Paper reference [redacted]

Prevent Mental Health Hubs

Final Evaluation report

[redacted]

December 2017

This report provides a summary of the learning from the three mental health hubs aligned to Counter Terrorism and Prevent pathways across the South, Midlands and North regions. These hubs were each developed with the aim of piloting the effectiveness of mental health professionals working alongside counter terrorism police officers in relation to the management of individuals referred to the police with known or suspected mental health difficulties and disorders. Each of the three hubs has conducted its own evaluation and these are available in Appendices A, B and C. This paper is not a repeat of those reports but rather provides a summary of the findings presented in support of a collection of recommendations for future service planning. Overall this paper concludes that the findings from all three mental health hubs do provide evidence of a range of benefits and value of the mental health hubs, and this is consistent with evidence provided in relation to the original aims and objectives outlined in the first interim evaluation report (Appendix D). Regular meetings convened by National Counter Terrorism Policing HQ have enabled all three hubs to be involved in the development of the final evaluation report, and the recommendations presented relate directly to the hubs' own local evaluation, data analyses and summaries.

Acknowledgements

This report has been prepared by [redacted], Birmingham and Solihull Mental Health Foundation Trust, BSMHFT) in collaboration National Counter Terrorism Policing Headquarters (NCTPHQ), and with Police and NHS colleagues from each of the three mental health hubs.

1. Introduction

This paper presents an overview of the learning from the three Prevent Mental Health hubs, drawing on activity and outcomes relating to their operation between April 2016 and October 2017. A summary is presented of findings outlined in more detail by each hub in their own evaluation reports (Appendices A, B and C) in addition to drawing on material presented in two previous interim evaluation reports (Appendices D and E).

1.1 Overview of the Prevent Mental Health Hubs

Three Prevent Mental Health hubs were established between February and September 2016, each with the aim of designing processes for joint working and evaluating their effectiveness. Each hub was located within a regional CTU, and staffed jointly by Police and Mental Health practitioners.

1.2 Objectives for the three pilot mental health hubs

Some of the objectives originally identified in discussions with NCTPHQ for the pilot mental health hubs are listed below. However local context also influenced the establishment of the hubs, and whilst these objectives formed the basis for the initial evaluation plan, that was based primarily on the earliest hub in the West Midlands.

1. To support CT Police in liaising effectively with health services to seek and share information. To develop and refine effective procedures for managing liaison and information sharing within current legislation.

2. To provide advice to referrers within Prevent and other regional CT teams, as well as other relevant stakeholders, regarding individual cases and mental health services, to support the early detection and engagement of individuals with mental health difficulties.

3. To provide a specialist, multidisciplinary clinical team able to undertake a range of activities to provide a professional viewpoint to referrers or other stakeholders as appropriate.

4. To ensure that cases with mental health vulnerabilities appropriate for mainstream services are identified and referred at the earliest possible opportunity, in order to effectively manage risk, improve clinical outcomes and thereby potentially reducing costs.

5. To develop working links with NHS Prevent leads, both local and national.

An early proposal to evaluate the hubs also identified the importance of learning from the hubs to inform the development of appropriate data, information and governance systems and for the hubs to share learning that supports the identification and development of best practice, and which maximises outcomes and added value, and provides a sustainable and evidenced model for future provision.

These objectives guided the development of the original evaluation plan which was developed initially in relation to the West Midlands hub, but was subsequently shared across all three hubs at the request of NCTPHQ. Early findings in relation to these objectives are discussed further in the first interim report (PMHH1, Appendix D). However, difficulties in measuring change and progress was felt to be limited beyond the first stage of service evaluation although it can be noted here that all can be said to have been achieved to varying degrees in each of the three hubs.

1.3. Introducing the three Prevent mental health hubs

The three mental health hubs are referred to as:-

- London Prevent Liaison and Diversion (PLAD)
- Northern Mental Health Team (NMHT)
- West Midlands Prevent in Place (WM-PiP)

Each hub consists of a team of dedicated police officers and mental health practitioners co-located within the SO15, West Midlands and Greater Manchester Counter-Terrorism Units. A detailed description of each of these hubs, including operating procedures and staffing is contained within their individual evaluation reports and will not be repeated here.

The term “hubs” will be used in this paper to refer to the three services collectively and individually, in addition to the terms “Prevent Mental Health Hubs” and “Mental Health Hubs”.

2. The Evaluation

It is appropriate here to summarise the process by which this evaluation was commissioned, and to highlight some of the resulting challenges and limitations.

The first hub to be established was the West Midlands PiP service in February 2016, and the evaluation was originally agreed and designed specifically to assess the local and regional benefits of that provision. Funding for this local WM-PiP evaluation was agreed for the financial year 2016-17 and a researcher identified within the mental health provider organisation, Birmingham and Solihull Mental Health Foundation Trust (BSMHFT).

In Spring 2016 it was requested that this evaluation plan be shared with the emerging hubs in London and Manchester. At that time it was requested by NCTPHQ and Home office colleagues that the WM-PiP evaluation be extended to include all three hubs to enable summative findings to be reviewed and to inform future service development and delivery. The value of this was recognised and this was agreed despite there being no opportunity to re-negotiate the original funding and based on a reporting timeline that would include two interim reports and a final report in April 2017. This timeline has subsequently required further adjustment in order to maximise the learning available from all three hubs, and thus all work done since April 2017 has been resourced by BSMHFT.

The three hubs have been working to different specifications and operating procedures based on how each service has been established in terms of its core purpose, and developed in relation to what was in place previously within that local area / region. In view of this it has not been possible to collate data for comparative purposes with a view to formally comparing one hub with another. Instead each hub has produced a thorough analysis of their own service data and these can be found within each of their separate reports (Appendices A, B and C). Each hub has presented quantitative and qualitative data relating to service activity, feedback from Police CT officers, and individual case studies and narrative. Each of the hubs have taken opportunities to present their data, conclusions and recommendations to a variety of local, regional and national forums, and it is recommended that each hub continue to expand upon their local evaluations over the coming months.

In line with the agreed cross hubs evaluation two interim reports (PMHH1, Appendix D; and PMHH2, Appendix E) have identified measures of success focusing on the added value of mental health professionals and police officers working together within CT and Prevent pathways, with a specific focus on risk, outcomes, efficiency and costs.

In view of the above it was felt that this paper could most usefully be based around a set of recommendations that capture learning from each of the three hubs, supported by findings presented within the individual hub reports. This is consistent with conclusions presented in the second interim report (PMHH2, Appendix E) produced in April 2017 which described the difficulties of trying to identify a "one size fits all" service model , and the importance of drawing on key learning from all of the hubs to outline core components of a service model.

The recommendations presented here have been further informed by discussions with NCTPHQ colleagues who have also been reviewing each of the mental health hubs from an operational perspective and facilitating discussions within and between the three hubs regarding the potential indicators of best practice.

3. Recommendations

Based on the process outlined above, there are twelve recommendations presented here that may be used to guide future service planning and development.

In summary these are as follows:-

1. For the Prevent mental health hubs to receive continued and recurrent funding to support their on-going delivery and to enable their provision to incorporate the recommendations outlined below.

2. For a full scale costings review to be undertaken to ensure funding appropriate to each hub's service needs, geographical coverage, and stakeholder expectations, utilising the knowledge regarding the needs and numbers of vulnerable people accessing the mental health hubs during the pilot period and with reference to these recommendations.

3. Each hub to be provided with a clear service scope and specification including relevant stakeholder expectations relating to service functions, required activity, priorities, and performance and reporting requirements.

4. In order to maximise safeguarding of vulnerable individuals and management / mitigation of CT risk the core elements of a Prevent Mental Health service model should include the following functions:- triage and screening, case management and consultation, liaison and diversion functions, comprehensive assessment and formulation based case management

5. Services to consider the benefits of providing appropriately skilled and informed mental health screening and triage to all CT Prevent referrals

6. Mental health practitioners require appropriate skills, knowledge and experience to safely and effectively deliver the service

7. Mental health practitioners to be co-located within CTU environments

8. Administration support is essential to maximise value from clinician and police officer resource

9. Clinical and case governance structures to be consistent with pilot, with overall case responsibility remaining with CTU officers as determined by current Case Management arrangements

10. Information governance structures need to be agreed and standardised, with information sharing agreements developed.

11. Data / Information management system to be developed to ensure consistent and relevant capture of data across each hub for future evaluation purposes and that any further cross-hub evaluation should continue to be directed, coordinated and overseen by NCTPHQ supported by a fully independent and specifically designed evaluation process

12. Prevent Mental Health hubs need to be appropriately aligned with other national, regional and local structures relating to the identification and support of individuals within Prevent pathways, and with mainstream and specialist mental health services and pathways

Each recommendation is now presented in more detail with links to supporting evidence and technical detail where appropriate.

1. For the Prevent mental health hubs to receive continued and recurrent funding to support their on-going delivery

- All three hubs have evidenced the benefits of mental health practitioners being embedded into CTU environments with both qualitative and quantitative evidence to demonstrate the added value to both safeguarding and CT risk management functions. Confirmation of recurrent funding will reduce delays in recruitment and enhance continuity of hub personnel.

- Each hub presents data demonstrating activity demand and flow, providing a helpful overview of the demographics of those individuals deemed to present both CT and mental health vulnerabilities.
- Police Officer feedback in each area illustrates the benefits of the mental health hubs in terms of speedier access to relevant health information, facilitated referral into mainstream and specialist mental health services, and benefits of mental health formulation in case management.
- All three hubs have provided evidence to support the impact of the mental health teams in enabling more efficient and effective case progression through the prevent pathway, successful safeguarding interventions and disruptions, and more efficient use of a range of other interventions, in addition to increasing the likelihood of positive outcomes for vulnerable individuals.
- In terms of resource, all three hubs have raised concerns regarding the capacity to deliver robust, effective and safe provision to extended geographical areas within current resource. Whilst each individual hub have demonstrated the value of the services provided to date against three operating models, it needs to be recognised that any extension to current provision will require additional funding.
- For example, without additional money West Midlands CTU MH hub will have to reduce experienced staff and Mental Health hubs will not be able to have a footprint in every CT region to initiate fast time MH assessments and Police / health joint triage will not be able to take place.
- Additionally hubs within London and Manchester would be unable to extend their current provision to widen the screening and triage functions beyond current provision without additional funding.
- All three MH hubs have submitted funding bids for what they consider is required to provide the best possible national service mitigating CT risk.

2. For a full scale costings analysis to be undertaken to ensure funding appropriate to each hub's service needs, geographical coverage, and stakeholder expectations, utilising the knowledge regarding the needs and numbers of vulnerable people accessing the mental health hubs during the pilot period and with reference to recommendation 1 above.

- Activity data is available for each hub and the details can be accessed within each hub report in Appendices A, B and C. Collectively the data demonstrates a significant level of demand within the areas covered. In total over 800 vulnerable people are reported to have been in receipt of some type of hub response or intervention during the pilot period, with basic demographics of age and gender indicating that the majority of those seen were male (over 90%) with ages ranging from 6 years to over 60. In PLAD and the NMHT, most referrals seen by the mental health teams were aged between 19 and 29, with WM-PiP showing a slightly greater presentation for people aged between 14 and 17 years. The majority of those referred to the mental health teams where ideology could be recorded presented with Islamist extremism, with extreme right wing being the next most commonly identified. For a significant number of referrals ideology could

not be specified and is recorded as either unknown or chaotic, where the individual seemed to change ideological stance rather than be fixed on one.

- In terms of mental health needs and diagnosis, each of the hubs has presented data on this. It needs to be recognised that each hub has functioned differently and therefore the nature of analysis of mental health needs and diagnostic data varies. However together the hubs have provided a rich source of information regarding how mental health vulnerability presents through CT and prevent pathways that can usefully inform future service planning and research both locally and nationally.
- In WM-PiP where every Prevent Case Management (PCM) referral was reviewed by a mental health practitioner, the most commonly identified presenting mental health problem was for behavioural and emotional difficulties. These would not necessarily be recognised by a psychiatric diagnostic process and are less likely to have been identified by police colleagues as requiring of mental health screening. The most commonly identified mental health conditions across NMHT and PLAD, and featuring next within WM-PiP, were diagnoses of psychotic disorders, followed by personality disorder, mood disorders and neuro-developmental / learning difficulties (e.g. Autistic Spectrum disorders)
- The WM-PiP approach of reviewing every referral into PCM for mental health needs identified a total of 68% with some form of mental health vulnerability. This cannot be compared with the other two hubs due to variance in the systems of operating and referral pathways. However it does suggest a benefit to screening all referrals into the Prevent pathways that may be appropriate for all three hubs in the future, and thus the importance of funding allocated to enable this. .
- Part way through the pilot period, all three sites were required to extend their geographical coverage without additional resource. Each hub has in their individual reports raised concerns regarding this in terms of only being able to provide a limited service to these extended areas. Future funding decisions will need to consider the appropriate resource required to support service delivery in accordance with these recommendations across the regions in order to maximise the benefits and impact on the management of CT risk.

3. Each hub to be provided with a clear service scope and specification including relevant stakeholder expectations relating to service functions, required activity, priorities, and performance and reporting requirements

- Across the three hubs a range of presentations and needs have been identified and it is recommended that service scope and specification in each hub be reviewed to consider the added value of assessing and managing this range of needs in relation to CT risk. Reviewing cases described across all three hubs suggests the following groupings of individuals have been seen:

  - **Individuals for whom mental health was the primary vulnerability** – these individuals present with a diagnosable mental illness, and formulation has indicated that mental

health was directly or indirectly linked to CT risk. For these cases treatment of the mental health condition was deemed likely to impact upon CT risk, and thus the main intervention required was rapid detection and assessment, along with liaison with and referral into mainstream mental health services as appropriate.

- **Individuals presenting with multiple and complex needs** – for these individuals mental health was part of a complex range of individual and contextual factors that were felt to interact to create and impact on risk and vulnerability. Whilst some of these individuals met the criteria for and engaged with mainstream or specialist mental health services, many did not. Even for those that did engage with mainstream services, often this was insufficient to significantly alter their presenting risk due to the complexity of their circumstances. It was concluded that this group were most likely to require a formulation* based approach and multi-agency interventions.

  * Formulation in this context uses risk assessment and psychological theories to explain why this person is at risk and how / when this may increase, and proposes hypotheses about how to facilitate change. This was mostly available within the West Midlands PiP service where a direct comprehensive clinical assessment was available for some referrals, the findings from a review of 302 cases which can usefully inform the range of needs identified for such provision

- All three hubs have between them provided evidence to support the objective of mitigating CT risk through the safeguarding of vulnerable individuals. This has been achieved at least in part through the early identification of individuals with mental health vulnerabilities, the facilitation of access to appropriate interventions, provision of consultation to support risk and case management, in addition to supporting other CT policing functions such as FIMU, investigations and in the provision of training and supervision.

4. In order to maximise safeguarding of vulnerable individuals and management of CT risk the core elements of a Prevent Mental Health service model should consider the following functions:- triage and screening, case management and consultation, liaison and diversion functions, comprehensive assessment and formulation based case management

- The three hubs have all demonstrated the range and complexity of cases being worked with, and it is recommended that the above service components are all considered in terms of their contribution to most effectively safeguarding individuals and mitigating CT risk. These core elements of a service model could collectively:-
  - Reduce the risks of cases with mental health needs or complexities being missed with potential consequences for risk management, inefficiencies in relation to case management and interventions, and missed opportunities for successful liaison and diversion into mental health or similar specialist services

- Enable the provision of a formulation based approach to support collaborative assessment and understanding of risk and vulnerability;
- Consider the impact of a range of mental health vulnerabilities, plus multiple and complex needs and other psychosocial factors, on CT risk;
- Inform risk assessment and the need for multi-agency support, interventions and management plans to mitigate risk and where possible support the mental health needs of the individual.

- All three hubs have been able to demonstrate the benefits of collaborative case consultation and review to support CTU responses. The benefits of also being able to provide direct comprehensive assessment in support of complex case formulation and management has also been demonstrated especially within the West Midlands hub. It is proposed that the risks of not providing an option for direct and comprehensive case assessment need to be considered, whereby highly complex cases may not only absorb considerable police time, but also may fail to fully consider CT risk and which interventions may mitigate this.
- It is also clear from the three hubs that considerable local variance exists in relation to how to achieve best value and maximum impact from the mental health hubs and it is recommended that these core elements of a service model are considered with local context and characteristics in mind.

5. Services to consider the benefits of providing appropriately skilled and informed mental health screening and triage to all CT Prevent referrals within highest risk areas especially and dependent upon available resource

- In the WM-PiP all referrals to Prevent were triaged during the 12 month evaluation period and 68% were identified as having some form of mental health difficulty requiring of further review. This is consistent with research mentioned in the introduction to the WM-PiP evaluation report (Fowler and Gatherer, 2016 unpublished) that suggested a higher prevalence of mental health difficulties in the Prevent / Channel pathways than had been previously thought.
- In order to maximise identification of individuals with complex mental health presentations and needs it is proposed here that consideration is given to the resource implications for this, and whether it is feasible for the hubs to operate a model that screens all CT referrals, especially to Prevent.
- The risk of false negatives needs to be considered in assessing the economic implications of this, and this is further discussed in the WM-PiP report (Appendix B). Additionally the NMHT acknowledges the importance of providing some level of screening to all CT referrals in proposals for future development. PLAD has been functioning to a Liaison and Diversion model and have focused on demonstrating the benefits of that approach, whilst also recognising the risks of false negatives.

- Each hub has delivered screening and triage in different ways, and the procedures, skills and competencies required for this will need to be agreed if it is felt important that this service function is delivered consistently across all three hubs.
- More economic approaches to triage and screening, such as training Police Officers and developing the use of assessment tools, have also been considered for further evaluation However these have not been evidenced within this pilot, and the complexity of presenting cases suggests this may not represent the most effective or efficient approach.

6. Mental health practitioners require appropriate skills, knowledge and experience to safely and effectively deliver the service

- All three hubs have utilised a range of mental health practitioners to support service delivery, working alongside Police Officers as part of a dedicated Prevent mental health team. From health, a combination of Psychiatry, Clinical Psychology, and Psychiatric Nursing seems to have enabled each hub to effectively deliver a range of triage, screening, liaison and diversion and complex case formulation functions. In order to effectively support the management of individuals with highly complex needs, practitioners with forensic mental health experience may be useful.
- The essential skills and knowledge that are recommended for the health practitioners within the hubs include knowledge and experience of a broad range of mental health, psychological, neurodevelopmental and cognitive difficulties, experience of working across the age span to enable consideration of developmental stage on risk and vulnerability, and an awareness of local structures and pathways along with relevant policy and practice guidelines.
- All practitioners across all three hubs have required SC vetting and STRAP accreditation and this is considered here to be essential to any future service provision

7. Mental health practitioners to be co-located within CTU environments

- Teams should be co-located within core CTU environments and work in partnership with frontline CT and Prevent Officers, with strategic and operational oversight provided by a senior CT Officer. This will ensure that cultural change and learning is achieved across the system to improve clinical and risk outcomes. Case responsibility should be retained by the host CTU and mental health teams should act in a consultancy capacity.
- Feedback from police and mental health colleagues across all three hubs have emphasised the importance of co-location. For the service to function safely and to maximise CT risk management in particular, the co-location of mental health practitioners and police has been found in all three hubs to represent one of the most important attributes of these services. The attendance at Prevent Case Management meetings to support triage, case discussion, supervision of police and health staff, and training opportunities have enabled working relationships to build over time, and joint

review of complex cases has enabled shared decision making focusing on the mitigation of risk.

8. Administration support is essential to maximise value from clinician and police Officer resources

- Clinicians across all three hubs have spent considerable time providing basic administration to the functioning of the service and to data collection and analysis. Therefore it would be considerably more cost effective to employ suitably trained and security cleared administrative staff to support these functions.

9. Clinical and case governance structures to be consistent with pilot, with overall case responsibility remaining with CTU officers as determined by current Case Management arrangements

- All three hubs have utilised a consistent approach to case governance consistent with co-location and the sensitive and confidential nature of the work. These need to be clearly detailed in future contracts, with clarification on the provision of supervision and consultancy roles for health staff, and accountability / responsibility for police based actions linked to identifiable individuals or roles. Routine and systematic review meetings will enable more complex and concerning cases to be discussed with clearly recorded agreed outcomes where appropriate.

10. Information governance structures need to be agreed and standardised, with information sharing agreements developed.

- Learning from the hubs suggests that current legislation relating to the sharing of sensitive and personal information between agencies are likely to be sufficient to enable the Prevent mental health hubs to function adequately. However there have been found to be some difficulties in the sharing of information from NHS sources, and time may be usefully invested in ensuring NHS partners are clear about the nature of the contract and the remit and expertise of the Prevent mental health hubs.

11. Data / Information management system to be developed to ensure consistent and relevant capture of data across each hub for future evaluation purposes and that any further cross-hub evaluation should continue to be directed, coordinated and overseen by NCTPHQ supported by a fully independent and specifically designed evaluation process

- All three hubs have been required to develop bespoke data collection systems to support the hub delivery and evaluation. This has been time consuming and has limited the comparative opportunity within the evaluation. It is therefore recommended that an appropriate information and data system is developed
- NCTPHQ should consider commissioning a fully independent second stage evaluation to enable a bespoke methodology to be designed, for appropriate resourcing to be

allocated across an agreed timeline, and to maximise credibility of findings and future recommendations.

12. Prevent Mental Health hubs need to be appropriately aligned with other national, regional and local structures relating to the identification and support of individuals within Prevent pathways, and with mainstream and specialist mental health services and pathways

- This should include the valuable role demonstrated by the hubs in contributing to local authority led functions such as Channel, and working closely with network of health and social care providers in supporting their delivery of Prevent legislative functions.
- It should be noted that recent NHS England guidance clarifies the role of mental health trusts in their delivery of Prevent legislation, and each hub should work with local NHS providers to ensure that they are supportive of these roles and not replacing them. The need for mental health trusts to be appropriately represented at Channel Panels is one area where such clarification is required.
- Gaps in health service provision have emerged and are referenced within the hub reports. This includes support for adults with high-moderate functioning Autistic spectrum disorders, especially at the point of transition from adolescent to adult services. It is recommended that these gaps are raised with local health providers and health commissioners in order that clinical service planning can take this into account

4. Conclusions

In conclusion, this paper has provided supportive evidence in favour of the mental health provision in adding value to the Police CT and Prevent pathway. The benefits demonstrated include safeguarding vulnerable individuals via liaison and diversion with mainstream mental health services, identification of vulnerable individuals in a pre-criminal context, and supporting other CTU functions as required including risk assessment and management, consultation, assessment and formulation, training and supervision for complex cases.

A set of recommendations relating to the continued and extended funding of these hubs has identified the potential components of a service model whilst acknowledging the importance of localisation. One key recommendation relates to the need for appropriate resourcing of the hubs in the future to ensure maximum CT risk mitigation through delivery of the core components of the service model across the required extended geographical areas. Furthermore the development and implementation of a suitable Information system would require additional financial support.

The need for ongoing evaluation and development of the Prevent Mental Health hubs in aligning with future Counter-Terrorism, Prevent, and NHS structures is also emphasised.

Prevent Mental Health Hubs

Second Interim Evaluation report – Update

Staff name removed

July 2017

Abstract

This is an update evaluation report into the three mental health hubs aligned to Prevent pathways across the South, Midlands and North regions. This update should be read in conjunction with the first interim report (PMHH1) and its Executive summary (PMHH2). Each of the three mental health hubs aims to pilot the effectiveness of mental health professionals working alongside counter terrorism police officers in relation to the management of individuals referred to the police with known or suspected mental health disorders. Due to the nature of their original commissioning, varying commencement dates and local priorities / funding, each hub delivers to a different specification Within this second update report brief activity data for the three hubs is presented, along with further details regarding each hubs current model of operation. Consistent with the first report, data presented from across the three sites continues to provide evidence of the benefits and value of the mental health hubs, and the collection and reporting of more standardised data is anticipated to provide more robust evidence of these benefits. This second update report also contains further detail regarding how the final report can be delivered, in relation to the wider research, to maximize learning and support recommendations regarding a future sustainable and effective shared clinical and policing model of care.

1. Introducing the three mental health hubs

The three hubs were introduced in detail in previous reports and thus only an update will be provided here. As the operational detail relating to the three hubs becomes clearer it is now possible to identify the similarities and differences between the hubs that will guide and inform the final report. These are summarised below.

1.1 Common features of all three hubs

- Liaison, diversion and channel consultancy
- Facilitate information transfer and interpretation
- Facilitate access to specialist mental health services where appropriate (and liaison between police and MHS)
- Develop links between Police and health / social care via clinical teams and Prevent Leads
- Support raising of mental health knowledge and awareness in Police colleagues (and Channel)
- Data on numbers of referrals presenting with mental ill health and mental health factors and case by case analysis of interactions
- All three hubs have recently been required to widen their scope of operation, without additional resource. Further detail on this is included in the brief update on each hub.

1.2 How the three hubs differ

- **London Prevent Liaison and Diversion (PLAD)** – principally a Liaison and Diversion model; includes Investigations / JLAR as well as PCM; works predominantly with those with mental ill health with a view to diverting into appropriate services. Offering advice for case managing officers and a joint sharing of risk information approach.
- **West Midlands Prevent in Place (PiP)** – The PiP team review all cases referred to Prevent other than those deemed to be malicious, misinformed or misguided to identify MH needs and involvement with MHS at the earliest possibly point and to directly inform the assessment of risk/ vulnerability and level of urgency. In addition to liaison and diversion for Prevent, PiP also provide a comprehensive assessment service to explore interactions between mental health factors and vulnerabilities (including Psychological and emotional functioning) and CT risks.
- **Greater Manchester Police / North West Mental Health Team (NWMHT)** – Will commence Piloting the use of Police Mental Health Screening Questionnaire (PolQuest) and sections of the CHAT (Learning disability, ASD sections) for prevent officers to detect issues or risk factors for mental ill health at an early stage, and determine if more comprehensive specialist MH assessment is required. Developed links with all mental health trusts in our patch to enable immediate knowledge of who is in contact with secondary mental health services and to

ensure early information transfer and collaboration. Police officers embedded in the team. Strong focus on links to Channel.

Other updates relating to each hub are detailed briefly below:-

1.1 London Prevent Liaison and Diversion (PLAD) awaiting feedback

The Metropolitan Police Service (MPS) Counter Terrorism Command (known as 'SO15') operates to give effect to the PREVENT and PURSUE pillars of the CONTEST strategy for counter terrorism policing. The service went live in July 2016, and is a joint police / NHS Prevent Liaison and Diversion team (PLAD) which originally set up to offer support to the 32 London Boroughs that constituted SO15 in the Metropolitan Police District. The service has more recently been extended to CT police in the South East Counter Terrorism Unit (SECTU and to the Eastern Counter Terrorism Intelligence Unit (ECTIU. Referrals to the PLAD from within SO15 originate from various teams including but not limited to investigations, prisons unit, international and local operations.

The geographical coverage of PLAD has been significantly extended to now include the south west counter terrorism unit.

There is funding for NHS personnel of two full time nurses (one as team leader) and a combination of part-time input from both psychiatry and psychology consultants (3 days per week) provided by Barnet, Enfield and Haringey Mental Health NHS Trust (BEH). Police personnel in the PLAD consist of two full time SO15 constables, overseen by a Sergeant and Inspector (part time). The team is located within SO15.

Interventions from PLAD have included, but are not limited to, telephone liaison with mental health teams, contact visits and attending case discussion and review meetings. PLAD have been utilising a RAG rating approach to the categorisation of risk that will now be adopted in the other hubs. It is a joint judgement made by clinicians and Prevent officers and provides a more quantitative assessment of impact on risk, alongside clinical ratings.

PLAD have been facilitating presentations across the south west, south east, east and London region to promote awareness of the team covering brief mental health awareness.

1.2 West Midlands Prevent in Place (PiP)

This specialist clinical team was commissioned to provide expert forensic mental health advice, proactive case review, consultation and comprehensive assessment directly to the West Midlands Prevent case management (PCM) pathway. The PiP (Prevent Intensive Psychological Liaison Assessment and Community Engagement) service currently supports the West Midlands Police which includes Birmingham and wider West Midlands. Referrals to PiP are received directly from the Prevent Referrals team within WMCTU although a small number have been received directly from Fixed Intelligence Management Unit (FIMU) / investigations and enquiries received from other agencies including health, social care and probation.

There is funding for Clinical Psychology (1.4 wte), Forensic Community Psychiatric Nurse (2.0 wte), Consultant Psychiatry (0.3 wte) (its 0.2 psychiatry to pay for additional nursing time which used to be 1.6) and a Research Assistant (we have one session admin and no research assistant). The clinical service is delivered by Birmingham and Solihull Mental Health Foundation Trust. The service became

operational in April 2016. The clinical team is situated alongside Prevent officers from West Midlands CTU. A Prevent Sergeant attends weekly PiP operational meetings.

The PiP service contract has been adapted to allow for referrals from wider geographical area incorporating Wales and the East Midlands As no additional resource has been identified an equivalent service cannot be provided across the wider area, however, specialist forensic mental health advice and consultancy will be provided at PCM meetings and referrals for Proactive Case Review and Comprehensive Assessment will be accepted based on capacity and level of concern. Two individual referrals had been made from the wider area to date.

1.3 Greater Manchester Police / North West Mental Health Team (NWMHT)

The North West Mental Health Team is the third and most recent hub to be established, with just one Mental Health Practitioner employed from July to November 2016, a second part time psychiatrist employed from November and two part time nurses employed in May 2017 .The focus to date has been to provide the following to Greater Manchester:

- Advising on Prevent cases that have had both undiagnosed and diagnosed mental health problems.
- Liaison with MH services for known cases
- Providing advice to the Prevent FIMU regarding signposting some referrals involving mental health problems.
- Attending Channel Panels for 8 local authorities; Bury, Bolton, Rochdale, Oldham, Wigan, Stockport, Trafford, Salford (Please note there are 10 local authorities in Greater Manchester, however Greater Manchester uses existing Multi Agency Safeguarding Hubs (MASH) to deal with cases and Tameside is currently redeveloping its channel panel).

Advice is also provided to the 6 constabularies across the North West region) on a case by case basis.

The two additional clinicians will enable the NWMHT to expand the service provided including:-

- To screen all prevent referrals to establish whether they have secondary mental health contact and to liaise with the teams and share information where appropriate.
- To screen for mental illness, LD and ASD for those cases not in contact with services (Manchester pilot).
- More precise role definition for the embedded police officers and the mental health practitioners.
- To provide training on Prevent awareness to Mental Health Services.
- To develop a research agenda.

The Greater Manchester Pilot will specifically provide opportunities to evaluate the following specific components of a potential future model including

- Consultation through Channel
- Embedding Prevent Officers into the Mental Health Team
- Training Prevent officers to screen for mental illness.

2. The evaluation

The final evaluation report for the mental health hubs will present evidence in relation to the following:-

- What are the mental health / psychological needs of Prevent / channel referrals
- What are the current unmet needs and mainstream clinical service requirements
- What is the added value of specialist MH clinicians in working with police in CT / Prevent to support liaison and diversion to MH services
- Advice and recommendations regarding scaling up each site to cover the extended geographical areas
- What is the added value of including wider mental health and psychological functioning assessment and formulation
- What is the role of screening tools (e.g. PolQuest) in supporting police led MH identification

The final mental health hubs evaluation will not directly provide evidence of mental health as a predictor of future behaviour and CT risk. However it is intended that some of the findings may contribute to wider research

All three hubs are charged with designing processes for joint working and evaluating their effectiveness. Measures of success will include the potential added value of mental health professionals to officers within Prevent pathways, with a specific focus on the following Key Lines of Enquiry:-

- Risk (CT and clinical)
- Efficiency of resource
- Outcomes
- Costs

The objectives identified for the pilot services will each be reviewed within the final evaluation report. These are:-

- To support CT Police in liaising effectively with health services to seek and share information.
- To develop and refine effective procedures for managing liaison and information sharing within current legislation.
- To provide advice to referrers within Prevent and other regional CT teams, and other relevant stakeholders, regarding individual cases and mental health services
- To support the early detection and engagement of individuals with mental health difficulties.
- To provide a specialist, multidisciplinary clinical team able to undertake a range of activities and interventions
- To ensure that cases with mental health vulnerabilities appropriate for mainstream services are identified and referred at the earliest possible opportunity
- To develop working links with NHS Prevent leads, both local and national.
- To develop appropriate IT systems to store and share information, and robust governance systems.

