there is someone around. I think the F2f project has helped to keep me out of crisis as much as I used to be. I would miss this service if it wasn't here.*"	The plans are always about diverting the person's engagement to mental health services. They are not, about excluding from services. They would also include clinical involvement from the access services whom may see the person also. For example Street Triage, CJLT in Custody, Psychiatric Liaison team at EDs etc.	The model involved the core team working jointly with high risk service users and their carers, to develop personalised risk management/safety response plans and closely supporting people to follow these plans. Plans are developed collaboratively with the person at centre, and shared with other agencies on consent basis. There has been reports through this project, including service user feedback, and the project has evolved in response to these. The project has developed with each review. It has a dedicated Clinical Lead form Community Services and works with Community teams and Care Co-ordinators.	What we are proactively trying to be in working with Police, is more trauma informed and we incorporate this into our scaffolding of police, ambulance etc. Also we place emphasis on helping Police, to understand formulations so they can get why the person behaves that way – all about increasing compassionate care.

North East and Yorkshire

Ref no	Trust	SIM Yes Yes - adapted Yes – stopped Yes – adapted then stopped No	Fidelity to national model	Evaluation (inc SU involvement)		Withholding treatment/use of sanctions	Data sharing	Police role
19 - 23	• Bradford; Humber; Leeds & York; Sheffield; TEW Valleys; Navigo	●	Do not use SIM or any version					
24	South West Yorkshire	◐ March 2020 decision to adapt model	Explicit and written consent from service users to their crisis response plans being shared with other agencies 5 service users in total				In March 2020, in a meeting between SWYFT and Mid Yorkshire Hospitals NHS Trust, there was consensus that the SIM approach and guidance about patient consent not being needed for information sharing between partner organisations (as stipulated in the training delivered by Paul Jennings with support from the Yorkshire and Humber Academic Health Science Network in Feb 2020) was flawed and was not an acceptable way forward for either of the trusts. Instead it was agreed to work only with service users who provided explicit and written consent to their Crisis Response Plans being shared with the other organisations involved. This was also subsequently agreed by all other partners in the local model.	Police officers accompanied the SIM Nurse on planned visits with service users to develop relationships, where the service user consented and agreed that it would be beneficial. When the SIM nurse and officer met them for the first time, they fully explained the SIM process, information sharing process and ensure they consented to participate in the service. The same SIM officer and nurse would attend on a regular basis to provide consistency, ensure changes in circumstances were addressed quickly and positive relationships were built. The frequency of the meetings would vary depending on the individuals need.
25	Doncaster	? Limited information	"Using SIM-like model but not identical and being evaluated". Most importantly consent for data sharing was obtained from all but one participant. Will no longer follow SIM methodology.					

North West

Ref no	Trust	SIM Yes Yes - adapted Yes – stopped Yes – adapted then stopped No	Fidelity to national model	Evaluation (inc SU involvement)	Withholding treatment/use of sanctions	Data sharing	Police role
26	Greater Manchester						
27	Cheshire & Merseyside		N/A. Considered inappropriate for our population.				

South East

Ref no	Trust	SIM Yes Yes - adapted Yes – stopped Yes – adapted then stopped No	Fidelity to national model	Evaluation (inc SU involvement)	Withholding treatment/use of sanctions	Data sharing	Police role
28	Isle of Wight	 Developed and delivered on IoW 2015 -2017	Hampshire Constabulary decided to discontinue delivering SIM in October 2017				
29	Berkshire		Not applicable. Reading adopted then [complex high intensity users group] model following consultation with Hampshire and Oxford. At an early stage, the SIM model was considered, and it was decided that SIM would not be adopted in its published form and instead a High Intensity Users Group approach would be used.	The CHIUG model remains in it's early implementation stage locally; as we move forward, a method of collecting the views of patients and their carers will be put into place. At this stage those who have had access to the model have not raised any concerns or complaints. The local model is ***constantly*** under review to ensure that it is it delivers a high quality level of care to some of our most vulnerable people	The use of sanction has not been included in the local model unless a crime has been committed. The model looks at supportive over coercive approaches to high intensity use with an overall aim to divert contact to Mental Health services to support the individuals needs.		The Police do not have any role, in providing ongoing care and support outside of crisis and urgent situations. This support is from MH services – the Police are provided guidance in the form of a joint care plan to support their responses to individual need and identify a named Mental Health team or individual with whom to liaise.