- To share learning that supports the identification and development of best practice which maximises outcomes / added value and which provides a sustainable and evidenced model for future provision
- To promote sharing of information and learning from the hubs, and to support the development of best practice through the attendance at local, regional and national meetings, and the delivery of presentations to a range of relevant audiences and networking events.

In order to maximise learning the differences between the hubs will be evaluated independently of each other. Thus overall the final evaluation report will provide the following:-

- Added value of specialist MH clinicians in working with police in CT / Prevent to support liaison and diversion to MH services
- Added value of extending that provision to include wider mental health and psychological functioning assessment and formulation
- Role of screening tools (e.g. PolQuest) in supporting police led MH identification
- Add to the wider research regarding links between MH vulnerability and CT risk

3. Results

A standardised approach to data collection within each hub has been agreed and will be available for the final evaluation report focusing on:-

(i) Service activity and flow data
(ii) Feedback from Police CT / Prevent officer colleagues
(iii) Individual case studies / narratives

Preliminary data was included in the first report, and only a very brief update is presented here incorporating data collected to end March 2017.

(i) Service activity and flow data

A combined total of 495 referrals had been responded to across the three hubs to the end of March 2017with the vast majority (over 80%) being male. Ages ranged from a youngest of 8 years to an oldest of 73 with the vast majority over 18 years of age (more than 80%). Where known to mental health services, the predominant diagnosis was Schizophrenia, but with a notable presence of Personality disorder, PTSD / Trauma, neuro-developmental disorders (e.g. autistic spectrum) and mood / anxiety disorders , and Autistic Spectrum presentations..

(ii) Feedback from Police CT / Prevent officers

Police officer feedback in all three hubs has been positive, and there are case examples illustrating the impact of consultation to other agencies. More detailed analysis of this data will be presented in the final report. However capacity within the three hubs as they adjust to cover extended geographical areas, plus required responses to recent serious incidents in Manchester and London , have limited what is available for reporting here. The evaluation team plan to visit each of the hubs between June

and August to provide additional support to data analysis, and to enable more thorough review of the data including independent collation of feedback and selected case studies.

4. Discussion

Preliminary analysis of the quantitative and qualitative data presented in this update report is consistent with the first interim report (PMHH1) in continuing to indicate a positive impact within all three mental health hubs in relation to the following outcomes:-

- ✓ Improved detection of mental health vulnerabilities
- ✓ Reducing the time it takes to get health information and has thus markedly saving police time and resources.
- ✓ Increased confidence in Police assessment of risk / vulnerability, and facilitated access to appropriate services
- ✓ Enabling more efficient use of interventions, including use of mentors and disruptions, which are now more targeted to assessed need with improved outcomes and reduced costs.
- ✓ Identifying previously unidentified mental health needs, thereby improving risk awareness and creating new treatment options and plans
- ✓ Enabling long standing Prevent cases to be discharged thus releasing police resource for responding to other cases
- ✓ Helping police Prevent and CTU colleagues to better understand how mental health vulnerabilities may impact upon behaviours and risk
- ✓ Creating better outcomes for individuals referred to Prevent

All hubs report encountering substantial complexity of psychological presentation and co-morbidity in referrals, supporting the notion of a broader complexity not explained by psychiatric diagnosis alone.

Key lines of enquiry:-

In relation to the four key lines of enquiry of Risk, Efficiency, Outcomes and Cost, evidence from all three hubs continues to demonstrate benefits for the provision of mental health expertise directly into Police CT and Prevent teams.

(i) Risk

- Faster access to and more complete information gathering and sharing has reduced the number of fewer unknowns has enhanced quality and reliability in the assessments of risk and vulnerability.
- The facilitation of specialist mental health and forensic assessment, along with onward referral into specialist provision, enables previously unmet psychological and psychiatric needs to be met, thus mitigating against CT vulnerabilities.
- A better awareness of mental health needs has also enabled access to more targeted interventions, with mental health clinicians being able to navigate often cumbersome clinical referral pathways into mainstream and specialist services.

In supporting all of the above activities, the presence of the mental health clinicians not only enables cases to progress to discharge from Prevent more rapidly, but also releases Police time to attend to other cases and referrals, enhancing their capacity to identify and respond to risk elsewhere.

(ii) Outcomes

Mental health outcomes

- Reliable and more rapid detection of previously unknown mental and psychiatric disorders enables vulnerable individuals to be directed to appropriate care and treatments, thus improving clinical outcomes. Appropriate treatment for mental ill health also increases the likely benefits from other interventions, for the individual themselves, and at times for family members.

All three mental health hub teams have been able to effectively utilise their knowledge of mental health mainstream services to circumvent what have previously been reported as inflexible access pathways to mainstream mental health services, and in some cases this has extended to accessing very highly specialist forensic clinical services.

Police Prevent / Channel outcomes

- Working with an informed understanding of the factors that may be influencing an individuals' behaviour and presentation from a Police / CT perspective enables Prevent Officers to approach cases more appropriately and maximise likelihood of engagement with clinical, social and Channel interventions. This improves the potential for positive outcomes from a police and social care perspective, either directly or through altering the individuals' capacity to engage and relate to those offering help.
- Discussions are currently taking place with Police colleagues to ensure the policing outcomes are best captured and presented in the final evaluation report.

(iii) Efficiency

There is emerging evidence within all three hubs that access to specialist assessment and consultancy has clearly improved the detection of mental health vulnerabilities, thus enabling individuals to access interventions that are appropriate to their needs. Case narratives indicate that this has been especially beneficial to those with added psychological, social and familial complexities, and for those who may have struggled to access mainstream health services due to homelessness or immigration status. Furthermore, untreated mental ill health increases the likelihood of costly unplanned and crisis care being required as the condition deteriorates.

Enhanced access to mental health consultation, assessment, accessing appropriate interventions, and a more targeted care plan for people with mental health vulnerabilities reduces wasteful use of police resources and interventions, reduces the time required to assess cases, reduces the Police burden of chasing information from agencies that are often reluctant to provide it, or when provided it is in a format that is hard to process or interpret, and reduces time to discharge.

(iv) Cost

Quantifiable economic benefits of all three mental health hub pilots are undergoing evaluation and will be reported on more substantially in the final report. Initial consideration suggests that the following may all contribute to financial efficiency:-

- Reduced police time spent in trying to source information
- Fewer but more productive and informed contacts with cases
- Reduced wastage in utilising ineffective channel and social care interventions

- moving referrals through the prevent pathway more rapidly,
- reducing the likelihood of re-referrals to Prevent

These will all be explored in future months and economic analysis completed for report in 2017.

4. Conclusions and Recommendations from interim evaluation

In conclusion, the ongoing evaluation continues to generate provisional supportive evidence in favour of the mental health provision in adding value to the Police CT and Prevent pathway. Due to the varying degree of data available between the three hubs at the point of preparing this interim report, it has not been possible at this stage to formulate recommendations regarding service model or its core components. The final analysis of more standardised data will enable some comparison between the three hubs, which will inform the ongoing work on an emerging operating model and wider economic analysis, and this will be incorporated into the final report which is due in the early autumn of 2017.

Prevent Mental Health Hubs

Interim Evaluation report 1 – Executive Summary

Staff name removed

January 2017

Abstract

This is an Executive Summary for the first interim evaluation report into the three mental health hubs aligned to Prevent pathways across the South, Midlands and North regions. Each hub is briefly summarised along with initial data relating to activity and flow, qualitative and quantitative outcomes. Each of the three mental health hubs aims to pilot the effectiveness of mental health professionals working alongside counter terrorism police officers in relation to the management of individuals referred to the police with known or suspected mental health disorders. Due to the nature of their original commissioning, varying commencement dates and local priorities / funding, each hub delivers to a different specification Therefore within this initial report there is considerable variance in the amount of data available and the degree to which the services have developed and embedded their operating procedures. However the data presented from each site does start to provide evidence of the benefits and value of the mental health hubs, and these are discussed in relation to risk, efficiency, effectiveness and cost. Regular meetings convened by National Counter Terrorism Policing HQ have ensured that all three hubs will in the future collect standardised data and full analysis will be presented in future reports. A second interim report is planned for March 2017 with final reporting due in September 2017.

Contents

1. Introducing the three mental health hubs

1.1 London Prevent Liaison and Diversion (PLAD)

The Metropolitan Police Service (MPS) Counter Terrorism Command (known as 'SO15') operates to give effect to the PREVENT and PURSUE pillars of the CONTEST strategy for counter terrorism policing. The joint police / NHS Prevent Liaison and Diversion team (PLAD) offers support to SO15, which covers the 32 London boroughs in the Metropolitan Police District, and to CT police in the South East Counter Terrorism Unit (SECTU and to the Eastern Counter Terrorism Intelligence Unit (ECTIU. Referrals to the PLAD from within SO15 originate from various teams including but not limited to investigations, prisons unit, international and local operations.

The pilot went live on 4 July 2016.There is funding for NHS personnel of two full time nurses (one as team leader) and a combination of part-time input from both psychiatry and psychology consultants (3 days per week) provided by Barnet, Enfield and Haringey Mental Health NHS Trust (BEH). Police personnel in the PLAD consist of two full time SO15 constables, overseen by a Sergeant and Inspector (part time). The team is located within SO15

Interventions from PLAD have included, but are not limited to, telephone liaison with mental health teams, contact visits and attending case discussion and review meetings. PLAD have been utilising a RAG rating approach to the categorisation of risk that will now be adopted in the other hubs. It is a joint judgement made by clinicians and Prevent officers and provides a more quantitative assessment of impact on risk, alongside clinical ratings.

1.2 West Midlands Prevent in Place (PiP)

This specialist clinical team was commissioned to provide expert mental health advice, proactive case review, consultation and comprehensive assessment directly to the West Midlands Prevent case management (PCM) pathway. The PiP (Prevent Intensive Psychological Liaison Assessment and Community Engagement) service currently supports the West Midlands Police which includes Birmingham and wider West Midlands. Referrals to PiP are received directly from within Prevent Case Management although a small number have been received directly from Fixed Intelligence Management Unit (FIMU) and enquiries received from other agencies including health, social care and probation.

There is funding for Clinical Psychology (1.4 wte), Forensic Community Psychiatric Nurse (2.0 wte), Consultant Psychiatry (0.3 wte) and a Research Assistant. The clinical service is delivered by Birmingham and Solihull Mental Health Foundation Trust. The service became operational in April 2016. The clinical team is situated alongside Prevent officers from West Midlands CTU. A Prevent Officer and Sergeant attend weekly PiP operational meetings.

The service provides two key areas of input, Proactive Case Review and Comprehensive Assessment. Proactive Case Review involves working with cases from the point of referral and includes initial review, screening and liaison, direct / indirect assessment, formulation and recommendations, actions such as onward referral and facilitation of further specialist intervention, formal consultation and complex case review, through to discharge. Additionally advice is provided directly to Channel / PCM regarding interventions and disruptions. The PiP team also provide written reports for appropriate parties and put alerts onto Police and NHS systems detailing concerns around mental health and radicalisation.

A consultancy model supports FIMU officers in understanding the mental health implications, identifying unknowns and assessing risk / vulnerabilities of anonymised cases. Comprehensive Assessment is available for high risk complex cases that do not meet the criteria of mainstream mental health services or where longstanding input from Channel / PCM has not mitigated risk

1.3 Greater Manchester Police / North West Mental Health Team (NWMHT)

The North West Mental Health Team is the third and most recent hub to be established, with just one Mental Health Practitioner employed from July to November 2016 .The focus to date has been to provide the following to Greater Manchester:

- Advising on Prevent cases that have had both undiagnosed and diagnosed mental health problems.
- Liaison with MH services for known cases
- Providing advice to the Prevent FIMU regarding signposting some referrals involving mental health problems.
- Attending Channel Panels for 8 local authorities; Bury, Bolton, Rochdale, Oldham, Wigan, Stockport, Trafford, Salford (Please note there are 10 local authorities in Greater Manchester, however Greater Manchester uses existing Multi Agency Safeguarding Hubs (MASH) to deal with cases and Tameside is currently redeveloping its channel panel).

Advice is also provided to the 6 constabularies across the North West region) on a case by case basis.

Two additional clinical posts joining the team between November 2016 and January 2017 will enable the NWMHT to expand the service provided including:-the service include:-

- To screen all prevent referrals to establish whether they have secondary mental health contact and to liaise with the teams and share information where appropriate.
- To screen for mental illness for those cases not in contact with services
- To provide training on Prevent awareness to Mental Health Services.
- To develop a research agenda.

The Greater Manchester Pilot will specifically provide opportunities to evaluate the following specific components of a potential future model including

- Consultation through Channel
- Embedding Prevent Officers into the Mental Health Team
- Training Prevent officers to screen for mental illness.

2. The evaluation

The planned final evaluation will reflect the aims and objectives for the hub services in addition to taking into account the needs and requirements of the various stakeholders including CT police colleagues, NHS, NCTPHQ and Home Office.

All three hubs are charged with designing processes for joint working and evaluating their effectiveness. Measures of success will include the potential added value of mental health professionals to officers within Prevent pathways, with a specific focus on the following Key Lines of Enquiry:-

- Risk (CT and clinical)
- Efficiency of resource
- Outcomes
- Costs

The objectives identified for the pilot services will also be reviewed through the evaluation. These are:-

- To support CT Police in liaising effectively with health services to seek and share information.
- To develop and refine effective procedures for managing liaison and information sharing within current legislation.
- To provide advice to referrers within Prevent and other regional CT teams, and other relevant stakeholders, regarding individual cases and mental health services
- To support the early detection and engagement of individuals with mental health difficulties.
- To provide a specialist, multidisciplinary clinical team able to undertake a range of activities and interventions
- To ensure that cases with mental health vulnerabilities appropriate for mainstream services are identified and referred at the earliest possible opportunity
- To develop working links with NHS Prevent leads, both local and national.
- To develop appropriate IT systems to store and share information, and robust governance systems.
- To share learning that supports the identification and development of best practice which maximises outcomes / added value and which provides a sustainable and evidenced model for future provision
- To promote sharing of information and learning from the hubs, and to support the development of best practice through the attendance at local, regional and national meetings, and the delivery of presentations to a range of relevant audiences and networking events.

Due to the varying duration of the three hubs and resultant restrictions on the potential for meaningful interpretation and comparison the data for the three hubs is presented separately on this occasion.

A standardised approach to data collection within each hub has been agreed and will be available for future reports focusing on:-

(i) Service activity and flow data
(ii) Feedback from Police CT / Prevent officer colleagues
(iii) Individual case studies / narratives

3. Preliminary results and discussion

A combined total of 297 referrals had been responded to across the three hubs at the time of writing (end November 2016) with the vast majority (90-95%) being male. Ages ranged from a youngest of 8 years to an oldest of 73 with an average between 25 and 35 years (based on available data). Diagnostic categories were available for the PLAD and West Midlands' data and indicated a predominance of Schizophrenia, Depression / Anxiety, and Autistic Spectrum disorders.

Preliminary analysis of the quantitative and qualitative data presented in this interim report is suggestive of a positive impact within all three mental health hubs in relation to the following outcomes:-

- ✓ Improved detection of mental health vulnerabilities
- ✓ Significantly reducing the time it takes to get health information and has thus markedly saving police time and resources.
- ✓ Increased confidence in Police assessment of risk / vulnerability, and facilitated access to appropriate services
- ✓ Enabling more efficient use of interventions, including use of mentors and disruptions, which are now more targeted to assessed need with improved outcomes and reduced costs.
- ✓ Identifying previously unidentified mental health needs, thereby improving risk awareness and creating new treatment options and plans
- ✓ Enabling long standing Prevent cases to be discharged thus releasing police resource for responding to other cases
- ✓ Helping police Prevent and CTU colleagues to better understand how mental health vulnerabilities may impact upon behaviours and risk
- ✓ Creating better outcomes for individuals referred to Prevent

In relation to the four key lines of enquiry of Risk, Efficiency, Outcomes and Cost, evidence from all three hubs has demonstrated some notable benefits for the provision of mental health expertise directly into Police CT and Prevent teams.

(i) Risk

Faster access to and more complete information gathering and sharing has reduced the number of fewer unknowns has enhanced quality and reliability in the assessments of risk and vulnerability. The facilitation of specialist mental health and forensic assessment, along with onward referral into specialist provision, enables previously unmet psychological and psychiatric needs to be met, thus mitigating against CT vulnerabilities. A better awareness of mental health needs has also enabled access to more targeted interventions, with mental health clinicians being able to navigate often cumbersome clinical referral pathways into mainstream and specialist services. In supporting all of the above activities, the presence of the mental health clinicians not only enables cases to progress to discharge from Prevent more rapidly, but also releases Police time to attend to other cases and referrals, enhancing their capacity to identify and respond to risk elsewhere.

Police officer feedback in all three hubs has been positive, and there are case examples illustrating the impact of consultation to other agencies.

(ii) Outcomes

From a mental health perspective, reliable and more rapid detection of previously unknown mental and psychiatric disorders enables vulnerable individuals to be directed to appropriate care and treatments, thus improving clinical outcomes. Appropriate treatment for mental ill health also increases the likely benefits from other interventions, for the individual themselves, and at times for family members.

All three mental health hub teams have been able to effectively utilise their knowledge of mental health mainstream services to circumvent inflexible existing systems of care improve outcomes, and in some cases this has extended to highly specialist knowledge and networks.

Working with an informed understanding of the factors that may be influencing an individuals' behaviour and presentation from a Police / CT perspective enables Prevent Officers to approach cases more appropriately and maximise likelihood of engagement with clinical, social and Channel interventions. This improves the potential for positive outcomes from a police and social care perspective, either directly or through altering the individuals' capacity to engage and relate to those offering help.

(iii) Efficiency

There is emerging evidence within all three hubs that access to specialist assessment and consultancy has clearly improved the detection of mental health vulnerabilities, thus enabling individuals to access interventions that are appropriate to their needs. Case narratives indicate that this has been especially beneficial to those with added psychological, social and familial complexities, and for those who may have struggled to access mainstream health services due to homelessness or immigration status. Furthermore, untreated mental ill health increases the likelihood of costly unplanned and crisis care being required as the condition deteriorates.

Enhanced access to mental health consultation, assessment, accessing appropriate interventions, and a more targeted care plan for people with mental health vulnerabilities reduces wasteful use of police resources and interventions, reduces the time required to assess cases, reduces the Police burden of chasing information from agencies that are often reluctant to provide it, or when provided it is in a format that is hard to process or interpret, and reduces time to discharge.

(iv) Cost

Quantifiable economic benefits of all three mental health hub pilots are undergoing evaluation and will be reported on more substantially in the final report. Initial consideration suggests that the following may all contribute to financial efficiency:-

- Reduced police time spent in trying to source information
- Fewer but more productive and informed contacts with cases
- Reduced wastage in utilising ineffective channel and social care interventions
- moving referrals through the prevent pathway more rapidly,
- reducing the likelihood of re-referrals to Prevent

These will all be explored in future months and economic analysis completed for report in 2017.

4. Conclusions and Recommendations from interim evaluation

In conclusion, the evaluation has provided provisional supportive evidence in favour of the mental health provision in adding value to the Police CT and Prevent pathway. Due to the varying degree of data available between the three hubs at the point of preparing this initial interim evaluation report, it has not been possible to formulate recommendation regarding service model or its core components. It is recommended that the evaluation continues for the now extended duration of the three hubs, with a second interim report submitted in March 2017 and final reporting in September 2017. The collection of more standardised data will enable some comparison between the three hubs, which will inform the ongoing work on an emerging clinical service model and wider economic analysis.

Prevent In-Place Operational Guidelines

(Revised October 2017)

Note: the use of xxxx within the document indicates that a piece or section of information has been withheld under exemption 43(2) commercially sensitive.

1. Service Description

The Prevent In-Place service (PiP) is a NHS-Police partnership that is commissioned by the Office of Security and Counter Terrorism (OSCT) at the Home Office and West Midlands Counter Terrorism Unit (WMCTU). There is shared ownership, joint responsibility and joint operations between the commissioners, National Counter Terrorism Police Head Quarters (NCTPHQ), WMCTU and Birmingham and Solihull Mental Health Foundation Trust.

PiP is delivered by a multi professional clinical team and managed as part of BSMHFT Secure Care psychological services. The team includes a Clinical Lead (clinical psychologist), xxxx Forensic Mental Health Nurses, further psychology input and input from consultant forensic psychiatrists. All staff involved in the service delivery will have security clearance to SC level. The team xxxx and work in partnership with WMCTU Prevent team and work with the Prevent Hubs across the regions (WMCTU, East Midlands CTU, Welsh Extremism CTU).

WMCTU legally retain case responsibility and monitor and manage risk. Individuals are excluded if they are deemed to be unsuitable for the PCM process, although they will remain under PCM until health actions are completed (e.g. referrals).

Service Aims

Joint NHS-Police partnership service with the capacity to ameliorate the varied and complex psychosocial and mental health vulnerabilities of individuals identified by West Midlands Prevent Case Management (PCM), and so;

1) Mitigate risk

2) Identify unmet mental health need and improve health and criminal justice outcomes for individuals
3) Reduce the vulnerabilities associated with radicalisation and extremism and thus reduce potential risk to individuals and the public
4) Reduce costs through efficient partnership working, shorter durations of untreated mental illness and fewer investigations.

6. Service Objectives

- Rapid identification of the broad range of difficulties that may impact on risk / vulnerability xxxx
- Effective liaison and information sharing with health and other relevant agencies
- Case formulation to understand the relationship between MH, psychological, developmental, social , environmental factors and how these might increase / reduce risk and vulnerability
- Identify and address unmet mental health needs that may be impacting on CT vulnerabilities (Undertake assessments, refer to, provide consultancy or catalyse response from mainstream services and third sector organisations)
- Promote effective management planning and interventions
- Provide a consultancy service to PCM/ Channel regarding complex individuals
- Research and service development; Robust evaluation, scope 'complex needs' and develop service models, further research and development of assessment tools

7. Population Covered

xxxx West Midlands Region (West Midlands, Staffordshire and The Alliance (Hereford and Warwickshire). xxxx East Midlands CTU and Wales xxxx

8. Governance

Overall governance responsibility lies with the multiagency Governance Board that is held monthly (see appendices for Terms of Reference).

All cases are reviewed on a fortnightly basis, with high concern or complex cases reviewed weekly at a weekly clinical / operational meeting. There is dedicated time for in depth case reviews.

Individual hubs across the three regions and relevant teams (Safeguarding, Probation) provide input to the meeting and case discussions in person or via telephone conferencing. A senior Prevent Officer from WMCTU attends the meeting to provide oversight and consultancy and assume responsibility for Police based actions.

The NHS staff receive individual and peer clinical supervision on a monthly basis. Clinical supervision is provided to Police colleagues inputting to the team on request.

8.1 Management and contractual arrangements/obligations

All BSMHFT staff retain their managerial arrangements and job descriptions and BSMHFT staff maintain both Trust and professional standards and obligations.

8.2 Information Governance

Information Governance Procedures have been developed in consultation with the Department of Health, WMCTU and NCTPHQ and BSMHFT Legal and Informational Governance Leads and Caldecott Guardian.

8.2.1 Case Information

The Prevent In-Place Team manages different types of information from a variety of sources.

Each referral has their own paper file which is managed according to the BSMHFT Information Governance Policy. The paper file is the complete clinical record for each individual and comprises all relevant information from all sources. These files are stored in a locked fire proof cabinet.

Clinical information that is not appropriate for sharing with other agencies, including the Police, is stored in paper files. Digital copies of information e.g. reports is stored in a password protected file on a BSMHFT Sharepoint.
Information that is appropriate for sharing with the Police is stored on an individual's digital case record, i.e. CMIS/ Corvus.

8.2.2 Data Protection

A Privacy Impact Assessment has been completed and the service meets the requirements of Data Protection Legislation.

8.2.3 Information Sharing

Cases where the information sharing procedures where not clear have been reviewed as agreed in the WMCTU – BSMHFT contract. It has been concluded that the mental health hubs are able to work within current legislation and no legislative changes are required.
Procedures have been developed to support the legal sharing of information between Police Counter Terrorism Units and NHS.

The purpose of all information sharing and activity within Prevent In-Place is to safeguard individuals and divert them away from engaging in crime. Prevent In-Place do not support activities which aim to investigate crime or secure a conviction. A disclaimer is added to all written information as below.

It should be noted this report has been written as part of a routine assessment provided by the Prevent In-Place Service. In the event of legal proceedings an independent expert opinion regarding mental health and psychological difficulties should be sought.

8.2.4 Prevent Referrals

Information is shared under the Prevent Duty for the purposes of safeguarding the individual.

At initial Triage and as the case progresses as required consideration is given to whether seeking information from mental health services is proportionate according to the table below.

MH / CT	Mental Health indicators	Mental Health Historically	Mental Health Currently	Mental Health Unclear	No Mental Health	Raised by Mental Health	Not engaging with MH
CT	S & L – all	S & L -all	S & L	S & L - all		S & L	S & L
CT Unclear	S & L – all	S & L	S & L	Consider S & L		S & L	S & L
No Ideology	S & L – all	Consider S & L	Consider S & L			S & L	S & L
No CT							

S & L –liaise with Mental Health Service

S & L – all – liaise with any relevant agency that may have relevant information regarding an individual's current mental health or psychological needs

Consider S & L – ideology may not be the primary driver for engagement in extremism. Liaise with services if there appear to be vulnerable to engaging with extremist groups due to the presence of a mental health or psychological difficulty.

If appropriate NHS staff will seek information from NHS colleagues. NHS staff are clear and open about the purpose of the contact and remit of the team and an information leaflet is send to teams on request. Only information that is deemed to be relevant and proportionate is requested and what should be shared with Prevent / Channel is discussed and agreed with the host team.

If mental health professionals see individuals for a direct assessment written consent is obtained before information is shared with Police or other agencies.

8.2.5 Wider CTU (e.g. FIMU / Investigations)

Information from Health can be sought by the Police including wider CTU departments under the Crime and Disorders Act for the purposes of supporting Police in their statutory duties, to prevent crime and pursue a conviction.

The mental health team cannot directly share information but can support CTU in requesting information from health by advising them about the use of current processes (WA170 form with s29 exemption).

The mental health team can provide specialist advice and information about mental health, mental health services and the Mental Health Act and anonymous case consultation to teams outside of Prevent. The aim of this activity is to support professionals in their assessment of risk and to consider appropriate actions rather than to directly assess the individual.

8.2.6 Prevent Cases are detained under the Mental Health Act

When individuals are sectioned under the Mental Health Act it is reasonable to consider whether they should be exited them from Prevent as;

a) it is sometimes difficult / inappropriate to engage them in active Prevent / Channel interventions,
b) it is unclear whether health input will be sufficient to mitigate risk / vulnerability and
c) they may be detained under the MHA for months / years thus consideration should be given to whether it is appropriate to keep them as an open Prevent case.

Conversely, it may be also be proportionate for information to be shared with CTU/ Prevent if a change in their circumstances might impact on their CT/ DE vulnerabilities, e.g. if they are discharged. However, if they are not an active Prevent case this breaches information governance legislation – health should not be sharing any information for a closed Prevent case without the consent of the individual even if this is requested.

It has, therefore, been determined that specific considerations for information sharing procedures are required when open Prevent Cases are detained under the Mental Health Act. xxxx

9. Prevent In-Place Service Model

The service adopts a **Formulation-based approach**; recognising the evidence base that vulnerability to extremism is associated with a broad range of individual, social and contextual factors. There are xxxx levels of service delivery with clinical diagnosis being considered as part of the overall case formulation at each stage.

Xxxx

Xxxx

Supporting Discharge

Individuals are discharged from the PiP caseload when there are no further actions from a Prevent In-Place perspective (e.g. individuals are being appropriately supported by mainstream services).

Xxxx

xxxx

Specific guidance has been developed to support Prevent / health services in managing information sharing when individuals are admitted under the Mental Health Act. (see appendix)

Ongoing Case Consultancy

xxxx

xxxx

The team support liaison between Prevent Officers and health as required, however, the responsibility to maintain working relationships lies with the clinical team according to the Prevent Duty. Re-referrals to PiP are accepted from PCM if circumstances change, e.g. social situation, deterioration in mental health, increase in concern.

Figure 1- xxxx

10. Specialised Forensic Mental Health Consultancy to Wider CTU.

Anonymised Case Consultancy

Formal and informal case consultancy is offered to departments outside of Prevent:

xxxx

An anonymous case consultancy model is used as the aim is to provide expert consultancy / supervision to the professional (Police Officer) rather than assess the individual in line with the Offender Personality Disorder Pathway Strategy's model to support for Probation officers understand and manage high risk PD offenders. This model is believed to improve the skills, confidence and understanding of staff and improves decision making e.g. discharge or onward referral. This model also maintains confidentiality of both the Police and health service and protects Police and health professionals from breaching information governance legislation.

Information Sharing

The PiP team can support CTU colleagues in determining whether they require information from health to support them in their statutory duty and in legally and safely navigating this process.

Level 3 - Comprehensive Assessment

xxxx

Training and Clinical Supervision

The PiP team provides formal and informal training to Prevent Officers, Channel Panels and other local, national and international organisations on request. To date this has included awareness training of the PiP model, training about specific areas of interest, including autism, input to the National Prevent Training and training to support service development in Australia, United States and Denmark.

The team has presented at numerous Health, Police, Local Authority and Academic conferences.

Research and Service Development

There is an ongoing programme of research and evaluation of the service dataset and model. PiP are working collaboratively with Bath University and NCTPHQ to conduct research exploring autism and extremism.

PiP are working collaboratively with other agencies (Home Office, Local Authorities, Police, Department for Education, Health) to develop resources and systems to monitor and manage risk and better support migrants and unaccompanied minors who are seeking asylum.

Roles and Required Skill Set of the Multidisciplinary Team

The multi professional team provides the breadth of skills to deliver a high quality service and specifically:

xxxx

Empirical evidence and clinical experience indicates that, as a group, Prevent / Channel referrals present with a wide range of complex mental health, psychological, neurodevelopmental, social and risk needs, including extremist ideologies and they are often managed by complicated multi-agency systems.

xxxx

Appendices

1. Information for Professionals
2. Triage Decision Tool – **withheld under exemption 43(2) commercially sensitive.**
3. RAG rating guidance - **withheld under exemption 43(2) commercially sensitive.**
4. Triage / Screening/ Assessment / Discharge Forms - **withheld under exemption 43(2) commercially sensitive.**
5. Comprehensive Assessment Request Form - **withheld under exemption 43(2) commercially sensitive.**
6. Consent form for Prevent In-Place to seek and Share Information - **withheld under exemption 43(2) commercially sensitive.**
7. Consent Form to Allow Sharing of information with the Prevent In-Place Team - **withheld under exemption 43(2) commercially sensitive.**
8. Feedback form - **withheld under exemption 43(2) commercially sensitive.**
9. Sample Letter - **withheld under exemption 43(2) commercially sensitive.**
10. Prevent In-Place Governance Board Terms of Reference
11. Information Sharing when Prevent Cases are detained under the Mental Health Act

An Introduction to Prevent-in-Place for NHS Colleagues

Prevent-in-Place is a partnership service provided by the NHS and Police across the West Midlands and offered to individuals that have been referred to Prevent.

Prevent is a key part of the government's strategy to support people most at risk of being drawn into violent extremism and divert them away from potential threat at an early stage.

Health service providers are identified as being key partners in the delivery of Prevent and Prevent is one of the eight areas that are formally embedded in NHS England's Accountability and Assurance Framework for Safeguarding. This is because some people who are living with mental health difficulties may be particularly vulnerable to exploitation to radicalisation. A high prevalence of mental health and psychological need has also been found in individuals referred to Prevent.

The Prevent In-Place team will aim:

- to work in partnership with West Midlands Police Counter Terrorism and/or Prevent Officers to identify any poor mental health difficulties through a robust assessment of needs and, where necessary;
- to direct individuals towards specialist support from mental health teams across the West Midlands, and from other organisations to ensure that a joined-up approach to care intervention is delivered to vulnerable individuals to address vulnerabilities that increase their risk of exploitation.

Prevent-in-Place is a partnership between Birmingham and Solihull Mental Health Foundation Trust and West Midlands Police and commissioned by the Office of Security and Counter Terrorism at the Home Office.

Confidentiality and Information Sharing
The Prevent-in-Place team operates within a joint mental health/police unit. The work being undertaken requires careful attention in maintaining medical confidentiality and the team work within the confidentiality guidelines outlined by the Royal Collage of Psychiatrists; a Counter-terrorism and psychiatry position statement (September 2016) (available via their website).

All Prevent In-Place correspondence that contains personal information will be marked as Official- Sensitive according to standard Government Security Classifications. This can be managed according to your Trust's standard Confidentiality Policy.

Prevent-in-Place clinicians are:

Clinical Psychologist, Clinical Lead **(names withheld under exemption 40 personal information).**
Clinical Psychologist **(names withheld under exemption 40 personal information).**
Community Mental Health Nurse **(names withheld under exemption 40 personal information).**
Community Mental Health Nurse **(names withheld under exemption 40 personal information).**
Consultant Forensic Psychiatrist **(names withheld under exemption 40 personal information).**
Consultant Forensic Psychiatrist **(names withheld under exemption 40 personal information).**

The team can be contact by:

Telephone: 0121 251 0241
E-mail: bsm-tr.PIPTeam@nhs.net

Prevent in Place (PiP) Governance and Partnership Committee

Terms of Reference

1. Authority

1.1 The Prevent in Place (PiP) governance and partnership committee is tripartite organisational arrangement (BSMHFT, WMCTU and Home Office / Home Office Partners) to oversee the delivery and evaluation of the PiP project.

1.2 The PiP governance committee also monitors the commissioned contract(s) between BSMHFT and WMCTU and the Home Office / Home Office Partners

1.3 The reporting structure of the board to each organisation is as follows :

- Within BSMHFT the board report to the secure care and offender health governance committee
- Within WMCTU the board reports to NCTPHQ
- Home Office report to The Office of Security and Counter Terrorism

1.4 The multiagency constitution of the board is multi professional and collaborative and it terms of reference are as follows :

2. Purpose

2.1 The primary function of the committee is to provide an accountability and oversight structure for all three partner organisations involved in delivering and evaluating PiP.

2.2 The committee will provide assurance to all three partner organisations including the fulfilling of contractual requirements

3. Duties

3.1 To provide oversight to ensure the effective development of the Prevent In-Place service delivery model, appropriate procedures and KPI's

3.2 To support in the identification and management of operational risks and to ensure that lessons learnt are captured

3.3 Establishing and promoting wider links to enhance the development of relevant collaborative work

3.4 To Identify and liaise with key stakeholders to support progression of the Mental Health Hubs nationally

4. **Membership**

- BSMHFT
- WMCTU
- NCTPHQ
- Home Officer Partners
- Prevent Lead Birmingham City Council
- Forward Thinking Birmingham
- NHS England Regional Prevent Co-ordinators

The Governance Board will be chaired by the BSMHFT Operational Manager, Dr Kay Garvey. Membership is to be reviewed on an on-going basis.

5. **Frequency of Meetings**

PiP Governance and Partnership Committee Meetings will occur on a monthly basis. Meetings will have a specific focus on contract review, evaluation and engagement with wider stakeholders on a rolling basis so each is subject to quarterly review.

6. **Reporting**

Prevent in Place Governance and Partnership Committee will report to NCTPHQ and to their respective organisational Governance Boards.

Information Sharing when Prevent Cases are detained under the Mental Health Act

When individuals are sectioned under the Mental Health Act it is commonly deemed reasonable to exit them from Prevent as Prevent a) cant access them and b) it is assumed that health input will mitigate risk / vulnerability (although this may or not be the case), c) they may be detained under the MHA for months / years and it is not appropriate to keep them as an open Prevent case. However, Prevent have requested information from health for discharges cases due to concerns that the CT risk may not have been mitigated.

If individuals are not an active PCM case this breaches information governance – health should not be sharing any information for a closed case even if this is requested as Prevent do not have any active involvement.

Options for consideration;

1) keep open to Prevent and review every 6 months – Prevent Officer to contact Responsible Clinician for update (seek permission of client)

2) put CT vulnerability on CPA care plan / risk assessment and review every 6 months at CPA

3) continue to complete joint assess / joint work whilst in hospital

4) agree 'trip wires' when someone is first admitted to hospital –e.g. make sure health know the CT concerns and agree the circumstances that they will make a referral e.g. if similar concerns are noted.

5) Prevent to exit, no information to be shared Prevent will have to trust that the MH team will make a referral in the future if required

Any or all of these could be considered depending on the circumstances. In general it is recommended that if the risk is low, the mental health team could be asked to monitor and re-refer to Prevent, given advice about specific behaviours to monitor (e.g. saying…., doing……. going…….associating….)and asked to formally put it on their care plans to review at Care Plan Approach Reviews (CPA meetings).

If the risk is higher, deemed to be unrelated to mental health (i.e. is likely to remain after their mental health is treated) or they present with engagement difficulties it may be appropriate for the case to remain under PCM for review every 6 months so the Prevent Officer (with PiP support as required) can contact the Responsible Clinician (psychiatrist) directly to ask for an update and ensure they are informed about leave, discharge and follow up plans. This will also open the option for Channel to get involved prior to discharge e.g. a mentor.

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust
A University Teaching Trust

METROPOLITAN POLICE TOTAL POLICING

Prevent Liaison and Diversion (PLAD)

London Hub Pilot Evaluation

Data review period: July 2016-October 2017

1. Overview

The Prevent Liaison and Diversion team (PLAD) is the London based pilot site for the national counter terrorism police and mental health initiative set up to support the management of individuals of concern to CT policing, who exhibit mental health concerns.

This initiative was developed by the National Counter Terrorism Policing HQ (NCTPHQ) and PLAD is a jointly managed police and health service hosted by the Metropolitan Police Service (MPS) Counter Terrorism Command (known as 'SO15'). The PLAD team is located within SO15 Local Operations, which incorporates Prevent.

NHS staff for PLAD are provided by Barnet, Enfield and Haringey Mental Health NHS Trust. Police personnel in the PLAD are counter terrorism (CT) officers from SO15.

SO15 is the counter terrorism unit (CTU) for the MPS in London. 'Liaison and Diversion' services are provided to the MPS by the NHS, to support the management of individuals with mental disorder coming to police notice.

PLAD offers support to SO15 (which covers the 32 London boroughs), and to counter terrorism police in the South East Counter Terrorism Unit (SECTU, covering Oxfordshire, Buckinghamshire, Berkshire Hampshire, Surrey, Sussex and Kent), the Eastern Counter Terrorism Intelligence Unit (ECTIU, which covers Bedfordshire, Hertfordshire, Cambridgeshire, Norfolk, Suffolk and Essex), and the South West Counter Terrorism Intelligence Unit (SWCTIU, which covers Avon, Somerset, Devon and Cornwall).

Referrals from SO15 teams to the PLAD are not limited to Prevent referrals, rather referrals originate from various teams including investigations, prisons unit, international, and leads resolution.

The PLAD pilot went live on 4 July 2016; year 1 ended on the 31 March 2017. Year 2 spans from 1 April 2017 to 31 March 2018. This evaluation relates to data from the period July 2016 to October 2017.

1.1 Aims

The identified and agreed aims for PLAD are as follows:

- To support counter-terrorism policing to assess and manage individuals in their caseload who exhibit mental health concerns. In doing so;
- To direct severely mentally ill people, who are identified through such contacts, to the care that they need; and
- To provide effective and appropriate liaison between health and policing services.

1.2 London Hub Model

The London mental health hub, PLAD, adopted a 'liaison and diversion' operating model. This evidence-based model works on the premise that at the point of entry into a service any initial screening is undertaken by the relevant agency practitioner at that point in time, for example a custody sergeant or prison nurse.

In this case, PLAD operates by accepting referrals into the unit from officers working within counter terrorism who have responsibility for managing an individual. That officer is presumed to have already screened the subject for a mental health concern, prompting the referral to PLAD.

PLAD thus primarily provides a service to the referring police officer directly, and may additionally provide a service directly or indirectly to the subject of the referral (see section 1.5 interventions below).

At no time does the PLAD have sole responsibility for case managing an individual; there is always a CT police officer outside of the PLAD with overall responsibility.

1.3 Funding

The funding for PLAD is currently evenly split between the Home Office (Office for Security and Counter Terrorism) and NHS England.

1.4 Staffing

The funding thus far has been based on two full time nurses (one as team leader) and a combination of part-time input from both psychiatry and psychology consultants (totalling 3 days per week). Police personnel in PLAD consists of two full time SO15 constables, overseen by a Detective Sergeant and Detective Inspector.

PLAD clinicians and police officers are security cleared to at least SC STRAP.

1.5 Interventions overview

Interventions from PLAD have included, but are not limited to, telephone liaison with mental health teams, contact visits and attending various professionals' meetings. PLAD clinicians have also attended several contact visits to identified subjects. These visits have enabled PLAD staff to provide advice to both the subject and attending police officers about appropriate mental health support that would be available.

Feedback received from officers has been positive following a contact visit. The officers have reported they have been in a better position with our advice/direction to confidently and appropriately assess the impact or role of any mental health concern on the management of their case. In some instances, PLAD advice has been the difference between a case being kept open due to lack of information and confidence in closing the case from a police / prevent perspective.

In relation to high profile cases or referrals from investigations teams, it has been useful that PLAD clinicians have specialist security clearance. This has enabled clinicians to be better informed and thus able to provide appropriate advice to investigators.

PLAD has introduced an approach to categorising the level of concern of a referred subject based on a Red, Amber and Green rating system. This reflects similar uses of the model in the NHS and liaison services, and directs the action by the team.

When the referrals to PLAD are screened by the team they are initially given a level of priority concern assessment grading (based on combined MH concern and potential CT risk) to decide how quickly the team needs to act upon the information it has received. At present this is based on clinical and professional judgement jointly between police and mental health professionals, informed by the best evidence available to the PLAD in the area of threat and risk assessment. The three different grades are:

- High Concern (Red) – Immediate risk to self/others – evidence of potential risk to self or others is clear, or significant risk factors are present such as clear homicidal or suicidal ideation, high risk psychotic symptoms, or there is indication that the level of threat to others is imminent.

- Moderate Concern (Amber) – Intermediate risk to self/others – there is concern that the individual may pose a risk to self or others but there is no evidence

of the high concern risk factors or that immediate action is required or that there is insufficient information to make an informed decision.

- Low Concern (Green) – low risk to self/others – there is evidence that the individual is receiving appropriate mental health treatment and their mental illness is well-managed or there is no evidence for any mental health intervention and the risk to self or others is assessed to be low.

All cases are graded as moderate (amber) concern if insufficient information is available to record otherwise. This approach was shared with the other Prevent Mental Health hubs with a view to potentially being adopted there for evaluation purposes.

1.6 Presentations

The PLAD has been invited to speak at a number of conferences and events, including an event hosted by the British embassy in Belgium and an EU conference hosted by the Radicalisation Awareness Network (RAN). The feedback received from these events has been very positive about the service, specifically related to the idea of embedding NHS professionals within CT policing units.

PLAD has proactively sought to reach as wide an audience as possible of potential referral streams and mental health practitioners. Thus PLAD has presented to the majority of the specialist teams within SO15, and to many of the regional counter terrorism units. PLAD has also been active in engaging with NHSE and NHS Prevent Leads across the regions.

2. PLAD data review

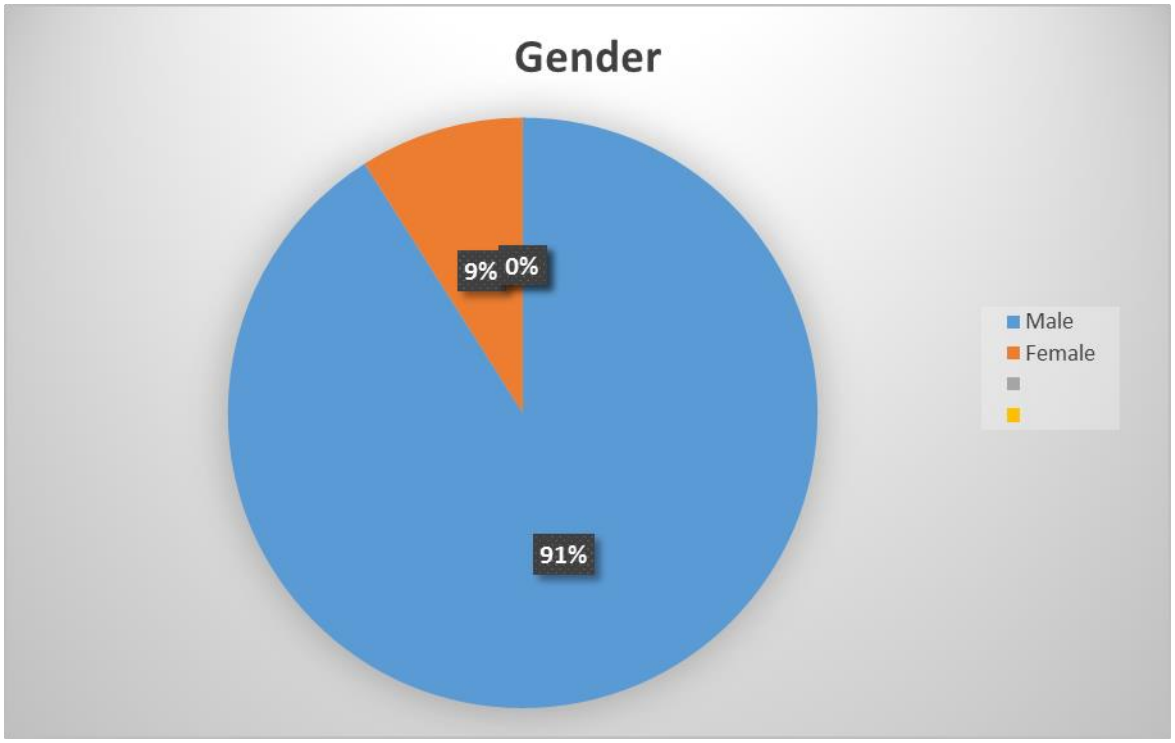
This report will review the data recorded from all of the referrals received by PLAD from 4th July 2016 to 20th October 2017 inclusively.

In this time frame the team received 295 referrals. All referrals to PLAD originated from an SO15 or other CT police officer. This is a requirement of all referrals to PLAD because the team does not have sole responsibility for case managing any individuals; PLAD is a support service to CT police officers and vulnerable people who come to their attention.

Following a review of the data below it would suggest that the most recurrent profile of person referred to PLAD is male, aged 25, presenting with an ideology relating to Daesh (ISIS), is of Asian ethnicity, with a diagnosis of schizophrenia, currently known to mental health services and has previous criminal convictions.

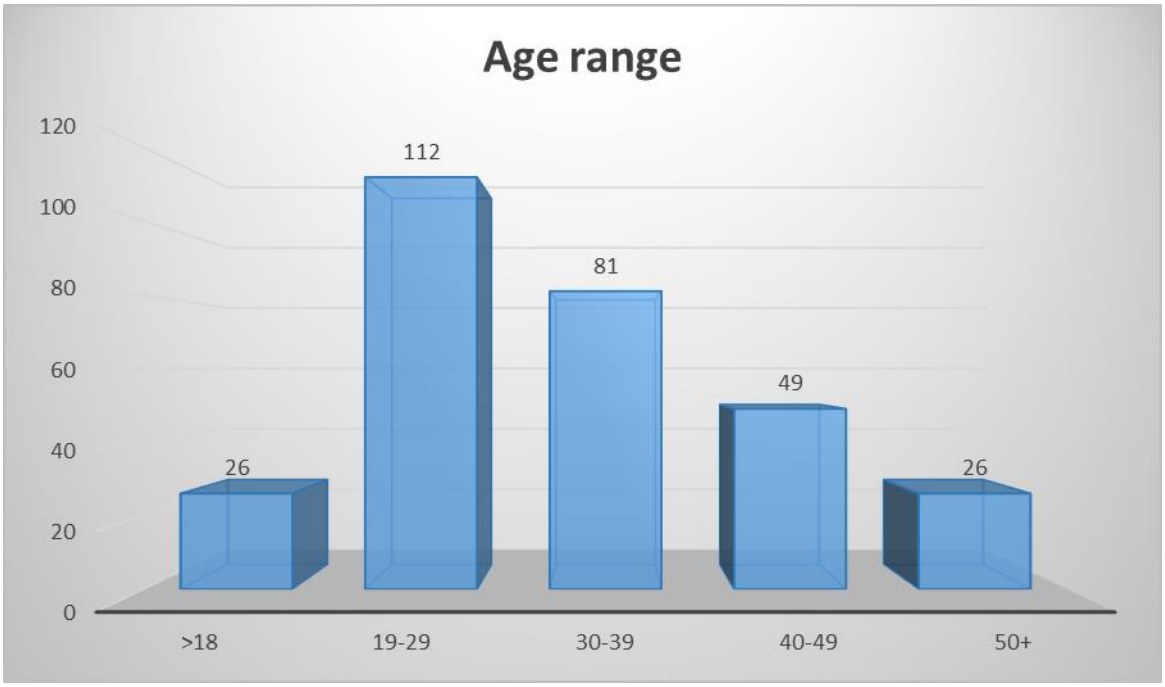
2.1 Demographics

Gender



Out of the 295 referrals, 268 of these were male and 26 were female. One of the referrals was for a family so gender was not assigned.

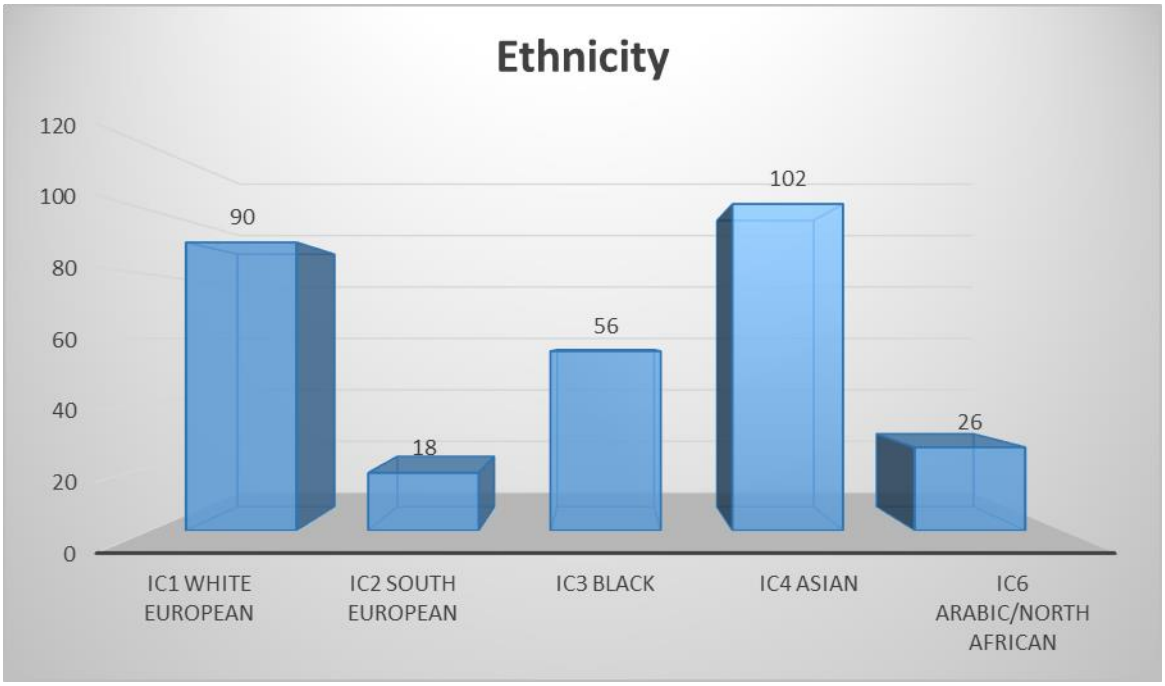
Age



Age range	#	%
18 and under	26	9%
19 to 29	112	38%
30 to 39	81	27%
40 to 49	49	17%
50+	26	9%

The largest age group were between 19 and 29 at 38%. However there were a significant number of referrals between 30 and 39 at 27% and combined these formed sixty five percent of the referrals. The average age is 32. The most common age is 25.

Ethnicity



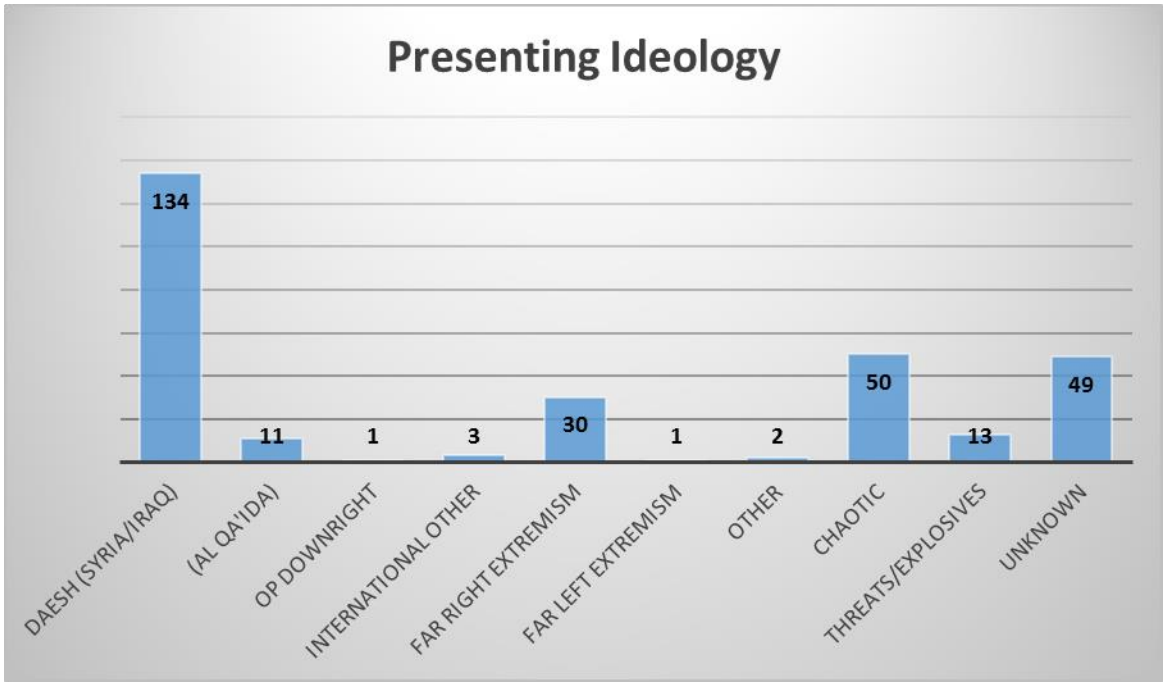
Ethnicity	#	%
IC1 White - North European	90	31%
IC2 Mediterranean - South European	18	6%
IC3 Black	56	19%
IC4 Asian (in the UK Asian refers to people from the Indian subcontinent like India, Pakistan, Bangladesh, Nepal)	102	34%
IC5 Chinese, Japanese or other (South) East Asian	0	0
IC6 Arabic or North African	26	9%
IC9 Unknown	3	1%

The most common ethnicity received by PLAD is IC4 Asian at 34% of referrals. This information has been taken from police indices, not necessarily defined by the person themselves.

2.2 Presenting Ideology

The presenting issue of referrals to CT policing focused on a range of ideologies and these have been recorded below. The ideology categories adopted by PLAD were taken from the 'Prevent Case Management' tracker used by the National CT Policing Network.

In some cases there was no obvious belief/ideology present, or the subject's beliefs seemed to be changeable. These cases were recorded as 'chaotic' under ideology and in this category PLAD received 17% referrals, see case studies for an example.



Initial presenting Ideology	#	%
International Islamist Extremism - Daesh (Syria/Iraq)	134	45%
International Islamist Extremism - (Al Qa'ida)	11	4%
International Islamist Extremism - (Op Downright)	1	0.3%
International Other Extremism	3	1%
Far Right Extremism	30	10%
Far Left Extremism	1	0.3%
Other - e.g. Anonymous	2	0.6%
Chaotic	50	17%
Threats/Explosives	13	4%
Unknown	49	17%

'International other' has covered – Sri Lankan Tigers and the YPG.

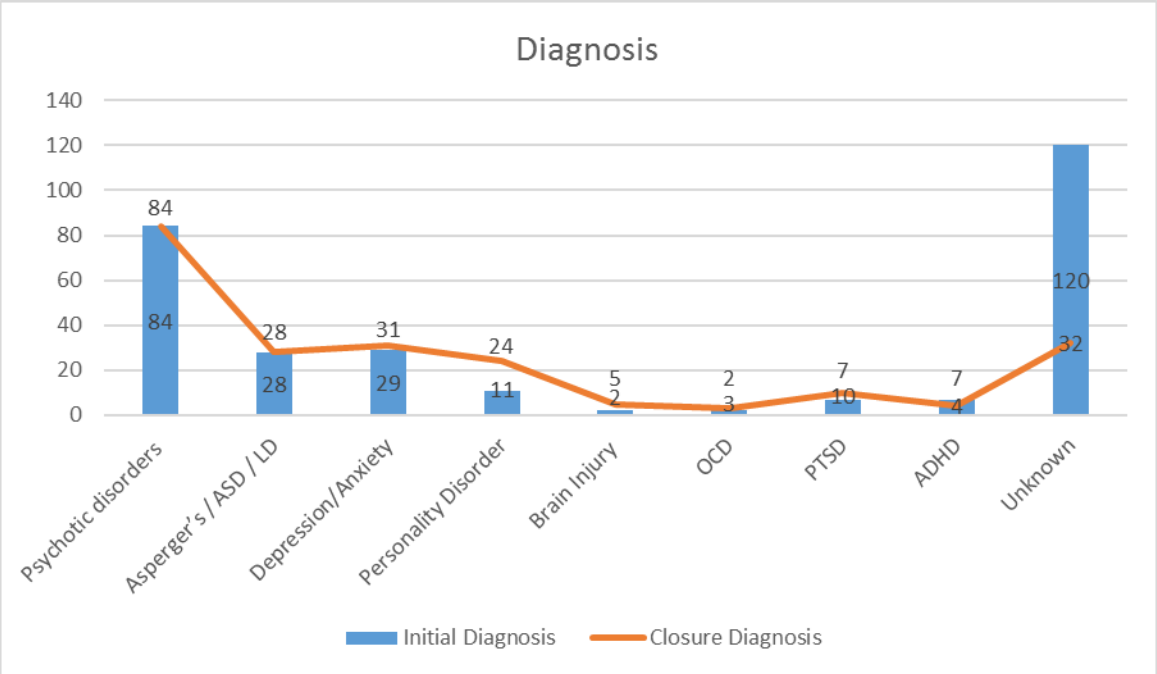
International Islamist Extremism - Daesh – of the 134: 123 were male with the most common age being 25. 83 of these cases were under the care of mental health services at the time of referral which represents 62% within the total of this group and 21% were not known to mental health services.

Chaotic – Of the 50: 46 were male with the most common age being 32. 38 are currently known to mental health services which represents 76% within the total of this group.

Far Right Extremism – of the 30: 26 were male and the average age is 32. 14 are currently known to mental health services which represents 47% within the total of this group.

2.3 Diagnosis

Diagnosis was recorded on receipt of the referral to PLAD as well as upon closure. In some cases the confirmed diagnosis was different to that noted in the referral. Clarifying the correct diagnosis or where there was no evidence of mental disorder provided important information in the ongoing management of the case.



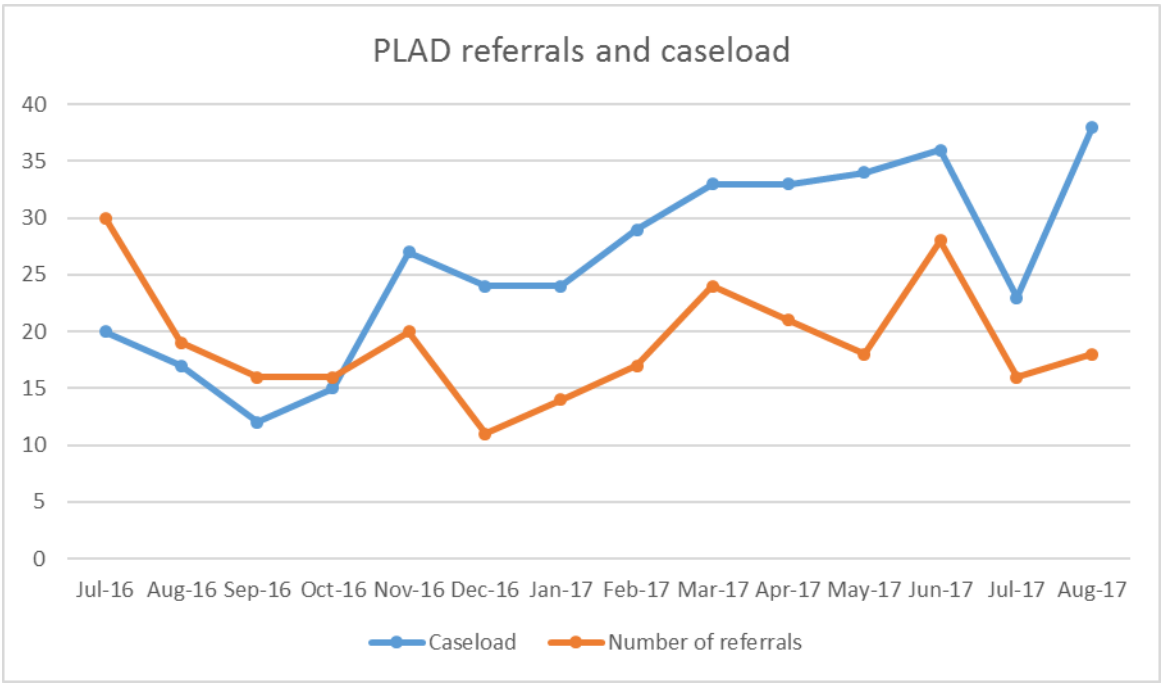
Diagnosis	Diagnosis upon receipt of	Diagnosis at closure of

	referral	referral
Psychotic disorders	84	84
Asperger's / ASD / LD	28	28
Depression/Anxiety	29	31
Personality Disorder	11	24
Brain Injury	2	5
OCD	2	3
PTSD	7	10
ADHD	7	4
Unknown	120	32

Substance dependency was not a primary diagnosis, however co-morbid substance misuse was prevalent amongst the sample.

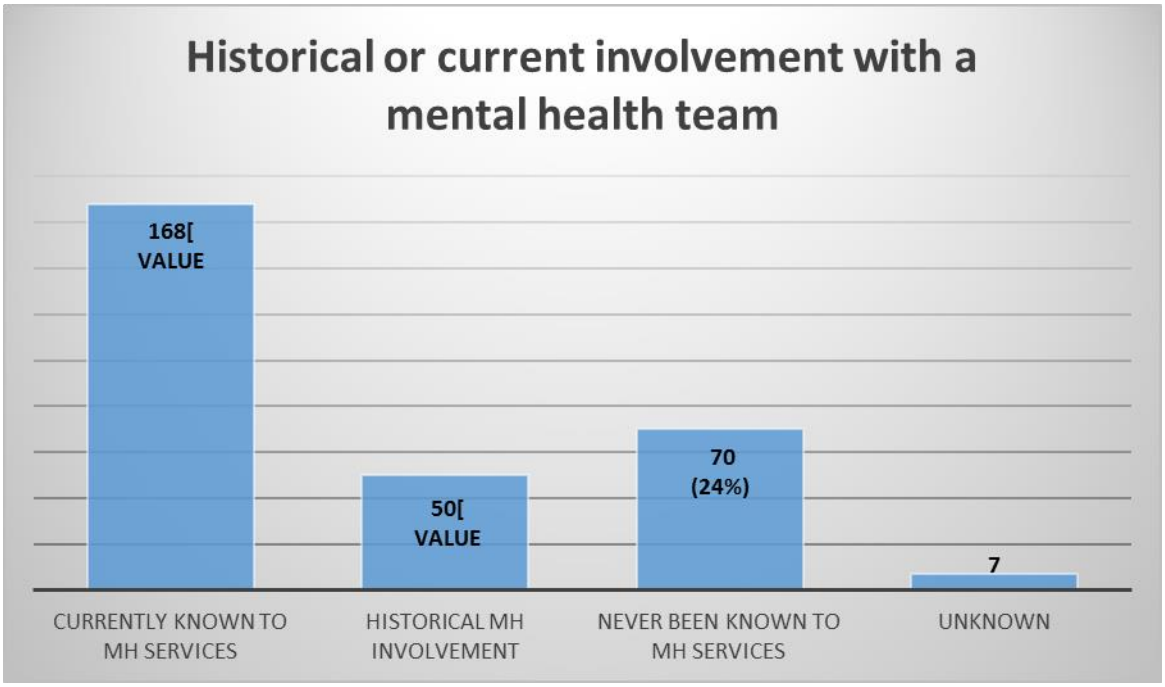
For the 120 referrals received where the diagnosis was unknown PLAD were able to reduce this to 32 at closure review. Of the 88 cases that were removed from the unknown category, 20 were assigned a formal diagnosis and for the remaining 68 it was either confirmed by a mental health service that there was no formal diagnosis of mental illness or mental disorder or due to PLAD intervention it was established that there was no evidence of mental disorder that warranted any mental health intervention.