South East

Ref no	Trust	SIM Yes Yes – adapted Yes – stopped Yes – adapted then stopped No	Fidelity to national model	Evaluation (inc SU involvement)	Withholding treatment/use of sanctions	Data sharing	Police role
30	Surrey and Borders	 Surrey High Intensity Partnership Programme (SHIPP) launched 2017.	Caseload numbers vary and typically would be approximately 20 people. The aim is to support people intensively for a period and then transition people back, so they are solely in the care of appropriate Mental Health Support (rather than needing that support alongside the support of the SHIPP team). As at 19th August 2021 the current caseload was 11 people with a further five referrals pending/under consideration. For people to be in the care of the SHIPP team there is a condition that they must also have the support of that referral from a Community Mental Health team (including the support from the Consultant Psychiatrist). They must also remain open to that team whilst also open to SHIPP (this is a true partnership programme). People referred into SHIPP must also have capacity and be able to choose to receive support from the SHIPP team. There are people who may choose not to accept the support of the SHIPP team (as is their right). In these instances, a SHIPP-style plan (with appropriate risk indicators and risk management plans) may be developed between SABP and Surrey Police but we would note the person has not agreed to the plan. We seek agreement and support from people and the majority of people welcome the support they receive from SHIPP	See case study next slide SABP have received two formal complaints regarding SHIPP. One was from a person who felt that her SHIPP plan was preventing her from accessing inpatient care when she thought it was required. She believed this was a form of discrimination. The response from the Trust was that the program did not (in the view of the organisation) prevent her from receiving appropriate support and that while her sense of a diminished response to her needs was regrettable, the allegation of discrimination could not be upheld. [The second complaint [ ] with an overview of the program aims and objectives and the typical support offer that was available to those under this. Continued next slide.	This would be exceptionally unusual – our normal approach wherever possible would be to work with people (see above) and it is more typical that people will be able to write crisis care plans with the SHIPP team that explain how they would like to be supported if they attend A&E. As we have stated, a pre-condition for SHIPP is that people must be open to a community mental health team – and the team must commit to keeping the person open whilst under SHIPP. Therefore we would not deny someone care, there would be a clear flag on the electronic record that would signpost all healthcare professionals (and Surrey AMHPs or other Surrey mental health social workers with access to the SABP records) to review risk plans and SHIPP plans to inform their decision making. These plans might indicate that admission to an acute psychiatric ward is not beneficial for the person – but we also recognise that a short crisis-focused admission may be appropriate and we would not prevent this (in all but the most exceptional cases). Continued next slide.		Complex case co-ordinator Police sergeant and 3 p-t police officers 2 nurses OT Input from consultant psychiatrist Input from CNS P-T psychologist We do not believe the police undertake scheduled healthcare, but they are involved in ongoing support/discussions for people open to the SHIPP team. The officers have received training in Trauma Informed Awareness (which SABP Psychologists and Recovery Coaches along with people with lived experience are offering across all Crisis Concordat stakeholders as part of the Community Crisis Care Transformation work) and have also received training in Positive Risk Taking and Trauma Focused Care, in addition they can access any courses run by the Recovery College. These courses are frequently facilitated by people who have lived experience too The main aim of SHIPP is for a partnership between SABP, Surrey Police and (ideally) people using services to work together and promote recovery-focused principles utilising a trauma informed approach. People will work together but there is no expectation that the police will become involved in scheduled healthcare are adopt the role of a care co-ordinator. However, they will seek to work alongside the person who needs support from SHIPP and understand their perspectives. The police officers will seek to point out where behaviour (that we view as symptomatic of distress or trauma) could be seen us criminal behaviour. Although the police are not involved in scheduled healthcare, they can have a positive impact on people's lives.