2.4 Active caseload and referrals



2.5 Contact with mental health services

57% of cases referred to PLAD were under the care of a mental health service at the time of referral, with a further 17% having previously been known to mental health services.



Of the 57% known to MH services the highest scoring categories were as follows –

49% Daesh

23% Chaotic

10% Unknown

8% Far-right

2.6 Previous convictions

From the data we can see that there is a higher number of referrals received for individuals who held a previous conviction record.

Previous convictions	#		%
Yes	198		67%
No	74		25%
Unknown	23		8%

Of those with previous convictions, 117 are known to MH services which represents 59% of the total within this group.

2.7 Referral source

Referrals to PLAD were recorded and are as follows:

Team	#	%
JLAR	33	11%
Local Operations (Prevent)	189	64%
Investigations	23	8%
LPU	8	3%
Hostile Reconnaissance	2	0.6%
SECTU	9	3%
SWCTU	7	2%
ECTIU	7	2%
FTAC	5	1.6%
NCTPOC	3	1%
Other SO15	3	1%

Note that in 'other SO15' the three referrals were received were from FIMU. The subjects of these referrals were not being case managed by any particular police team in SO15 therefore PLAD was unable to take these cases on. As a result of advice given to FIMU colleagues, no more such referrals were received.

During Q1 and Q2 of 2017-2018, 941 referrals were made to SO15 Prevent (across London) of which 72 were referred to PLAD, 8% of total SO15 Prevent referrals. Data for numbers of Prevent referrals into the other CTUs covered by PLAD is not available.

2.8 Referrals by area

The largest proportion of referrals originated from the SO15 (covering the Metropolitan Police District, London), 241 (82%). PLAD launched service provision to this region in July 2016, about 8 months prior to the expansion of the service to SECTU, SWCTIU and ECTIU in April 2017. In addition PLAD is based within SO15 and this has enabled staff to be more visible to SO15, and will undoubtedly have impacted on the number of referrals in comparison to the other regions.

2.9 Levels of concern

As described in **1.4** above, PLAD reviews each case and assigns it a high, moderate or low concern rating which directs the level of intervention. This is completed upon receipt of a referral and again at case closure by PLAD.

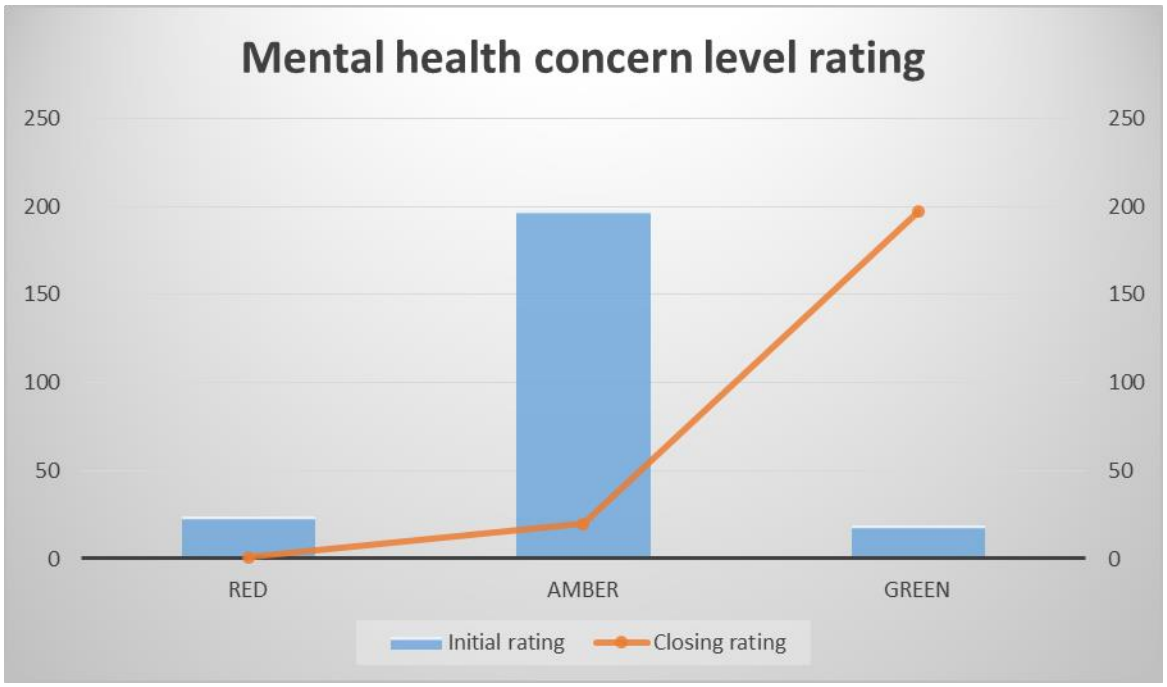
For the purposes of this report we are looking at a change in the concern level and in cases where the concern did not change or went up reviewing the reasons for this.

The majority of cases were opened at an amber concern rating and closed at a green concern rating.

To reiterate, the concern level rating at the point of PLAD case closure relates to the actions required by PLAD and does not necessarily suggest a change in the overall CT risk level the subject may pose, which is reviewed by the officer in charge of the case outside of PLAD.

In 7% of cases the rating was not closed at green and a brief review identified the following reasons for the concern level not being reduced:

- Individual was reported as missing therefore PLAD was not in a position to divert the individual into services.
- Discharged from community mental health services but PLAD still felt there was a risk present when unwell.
- Ongoing pattern of behaviour which concerned an individual's mental state.
- Sensitive information limited PLAD intervention.



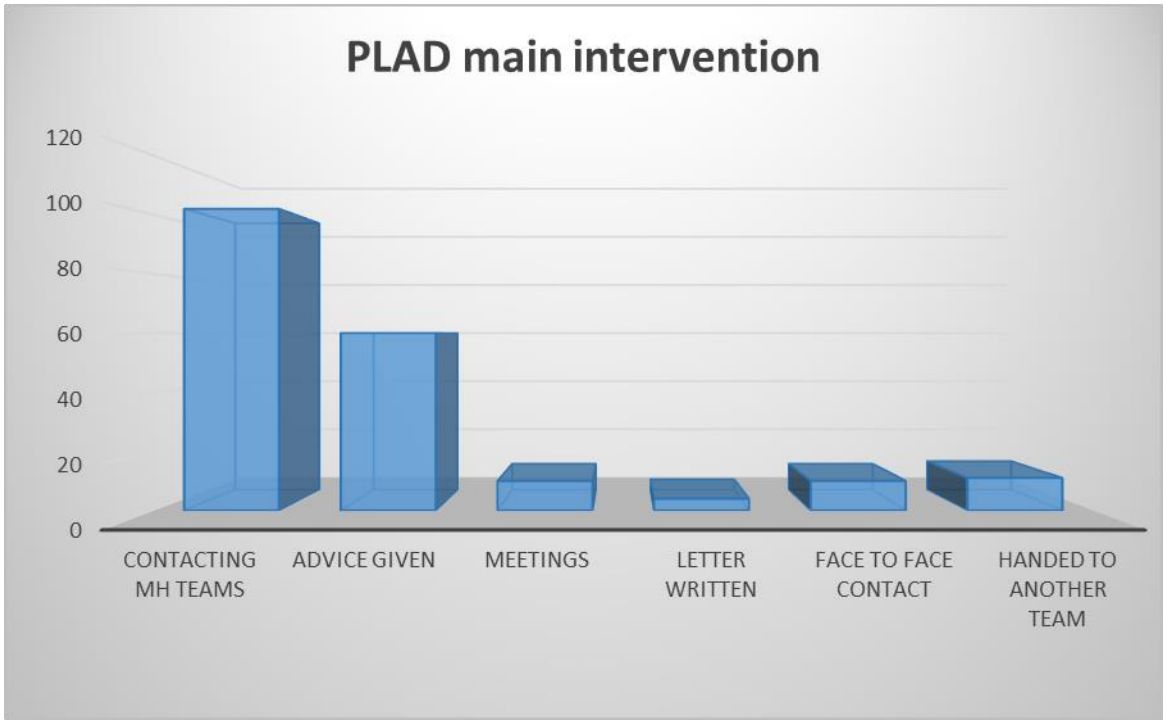
Initial rating	#	%	Closing rating	#	%
Red	24	8%	Red	1	0.3%
Amber	198	67%	Amber	20	7%
Green	19	6%	Green	197	67%

2.10 Interventions

In the majority of PLAD cases the primary intervention has been liaising with mental health professionals across the region. This has encompassed a number of methods including telephone contact, emails and face to face meetings. Appropriate information is then provided to the officer in charge of the case to assist in case management. This meets one of the primary aims of PLAD, to provide an effective liaison between health and police services.

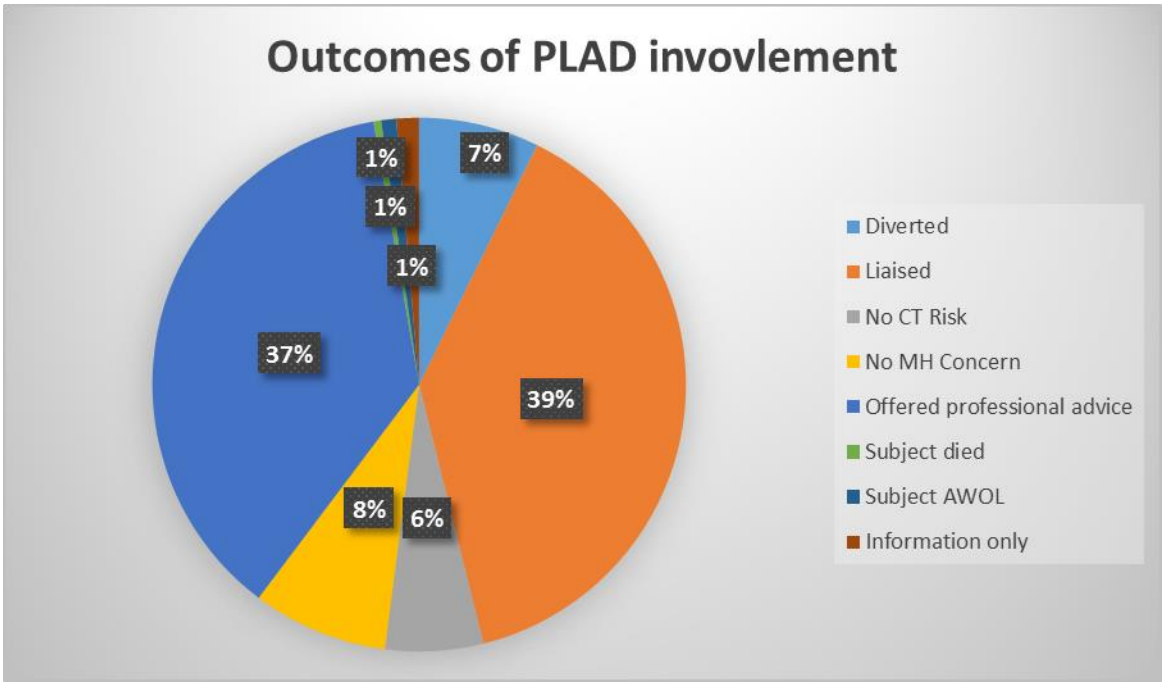
It should be noted that in the majority of cases PLAD utilised more than one intervention; this sits alongside the fact that a lot of these cases were complex and the needs changed whilst the case was open.

During involvement with cases it became clear that in a number of cases there were some service provision gaps within the health sector. The most evident is the lack of support for adults with high-moderate functioning Autism/Asperger's; notably upon the transfer from adolescent to adult services.



Main Intervention	#
Contacting mental health teams	102
Offering professional advice	60
Attending/arranging meetings	10
Face to face contact	10
Letter written to either GP or CMHT	4
Handover to another team	11

2.11 Outcomes



Outcome	#	%
Diverted	16	7%
Liaised	85	39%
No CT risk	13	6%
No MH concern	18	8%
Offered professional advice	81	37%
Patient Deceased	1	1%
Subject AWOL	2	1%
Information only referral	3	1%

Diversion in this case relates to either referring individuals into mental health services or onto a more appropriate team, such as drug and alcohol services.

Where the outcome has been recorded as No CT risk this has been because the OIC has deemed the case to require no further CT input and or the involvement of MH services has mitigated or clarified the low CT concern.

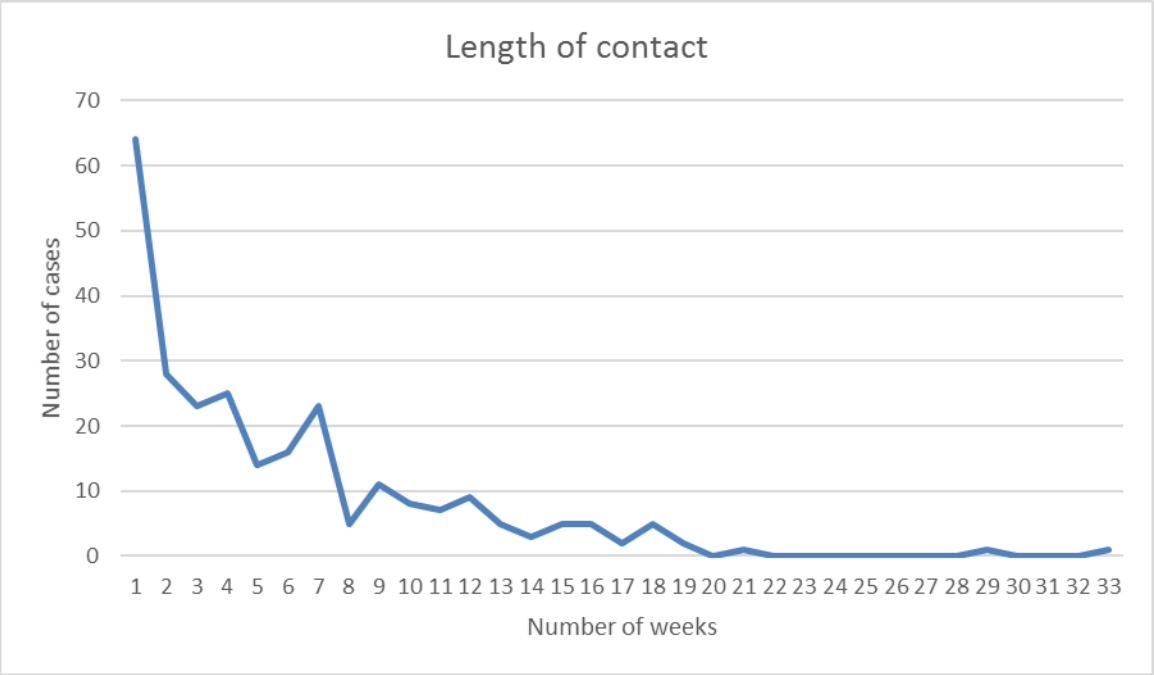
Where the outcome has been recorded as 'No MH concern' this has been either following contact with the individual, their MH team or a review of the available information and PLAD clinical staff did not feel that there was a severe mental illness present or relevant to the CT risk.

2.12 Length of contact

The range of days that each case was open to PLAD fell between 1 day and 228 days (1-33 weeks). The most common length of time to deal with a case was within one week, and the average length of contact with PLAD for the total data is 37 days, (within 5 weeks).

It was noted that there were 5 individual outliers over 18 weeks. The outliers were because the individual either experienced a breakdown in their mental state or they had come to police attention again and in both scenarios PLAD were required to provide ongoing liaison between NHS and Prevent.

There is no data available in respect of length of contact between the referring CT police officer and the subject; the data provided here relates only to period the case was open to PLAD, not to CT policing more broadly.



3. Feedback

Feedback forms were sent to a non-random sample of 60 referrers, of which 29 forms were returned, a return rate of 50%.

A copy of the feedback form and a summary of responses received from police officers can be found in the appendices. A summary of this is as follows:

- In all of these cases the feedback received was positive with statements about how useful officers found having an 'in-house' mental health team.

- Responses referred to greater confidence in decision making and risk assessment by having access to mental health professionals within counter terrorism.

- Officers reported that prior to the team existing they had experienced health professionals as somewhat hesitant in sharing potentially important information about their service users with police officers. The presence of PLAD greatly assisted in this communication.

4. Case Examples

4.1 Case Study 1

A 38 year old man who attended prominent London sites was seen to be acting in an odd manner which was potentially suggestive of hostile reconnaissance. During questions by police on these occasions he spoke about previous contact with mental health services and the officers were concerned about his presentation. Historic police checks note that two years ago the subject had been turned away on a number of occasions from Heathrow Airport attempting to travel without documents and stating that he had worked for secret services.

Given this background and the current vulnerability concerns PLAD made contact with the local mental health Trust and discovered that he was being managed under the primary care team from the GP surgery with a diagnosis of paranoid schizophrenia.

When PLAD discussed the above concerns with the allocated nurse the decision was taken to review his mental state with the psychiatrist. There was a consideration taken whether he met the criteria for detention under the Mental Health Act but the outcome was for him to be offered support with a home treatment team. This meant that he became more stable on his medication and he appeared to respond well to the engagement. The local clinical team addressed his understanding of vulnerability in the context of attending tourist sites.

4.2 Case Study 2

Police and ambulance services had received a call regarding a 58 year old man who was acting bizarrely. During this contact he made some comments which were of an extreme right wing nature.

There was a concern about the man's presentation and consequently PLAD made contact with the local mental health team who knew this man. The team reported that the extreme right wing statements were out of character because the subject was a convert to Islam. Following PLAD involvement he was reviewed by the local team and offered more intensive support and increased monitoring of compliance with medication.

4.3 Case Study 3

There were concerns about a 28 year old man in relation to potential travel to Syria. In addition there were suggestions that he had recently been detained under the Mental Health Act.

When PLAD made contact with the local mental health team they said that he had been discharged from the ward but had not been seen by the CMHT for five weeks. PLAD were in a position to disclose information about the current concerns which the local team were unaware about. They were able to make more active attempts to engage with him which proved productive and a more established routine for medication compliance was introduced.

4.4 Case Study 4

A **Section 38 Health and Safety** boy with a diagnosis of Autism was referred to Prevent **Section 38 Health and Safety** He has been referred to **Section 38 Health and Safety** services and is waiting for a psychological assessment to help review his needs and what support package can be put in place.

5. Discussion of Results

The results suggest that services such as PLAD are capable of providing valuable psychologically informed advice to CT police referrers in a responsive and timely fashion.

The primary aim of PLAD was to facilitate liaison and diversion into mental health services for individuals subject to case management by CT police officers, where appropriate, and the majority of PLAD cases have been dealt with in this way.

A further aim was to assist CT police officers in their management of their cases where there was an element of mental illness or mental disorder. The results, and case studies, demonstrate that this can also be effectively delivered.

Feedback from police officers clearly demonstrates that referrers consider the L&D service provided by PLAD to be valuable and effective.

A brief trial of screening all Prevent referrals was undertaken by PLAD police officers. The trial revealed that the cases with a mental health component not referred to PLAD were cases where effective health and police liaison was already in place. Given the increased demand on PLAD resource to undertake this exercise, and there being no clear benefit of conducting the exercise, it was the decision of PLAD to continue with service delivery of a circumscribed liaison and diversion model which has been used effectively in other areas such as court diversion, police custody and FTAC. It should be noted that the pre-PLAD referral screening exercise was not conducted by PLAD health professionals; there remains the potential that health professionals conducting the same exercise could have yielded different results.

The discourse here so far has concentrated on the benefits the PLAD service has brought to CT police colleagues. Whilst no formal feedback was sought from health professionals, there is anecdotal evidence arising from PLAD casework that there is tangible benefit to mental health professionals. PLAD liaison enables a level of upskilling for mental health professionals working with service users particularly in relation to their understanding of Prevent in a broad sense, and Prevent resources available to them through their own NHS Trust Prevent Lead, simply through direct interfacing with PLAD. It also adds an additional avenue for police information to be shared with health professionals in respect of specific service users.

Moreover, NHS Trust Prevent Leads have a responsibility to report numbers of their service users who are known to Prevent to NHS England. It is unlikely the Trust Prevent Lead would know that their service user is known to Prevent unless the Trust itself made a referral. Anecdotally, PLAD L&D has resulted in a Trust Prevent

Lead being informed a service user is known to Prevent as a result of their referral to police Prevent through a different pathway.

6. Conclusions and Recommendations

Feedback from referring police officers indicates there is value in an in-house multi-discipline mental health team such as the PLAD. Feedback also indicates the PLAD is delivering consistently against the primary aims of the pilot.

PLAD adopted a liaison and diversion model from the outset which is used broadly throughout the criminal justice system and has a clear evidence base. The liaison and diversion model has been an effective approach for PLAD casework.

Recommendation 1

It is recommended to continue with the current PLAD operating model for a number of reasons:

a) It has been demonstrated to be effective within this population
b) It fits with the current joint team resource model
c) The operating model complements existing examples of good practice, and by not duplicating effective liaison where it already exists
d) Exposing health professionals in the joint team to Prevent referrals received by CT policing at the pre-screening stage risks compromising professionals (both health and police) by blurring the boundaries between roles and functions.

PLAD recognises that an inherent risk in the L&D operating model is the potential to miss individuals referred to Prevent policing that may benefit from a health intervention, but are not directly referred to PLAD.

Recommendation 2

It is recommended that consideration is given to scoping options for mitigating the potential for missed cases, whilst taking into account the point at recommendation 1(d). Options should look at benefits of extending current practice to capture potential missed cases, how capturing missed cases would work in operation within SO15 Local Ops, whether such an enhancement to the L&D model could be achieved across all CTUs covered by PLAD, and any resourcing implications for the PLAD.

It appears that co-locating PLAD with CT policing is a key factor in the identification and referral of quality cases. This is accepted to be due to easy access to PLAD for informal contact, frequent and repeated opportunities for PLAD to present to police teams, and PLAD responsiveness facilitated by co-location. This appears to generate numbers of referrals, and also addresses the quality of referrals as CT police customers improve their understanding of how PLAD can support their case management.

Recommendation 3

It is recommended (and already intended) that PLAD will provide more of a physical presence in the regions outside of London, to raise awareness, assist with case discussion and support referrals to PLAD, through planned monthly Prevent referral meetings to the CTUs outside of London.

Taking into account recommendation 3, we are confident that we could continue to provide the current model of liaison and diversion service for SO15, SECTU, ECTIU and SWCTIU based on the current funding agreement and the personnel in post. Changes to the PLAD service model, however, could have resource implications.

Recommendation 4

It is recommended that the PLAD staffing model remain as it is currently, based on delivering the same service, with the same aims and objectives.

The ability to record and evaluate the service has been crucial but somewhat hampered by limited IT support and infrastructure. Further, current PLAD processes and recording does not provide the same level of auditing for decision-making and actions in PLAD cases as exist in other police systems used for case management.

Throughout the pilot, PLAD has been in communication with NCTPHQ (ICT Demand strand) on securing project approval and capital investment for the procurement (off the shelf or bespoke development) of a case management and reporting tool. Progress is stalled at present due to PLAD's status as a pilot, uncertainty over future funding, lack of capital investment for the pilot, and uncertainty of future operating model and governance structures. This has rendered defining user requirements for such a system impossible, which in turn means options, feasibility or costing cannot be assessed.

Recommendation 5

It is recommended that this is revisited when enough of the dependencies referred to above are resolved to enable progress.

Prevent Liaison and Diversion

London Mental Health Hub

November 2017

PREVENT In-Place

Intensive Psychological Liaison Assessment and Community Engagement

Evaluation Report November 2017

Staff name removed, Clinical Lead

PREVENT In-Place

(Intensive Psychological Liaison Assessment and Community Engagement)

Service Evaluation November 2017

Executive Summary

Background

Empirical evidence and clinical experience indicates that, as a group, Prevent / Channel referrals present with a wide range of complex mental health, psychological, neurodevelopmental, social and risk needs, including extremist ideologies and they are often managed by complicated multi-agency systems.

Based on the findings of a two year OSCT funded project and research comprising local and national data it was concluded that mental health services could not be adapted within their current criteria, remit and ways of working to meet the needs of all Prevent/ Channel referrals and, thus, a bespoke service model was required.

Service Model

The Prevent In-Place service (PiP) is a NHS-Police partnership that is commissioned by the Office of Security and Counter Terrorism (OSCT) at the Home Office and West Midlands Counter Terrorism Unit (WMCTU).

PiP is delivered by a multi professional Forensic Mental Health Team with the extensive knowledge and expertise required to assess, treat and managing high risk, high need adolescents and adults presenting with the broad range of mental health and psychological difficulties and multiple and complex needs in community, hospital and prison settings.

The service model comprises three levels of service in order to assess, understand and address the broad range of mental health and psychological difficulties and risk; Triage, Proactive Case Management and Comprehensive Assessment.

Results

68% of Triaged cases had mental health or psychological difficulties. 26% (80/302) have a diagnosable mental illness as the primary vulnerability compared to 41% with mental health difficulties are part of multiple and complex needs (mental health (*including; autism, complex trauma, personality disorder, emotional difficulties and poor impulse control*, substance misuse, poverty/ housing, offending). 35 of the 43 high risk cases presented with multiple and complex needs.

Although 43% of those with mental health needs were already known to services, new referrals to services were made (and accepted) for 44 individuals, (15%).

Key Deliverables

- ✓ Efficient, effective and lawful information sharing
- ✓ Rapid detection of wide range of mental health difficulties
- ✓ Consultancy formulations and advice regarding mental health and risk / vulnerability across CTU departments
- ✓ Efficient liaison and diversion to mainstream mental health and other statutory and voluntary organisations, including direct assessment as required
- ✓ Support and advice for crisis support and rapid response
- ✓ Agreed joint working across agencies via PCM / Channel as appropriate
- ✓ Team caseload as appropriate – complex cases managed by multidisciplinary team
- ✓ Targeted recommendations for interventions as appropriate
- ✓ In-depth assessments and formulations for both risk and mental health factors for high risk / concern cases
- ✓ Whole pathway support – from referral to exit
- ✓ Supervision and support for other colleagues and co-workers
- ✓ Training and resource development

Conclusions and Recommendations

Qualitative and quantitative evaluation of the service model indicates it is effective with respect to key deliverables including clinical, cost and risk outcomes and increased efficiencies. Key recommendations include;

- **'no wrong patient'** i.e. consideration of the full range of mental health and psychological difficulties;
- **all three levels** of assessment and formulation are required to effective mitigate risk;
- services should be **formulation based** to address complexity, with clinical diagnosis considered at each stage
- **triage** (rather than mental health screening) of **all cases** with identified CT vulnerabilities
- consultancy is not sufficient - the option for **direct assessment** is essential.
- more **intense levels of intervention** should be directed to **high risk** (rather than high need) cases.
- services should be delivered by an experienced **forensic** multidisciplinary mental health team
- teams should be **co-located** and work in partnership with existing Prevent teams.

Service Proposal for Mental Health Hubs

It is proposed that a multidisciplinary formulation based hub and spoke model is required to address the different levels of COMPLEXITY and RISK. This proposed model incorporates the 1) learning and recommendations from the pilots, 2) relevant policy, best practice and legislation from crisis and urgent care and offender mental health and 3) the national developments in the way that Prevent and Channel will be delivered (Dovetail/ RSOI's).

This comprehensive service model is designed to robustly support the mitigation of risk by providing whole pathway support. However, by allowing Channel and mainstream services to support lower risk, vulnerable individuals and targeting Prevent mental health hub resources on triage and the assessment, formulation and management of high risk / high concern individuals cases managed by PCM, it is asserted that this model will be efficient and cost effective as well as robustly managing risk and improving clinical and criminal justice outcomes for individuals.

Service Overview

Background

Research commissioned by NCTPHQ and conducted by BSMHFT used template analysis to explore the psychological and mental health needs of Channel referrals across England and Wales (n=497). Mental health and psychological difficulties were identified in 44%-59% of cases, most commonly psychosis, depression, dysregulated emotions and behaviours and social competence, complex communication difficulties or autism. 25% of the total sample were identified as having 'unmet need', i.e. they had mental health and psychological difficulties but were not known to services.

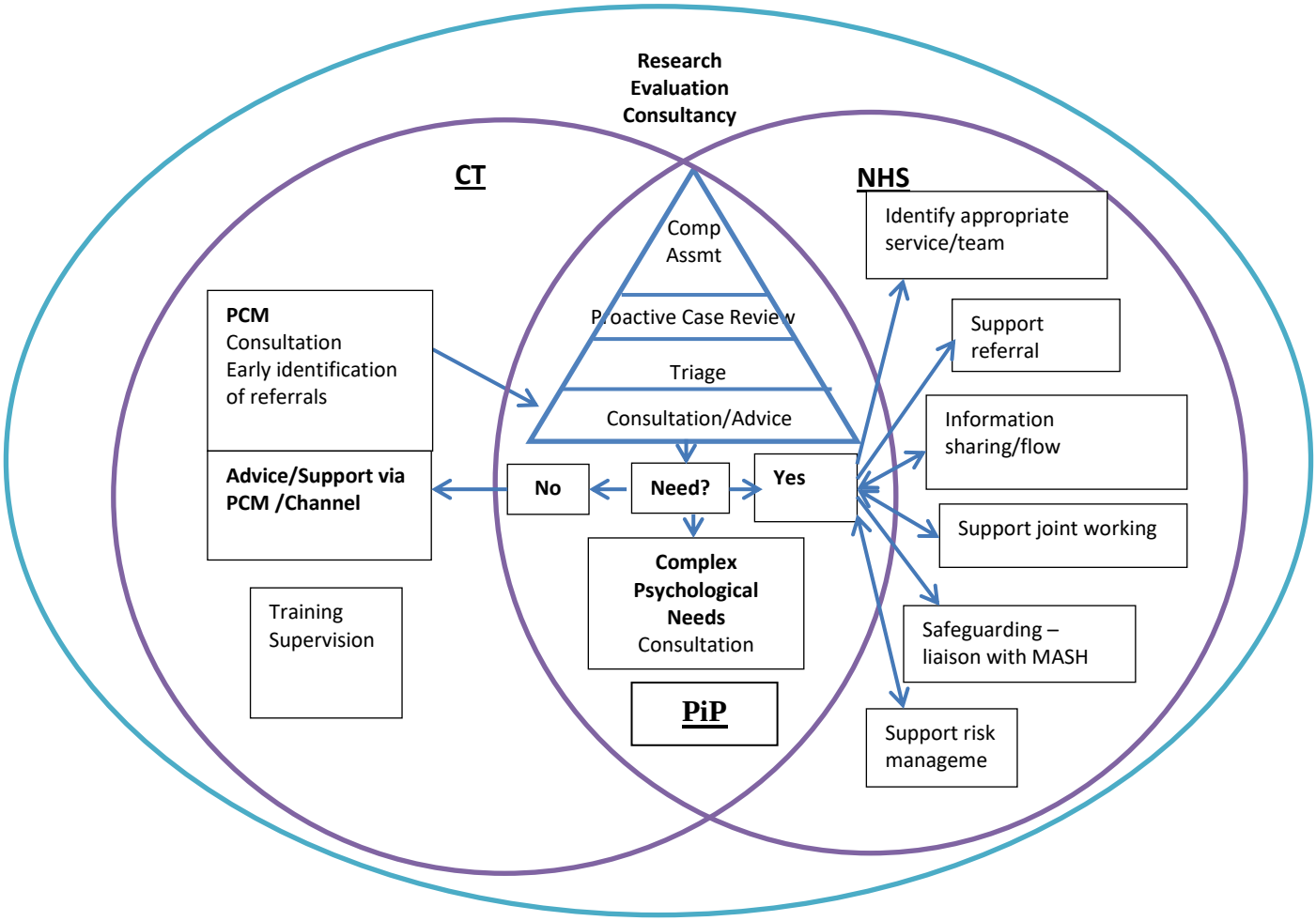
Of the group where mental health and psychological difficulties were indicated, 93% had additional complex needs (homelessness, problematic substance misuse, offending), 60% had convictions for offending and 37% had past supervision failures. Other common themes in the mental health group included childhood trauma, social and relationship instability and current stressors or periods of transition.

It was concluded that current services cannot be adapted within their current criteria, remit and ways of working to meet the needs of all Prevent/ Channel referrals as some individuals;

a) Do not meet the criteria of mainstream services,
b) Present with significant engagement issues and are, therefore, unlikely to attend,
c) Have complex social, risk, psychological and developmental needs that community mental health services are not commissioned / designed to treat or manage
d) Those presenting with the highest risk were likely to be the most challenging to engage in services

It was concluded in consultation with Health, Police and the Office of Security and Counter Terrorism at the Home Office that current service structures were insufficient and that a bespoke evidence based service was required to meet the specific needs of individuals with mental health needs that had been referred to Prevent. Prevent In-Place: a service model based on empirical evidence, learning gained from consultancy, training, and case

management and informed by policy and best practice in crisis and urgent care and offender mental health was developed and commissioned.



Further Case Review (n=127; Sept 2016 – March 2017)

In line with the research outcomes detailed above a review of cases referred to Prevent In-Place revealed two main groups.

1) Individuals for whom mental health was the primary vulnerability

These cases presented with a diagnosable mental illness and formulation indicated that mental health was directly or indirect linked to risk and vulnerability. As it was hypothesised that input from mental health services was likely to impact upon CT/ DE risk/ vulnerability (if they engaged) the main intervention required was rapid detection and assessment / referral or liaison / consultancy with mainstream MH services.

2) Individuals presenting with Multiple and Complex Needs and Risks

For these referrals mental health was one of a complex range of individual and contextual factors that **all interact** to create and impact on risk and vulnerability. While some individuals met the criteria of and engaged with mainstream services many did not and due to complex range of factors that were impacting on their risk and vulnerability input from MH services was unlikely to be sufficient. However, as with other multiple and complex needs populations this group tended to be excluded from or have ineffective contact with all services. It was concluded that they were likely to require a formulation based approach* and multiagency working .

* *** formulation** uses risk assessment and psychological theories to explain why this person is at this risk at this time and how and when this may increase and proposes hypotheses about how to facilitate change

Aims

Joint NHS-Police partnership service with the capacity to ameliorate the varied and complex psychosocial and mental health vulnerabilities of individuals identified by West Midlands Prevent Case Management (PCM), and so;

1) Mitigate CT risk

Additional aims include;

2) Identify unmet mental health need and improve health and criminal justice outcomes for individuals
3) Reduce the vulnerabilities associated with radicalisation and extremism and thus reduce potential risk to individuals and the public
4) Reduce costs through efficient partnership working, shorter durations of untreated mental illness and fewer investigations.

Objectives

- Rapid identification of the broad range of difficulties that may impact on risk / vulnerability (e.g. MH/ psychological difficulties, personality, coping styles, historical experiences, social & relationship factors). **What are the unknowns?**
- Effective liaison and information sharing with health
- Case formulation to understand the relationship between MH, psychological, developmental, social , environmental factors and how these might increase / reduce risk and vulnerability
- Identify and address unmet mental health needs that may be impacting on CT vulnerabilities (Undertake assessments, refer to, provide consultancy or catalyse response from mainstream services and third sector organisations)
- Promote effective management planning and interventions
- Provide a consultancy service to PCM/ Channel regarding complex individuals
- Research and service development; Robust evaluation, scope 'complex needs' and develop service models, further research and development of assessment tools

Relevant policy and best practice in Crisis and Urgent Care and Offender Mental Health

NHS England 5 Year Forward View

- To improve access to early identification, intervention and crisis care and ensure racial equality
- To prevent mental health difficulties by addressing broad vulnerabilities

Crisis Care Concordat

- Effective partnership working, information sharing, and consultation with Police and other partners to support individuals in accessing support before crisis point

Assertive Outreach Model for clients and services -'Safety Net

- To provide intensive, coordinated, flexible support and engagement over extended period as required and provide advice and consultancy to local services via Channel
- To monitor cases to ensure they do not 'fall through the gaps' between referral and assessment

Offender Personality Disorder Pathway Strategy - 'Then what?'

- Comprehensive assessment and case formulation of mental health, psychological, social and behavioural difficulties, complex needs and risk to support planned management and effective interventions
- Scope unmet mental health and psychological needs to develop psychologically informed intervention models

Liaison and Diversion Services

- To support the understanding of broad range of mental health and psychological issues in individuals presenting with offending / CT/ DE related behaviours via PCM
- To refer for appropriate health or social care or enable individuals to be diverted away from the criminal justice system, if appropriate.

Prevent In-Place Service Operational Structure

The service model is delivered by a multidisciplinary forensic mental health team comprising;

- psychologists (incl. Clinical Lead)
- forensic mental health nurses
- forensic consultant psychiatrists
- administrator
- clinical / forensic doctoral trainee

The team are co-located within WMCTU and work in partnership with existing Prevent / Safeguarding Officers across the hubs / regions.

Strategic and operational oversight from senior officers but local Prevent Officers retain case management responsibility, work in partnership with PiP and input to clinical team meetings.

Prevent In-Place Service Model

The service adopts a **Formulation-based approach**; recognising the evidence base that vulnerability to extremism is associated with a broad range of individual, social and

contextual factors. There are three levels of service delivery with clinical diagnosis being considered as part of the overall case formulation at each stage.

Level 1 –Triage and collaborative rating of urgency / concern
Level 2 - Proactive Case Review and case consultation
Level 3 - Comprehensive Assessments and case formulation

Regional Cover

The team provides the full service (Level 1 – Triage; Level 2 - Proactive Case Review and Level 3 - Comprehensive Assessment) across the West Midlands Region (West Midlands, Staffordshire and The Alliance (Hereford and Warwickshire). Proactive Case Review is available to the East Midlands CTU and Wales although further advice and consultancy is available on request.

The PiP team attend PCM meetings across all regions and use telephone / video conferencing facilities as appropriate. Channel Panels have input from mainstream Mental Health Services PCM retain case management responsibility for high concern cases. PiP do not routinely attend Channel meetings unless invited to specifically discuss complex or high concern cases but liaise with Prevent Officers and Prevent Leads as appropriate.

The Prevent In-Place team continue to provide advice, consultancy and ongoing case formulation for individuals that remain under PCM as required.

The team support liaison between Prevent Officers and health as required, however, where the individuals is a client of mental health services the responsibility to maintain working relationships lies with the clinical team according to the Prevent Duty. Re-referrals to PiP are accepted from PCM if circumstances change, e.g. social situation, deterioration in mental health that may impact on CT vulnerability, increase in concern.

Summary of Operational Guidelines

A summary of the clinical activities undertaken at each level of service is described below (see also Figure 1). Full details can be found in the Operational Guidelines in the appendices along with information regarding;

- governance procedures (management and contractual arrangements, Governance Board / Terms of Reference, strategic and operational oversight)
- Information Governance (Data protection, information sharing protocols (Prevent, Wider CTU, Prevent cases detailed under the Mental Health Act)
- Training and clinical supervision
- Research and service development

Level 1 - Triage and Collaborative Rating of Concern

All cases are subject to screening by police (FIMU, Referrals team) and exited from the process if deemed to be misinformed, misguided or malicious (3Med)

All remaining cases are subject to Level 1 Triage. The aim of the triage process is to support the robust and collaborative rating of concern and to determine which cases warrant further action. The Triage process (see Decision Support Tool below) is informed by the formulation based approach detailed in the Offender Personality Disorder Pathway Strategy (Logan, 2017), and aims to support defendable decision making and ameliorate the risk of false negatives (missed cases) and minimise the risk of over whelming resources with unnecessary referrals. Decision making is, multidisciplinary when required e.g. in the case of multiple and complex needs and is peer reviewed in Operational Team Meetings.

Triage Process;

i. PiP clinicians to review available information
ii. Determine current or historical involvement with MH services
iii. Collaborative case discussion (police / health) and Level 1 formulation using the 'Triage Decision Tool' (see below)
iv. RAG rating (see Operational Guidelines for details)
v. Allocate (Exit, no PiP action, Level 2 Intervention)

<table>
<tr><td>INITIAL REVIEW</td><td colspan="4">DECISION SUPPORT TOOL</td></tr>
<tr><td>Primary : CT/DE</td><td>Secondary: Mental Health</td><td>Escalation/ Change in Behaviours</td><td>Unknowns</td><td>RAG Rating</td></tr>
<tr><td></td><td>Concerns:

Protective Factors:</td><td>Yes/No/ Unknown:</td><td></td><td>RED
☐

AMBER
☐ Further Info required from Prevent
☐ Further Actions
☐ No PIP Actions
☐ Other

GREEN
☐ No Concerns
☐ Concerns Reduced</td></tr>
<tr><td>Actions/ Discussion</td><td colspan="4"></td></tr>
</table>

Level 2 - Proactive Case Review

Proactive Case Review is available across regions and involves working with cases from the point of referral and includes;

1. **Screening and Liaison** with MH services where indicated to facilitate information sharing, identify unmet needs and reduce bias in assessments due to 'unknowns'.
2. **Formulation and Recommendations** - offering an expert opinion regarding mental health and risk / vulnerability to support Police / Channel assessments and inform interventions (including discharge)
3. **Direct Assessment** – direct assessment of individuals for whom there are concerns regarding unmet mental health needs because a) they are unknown to services, b) they are not engaging with services / require more intensive engagement or c) they present with other multiple and complex needs beyond the scope of mainstream services.
4. **Further Action** - includes direct referral / supporting referrals to secondary and tertiary mental health services, initiating additional action from mainstream

services (further appointments, home visits, professionals meetings, forensic risk assessments), formal consultancy with other professionals and signposting to other agencies. Ongoing monitoring prevents individuals falling though the net unnoticed.

5. Providing **advice and recommendations** to Channel / PCM to regarding interventions and disruptions.
6. **Supporting discharge**- employing a formulation based approach to determine whether risks / vulnerabilities have been sufficiently mitigated. To support services in developing robust 'trip wires' to ensure that an escalation of vulnerability factors is identified and addressed to support a safe exit process.

Level 2 Consultancy - Specialised Forensic Mental Health Consultancy to Wider CTU.

Advice and anonymous case consultancy is offered to departments outside of Prevent (e.g. FIMU/ Investigations, TPIMs /Part 4s) including;

- Information regarding MH and psychological difficulties and possible treatments,
- MH services, referral pathways, the Mental Health Act / DOLS (Deprivation Of Liberty Safeguards)
- Biopsychosocial model - how MH and other vulnerabilities, early experience and social factors may impact on risk / vulnerability.

The aim is to provide expert consultancy / supervision to the professional (Police Officer) rather than assess the individual in line with the Offender Personality Disorder Pathway Strategy's model to support for Probation officers understand and manage high risk PD offenders. This model is believed to improve the skills, confidence and understanding of staff and improves decision making e.g. discharge or onward referral. This model also maintains confidentiality of both the Police and health service and protects Police and health professionals from breaching information governance legislation.

Level 3 - Comprehensive Assessment

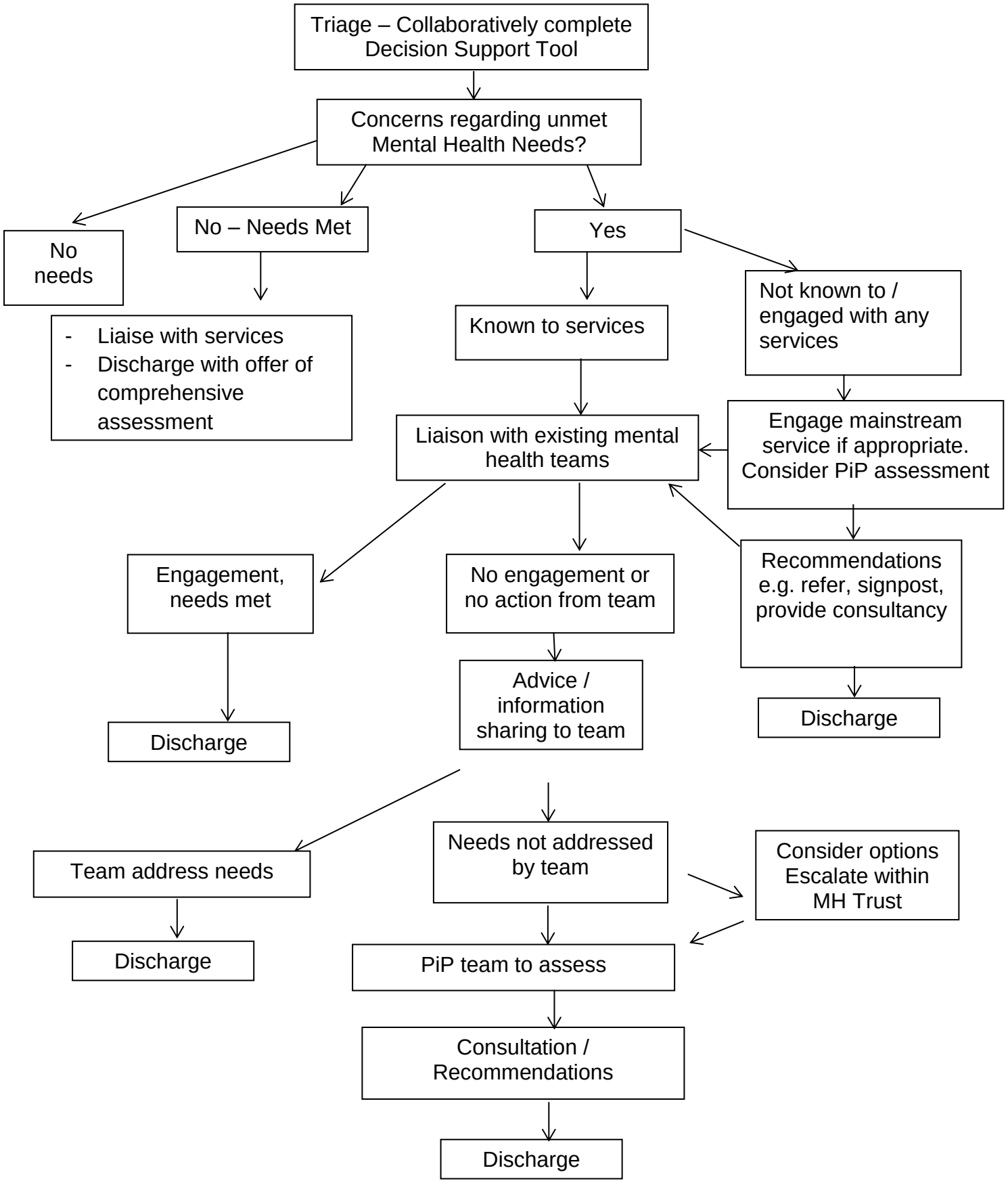
The aim of Comprehensive Assessment is apply robust risk assessment strategies and psychological theories to define an individual's likely risk behaviour and gain an in depth understanding of the broad range of risk and vulnerability factors that are impacting on an individual's CT and to propose hypotheses about how to facilitate change and manage any potential barriers (e.g. poor engagement).

It is only appropriate for high CT/ DE risk, complex cases including those that have;

- poor engagement or chaotic lives
- multiple complex needs that impact on their CT risks and vulnerabilities
- complex mental health or psychological needs but are unsuitable for mainstream services
- not been responsive to interventions from PCM / Channel / other services or interventions have not mitigated risk/ vulnerability sufficiently to support discharge

Comprehensive assessment most commonly involves direct assessment of the individual who is required to consent to the assessment and is provided with feedback. Comprehensive assessment can also be undertaken indirectly e.g. with carers if the individual is a child.

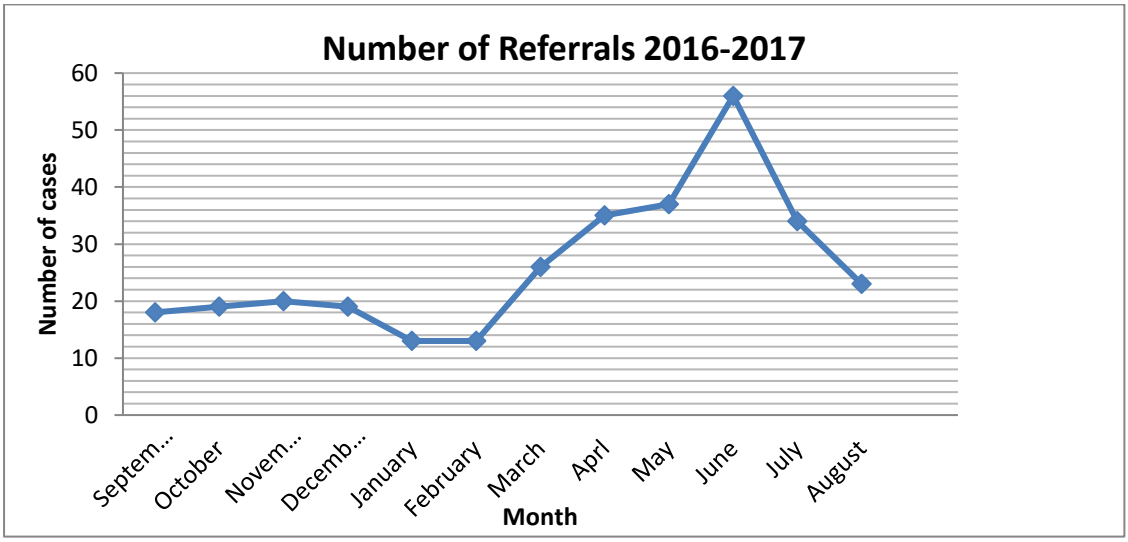
Figure 1- Triage and Proactive Case Review



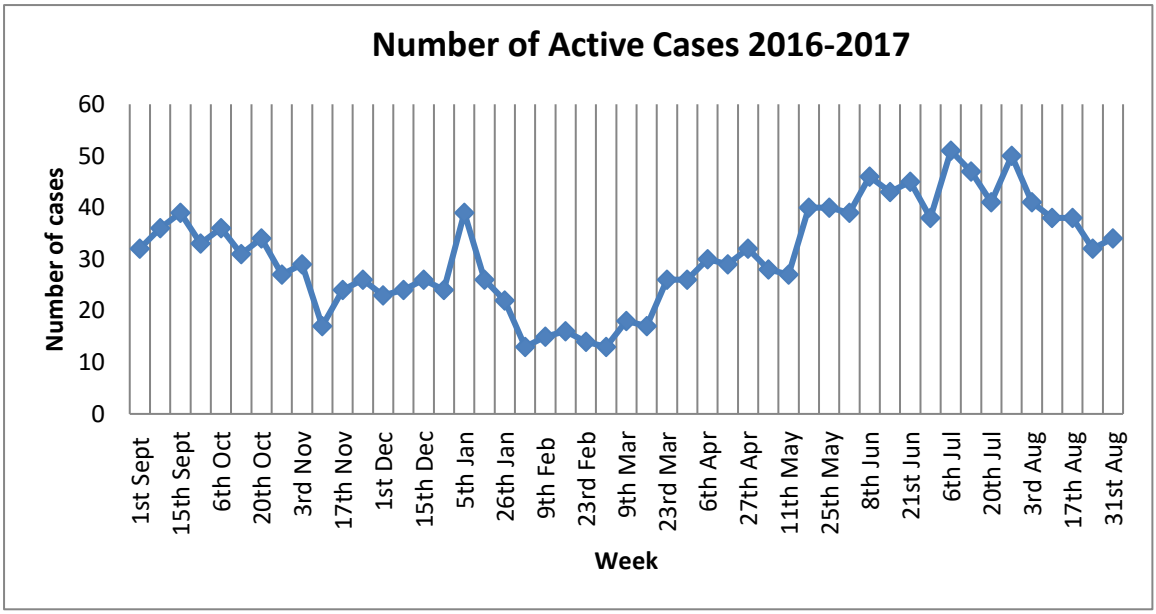
11. Preliminary Findings

11.1 Referrals

Between the 1st September 2016 and the 1st September 2017 the PiP Team received 312 referrals in total. The graph below displays how these were broken down across the months. Referrals remained constant between September – December 2016, averaging at 19 referrals a month. From February 2017 there was an s increase in the number of referrals, which peaked at its highest of 56 during June 2017.



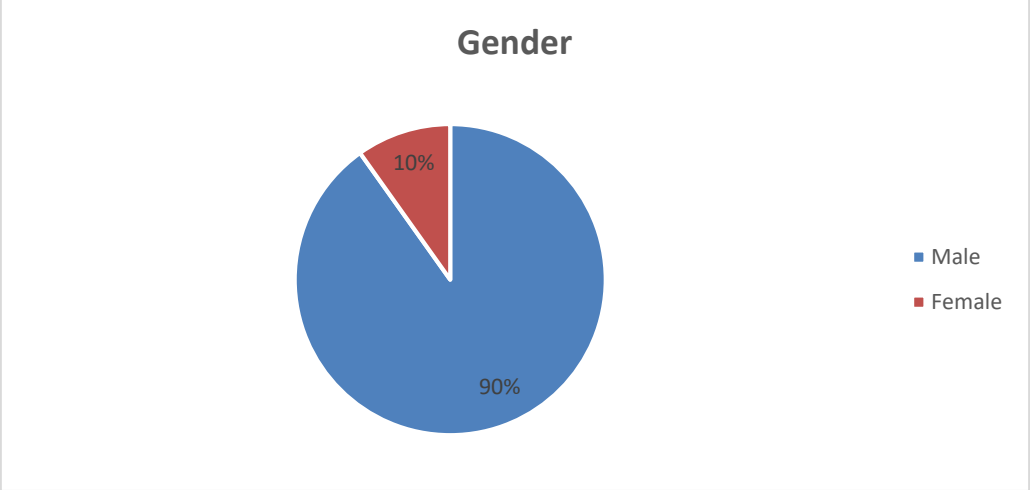
The number of active cases held by the PiP Team within this time period has been broken down into weeks and is displayed below. As the graph shows the number of active cases reduced between the end of January and the beginning of March 2017. Since then they have continued to increase.



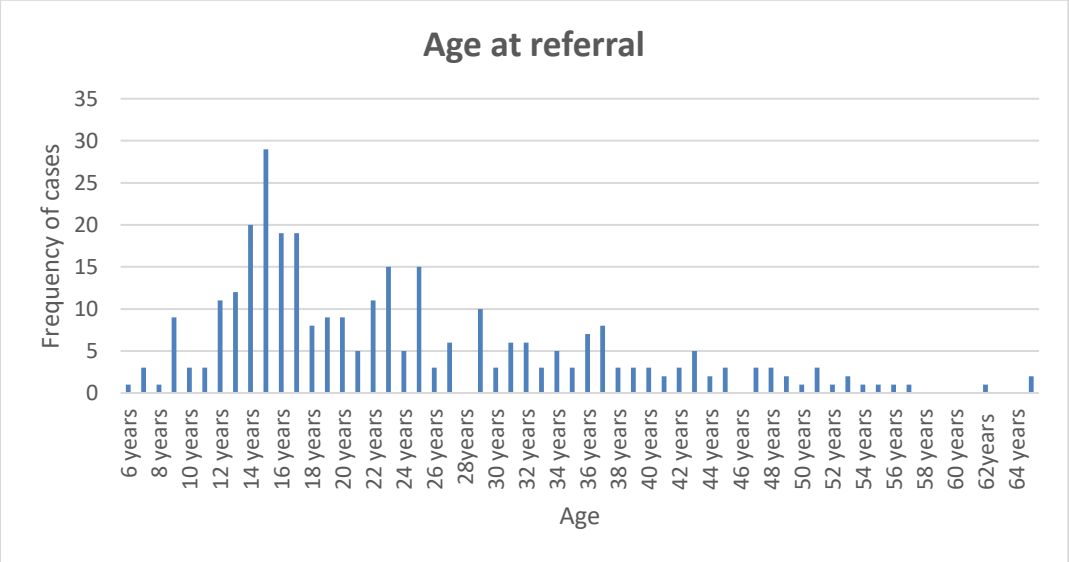
11.2 *Demographics*

The data for the 336 referrals was screened prior to the analysis taking place. During this process 8 cases were removed due to them being duplicate referrals for the same case and 2 were removed due to the source of the referral and the limited amount of information available. As a result the following findings are based on 302 cases.

90% of the all of the cases within this period were males and 10% were females.

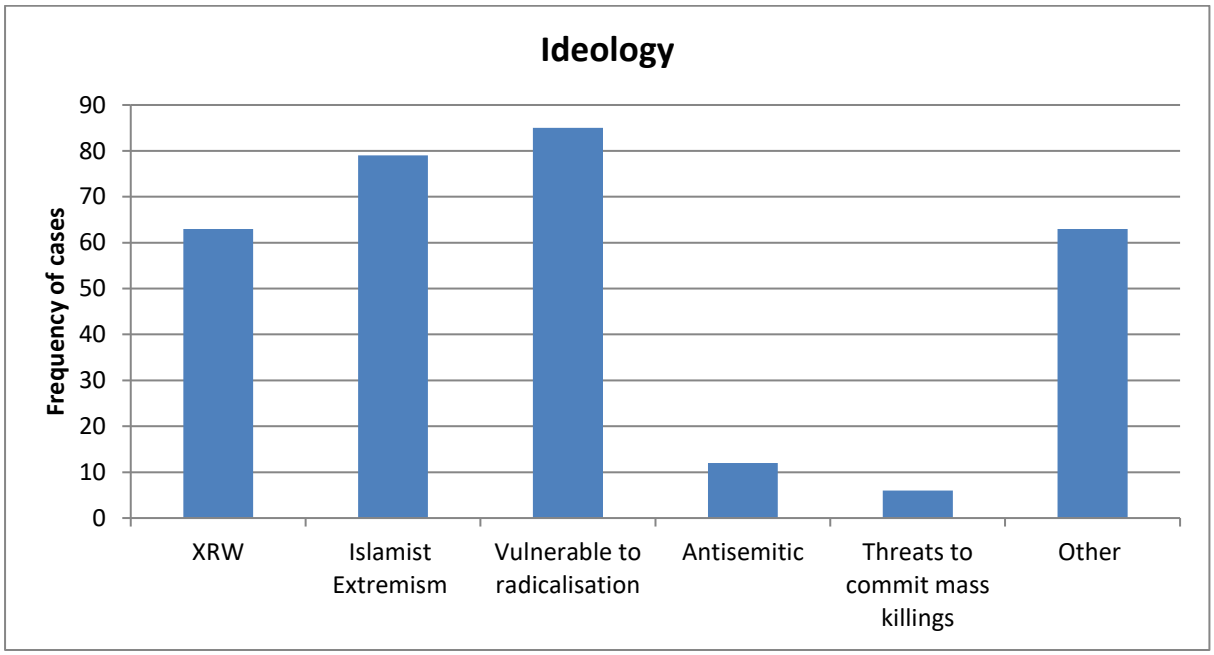


In relation to age at the time of referral it can be seen from the below graph that ages ranged from 6 years to 65 years old. The highest proportion of referrals were for ages between 14-17 years, with the highest peak at age 15 years.



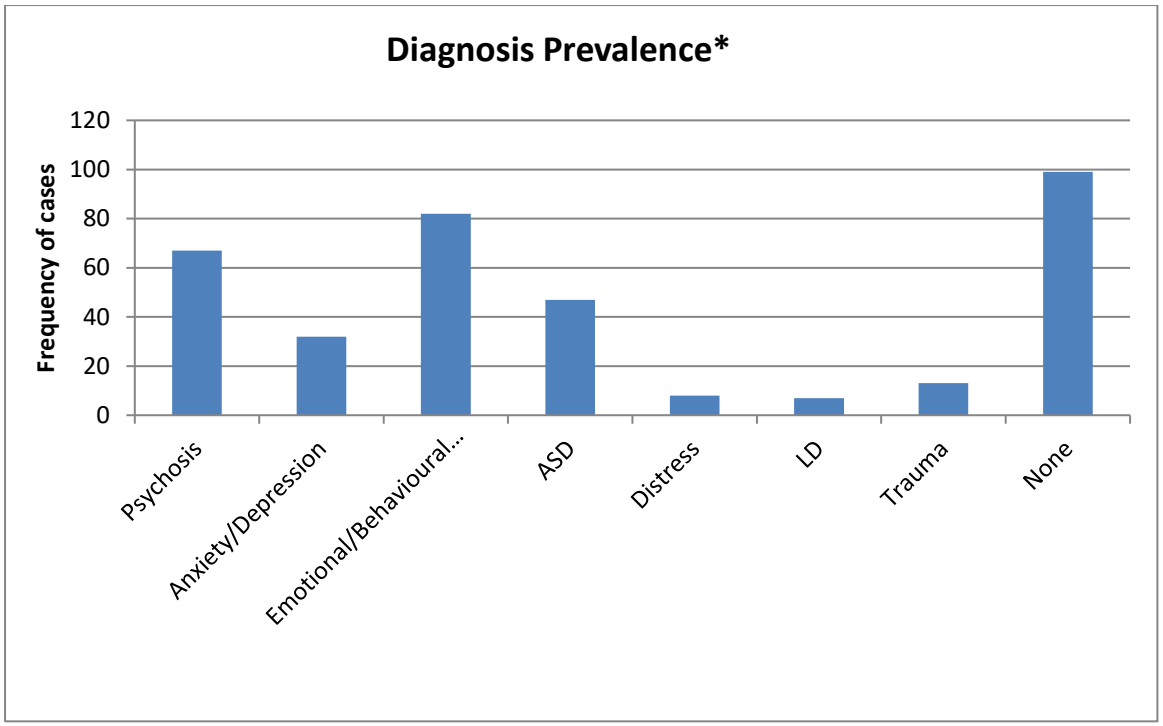
11.3 *Ideology*

The ideology of the cases was recorded and can be seen in the below graph. 79 of the cases were reported to have an Islamist Extremism ideology and 63 had an ideology of Extreme Right Wing. The highest number of cases (85) were recorded as being vulnerable to radicalisation, the direction of this ideology is unknown and could be explored further in future research.



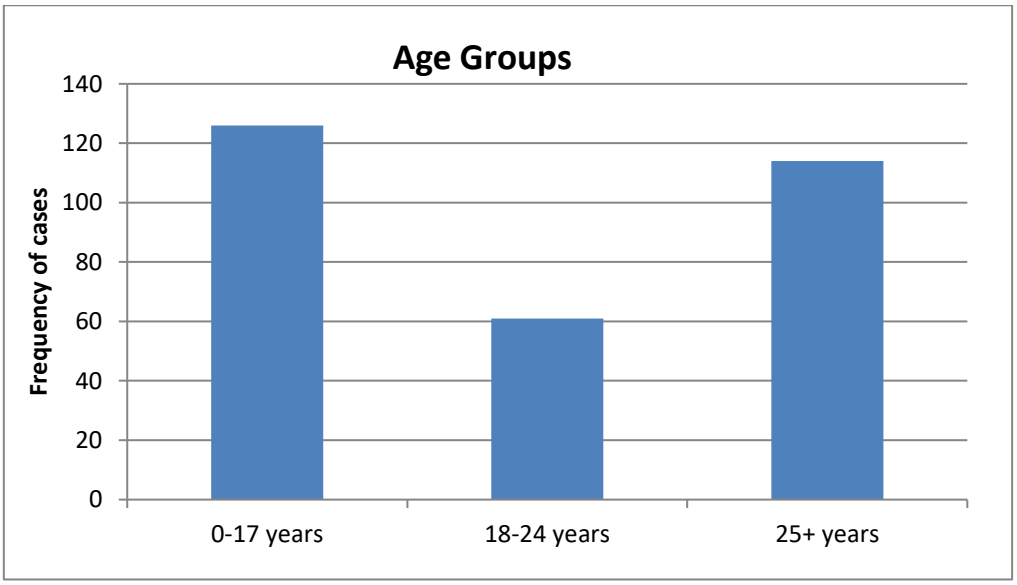
11.4 *Diagnosis*

Analysis of the 302 referrals highlighted that overall 68% had traits of a mental health difficulty following initial Triage. As the graph highlights the highest prevalence was for Emotional or Behavioural Dysregulation (individuals with difficulties managing their emotions and behaviour), which totalled 27%. Psychosis was also identified in 22% of the cases. Interestingly Distress (e.g. due to aversive life events) was prevalent in only 2.6%, which is lower than expected. One hypothesis for this may be that distress is getting misinterpreted for another mental health difficulty.