South East

Ref no	Trust	SIM Yes Yes – adapted Yes – stopped Yes – adapted then stopped No	Fidelity to national model	Evaluation (inc SU involvement)	Withholding treatment/use of sanctions	Data sharing	Police role
30	Surrey and Borders **continued from previous slide**	 Surrey High Intensity Partnership Programme (SHIPP) launched 2017.		Continued from previous slide Trust and police staff report that involvement with SHIPP eases pressure, enabling them to feel safer and more supported in managing people who feel chaotic and 'high-risk'. This has led to improved staff health and wellbeing and reduced sickness absence. Trust staff report that less admissions and better management of these cases ensures inpatient wards feel more therapeutic and less chaotic. This is beneficial for people who use services and staff. Closer working between police and health services has also enabled better understanding of the roles and limitations of other services which has improved partnership working and communication.	Continued from previous slide However there are 2 individuals where Criminal Behaviour Orders have been sought. In any such instance this would not only be discussed within the SHIPP team but also at the Community MDT and with a Risk/Complex Care panel and then subject to additional scrutiny through the judicial process. We are satisfied that for these exceptional cases this approach was necessary, and not one that was considered lightly or frivolously. It would not be appropriate to provide too much detail but in one case an individual was seeking frequent admission to psychiatric wards (via s136) across the Country and on occasions had been admitted to paediatric wards (which was a clear safeguarding issue). Although the person was well managed in Surrey their behaviour meant we felt there was no alternative than to seek the CBO to seek to protect the public in other areas.		Complex case co-ordinator Police sergeant and 3 p-t police officers 2 nurses OT Input from consultant psychiatrist Input from CNS P-T psychologist We do not believe the police undertake scheduled healthcare, but they are involved in ongoing support/discussions for people open to the SHIPP team. The officers have received training in Trauma Informed Awareness (which SABP Psychologists and Recovery Coaches along with people with lived experience are offering across all Crisis Concordat stakeholders as part of the Community Crisis Care Transformation work) and have also received training in Positive Risk Taking and Trauma Focused Care, in addition they can access any courses run by the Recovery College. These courses are frequently facilitated by people who have lived experience too The main aim of SHIPP is for a partnership between SABP, Surrey Police and (ideally) people using services to work together and promote recovery-focused principles utilising a trauma informed approach. People will work together but there is no expectation that the police will become involved in scheduled healthcare are adopt the role of a care co-ordinator. However, they will seek to work alongside the person who needs support from SHIPP and understand their perspectives. The police officers will seek to point out where behaviour (that we view as symptomatic of distress or trauma) could be seen us criminal behaviour. Although the police are not involved in scheduled healthcare, they can have a positive impact on people's lives.