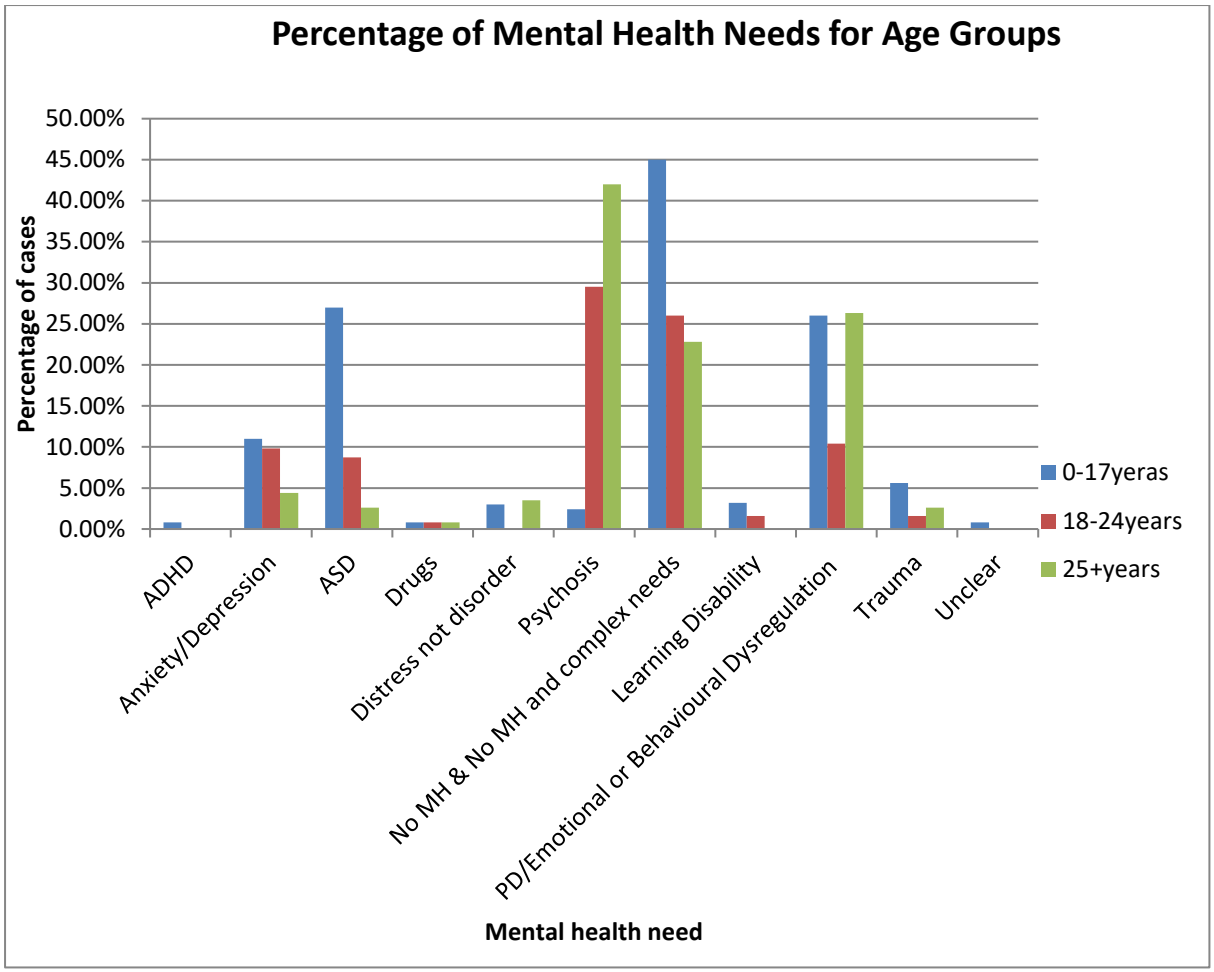


*17% of the cases had comorbidity

The data were grouped into age ranges in order to explore whether different age groups had different presenting difficulties. There were in total 126 cases in the 0-17 year age range, 61 cases in the age range of 18-24 years and 114 cases within the 25 years and over.



The prevalence of mental health needs for each of these age groups is demonstrated in the graph below.



As it can be seen form the graph Psychosis was prevalent in 42% of cases for those 25 years and over and 29.5% of 18-24 year olds, compared to only 2.4% of 0-17 year olds. Considering the onset of Psychosis is usually not until the mid to late twenties this data appears to follow this pattern. ASD is found to be present in 27% of the cases for 0-17 year olds and much lower in the other two groups. In relation to Personality Disorder/Emotional or Behaviour Dysregulation the figures are around the same for 0-17 year olds (26%) and 25 and overs (26.3%).

11.5 *Mental Illness verses Multiple and Complex Needs*

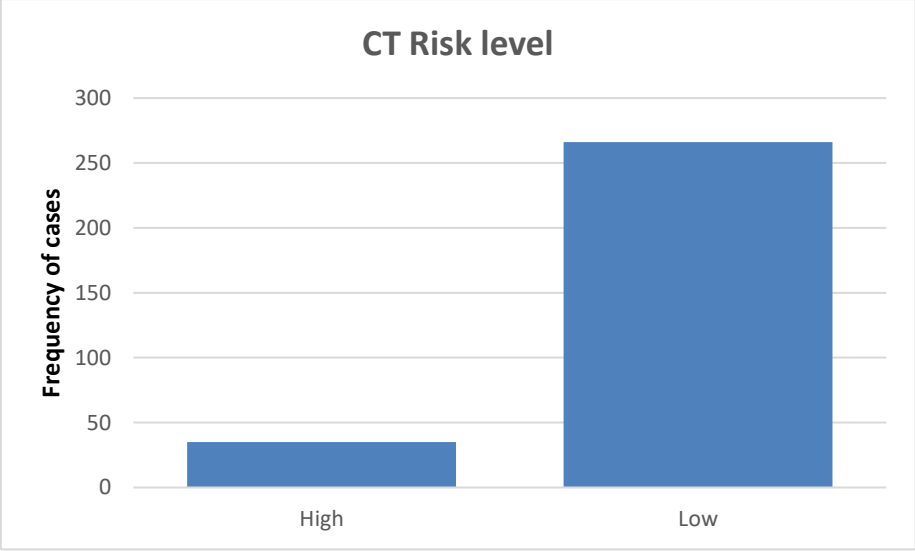
In line with the research outcomes detailed above a review of cases referred to Prevent In-Place revealed two main groups.

1) 26% (80/302**)** of cases presented with a diagnosable mental illness where formulation indicated that mental health was likely to be directly or indirect linked to risk and vulnerability.

3) 41% (125/302) of cases presented with mental health or psychological difficulties as part of Multiple and Complex Needs and Risks

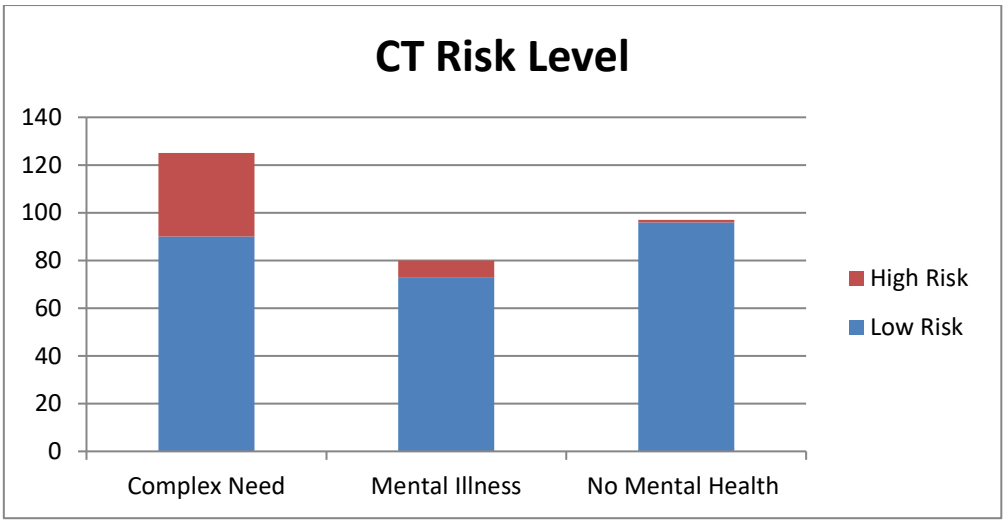
11.5 Risk Levels

The data was analysed to explore the Counter Terrorism (CT) Risk status. 226 of the cases were categorised as low CT risk.



This was explored further to identify the needs of these individuals. The graph shows that the majority of the cases with no mental health needs are low risk, with only one case categorised as high risk. For individuals with complex needs the number deemed to have a high CT risk level increases.

Of the 43 high risk cases 35 were described as complex needs.



Comprehensive Assessment

Qualitative feedback from Prevent Officers has indicated the importance of Comprehensive Assessment, most notably with individuals presenting with multiple and complex needs. See example below;

The Prevent in Place team assisted in the understanding of a young resident with exceptionally complex needs. The young man had converted to Sikhism **S38 Health and Safety**. His **S38 Health and Safety** demeanour in public and when interacting with care staff was bizarre and intimidating. **S38 Health and Safety**. This confrontation had the potential to place him and others at considerable risk. Several strategies had been employed to assist the individual including a Home Office Mentor and local religious support. He later declared that he would become a Muslim.

The Channel panel sought to understand the circumstance and condition of the young man. The PiP team met with him on several occasions and established an effective rapport. The subsequent report was invaluable for mental health professionals and social workers to understand his circumstance and to tailor a support package for him. Moreover, the report outlined in some detail the young man's difficult past which placed some context on his situation and allowed the panel to understand his other needs. Those needs extended well beyond mental health and support. The report recommended effective strategies to support the young man and signposted where the support could be sourced.

The contribution of the PiP team was invaluable in the management of this vulnerable individual. The team clarified where the support was needed and established a sound working relationship allowing the effectiveness of the on-going support to be communicated back to the panel.

11.6 Activity and Outcomes

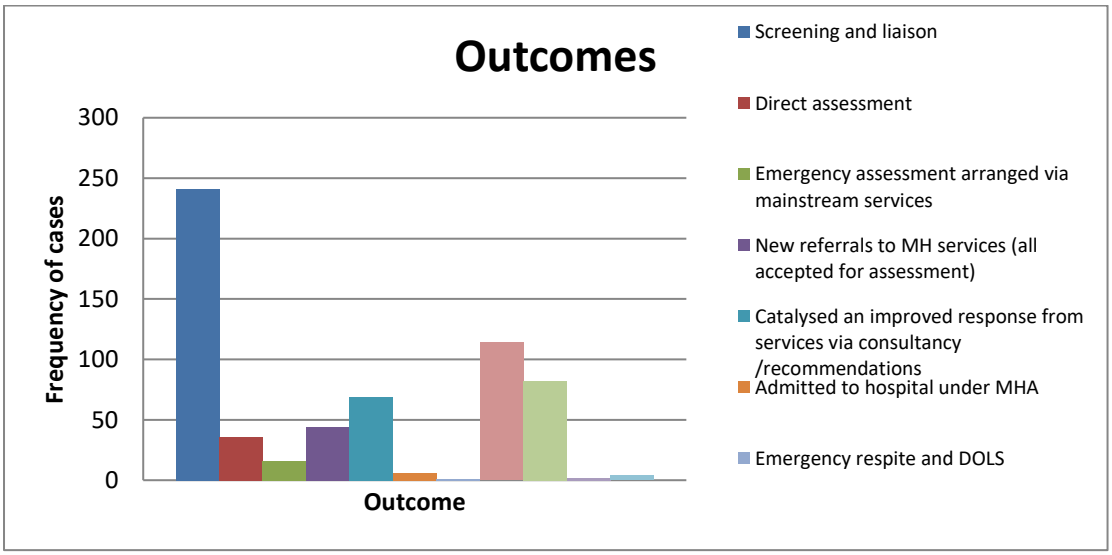
Referrals to Mental Health Services

Of 205 / 302 (68%) with identified mental health vulnerabilities;

- 132 (43%) were historically or currently known to services
- 73 (24%) had no previous contact with MH services
- 44 new referrals were made (first referrals / not currently open to a MH service)
- 35 (11.5%) were not suitable (thresholds, criteria) / refused referral to MH services

Outcomes

The final graph highlights the outcomes of the cases with specific numbers detailed in the table below. 241 of the cases went through a screening and liaison process. 1 of the cases received emergency respite and DOLS and consultation to other services (e.g. schools, prison, probation) occurred in 82 of the cases.



Activity	Number
Screening and liaison	241
Direct assessment	36 (12%)
Emergency assessment arranged via mainstream services	16
New referrals to MH services (all accepted for assessment)	44
Catalysed an improved response from services via consultancy /recommendations	69
Admitted to hospital under MHA . Emergency respite and DOLS	6 /1
Consultation to MH services/ trip wires	114
Consultation to other services (e.g. school, social services/ safeguarding, GP, prison, probation)	82
Assessment / consultation for unaccompanied minors	2
Comprehensive assessment	4

Case Studies

Examples of case studies illustrating the impact of the range of clinical activities across the levels of service can be found in the appendices.

Outputs

Additional aims and objectives of the pilot included;

a) scoping the intervention needs of complex cases that could not be met by mainstream services and
b) reviewing cases where there were difficulties / barriers to information sharing and developing recommendations for the development of robust informaiton sharing protocols.

Review of Intervention Needs for Individuals with Complex Needs

A scoping exercise explored the intervention needs of Prevent Referrals with Multiple and Complex Needs and Risks that were suitable available / accessible via mainstream services. (Dr Nicola Fowler, Birmingham and Solihull Mental Health Foundation Trust, January 2017; unpublished).

These included;

- Specialist Prevent / forensic mental health assessments of broad mental health, risk and CT vulnerability
- Engagement and stability – structured 'Life Mentoring' to create stability, promote engagement and develop adaptive / effective coping skills

- Coping and problem solving skills to address personal grievance
- Emotional / behavioural regulation skills
- Diagnostic assessments of autistic spectrum disorders, trauma, and complex mental health difficulties
- Targeted psychological interventions for individuals with a) autism and b) multiple and complex needs and c) high concern groups (e.g. military, siblings, UASC, high risk offenders) to understand and ameliorate risk
- Psychological and practical support for asylum seekers/ migrants and unaccompanied minors and their carers, e.g. in understanding and managing adjustment and trauma
- Support / interventions for individuals with CT vulnerabilities facing deportation
- Specialist trauma / bereavement therapies e.g. for UASC, migrants, siblings of individuals that have travelled to a conflict zone

It is asserted that in the absence of a service model that is able to provide interventions to address them, these complex needs represent an **unmitigated risk**.

Information Governance Protocols

Cases where the information sharing procedures where not clear have been reviewed as agreed in the WMCTU – BSMHFT contract. It has been concluded that PiP is able to work within current legislation and no legislative changes are required. Procedures have been developed to support the legal sharing of information between Police Counter Terrorism Units and NHS for Prevent referrals, wider CTU and individuals detained under the Mental Health Act.

8.2.4 *Prevent Referrals*

Information is shared under the Prevent Duty for the purposes of safeguarding the individual. Information is nonetheless sharing in accordance with information sharing legislation (e.g. relevant, proportionate, timely etc.). a detailed review of information sharing protocols for Prevent referrals can be found in the Operational Guidelines.

8.2.5 *Wider CTU (e.g. FIMU / Investigations)*

Information from Health can be sought by the Police including wider CTU departments under the Crime and Disorders Act for the purposes of supporting Police in their statutory duties, to prevent crime and pursue a conviction.

The mental health team cannot directly share information but can support CTU in requesting information from health by advising them about the use of current processes (WA170 form with s29 exemption).

The mental health team can provide specialist advice and information about mental health, mental health services and the Mental Health Act and anonymous case consultation to teams outside of Prevent. The aim of this activity is to support professionals in their assessment of risk and to consider appropriate actions rather than to directly assess the individual.

8.2.6 *Prevent Cases are detained under the Mental Health Act*

When individuals are sectioned under the Mental Health Act it is reasonable to consider whether they should be exited them from Prevent as;

a) it is sometimes difficult / inappropriate to engage them in active Prevent / Channel interventions,
b) it is unclear whether health input will be sufficient to mitigate risk / vulnerability and
c) they may be detained under the MHA for months / years thus consideration should be given to whether it is appropriate to keep them as an open Prevent case.

Conversely, it may be also be proportionate for information to be shared with CTU/ Prevent if a change in their circumstances might impact on their CT/ DE vulnerabilities, e.g. if they are discharged. However, if they are not an active Prevent case this breaches information governance legislation – health should not be sharing any information for a closed Prevent case without the consent of the individual even if this is requested.

It has, therefore, been determined that specific considerations for information sharing procedures are required when open Prevent Cases are detained under the Mental Health Act. Details of the relevant procedures can be found in the Appendices.

Conclusions and Recommendations

Key Deliverables

- ✓ Efficient, effective and lawful information sharing
- ✓ Rapid detection of wide range of mental health difficulties
- ✓ Consultancy formulations and advice regarding mental health and risk / vulnerability across CTU departments
- ✓ Efficient liaison and diversion to mainstream mental health and other statutory and voluntary organisations, including direct assessment as required
- ✓ Support and advice for crisis support and rapid response
- ✓ Agreed joint working across agencies via PCM / Channel as appropriate
- ✓ Team caseload as appropriate – complex cases managed by multidisciplinary team
- ✓ Targeted recommendations for interventions as appropriate
- ✓ In-depth assessments and formulations for both risk and mental health factors for high risk / concern cases
- ✓ Whole pathway support – from referral to exit
- ✓ Supervision and support for other colleagues and co-workers
- ✓ Training and resource development

Conclusions

The Prevent In-Place is a bespoke service model designed to reduce risk and safeguard people from engaging in extremism by understanding and ameliorating the wide variety of mental health and psychological needs of individuals referred to Prevent. It is based on empirical evidence, existing relevant policy, best practice and legislation and a robust on-going evaluation of cases and operational and clinical practice.

It is concluded that the Prevent In-Place service model is effective in order to;

1) understand and manage risk,

2) identify the broad range of mental health and psychological needs at the earliest possibly point and divert individuals to relevant services and thus improve clinical and criminal justice outcomes for individuals,
3) increase efficiency and supports effective and appropriate sharing of information
4) reduce costs, due to increased efficiencies, reduced duration of untreated mental illness, better use of resources and more targeted interventions and reduced likelihood of offences and thus costly investigations.

Recommendations

Key recommendations include;

- clarify the requires service specification – is the primary aim to identify metal illness or to mitigate risk?
- **'no wrong patient'** i.e. consideration of the full range of mental health and psychological difficulties;
- services should be **formulation based** to address complexity, with clinical diagnosis considered at each stage
- **all three levels** of assessment and formulation are required to effective mitigate risk;
- **triage** (rather than mental health screening) of **all cases** with identified CT vulnerabilities
- consultancy is not sufficient - the option for **direct assessment** is essential.
- more **intense levels of intervention** should be directed to **high risk** (rather than high need) cases.
- services should be delivered by an experienced **forensic** multidisciplinary mental health team
- expertise should be **frontloaded** i.e. knowledgeable and experienced clinicians are required to perform Triage
- teams should be **co-located** and working in partnership within existing CTU Prevent teams.

- Service development should include the standardisation of Information Governance processes, comms strategies, complaints and safeguarding procedures and IT e.g. case databases.

Clarify Service Specification

The PiP service has been developed based on the assumption that the main aim is to safeguard individuals and mitigate risk by facilitating an understanding of the impact of the broad range of mental health, psychological and other complex needs on risk and acting in partnership with Prevent Officers and other agencies (mental health services, probation, etc.) to reduce or ameliorate these vulnerabilities.

If the primary aim of the mental health hubs is to identify mental health difficulties and divert individuals to mainstream mental health services in order to improve clinical outcomes for individuals then a service model based on policy and best practice from other NHS England Urgent Care Pathway services could be adopted (Liaison and Diversion, Street Triage). In cases where mental illness is associated with increased CT risk and vulnerability then identifying and treating / managing mental health at an early stage would also reduce risk. Such partnership working has been deemed to be effective in improving clinical and criminal justice outcomes for individuals and increasing efficiencies, e.g. due to rapid detection of mental health difficulties, information sharing and access to services. However, a service model modelled on Urgent Care Pathway services and focussed on identifying mental illness is unlikely to be sufficient to mitigate risk.

Clarification regarding the service specification is essential in supporting decisions about future service development.

'No wrong patient'

Data analysis, case review and previous research studies have identified that while some people have mental health as a primary vulnerability a greater percentage of Prevent present with a complex range of mental health vulnerabilities (including mental health,

psychological, neurodevelopmental, cognitive and learning disabilities) and multiple and complex needs (mental health, offending, homelessness and substance misuse).

This complex range of individual and contextual factors **all interact** to create and impact on risk and vulnerability. Individuals with multiple and complex needs are likely to present with higher levels of risk and be subject to more disruptions yet they may or may not *meet criteria* or *engage* with mainstream MH services and input from MH services is unlikely to be sufficient.

It is recommended that individuals are not excluded from the mental health hubs on the basis of diagnosis, but that a formulation based approach is adopted in order to understand the impact of the broad range of vulnerability factors on risk / vulnerability and support effective support, management and interventions.

*Services should be **formulation based** to address complexity, with clinical diagnosis considered at each stage*

As described throughout the report, if the primary aim is to safeguard individuals and mitigate risk then identifying mental illness and diverting to mainstream services will not be sufficient. The aim should be to understand the relationship between mental health, psychological, developmental, social , environmental factors and how these might increase / reduce risk and vulnerability. Is it, therefore, essential that the service model is based on a **formulation** uses risk assessment and psychological theories to explain why this person is at this risk at this time and how and when this may increase and proposes hypotheses about how to facilitate change. The implications is that prevent mental health hubs will need to have robust knowledge and expertise of formulation with respect to **both** broad mental health and psychological difficulties **and** of risk.

All three levels** of assessment and formulation are **required to mitigate risk;

Level 1 - Triage

The aims is to support defendable decision making and ameliorate the risk of false negatives (missed cases) and minimise false positives (unnecessary referrals) and appropriate target resources. If the primary purpose of the service is to mitigate risk then the aim of the initial triage process should be to screen for the presence of the broad range of mental health and psychological difficulties, determine whether the individual is known to services and to conduct a Level 1 Triage formulation to support an assessment of concern and urgency.

**Screening vs Triage*

> *It is noted that in this context Screening and Triage represent different activities with different aims. Screening here refers to detecting whether a mental health or psychological difficulty is present. This can be achieved by liaising with mental health services, or direct or indirect assessment. Triage is an initial formulation / understanding of someone's risk and vulnerability (i.e. clarify the CT risk and supporting evidence, identify the presence of the broad range of risk and protective factors including mental health, and assess escalation and whether sufficient information is available to support a reliable assessment of risk) to decide on an initial rating of concern and urgency and to guide further actions.*

Level 2 - Proactive Case Review

The aim of Proactive Case Review is to undertake further assessment to clarify the nature, level and impact of mental health, psychological and other complex needs and to determine whether individuals are receiving the appropriate support, treatment and monitoring to address this vulnerability. A standard liaison and diversion model can be applied with some recommendations for adaptation.

1) Option for **direct assessment** is essential
2) Teams should maintain oversight of cases during the referral process to ensure individuals do not 'fall through the net un-noticed' and that concerns can be escalated. This recommendation is based on learning from a serious case review within BSMHFT.
3) Specialist consultancy for mainstream mental health services to support them in considering the impact of mental health on vulnerability and in developing appropriate care plans and establishing 'tripwires' to ensure an escalation in concern is noticed and triggers re-referral / re-engagement with Prevent.

Level 3 - Comprehensive Assessment

The definition of comprehensive assessment should reflect the aim and breath of this level of intervention rather than the method of assessment utilised i.e. a broad assessment of an individual's risks, vulnerabilities and protective factors, a formulation of a function of their risky behaviour, and their engagement in services to support the ongoing assessment of their risk and to provide recommendations for effective engagement, management and interventions with clear and goals and expected outcomes.

Level 3 Comprehensive assessment is likely to require a more intensive level of input over a longer period of time. It is therefore likely to be appropriate for individuals presenting with a higher level of risk (i.e. greater engagement in extremist groups, demonstration of CT related behaviours, high risk offenders, high concern groups e.g. unaccompanied minors/ individuals with military experience and expertise). It is likely to require a multidisciplinary and multiagency approach but case management should be retained by the Police via Prevent Case Management.

Triage** (rather than mental health screening) of **all cases** with identified CT vulnerabilities and '**frontload' expertise

Triage is arguably the stage of assessment associated with the highest risk due to the potential for a) missed cases and b) overwhelming resources with unnecessary referrals.

There are risks associated with relying on Prevent Officers to detect MH due to the range of mental health and psychological needs present in Prevent referrals and because mental health needs present differently in different populations e.g. ages, cultural backgrounds, gender. Similarly, of the 302 cases analysed 44 of these were referred to mental health services for the first time. Therefore relying on checking whether someone is currently / historically has been known to services may miss a notable proportion.

It is asserted that the triage process should be conducted collaboratively by a mental health professional and Prevent Officer for all cases where there is a CT concern following the 3m

process and furthermore that expertise should be **'Frontloaded' at Level 1 - Triage** (i.e. should be conducted by experienced and senior mental health professionals and Prevent Officers) because;

- Changing landscapes – new types of attackers with a broader range of RISK **AND** VULNERABILITY factors – requires sophisticated health and police 'eyes'
- Difficult balance between specificity and sensitivity – it is essential to avoid false negatives and at the same time minimise unnecessary Prevent referrals (overloads resources, disproportionate to subject low concern individuals to additional assessment, negatively impacts on the reputation of Prevent)
- Triage is arguably the stage with the highest associated risk. Poor triage – less efficient, less effective, less safe.
- Level 1 formulation CHANGES level and type of intervention

*Consultancy is not sufficient - the option for **direct assessment** is essential.*

The number of direct assessments has reduced overall as PiP developed robust procedures for engaging effectively with mainstream services e.g. other Urgent Care Pathway services such as Street Triage. However, it is argued that the option for direct assessment remains essential to engage challenging clients and provide safety net and to support / improve engagement from other agencies.

It is also recognised that PiP is a multidisciplinary forensic team with highly specialist expertise and that this expertise is not available elsewhere, including in regional forensic services. Although it actively supports other health and police colleagues by providing training and supervision feedback from CTU and health colleagues has illustrated how this is an invaluable resource.

*More **intense levels** of intervention should be directed to **high risk** (rather than high need) cases.*

When the level of CT concern is LOW the aim should be to safeguard vulnerable individuals by addressing their vulnerabilities via Channel / mainstream services e.g. using a liaison and diversion approach. Individuals presenting with low risk and with capacity to do so may

refuse to engage with services. It is likely to be disproportionate to undertake a comprehensive assessment or support disruptions unless the concern escalates.

Individuals presenting with a high level of concern, particularly those with multiple and complex needs are likely to require a more assertive / proactive approach. Specialist forensic MH approach to manage risk and vulnerability.

In this group **complex needs** represent an **unmitigated risk**

- E.g. autism, poor emotional / behavioural control, grievance linked to poor coping, specific groups
- Specialist multidisciplinary forensic mental health consultancy / formulation to support understanding and effective management of complex needs and difficulties that don't reach the criteria / thresholds of services

It is recommended that consideration be given to expanding the scope of the mental health hubs to include interventions

*Services should be delivered by an experienced **forensic** multidisciplinary mental health team*

Empirical evidence and clinical experience indicates that, as a group, Prevent / Channel referrals present with a wide range of complex mental health, psychological, neurodevelopmental, social and risk needs, including extremist ideologies and they are often managed by complicated multi-agency systems. Furthermore, data-analysis indicates that the individuals presenting with the highest level of CT risk are those with multiple and complex needs and commonly other offending behaviours.
Extensive knowledge and expertise is required to assess, treat and managing high risk, high need adolescents and adults presenting with the broad range of mental health and psychological difficulties and multiple and complex needs in community, hospital and prison settings.

Teams should have robust knowledge of (more detailed recommendations can be found in the Operational Guidelines);

- Mental health and mental health services
- Forensic mental health i.e. assessment, formulation, management and treatment / interventions where mental health is linked to risk / vulnerability
- Legislation that can be applied to mentally disordered offenders and multiagency working
- undertaking comprehensive forensic mental health risk assessments and formulations (inter-relationship between risk and mental health)across the broad range of mental health and psychological difficulties and risk behaviours

It is therefore, asserted that the mental health hubs should be delivered by a multi professional Forensic Mental Health Team with the breath of skills to deliver a high quality service and specifically;

- Clinical psychologist with forensic expertise / Forensic psychologist with clinical expertise
- Forensic Mental Health Nurses
- Consultant Forensic Psychiatrist
- Administrators
- Approved Forensic Mental Health / Children's Social worker

Teams will require the availability of relevant expertise and support services (e.g. legal, information governance and Comms departments) and there would be marked advantages if the team were delivered and hosted by a Regional Forensic Mental Health Service.

*Teams should be **co-located** and working in partnership within existing CTU Prevent teams.*
Experience and feedback indicates the importance of mental health hubs being co-located in CTU departments to support genuine partnership working rather than functioning as standalone teams. However, the benefits of dedicated and consistent support and strategic and operational oversight from a senior Prevent Officer cannot be under-estimated.

Standardisation of Procedures

If services are to become substantive rather than pilot services service development should include the standardisation of;

- Information Governance processes,
- comms strategies,
- complaints and safeguarding procedures
- IT e.g. case databases.

Proposal for Future Service Development

These recommendations have been incorporated into a Proposed Model for Mental Health Hubs (Dr Nicola Fowler and Dr Kay Garvey, BSMHFT, October 2017) a full copy of which can be found in the appendices. Provisional costings for the full service model across the East and West Midlands regions are included.

In summary it is proposed that a multidisciplinary formulation based hub and spoke model is required to address the different levels of COMPLEXITY and RISK. This proposed model incorporates the 1) learning and recommendations from the pilots, 2) relevant policy, best practice and legislation from crisis and urgent care and offender mental health and 3) the national developments in the way that Prevent and Channel will be delivered (Dovetail/ RSOI's).

This comprehensive service model is designed to robustly support the mitigation of risk by providing whole pathway support. However, by allowing Channel and mainstream services to support lower risk, vulnerable individuals and targeting Prevent mental health hub resources on triage and the assessment, formulation and management of high risk / high concern individuals cases managed by PCM, it is asserted that this model will be efficient and cost effective as well as robustly managing risk and improving clinical and criminal justice outcomes for individuals.

Appendices

1 - Proposed Model for Mental Health Hubs, Dr Nicola Fowler and Dr Kay Garvey, BSMHFT October 2017

2 – Case studies

3 – Operational Guidelines

Appendix 1 Case Studies of Complex Needs and Risks

WESTMINSTER COPY CAT

High Risk, Mental Health

TRIAGE

Primary (CT)	Secondary (MH)	Triggers, Escalation	Unknowns	Allocation
Behaviour on bridge / M5 Car Hx criminality	Psychosis Home treatment 136 Bank holiday Friday	Recent attack Travel New 'interests' Increased risk behaviours	Intent Motivation Influences Effectiveness of MH input	RED

PCR

Liaison with team	New behaviours but 'we known him well'. Plan - Continue Home Treatment
Formulation	Trigger for escalation and motivation unclear – *unacceptable unknown* Not possible to adequately **formulate** (understand) risk Requires secure hospital setting.
Action	Referral / escalation to secure admission and prevent discharge Advice and consultancy - effective risk assessment and management
Outcome	Admission within an hour Prompt information sharing and effective multiagency working, risk assessment and risk management

CONVERT OF MASOOD

High risk, Complex Needs

TRIAGE

Primary CT	Secondary MH	Triggers, Escalation	Unknowns	Allocation
Converted by Masood Concern from mum	Vulnerable Chaotic Sexual exploitation	Attack by Masood	MH? Known to MH services? Ideology?	AMBER

PCR

Liaison	Not known to services.
Formulation	MH impacting on vulnerability Likely to be suggestible – assess ideology
Action	Multiple referrals to MH services and escalation. Initial response deemed insufficient and inappropriate – consultancy and further escalation.
Outcome	Diagnosed first episode psychosis – appropriately treated. Now appropriate for mentoring Risk and vulnerability understood, monitored and managed

THREATENED SUICIDE BOMBER

High Risk, Complex Needs

TRIAGE

Primary CT	Secondary MH	Triggers, Escalation	Unknowns	Allocation
TACT Arrest 'Near miss'- self High risk to public	Suicidal ideation 'odd' Hx of trauma	Increased distress Index offence	Known to MH services? Ideology? Level of risk?	RED

PCR / Comprehensive Assessment

Liaison	Not known to MH services.
Formulation	Psychological difficulties and ? Mental illness Requires urgent assessment, referral and intensive follow up
Action	Strategic engagement of health (police custody, prison, hospital). Level 3 comprehensive forensic mental health assessment
Outcome	Accepted by Channel and mental health services with PiP oversight Specialist consultation to health / Police / Channel Psychoeducation and crisis planning

COMPLEX MULTI-AGENCY MANAGEMENT

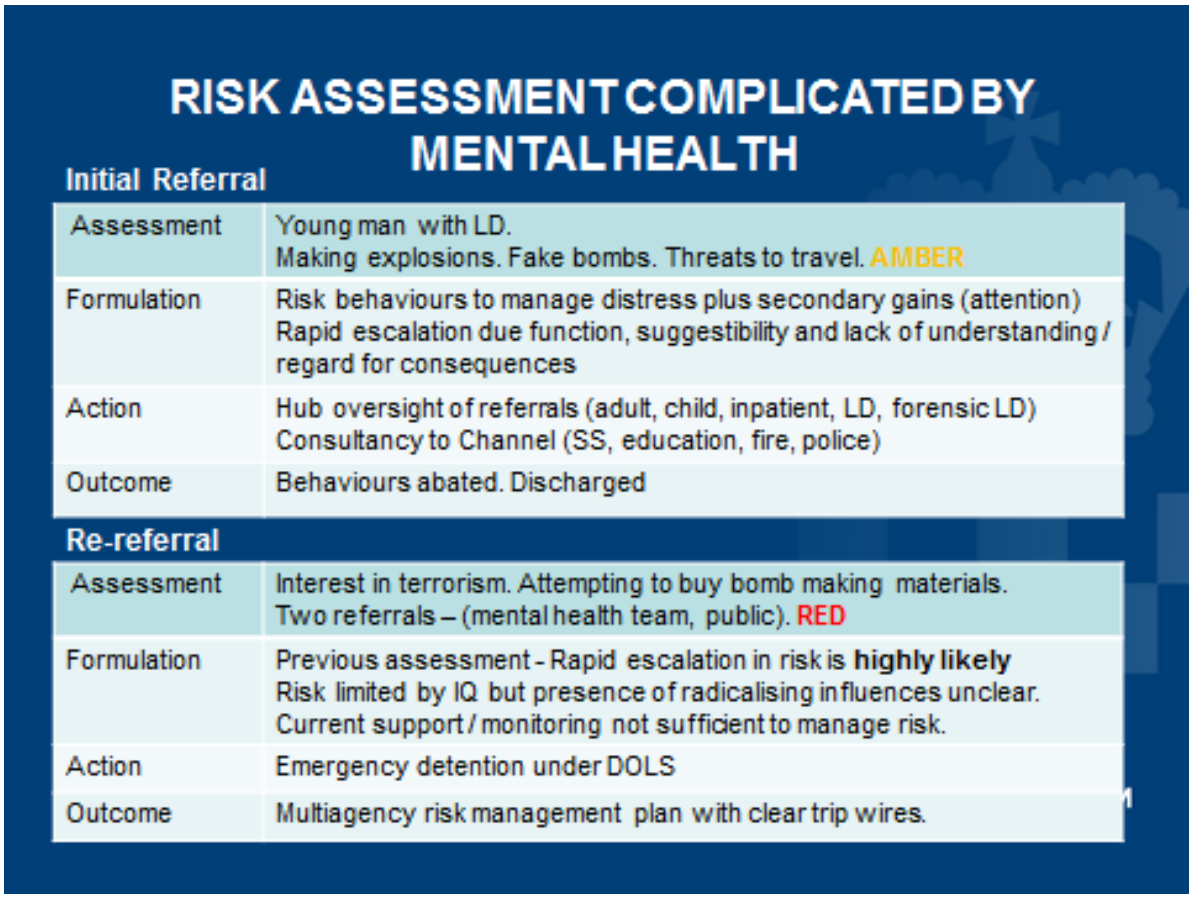
High Risk, Complex Needs

TRIAGE

Primary CT	Secondary incl. MH	Triggers, Escalation	Unknowns	Allocation
Engagement with ideology Threats with weapons	PD/ schizoaffective Offending Absconding	Deterioration in mental health Deportation	Immediate management plan	RED

PCR / Consultancy

Liaison	Actively managed by 16 teams across 8 agencies
Formulation	High risk offender – risk of imminent release to the community Lack of agreed lead agency / legislation
Action	Liaison. Expert advice and consultancy regarding appropriate processes, procedures and legislation for the management of mentally disordered offenders.
Outcome	Multiagency understanding and agreement on immediate management plan. Transfer to secure hospital. Ongoing liaison and consultancy role.



Detailed Case Examples

Case 1

Mr X **S38 Health and Safety** had a diagnosis of learning difficulties **S38 Health and Safety**

Mr X had been presenting with risk behaviours that had being increasing in frequency and severity over recent months. More specifically, Mr X **S38 Health and Safety**. He was known to be accessing and sharing extreme images and videos **S38 Health and Safety**, making threats to travel and **S38 Health and Safety** attempting to make links with extremist groups online. It was believed that Mr X was vulnerable to exploitation in the community **S38 Health and Safety**.

Prevent In-Place undertook a rapid assessment and formulation of his difficulties. **S38 Health and Safety**
The formulation indicated that Mr X was highly suggestible and vulnerable to exploitation **S38 Health and Safety**. These behaviours were reinforced directly **S38 Health and Safety** and indirectly through the responses and attention he received from others and he had limited capacity to understand the potential risks and consequences of using such strategies. It was concluded, therefore, that Mr X was likely to present a significant risk to himself and others and that his risk behaviours and engagement in extremism was likely to increase.

Based on PiP recommendations Mr X was rapidly adopted by Channel and a proactive and multi-agency approach was used in order to provide support and to introduce clear boundaries and consequences for risky behaviours. PiP was able to catalyse a referral to mental health services and to oversee his transfer between **S38 Health and Safety** organisations to ensure Mr X did not 'fall through the gaps'. **S38 Health and Safety** He was referred for intervention by the Fire Service and education supported him in accessing activities and further educational courses at college.
After 6 months all Mr X's risk behaviours have abated and he is due to be discharged from Channel.

S38 Health and Safety

Case 2

Mr X was an individual who had caused concerns for a long period of time due to the nature of the statements he was posting on social media and his history of active engagement with Extreme Right Wing groups. He was also known to Local Policing due to making threats of physical violence to others. He had been managed by **S38 Health and Safety** offered extensive sessions with a mentor. **S38 Health and Safety**. However, he had not consistently engaged and this intervention had not impacted significantly on his CT vulnerabilities / behaviour. **S38 Health and Safety** As there had been ongoing queries regarding his mental health, Prevent In-Place was asked to review the case to ensure that there were no significant unmet needs and to provide an alternative perspective to inform future support / interventions.

A PiP clinician attended with a Prevent Officer to complete an assessment of his mental health needs and to understand the function and triggers to his CT related behaviours. AB consented to and engaged well in the session.

S38 Health and Safety Although limited support was available via his housing provider **S38 Health and Safety** otherwise had ineffective contact with a number of mainstream services and had a history of being difficult to engage.

S38 Health and Safety

The Prevent In-Place team facilitated a referral to mainstream mental health services for assessment. **S38 Health and Safety** He was offered bereavement counselling and support from drug and alcohol services, although it was acknowledged that he was unlikely to be able to effectively engage.

The improved understanding of the context and function of Mr X's CT related behaviours has significantly aided his management by PCM and the Local Policing Unit. AB's activity is now monitored and disruptions will only be considered if there is an increase in his engagement or activity. However, there continues to be clear unmet needs that are likely to be acting as significant vulnerability factors to further engagement in extremist behaviours.

Rapid Identification of Unmet Need, Liaison and Diversion to MH services

Case 3

Mr X was referred to the Prevent-in-Place Team following concerns that he was **S38 Health and Safety**, and making inflammatory and threatening statements. There were concerns regarding his behaviour, and general presentation.

A PiP clinician attended a joint visit with the Prevent Officer to complete an assessment of Mr X's mental health needs. **S38 Health and Safety** the PiP clinician was able to gather information and facilitate the arrangement of a new GP. Via liaison with the GP, a referral to secondary mental health services was made and a diagnosis of First Episode Psychosis was made. Mr X is now engaging with mental health services, and receiving treatment for psychosis.

This is a case which highlights the need for flexibility and creativity, when an individual is not able to engage fully in an assessment. The negative consequences of untreated psychosis are well documented, in terms of the long term trajectory of the illness and the negative impact on an individual's functioning. Being able to identify needs swiftly, is a vitally important and has clear benefits for an individual's future mental health. It also reduces costs as it enables Police resources to be used more effectively as this individual was rapidly identified and diverted away from Prevent and to MH services.

Case 4

Mr X was referred to the Prevent-in-Place team following concerns about his mental state, behavioural difficulties and accessing extremist images **S38 Health and Safety**. On reviewing his case further, he had been previously been assessed by **S38 Health and Safety** mental health services but had not met the criteria for any of them or signposted further.

A PiP clinician reviewed his case file, offered consultation to Prevent Officers and conducted a joint visit to Mr X. Over the course of **S38 Health and Safety** assessment visits, during which the PiP clinician interviewed **S38 Health and Safety**, a comprehensive psychological assessment was completed. The clinician liaised with previous services, **S38 Health and Safety** and the PiP clinician has made a referral to **S38 Health and Safety** service to offer Mr X and his family appropriate support.

Mr X completed a feedback questionnaire and stated **S38 Health and Safety**

This is a case whereby an individual with clear emotional difficulties and needs was "slipping through the net" of mainstream services. The PiP team was able to offer a consistent and comprehensive approach to assessment across his whole range of needs and act as a conduit to him accessing the appropriate service. Prevent In-Place was also able to offer a formulation (an understanding of what was driving/ underpinning) of the behaviours that had cause concern from a CT perspective and this case was rapidly discharged from PCM.

Reducing Risk by Reducing Demand on Police Resources

Case 5

Mr X was referred to the Prevent-in-Place Team following concerns that he had converted to Islam in prison, that he was behaving bizarrely and that he had a history of threatening behaviour **S38 Health and Safety**. This referral was presented as an urgent referral **S38 Health and Safety**

A PiP clinician reviewed his case file, and arranged to visit jointly with the Prevent Officer and Local Policing, the following day. The PiP clinician was able to complete the assessment with **S38 Health and Safety** Mr X **S38 Health and Safety**.

This is a case which highlights the responsiveness of the PiP team, and the benefit of being imbedded within the Prevent Team. PiP were able to review the case swiftly, and complete an assessment in a responsive manner. Our knowledge of the Care Act also allowed us to utilise existing care pathways **S38 Health and Safety**.

Case 6

Mr X was a 25 year old male with a history of substance misuse, violence and criminality. **S38 Health and Safety**

A rapid assessment by the Consultant Forensic Psychiatrist on the PiP team revealed no diagnosable mental disorder or concerns about his wider mental health and recommended that he was managed via the criminal justice system.

Prevent Officers reported that prior to PiP, they had dedicated significant time and resources to obtaining mental health assessments for individuals and without such assessments struggled when assessing and managing individuals risks and vulnerabilities.

Appendix 2

Proposed Model for Mental Health Hubs

Staff name removed and Staff name removed,

BSMHFT October 2017

1.1 Core Purpose

1) To mitigate CT risk.

Additional Aims

1) Identify unmet mental health need and improve health and criminal justice outcomes for individuals
2) Reduce the vulnerabilities associated with radicalisation and extremism and thus reduce potential risk to individuals and the public
3) Reduce costs through efficient partnership working, shorter durations of untreated mental illness and fewer investigations.

1.2 Required Scope

- Safeguarding vulnerable individuals (Dovetail)
- Identification, risk management and intervention / diversion of high risk, pre-criminal cases (PCM)
- RSOIs (Clearing House)
- Supporting other CTU functions e.g. FIMU, investigations, training / supervision

2.1 BACKGROUND

Data - West Midlands Mental Health Hub (Prevent In-Place; Sept 2016-Sep 2017)*

**Due to the design of the service model, data in the WM hub includes all cases referred to Prevent.*

44% - misguided, misinformed or malicious.

56% (302 cases) subject to mental health triage;

1) 68% presented with a mental health or psychological difficulty (17% have more than one diagnosis)
    - 27% Personality Disorder / emotional or behavioural dysregulation
    - 22% Psychosis / bipolar
    - 11% Anxiety / depression
    - 16% Autism/ autistic traits
    - 5% Trauma
    - 2% Learning Disabilities
    - 3% are experiencing significant distress (due to life events) that impacts on their day to day functioning
2) 26% (80 cases) have a diagnosable mental illness as the primary vulnerability
3) 41% (125 cases) have **multiple and complex needs** (mental health*, substance misuse, homelessness, offending).

*Mental health' also includes; autism, complex trauma, personality disorder, poor impulse control (risk to self and others). Mental health services are commissioned to treat 'mental illness' rather than poor mental health.

2.2 Multiple and Complex Needs and Services

Individuals with multiple and complex needs;

- are often excluded from or fall between the gaps in all services (do not meet thresholds for single agencies)
- have ineffective contact with services due to poor engagement and no single agency having responsibility for coordinating interventions

A standard model could have referred 80 individuals into mental health services, 125 will have been missed.

2.3 Multiple and Complex Needs and Risk

64% of offenders have multiple and complex needs (mental health, offending, substance misuse and homelessness; Lankelly Chase Foundation, 2015) and a significant proportion of crime is committed by offenders with multiple problems (Breaking the Cycle, MoJ, 2010)

Managing multiple and complex needs and risk requires a ***psychological formulation based approach*** (Offender Personality Disorder Strategy Pathway, 2015).

2.4 Mental Illness, Multiple and Complex Needs and CT Risk

Mental illness and complex needs are increasingly prevalent in TACT offenders.

42 of 302 cases were deemed HIGH RISK (engagement, behaviours, subject to disruptions);

- 35 of these had multiple and complex needs,
- 7 had mental illness as the primary vulnerability.

PCM September 2017 – 13/15 high risk cases were active to WMCTU Mental Health Hub.

3.1 Proposed Model

The service adopts a **Formulation-based approach** to consider the impact of a broad range of individual, social and contextual factors on risk. There are three levels of service delivery with clinical diagnosis being considered as part of the overall case formulation at each stage.

Level 1 –Triage and collaborative CT/ health rating of urgency / concern

A collaborative formulation based TRIAGE process is employed to identify risk and protective factors and determine trajectory / likely escalation. This mitigates the risks associated with the use of static risk assessment processes (presence of vulnerability factors) and thresholds and lack of relevant information to avoid missed cases and minimise unnecessary referrals.

Level 2 - Proactive Case Review and case consultation

Activity to ameliorate mental health difficulties that impact on CT risk and support mainstream services in meeting these needs. Includes liaison, indirect and direct assessment, referral to mainstream services and case consultation to other agencies.

Level 3 - Comprehensive Assessments and Intervention

Level 3 Assessment and Intervention considers the broad range of multiple and complex risks and needs and interventions for risky, complex cases, high risk groups (e.g. high risk offenders, UASC, RSOIs) or where interventions have failed to mitigate risk.

3.2 Complexity and Risk – Hub and Spoke Model

A hub and spoke model is proposed to address different levels of COMPLEXITY and RISK.

3.2.1 Supra-Regional Hubs

Supra-Regional Hubs will provide a specialist formulation based service for complex, high risk PCM / MAOC cases. The hubs will act in a CONSULTANCY CAPACITY to Prevent Case Management, CTUs and NCTPHQ. Case responsibility will be retained by PCM and referrals will be accepted from PCM, regional hubs and from the Clearing House via PCM as appropriate.

The multidisciplinary team will;

- Provide specialist case consultancy including expert knowledge of the range of procedures and legislation that can be applied to the management of mentally disordered offenders
- Act as the mental health 'doing arm' for PCM/ MAOC
- Apply risk and psychological models to support the multiagency risk assessment of RSOIs and high risk Prevent referrals and to provide anonymous case consultation to the Investigations departments.
- Deliver Level 2-3 service for risky/ complex cases and high concern groups (UASC, RSOI's, high risk offenders) managed by PCM and to Channel cases where there is an escalation of concern
- Use risk/ psychological models to understand how complex needs impact on risk and inform the development of bespoke PCM/ multiagency intervention plans
- Ameliorate risk by providing specific interventions unavailable/ inaccessible via mainstream services.

Specific interventions will be evidence based and bespoke to the individual requirements of the case. Based on previous work scoping the intervention needs of complex cases (see appendix 4), these are likely to include;

- Comprehensive forensic mental health risk assessments conducted by a highly specialist multidisciplinary forensic mental health team
- Diagnostic assessments; e.g. mental illness, autism, trauma.
- Stabilisation and engagement
- Time limited therapeutic interventions, e.g. psychoeducation/ formulation, emotional regulation and crisis planning,
- Structured, bespoke 'Life Mentoring' for individuals for whom life stressors, poor coping and limited social support is associated with greater vulnerability / increased risk e.g. in maintaining a personal grievance.
  (see https://kar.kent.ac.uk/62657/1/Executive%20Summary%20RA%20Final.pdf)

Partnerships will be developed with third sector organisations where appropriate (e.g. specialist trauma therapy services).
These hubs should be hosted by forensic services and comprise of a multidisciplinary mental health team (dedicated Prevent Officer, Clinical / Forensic psychologist, Forensic Mental Health Nurse, Consultant Forensic Psychiatrist, Social Worker, life mentor (graduate mental health worker)) with specialist expertise in required areas (e.g. forensic Adult and CAMHS mental health legislation, assessment, management and intervention of high risk offenders, complex needs, autism, trauma). It is expected that one whole time equivalent clinician will hold a caseload of 6 at any one time.

Supra-regional hubs may be aligned according to priority areas or the location of MAOCs. Supra-regional hubs may provide support across a number of PCM areas.

3.2.2 Regional Spokes

The supra-regional hub will support regional 'spokes' where forensic mental health practitioners will;

- Provide Level 1 Triage of all cases remaining further to 3Ms assessment in collaboration with Prevent Officers.

- Provide Level 2 (Proactive Case Review) to effectively safeguard lower risk cases as appropriate
- Support local delivery of Prevent / Channel in line with Dovetail
- Identify and refer complex / high risk, high need individuals to supra-regional service

Regional spokes should be hosted by regional forensic services and Forensic Mental Health Nurses and clinical / forensic psychologists are required to address the range of need and complexity. One whole time equivalent clinician = 8-10 referrals per week.

4.1 Strategic Planning and Management

A strategic leadership team will be required to ensure robust governance (e.g. information sharing protocols), effective service delivery (KPIs, ongoing evaluation) and service development (assessment procedures, interventions, research) and deliver training.

4.2 Governance

The Supra-Regional Mental Health Hubs will act in a consultancy capacity to CTU / CTU Prevent Case Management which will retain case responsibility.

Regional spokes will report to Channel directly and to PCM via the allocated Prevent Officer/ case manager, although overall case responsibility for cases will remain with CTU Prevent Case Management.

5.1 Service Development

An interim service is required to allow for service development (contracting, recruitment, training, technical support / infrastructure and the development of standardised operational guidelines, policies, procedures, information sharing agreements, KPIs, interventions, training programmes and ongoing evaluation and research)
The development of a comprehensive national service should be staged over a period of three years.

Interim Service (Year 1)

During year one, regional hubs will be developed offering Triage and Level 2 intervention to low risk cases, Levels 1-3 will be offered to high risk cases in the West Midlands Region and multidisciplinary support will be provided to the MAOC in line with the current service model. The model will remain a consultation rather than consultation and intervention model.

Interim Service (Year 2)

During year two, regional hubs will offer Triage and Level 2 intervention to low risk cases, Levels 1-3 will be offered to high risk cases across the regions and multidisciplinary support will be provided to the MAOC in line with the current service model. The model will remain consultation rather than consultation and intervention model.

National Coverage of the Full Service Model (Year 3)

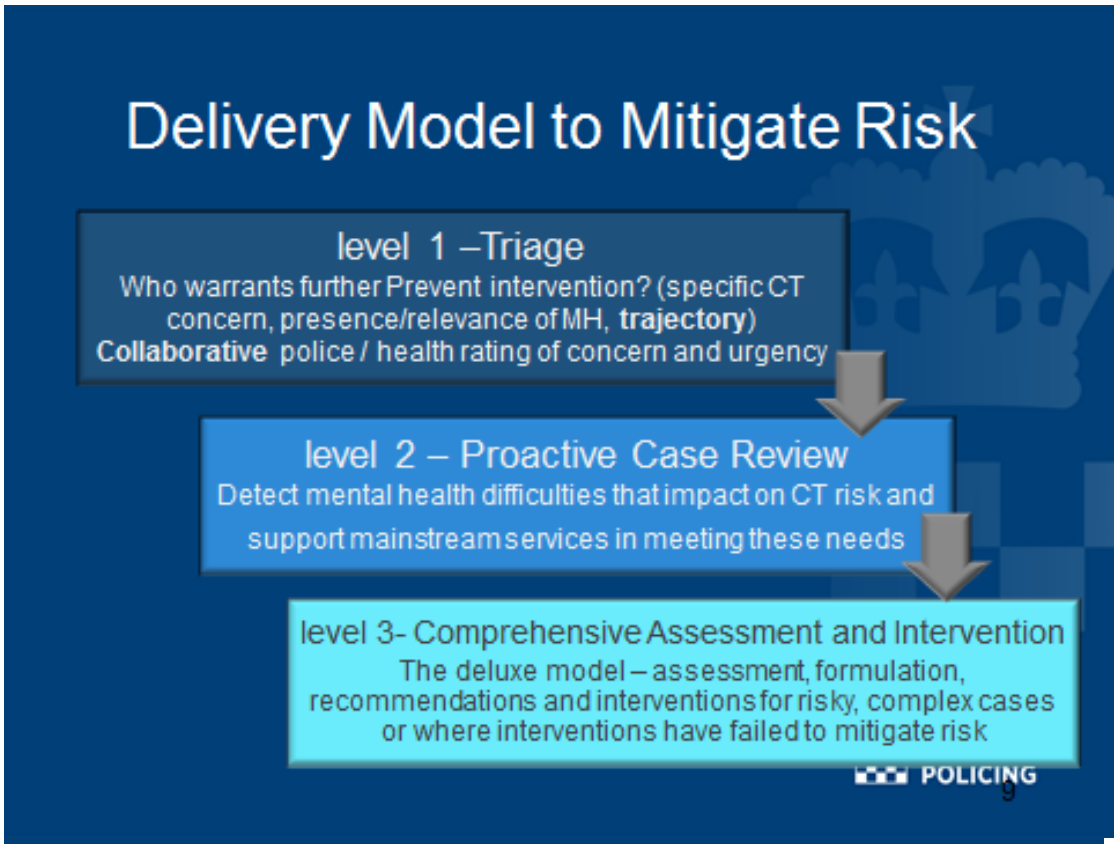
A comprehensive service with national coverage will be operational at the end of year 3 including; regional hubs (Levels 1 and 2) to low risk cases and anonymous case consultancy to support other CTU functions, and; Supra-regional Hubs providing 3 levels of service, diagnostic assessments and specific targeted interventions to high risk cases, RSOIs and high concern cases (e.g. high risk offenders and UASC).

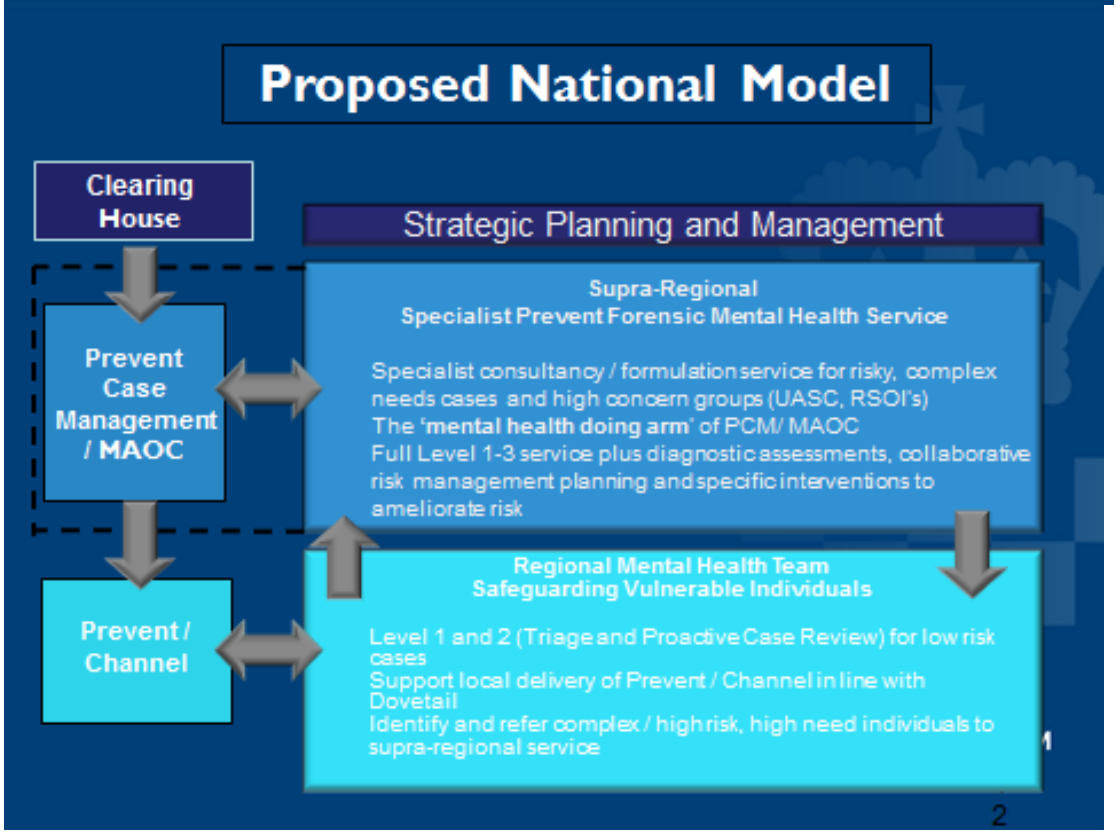
6.1 Costings for Current Model Across the East Midlands and West Midlands Regions

Provisional costings have been based on the Prevent Quarterly data and according to the full service model across the East and West Midland regions (Supra-regional hub with two spokes providing 3 levels of service). These costings are provisional and do not include the additional RSOI's or interventions.

DESCRIPTION	Year 1 WTE	Year 1 £	Year 2 WTE	Year 2 £	Year 3 WTE	Year 3 £
Clinical team						
Consultant	0.40	48,973	0.40	49,952	0.40	50,951
8C Psychologist	0.80	67,207	0.80	68,552	0.80	69,923
8B Psychologist	1.40	99,504	1.40	101,495	1.40	103,524
8A Psychologist	0.80	47,321	0.80	48,268	0.80	49,233
B8A Nurse						
B7 Nurse	2.80	132,944	2.80	135,603	2.80	138,315
B4 Admin	0.60	16,244	0.60	16,569	0.60	16,900
8A Social Worker	0.40	23,661	0.40	24,134	0.40	24,617
Mgt team						
8C Psychologist	0.10	8,401	0.10	8,569	0.10	8,740
8D Psychologist	0.10	10,017	0.10	10,217	0.10	10,422
Consultant	0.10	11,177	0.10	11,401	0.10	11,629
TOTAL PAY	**7.50**	**465,449**	**7.50**	**474,758**	**7.50**	**484,254**
Non-Pay Other 10%		46,545		47,476		48,425
TOTAL NON PAY		**46,545**		**47,476**		**48,425**
OVERHEADS @ 12%		61,439		62,668		63,921
MARGIN @ 5%		28,672		29,245		29,830
TOTAL OVERHEAD/MARGIN		**90,111**		**91,913**		**93,752**
GRAND TOTAL	**7.50**	**602,105**	**7.50**	**614,148**	**7.50**	**626,430**

Diagrammatic Representations of Proposed Service Model and Organisational Structure





COUNTER TERRORISM POLICING

Northern Mental Health Pilot

Interim Evaluation- Briefing Paper v2

Authors	**Mental Health Practitioner – Staff Name Removed** **Consultant Psychiatrist - Staff Name Removed**
Authorising Officer	**CTPNW Regional Safeguarding Lead Staff Name Removed**
Purpose	Interim Evaluation Northern Mental Health Pilot Evaluation v2
Sourcing	▪ NCTPHQ Terms of Reference for joint NHS/CT Policing Mental Health pilot sites. ▪ Operational Implementation Policy v3 ▪ Northern Mental Health Pilot Interim Evaluation – Briefing Paper v1 ▪ Northern Mental Health Team Pilot Bid document
Date of Production	**30th October 2017**

ABSTRACT

The aim of this second interim evaluation is to provide an updated review of the joint NHS and CT Policing Greater Manchester Mental Health pilot site. This evaluation should be read in conjunction with the following documents; NCTPHQ Terms of Reference for joint NHS/ CT policing Mental Health pilot sites, the Counter Terrorism Policing Northern Mental Health Pilot Operational Policy v4, the Northern Mental Health Pilot Interim Evaluation – Briefing Paper v1 and the Northern Mental Health Team Pilot bid.

In line with the first Northern Mental Health Pilot interim evaluation, this interim evaluation supports evidence of the benefit and value of having NHS mental health practitioners embedded within Counter Terrorism Policing. It also provides additional recommendations for the future direction of the joint NHS and Counter Terrorism Policing pilot.

Many benefits of embedding mental health provision in Counter Terrorism Policing have been identified during the course of the Northern Mental Health team pilot including; early detection of mental health problems, identification of suitable interventions to develop comprehensive CT risk management of individuals referred into prevent, upskilling of both police officers and NHS mental health colleagues to enable sustainability of the pilot and a full roll out of mental health embedded provision to both regions.

In order to mitigate risk at the earliest opportunity, a clear advantage and benefit of the embedded mental health provision includes attendance at Prevent Case Management (PCM) meetings in all high risk areas, at which Mental Health Practitioners have oversight of and triage all cases being opened to the Prevent team. Along with early mitigation of risk, attendance at the PCM meetings also allows for the early detection of mental health problems for people referred into Prevent. As alluded to in the first interim evaluation, this process will be strengthened further if we are accorded an uplift of resources which would enable the introduction of the new screening proposal outlined in the proposal section of this document.

Operationally, the Northern Mental Health team have been an integral part of many successful safeguarding interventions, as well as disruptive work on behalf of the North West Counter Terrorism Unit (NWCTU). The benefit of this work has been recognised by a variety of other departments within NWCTU and consequently the Northern mental health team are receiving more and more requests to support with investigations where early detection of mental health and an urgent safeguarding response is imperative.

The challenges faced by the Northern Mental Health team remain the same as those discussed previously in the first interim evaluation and specifically relate to; lack of funding, time constraints and staff recruitment impacted by non-recurrent funding. In order to overcome these challenges, a realistic bid for additional resources to streamline the future direction of the pilot has been created. This is discussed further as part of this evaluation.

CONTENTS

1. NORTHERN MENTAL HEALTH TEAM

1.1 Historical data findings

At the time of writing the original evaluation (August 2017), the total number of referrals into the Northern Mental Health Team was **198**. In line with the national trend, there was a substantial increase in the number of referrals to the Mental Health Team following the attacks in Westminster, Manchester and at London Bridge.

A snapshot of data (61 cases) was taken from July 2016- January 2017 in order to establish early learning from the Greater Manchester pilot. It was found that 88% of referrals into the team were male and 84% of the referrals were over the age of 18. The prevalence of schizophrenia was found to be 38% which is considerably higher than in the general population, where the prevalence of schizophrenia is around 1%. It was also found that 48% of cases were not known to mental health services at the time of referral, however a significant number of referrals were subsequently diagnosed with a mental illness by mental health services following the pilots involvement.

Additional analysis was conducted in April 2017 with 130 cases. Similar to the first analysis, it was found that 85% of cases referred in were male. There was a higher proportion with schizophrenia (60%). Seventy-five percent of referrals were Asian, 15% White, 5% Black. In relation to ideology, 75% of referrals were believed to hold an Islamist ideology whilst the others involved extreme right wing or conflicted ideologies.