South East

Ref no	Trust	Evaluation (inc SU involvement)
30	Surrey and Borders continued	One person said this about the Police Sergeant *'I have been open to mental health services for 15 years since I was a child. I have had a vast amount of professionals come and go in my life making it challenging for me to see the point in investing in new relationships with yet another new professional. But the SHIPP project has enabled me to invest my trust in [ ] (SHIPP officer). Apart from my psychiatrist, [ ] has been the most consistent professional in my life for the last couple of years. [ ] has seen me through many Care Co-ordinators. Having that consistency has been invaluable. [ ] is always open that [ ] is not a mental health professional so there are limitations such as not talking to me on [ ] own (without a mental health professional) but having someone so real is refreshing. Having had involvement from many different services over the years such as police, ambulance and health services my care had always felt disjointed and I would not have a clue about what kind of response I would get and I never knew what information was being passed between agencies meaning often having to retell traumatic incidents that I have been through to various professionals. However since I have been with SHIPP I have one care plan that is shared at A&E, with police, my mental health team and with ambulance. This is a massive relief as everyone is coming from the same angle and I now get a joint up response which is exactly what I need in times of crisis.* *Also being able to debrief with [ ] after a crisis is very helpful. [ ] helps me to see things in a different way and is able to help me understand why police for example might have made certain decisions during a particular crisis which makes the healing process a lot quicker'* We think these comments encapsulate the value of the SHIPP partnership approach. The SHIPP team work collaboratively with individuals and their carers to produce their care plan. This allows people to reclaim responsibility for their lives and play an active role in their care. Moreover, SHIPP empowers people with the skills needed to effectively manage their specific circumstances and decrease their dependence on public services and unhelpful patterns of behavior. Most people value the support of the SHIPP team and report positive experiences. People who have engaged with SHIPP report feeling better able to manage or prevent a mental health crisis, less need to contact emergency/mental health crisis services and safer and more understood due to the more joined up support and clear boundaries. Feedback from a SHIPP service user captures the difference SHIPP is making: *"I'm now getting really good support in the community which has helped me to avoid reaching crisis point. I think better information sharing between the police and mental health services has meant things can be dealt with more informally and has prevented me being from being detained under Section 136 on some occasions."* It is worth noting that we are already undertaking work to consider how the SHIPP team can routinely capture the views of people who use services (and family carers) and we had also been discussing an independent evaluation of the SHIPP approach with the University of Surrey, these discussions were postponed for some months due to Covid-19 but have resumed and we are hopeful that funding will be secured for this evaluation. As detailed above we have had one complaint from someone open to the SHIPP team and we are also aware of comments made on social media. Like other comments made on social media we are not sure of the extent to which they should be considered the majority view. As detailed in previous responses we believe that the vast majority of people who have been supported by SHIPP have viewed it as a positive intervention. The SHIPP approach has received support from other connected networks in Surrey. For example as part of an 'every adult matters' approach (SAM) and CHARM (Community Harm and Risk Management) and Frequent Attenders networks with Acute Trusts/Ambulance Trusts. The work is well regarded and has also been considered by CQC as part of inspections of Crisis Care pathways (with no concerns raised). SHIPP tackles a common problem experienced by all mental health trusts, police forces and other emergency services – where a small number of individuals are struggling with mental health issues and where a well thought out and co-ordinated response to support them would benefit both the individual as well as the system. Since its launch, both Surrey and Borders Partnership NHS Foundation Trust and Surrey Police have been contacted by both mental health trusts and police forces nationwide with requests for more information about SHIPP. In addition, SHIPP has been identified as best practice by the national NHS Innovation Accelerator Programme. and by the Kent, Surrey, Sussex Academic Health Science Network. SHIPP was highly commended in the HSJ Awards in 2020 – being one of 8 finalists in a category of over 800 —applicants.

South West

Ref no	Trust	SIM Yes Yes - adapted Yes – stopped Yes – adapted then stopped No	Fidelity to national model	Evaluation (inc SU involvement)	Withholding treatment/use of sanctions	Data sharing	Police role
31	Devon Partnership	 Principles of original innovation were attractive and we have progressed a careful innovation, delivering a similar approach – our High Intensity Programme		HIP cared for 12 people in total. Full evaluation has occurred for seven individuals. Work subject to rapid review including experts by experience and multi-professional leads and scrutinised by Trust's clinical effectiveness committee. We have direct positive appreciation from one of the people cared for on this programme and evidence in existing evaluations of positive appreciation from others. There is no evidence that individuals have experienced barriers to accessing evidence-based, timely mental health intervention as a consequence of being supported by this programme. There have been no serious untoward incidents and no complaints in regard to the concerns you raise from individuals or carers, friends or family. Our Clinical Effectiveness Committee are recommending to our Strategic Executive Committee and the Trust board that we continue with the HIP model, with the strong support of the experts by experience it seeks to serve. This work will be continued under strengthened governance by an HIP pilot oversight group to include lived experience and reviewed monthly by our Clinical Effectiveness Committee. A planned formal evaluation (interrupted by COVID pandemic) will include evaluation of patient experience.	The concerns raised by the STOP SIM coalition about the model not aligning with relevant NICE guidance are not supported by our review. The primary concerns raised about withdrawal and exclusion from services and about lack of access to emergency care in a crisis were not supported. However, some aspects of the language used within care planning (eg "behavioural," "non-illness" driven is dated and not trauma informed and needs to be reviewed Additionally , our review has highlighted that there are areas of our usual practice when constructing care plans for people who attract diagnoses of Personality Disorder that need to be reviewed There is no evidence of any withdrawal of service, lack of access to health care in a crisis or increase in SUIs	There is work to be done to improve the information processing arrangement with our partner agencies, co-production of care plans and the quality of evidence so that individuals understand what information about them is being processed and why. We will review the effectiveness of our consent procedures.	

South West

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31	Avon & Wilts Trust	Police Health Integrated Mentoring in Swindon and Wiltshire	PHIM model now withdrawn				
32	Dorset						
33	Cornwall						
34	Gloucestershire		Caseload of a maximum of seven people at one time	The service works collaboratively with patients to support them to use healthier coping mechanisms, help them to communicate their needs through person centred care plans which they write themselves and enable continuity of care through numerous services. Patients identify goals with the team, including reducing crisis periods and contact with emergency services which patients describe as traumatising, invalidating and bring no benefits to their situations. The focus and ethos of the team is to try and make the occasions that people do come into contact with emergency services as safe as possible. This takes place within organisational policies and risk management processes; and includes training staff to respond in a professional and appropriate manner. The team work within NICE guidelines in their engagement with patients. The patients supported by the team will often ask for support to reduce their contacts with emergency services. The team seek to enable this by going though alternative coping mechanisms, by continually reviewing if all the available wrap around services are meeting the patients' needs via a multi-disciplinary team approach, by co-producing crisis and contingency plans and by ensuring powers are not used inappropriately to coerce patients, such as the inappropriate use of S136. As stated by the Team Leader; "We have not in any way, nor would we, tell a patient, or emergency services, that a person 'cannot' access them. I have not known, or been informed of a situation that a person could not access a service because they are supported by GHIN". (see next slide for case studies)	Regarding any approaches that seek to reduce the use of care through the potential use of sanctions, behavioural contracts with instructions to deny care if people attend A&E / crisis team, criminal sanctions related to healthcare / suicidality (e.g. community protection/behaviour orders, bail conditions, arrests, charges, cautions prosecutions or imprisonment). This is not what the service does. As the Team Leader states; "we have never given any verbal or written instruction to deny any care, at any point, to any service".		

South East

Ref no	Trust	Evaluation (inc SU involvement)
34	Gloucestershire continued	The team will then work with the patient to avoid/manage these behaviours that may lead to their arrest. The team can offer alternative ideas, discuss crisis management and talk honestly with the patient about what might happen if they continue to repeat the behaviours. Not from the basis of any threat, but in order so they can understand fully. The team have worked with a patient who was at risk of arrest from repeatedly trespassing on railway lines. The team discussed the risk of this leading to arrest and the person has not returned because they did not want to risk arrest. As a further example the team supported a patient who was due to be given a custodial sentence for carrying knives in public. The judge delayed this in order for the service to work with the patient; this was successful and prison avoided. **Summary of patient/public views:** Patient views are regularly sought on service delivery and on whether the patient wants to continue to work with the team as it's completely voluntary. Patient satisfaction surveys are conducted with recipients of the service and have been rated by all as 4 (scale 4 to 0, with 4 being excellent, 0 being poor). What has been identified as good about the service; comments include: The staff are brilliant, ***** has been a great help to me. GHIN listen to me, they take on board how I feel, I feel supported. I would like to say that ***** has been excellent in supporting me, she is very understanding, which has helped me a lot to get well again. Weekly contact and regular support has been helpful Help with other activities when needed, especially when I would have struggled to do it myself. I have always felt listened to, supported, not judged, which has enabled me to talk more openly. I feel I can trust ***** and ask for help Consistent point of contact is useful, especially when struggling. I have found GHIN to be very helpful, and think that the support I've received has made a big difference to how I'm managing, especially with everything going on at the moment, I don't think I would be coping as well as I am without *****. Working with ***** has helped me feel less alone, and gives me an extra person to help me fight for what I need, also the police deal with incidences better. The GHIN plan is useful as when services are involved they have a background and plan to follow. What can be improved, comments include: To be able to continue to support me (context was working towards discharge) Longer meetings On occasions in A and E the doctor did not read/agree with what the nurse told him was in the care plan, so would not let me leave despite me having capacity. Sometimes it felt as if A and E ignored the care plan.