1.2 Developments in Data Collection

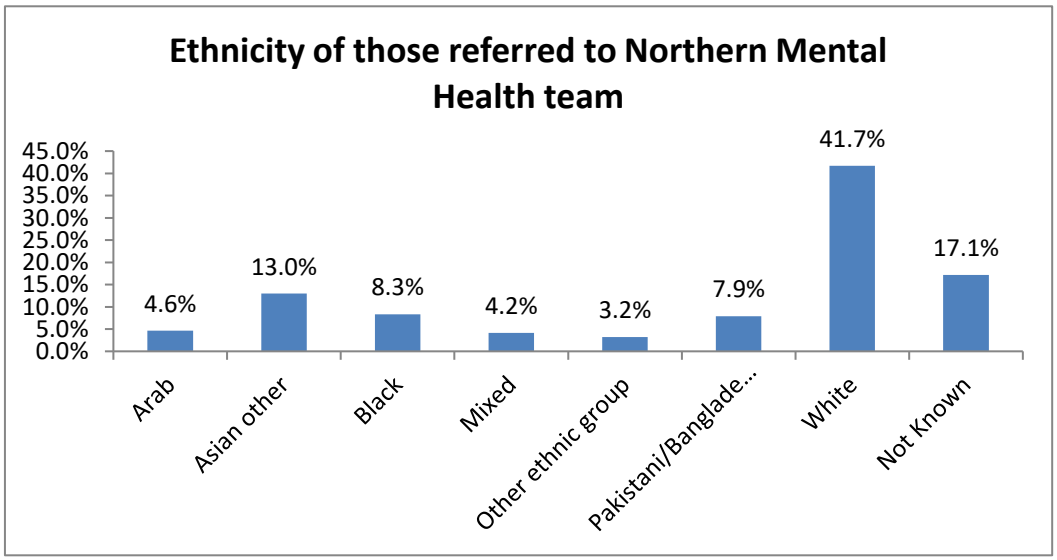
A new database has been established and data has been inputted retrospectively in order to facilitate meaningful data analysis. This has facilitated a data analysis of 216 referrals. At the time of writing this evaluation, the total number of referrals into the Northern Mental Health team was **230.** Of these referrals, **189** are archived cases, leaving a total of **41** live cases. Since June 2016 (the beginning of the GM Pilot) the North West region has submitted a total of 213 referrals. Since June 2017 the North East has submitted a total number of 18 referrals.

2. PRELIMINARY FINDINGS

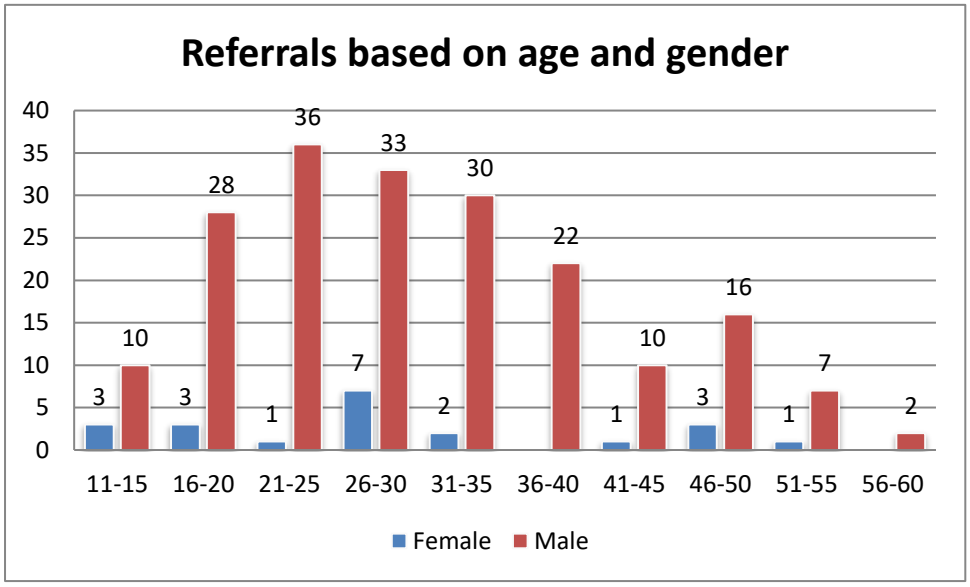
Following the development of the Northern Mental Health team database, statistical analysis was conducted on **216** cases referred into the team. This data is preliminary and further analysis will be completed over the next few weeks.

2.1 Demographics

52% of referrals into the Northern Mental Health hub were born in the UK. In terms of ethnicity, the majority of referrals were white (41.2%) and 25.5% of were of Asian ethnicity. However, further data cleaning is required as 17.1% of the referrals ethnicity was unknown.



90% of all referrals made to the team were male, with 19% being aged between 21-25 and 17% aged between 26-30. Females constituted 10% of all referrals into the team; the highest proportions were aged between 26-30.



When taking into account marital status, it was found that 46.8% of the referrals were single and never married. Furthermore, in relation to living circumstances, 15.7% of the referrals lived alone, 16.2% lived with parents and 17.1% lived in 'other' conditions. This category encompasses people who were homeless, AWOL or in hospital at the time of the referral. Alterations to the database will be made to capture these individual categories separately. In addition where employment status was recorded, it was found that, 56.9% of individuals referred to the team were unemployed.

2.2 Data established from Police records

30% of those referred into the Northern Mental Health team had an offence recorded on police systems. Data on violent offences was available on the 173 Greater Manchester Police referrals. It was found that only 18% of these referrals had a violent offence recorded. In order to interrogate these findings for the whole of the North of England, the plan is to review data on the Police National Computer (PNC) to establish if they have been arrested or convicted of any offences nationwide.

Nearly a third (31%) of those referred to the Northern Mental Health Team had mental health issues highlighted on local police systems within entries. Furthermore, 57% of these individuals had a Police Mental Health Warning Marker documented on the police intelligence system, with 36% having a marker for both mental health and suicidality and 7% having a marker for suicide alone.

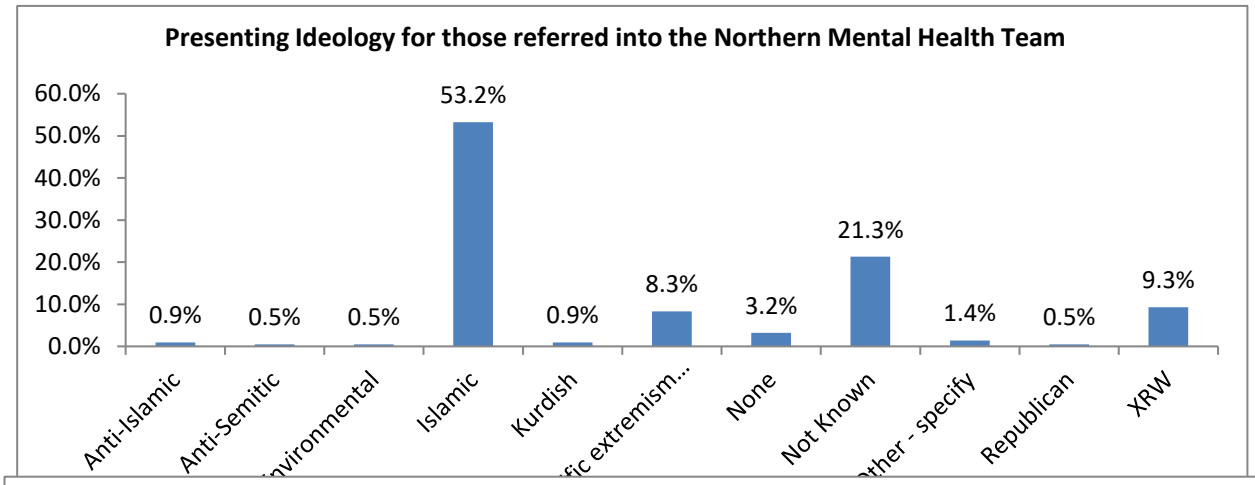
2.3 Primary Radical Influence

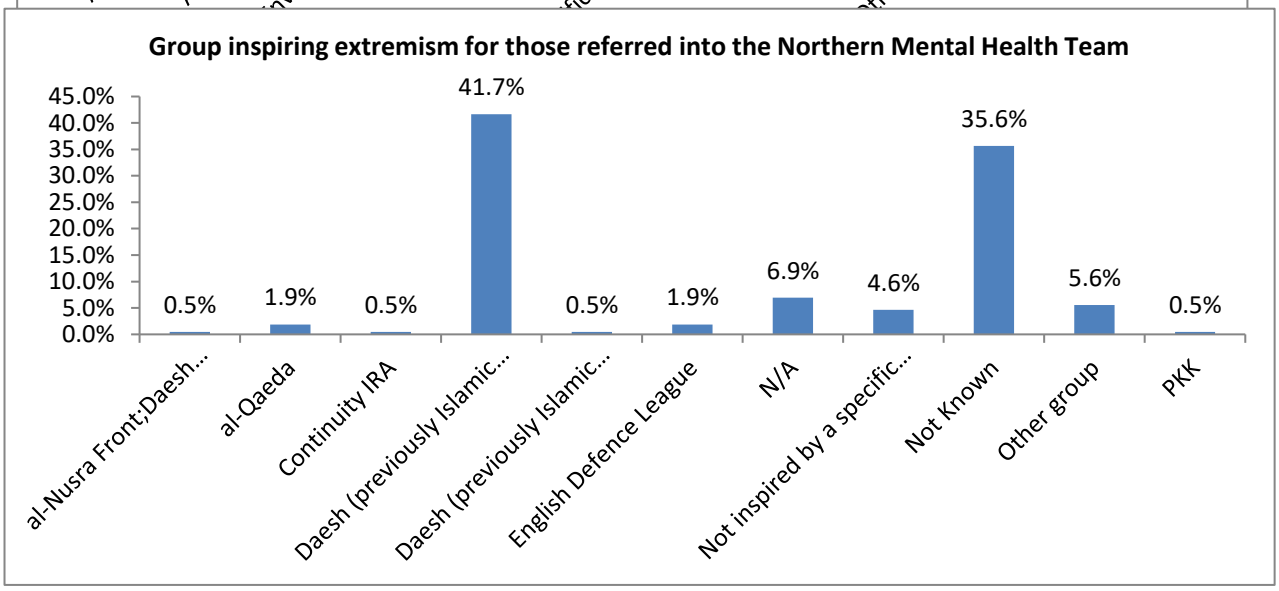
For those referred into the Northern Mental Health team, it was found that for a significant proportion (80.5%) the primary radical influence was not known at the time of the referral. However, when recorded 'friends' (6.9%) were most often the primary radical influence. Attempts to establish the primary radical influence in cases where it was not known will be made and inputted into the database retrospectively.

2.4 Ideology and Group Inspiring Extremism.

Of those referred into the Northern Mental Health team, Islamist related ideology was the found to be the most frequent ideology presenting in individuals (53.2%) and Daesh was the most prominent group inspiring extremism in 41.7% of referees.

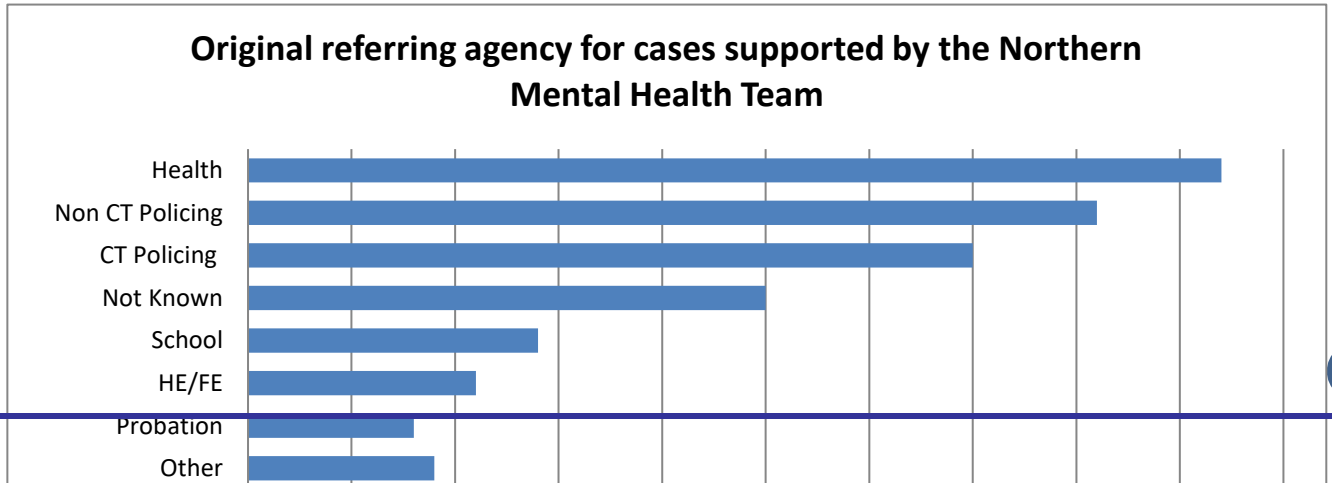
The most commonly occurring CT issue was extremist rhetoric (making comments considered to be of an extremist nature) constituting 58% of those referred into the Northern Mental Health team for support.





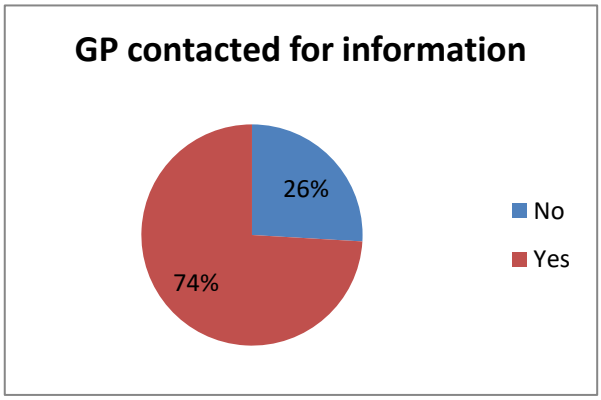
2.5 Referrals into the Northern Mental Health team

As expected, Prevent officer's (76.84%) made the most referrals into the Northern Mental Health team for support, followed by FIMU who made 9.47% of referrals into the team for assistance. The other referrals were received from NWCTU Intelligence Collection Unit, NWCTU Prison Department, NWCTU Investigations, NWCTU OIMU. When broken down by original referring agency into PREVENT, using data on the PCM tracker, it was found that health organisations were responsible for 22% of the referrals, followed by non-CT Policing (19%) and CT policing (16%).



2.6 Secondary Care Mental Health Service Involvement

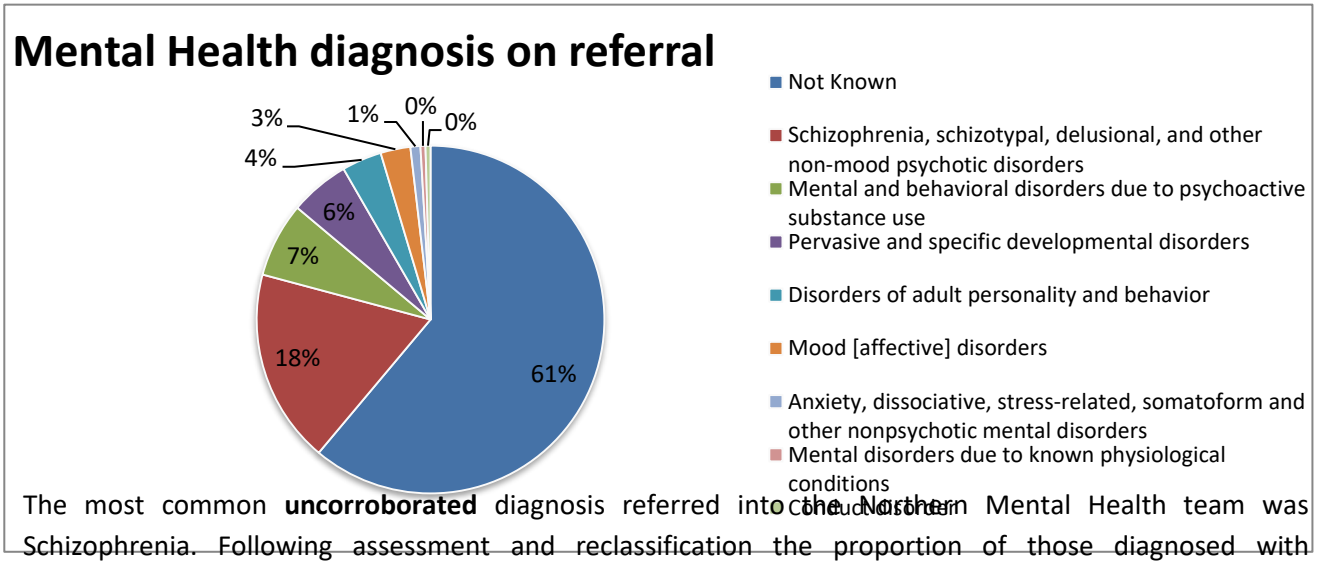
In line with the Northern Mental Health team screening pathway, the individual's GP was contacted for 74% of referrals into the team. The information requested from the GP includes mental health diagnosis, whether they are currently known or have been known to secondary mental health care and if so who the responsible clinicians are. For the Prevent referrals where the GP was not contacted, it is likely that it was already known that the individual was in contact with secondary care mental health services. On these occasions, the responsible clinicians were contacted directly rather than requesting this information from the registered GP.



42.6% of referees were in current contact with secondary mental health services and 46.8% had been known at some point to secondary mental health services (including those currently in contact). 46.7% of those currently in contact with secondary mental health services were present inpatients, of which 83.7% were detained under the Mental Health Act. Additionally, 5.6% had previously been an inpatient at some time in their life. Where services were known, the most frequent secondary mental health service used by referees was community mental health teams (13%).

2.7 Diagnosis

In 82 cases referred into the Northern Mental Health team, the confirmed diagnosed mental illness was different than highlighted by the referring officer. Successful communication with partner agencies to either obtain an accurate diagnosis or assist in a mental health assessment being conducted has been fundamental in supporting accurate recording of mental illness and management of these cases.



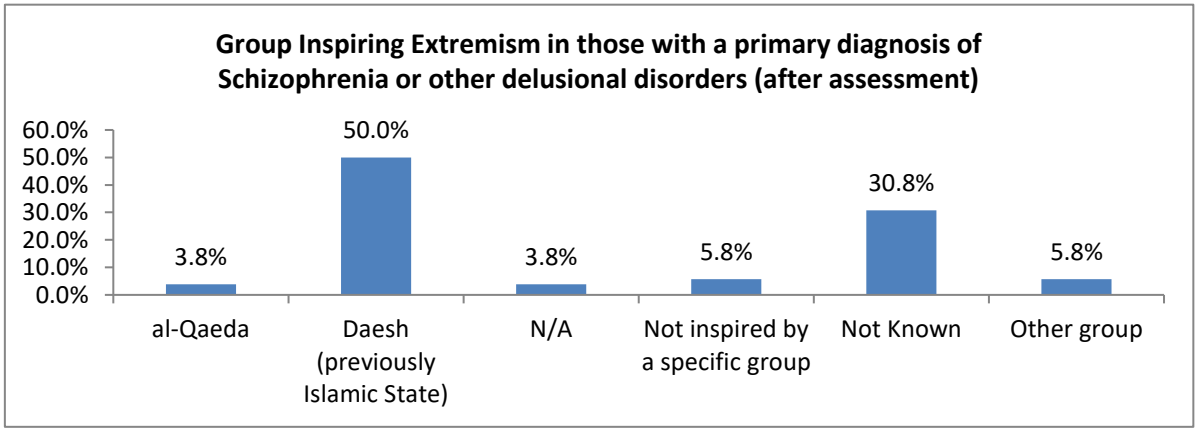
The most common **uncorroborated** diagnosis referred into the Northern Mental Health team was Schizophrenia. Following assessment and reclassification the proportion of those diagnosed with schizophrenia declined. Some of the misclassified cases had no mental disorder (6%) and others had alternative diagnoses given including mental disorder due to psychoactive substance misuse.

		Primary Diagnosis After Assessment									
		F00-F09	F10-F19	F20-F29	F30-F39	F40-F48	F60-F69	F80-89	F90-F98	None/Not Known	Total
Primary Diagnosis at Referral	F00-F09	0	0	0	0	0	0	0	0	1	1
	F10-F19	0	6	5	0	0	0	0	0	4	15
	F20-F29	1	1	20	0	1	4	0	0	12	39
	F30-F39	0	0	0	4	0	0	0	1	1	6
	F40-F48	0	0	0	0	0	0	0	0	2	2
	F60-F69	0	0	0	0	0	6	0	0	2	8
	F80-F89	0	0	0	0	0	0	0	8	4	12
	F99	0	0	0	1	0	0	0	0	0	1
	None/Not Known	0	1	27	5	2	2	1	4	90	132
	Total	1	8	52	10	3	12	13	1	116	216

The most common **primary** mental health diagnosis for individuals referred into the mental health team was ICD-10 F20-F29 (Schizophrenia, schizotypal and delusional disorders) with 24% of referees suffering from such disorders. The second most common primary diagnosis (6%) after referral and assessment was ICD-10 F80-89 (Pervasive and Specific development disorder). Specifically, this refers to Autistic Spectrum Disorder. 54% of referrals currently have no confirmed primary mental health diagnosis due to either on going work on the case or the individual not actually being mentally ill.

2.8 Influence of mental illness on vulnerability to radicalisation

Of those primarily diagnosed with Schizophrenia or other delusional disorders after referral and assessment 55.8% had Islamist related ideology and 50% demonstrated extremism inspired by Daesh.



No differences were found between mental health diagnosis and most frequent type of CT issue reported e.g. travel related, engaging with extremist group, behaviour change and extremist comments and rhetoric.

2.9 Northern Mental Health Team Interventions

On average, cases were in contact with the Northern Mental Health team for 36 days, in comparison to an average of 86 days open to the PREVENT team. It was found that the quicker the case was referred into the mental health team for support the average days open to PREVENT reduced. This may be because of the teams' proactive engagement with mainstream mental health services to implement appropriate risk management and safeguarding plans in order to address and monitor the Counter Terrorism risk the individual may pose. This is supported by findings from a recent survey of Police officers who have used the Northern Mental health team for support with a case, where they indicated that the timely response from the team and their input had assisted with managing the Counter Terrorism risk and vulnerability.

The most common actions conducted by the Northern Mental Health team in response to receiving a referrals was to provide advice to the referrer following a period of information gathering with partner agencies (45.2%). In 21% of cases the referral required ongoing proactive liaison with secondary care mental health services to address the CT concerns.

For individuals with a primary mental health diagnosis of ASD the most frequent type of response was providing advice to the referring officer (46.2%). More proactive liaison with secondary mental health services was required when individuals had a primary diagnosis of schizophrenia or other delusional disorder (48.1%).

**N.B. unless otherwise stated percentages take into account missing information and therefore are based on the % of 216 individuals.*

2.10 Feedback

In order to establish if Policing colleagues found support from the Northern Mental Health team useful, a feedback questionnaire (appendix 1) was established. To date we have received 10 responses. All responders rated the service received from the mental health pilot as good or excellent. Staff indicated that the response from the team had been timely and that the team's input had assisted with managing the Counter Terrorism risk and vulnerability.

A feedback questionnaire for Mental Health training delivered by the team to Greater Manchester Police officers was devised. All officers who received the training described it as useful and informative. Some staff also requested further specific training on Autistic Spectrum Disorder.

The Northern Mental Health hub recently conducted a PREVENT seminar in conjunction with the University of Manchester and NHS England. On ratings relating to session content, teaching materials and teaching style the average scores out of 10 received were 8.7, 8.6 and 8.6 respectively. Attendees at the event were from a variety of backgrounds including healthcare professionals from hospitals, the community and Prisons, as well as Prison Officers and MSc Forensic Psychology students.

2.11 Future direction of data analysis

The database was only recently upgraded and from initial analysis, it is apparent that there is some data missing and some data quality issues. This is largely redeemable but will require going back to the cases and gathering further data from referring officers. Going forward, it is hoped that further analysis of the data can be conducted in order to provide additional empirical evidence, demonstrating the effectiveness of the Northern Mental Health team in both safeguarding vulnerable individuals with mental health problems whilst assisting in the management of the Counter Terrorism risk.

However, it is clear even from these preliminary analyses that the embedded mental health provision has many benefits and is directly impacting on the management of the CT risk posed by individuals suffering with mental health problems.

3. PILOT SUCCESSES

3.1 Meeting the objectives

The main aim of the joint NHS and CT Policing pilot is to:

- Effectively and efficiently assess and manage the risk of individuals that may have vulnerabilities linked to mental health.
- Identify suitable interventions at an early stage.
- Improve outcomes for individuals that may have vulnerabilities linked to mental health.

Initially, the pilot was set up as a service within Greater Manchester and was covered by one full time Lancashire Care NHS practitioner. Much time was spent building relationships with partner NHS trusts across the borough, providing advice to officers on cases, spending time on the 10 GM divisions with the allocated Prevent Officers, attending channel panels and up-skilling the Prevent Officers in mental health.

Covering a small geographical area initially was ideal as it allowed the NHS practitioner to spend time learning CT processes. We feel this is integral to understanding what mental health interventions were needed at an early stage to not only improve the outcome for the individual referred in, but also importantly to help effectively manage the CT risk. The secondment of a part-time Consultant Psychiatrist and another part time practitioner has allowed for the development of the pathway and enabled partial coverage of the wider geographical area. However, despite the successful roll out across the North East and North West, there are limitations which will be the discussed as part of this evaluation.

3.2 Effective Risk Management

Formalised risk management responses to partner agencies were developed to help achieve some of the other objectives of the pilot. These include; improved engagement and communication with mental health service providers, providing a liaison and advisory service to mental health teams on the management of people referred into Prevent and managing and understanding the risk individuals may pose to self and others. The part played by the team in improving outcomes, recovery and wellbeing for individuals referred into Prevent is more difficult to measure but there are indications that this has also been met from the promising feedback received from teams.

On a routine basis the team have liaised directly with the Prevent subjects Consultant and have been able to provide risk pertinent information regarding CT risk, which has informed the management and interventions to manage both the mental illness and the CT risk.

We have also actively been involved in liaising with those responsible for a patient's care and influencing risk management plans to ensure that the CT risk is considered and a strategy is implemented to manage it. The Northern Mental Health Team work closely with NHS Mental Health colleagues to formulate suitable CT risk management strategies to safeguard the individual, whilst considering the most effective way to manage the mental illness. Another benefit of this is that it has helped to avoid individuals suffering with mental illness from continuously being re-referred back into Prevent due to lack of understanding about the individuals mental health condition, therefore demonstrating how the embedded provision has improved efficiencies.

3.3 Effective North West and North East roll-out

The pilot was initially designed for Greater Manchester only, but from July 2016 support was offered to Merseyside, Lancashire, Cumbria, Isle of Man, and Cheshire to provide full coverage to the North West region.

Funding was subsequently secured for a further 12 months, with expectations of coverage to both the North West and the North East region. Concerns about doing this with no additional resource and current staffing levels were expressed along with the suggestion that the level of service would have to be reduced meaning the risk could no longer be managed as effectively as it had previously.

A series of changes were implemented and in May 2017 **Staff Name Removed** (Regional Safeguarding Lead) undertook formal line management of the pilot. **Staff Name Removed** also became responsible for the supervision of the effective roll out of the pilot. The official roll-out to both regions was completed in July 2017. The mental health team visited each force in the two regions to provide details about the service. The

official roll-out was initially postponed due to the delayed recruitment of practitioners and most significant the Manchester attack.

3.4 Successful Interventions

Since the implementation of the pilot, we have seen benefits in collaboration between Police Officers and mental health practitioners. These can be split into two main areas; safeguarding interventions and safeguarding disruptions.

Safeguarding Interventions

The mental health team have actively participated in safeguarding vulnerable individuals with no current mental health support.

Case Study 1

One example was an **urgent** case which came through on Friday afternoon. A Prevent action was raised and a GMP Prevent officer was tasked with work around the subject. The subject had made comments which suggested he posed a risk to members of the Muslim community. His mental health was considered a key and primary component of this risk. Our embedded practitioner requested the emergency duty team to complete a full mental health assessment accompanied by two Prevent officers. This was to not only support the duty worker, but also to explore the ideology around the comments if appropriate in an attempt to try and mitigate the CT risk or disrupt/escalate the case if the risk remained or increased. The duty worker concluded that the individual did not require admission under the Mental Health Act and that the most likely diagnosis was antisocial personality disorder. The urgency of response was deemed necessary due to a planned extreme right wing protest scheduled to take place at the weekend. The individual was later assessed by the access and crisis team and the embedded mental health practitioner liaised with the community mental health team closely to pass on the CT concerns to enable mitigation of the CT risk. This is a good example of collaborative working not only between embedded practitioners and Police officers, but also liaison with mental health teams in the community in order to safeguard both the public and the individual.

Case Study 2

Another recent safeguarding intervention involved an individual who attended A & E and said that he monitored IS websites and was looking to purchase a gun and kill people. **Section 38 Health and Safety** Contact was made with the individual's GP to see if the he was known to community mental health teams. We established that he did not currently have an open referral and had no mental health diagnosis. Contact was made with the community mental health team and we managed to get an urgent mental health psychiatry appointment. A full disclosure around CT concerns was made to the psychiatrist who agreed to directly challenge the comments of concern. On the day of the assessment, the consultant psychiatrist made contact with our team and provided feedback about the assessment. She informed us that she did not find any evidence of psychotic illness, however felt that his anger had stemmed from childhood experiences and she was prepared to offer the individual a review appointment 6 weeks later. This information was fed back to the Prevent officer who was attending a Channel panel that day and was able to provide an update which directly informed the panel's decision making. The Prevent officer was able to visit the individual, knowing that the individual was not suffering with a psychotic illness and instigated appropriate safeguarding measures for other established vulnerabilities. As mental illness was not the primary CT concern as originally thought, the case was closed to the mental health team and the Prevent officer was able to effectively and

efficiently manage the case. This individual would not have been assessed by a Consultant Psychiatrist as quickly without the Northern Mental Health Team's intervention.

Case Study 3

A final example of a safeguarding intervention coordinated by the Northern Mental Health team involved a case in which the NWCTU was contacted by FTAC and told that an individual's mental health had recently deteriorated and that he was having suicidal and violent thoughts, specifically around death by cop. He also stated that he had thoughts of killing **Section 38 Health and Safety**. The Northern Mental health team liaised with the patient's GP who knew him well. The Northern Mental Health team arranged an urgent safeguarding meeting the following day. The GP, local authority safeguarding lead, Prevent officer and Sergeant as well as the embedded mental health practitioner attended this meeting and a strategy was put in place. It was felt that the Prevent Officer should wait for the mental health assessment before visiting the individual **Section 38 Health and Safety**. A comprehensive risk management plan was agreed and the individual was assessed by the Urgent Care Assessment team. He had symptoms of low mood and psychosis and was prescribed anti-psychotic medication. A referral was made into to the Home Based Treatment team, who provided intensive support to the individual. The Prevent officer and the embedded practitioner continued to work closely alongside the home based treatment team having regular safeguarding meetings to ensure the risk management plan was up to date and reflected the current level of risk. Once an improvement in the individual's mental health was seen, the CT risk began to diminish and a plan to withdraw support from the Home Based Treatment Team (a short term intervention) was established. This case demonstrates how the Northern Mental Health team enabled the early detection of mental health problems and supported effective management of the CT risk. This also demonstrates an improved outcome for the individual, who had attended A & E in crisis but had been discharged with no mental health support.

The above safeguarding intervention examples are not an exhaustive list, yet they clearly demonstrate how the team has improved engagement and communication with mental health service providers, managed and understood the risk vulnerable individuals may pose to themselves or others whilst improving outcomes, recovery and wellbeing for the individual through the established collaborative relationships with partner agencies. They also demonstrate how our hub actively identifies the unmet need of vulnerable individual's and puts appropriate interventions in place in order to mitigate the CT risk. This work would not take place as effectively and efficiently without the mental health practitioner embedded as suitable interventions are identified at an early stage in order to improve the outcome for the individual. Essentially, these examples also demonstrate how working closely alongside NHS partners, has encouraged the development of specialist skills by up-skilling our partners in managing CT risk, facilitating future sustainability of the pilot.

Disruptive Safeguarding Work

Since the mental health hub was established, many disruptions have been completed which arguably would not have happened as efficiently without the collaborative work between the embedded practitioner and police officers attached to the Northern Mental Health team. Two of these disruptions occurred days after the Manchester terror attack and were essential in order to safeguard both the individual and the public.

Case Study 1

The first example of disruptive work occurred after one individual with extreme right wing views suffered deterioration in his mental health **Section 38 Health and Safety**. This individual had a diagnosis of schizophrenia and had a history of noncompliance with treatment and non-engagement with community mental health teams. He also had a history of violence and had demonstrated a recent escalation in his behaviour (verbally abusing people from ethnic minorities). He had also failed to engage with the Channel

process on numerous occasions. Our team was able to escalate concerns with the relevant community services which prompted a Section 135 warrant being obtained and led to the individual being detained under the Mental Health Act. This individual has since been discharged from hospital back into the community and following treatment is now willing to engage with the Channel Process to work on his right wing views. The embedded practitioner was also able to work with the Prevent officer and provide advice on a suitable intervention provider as well as upskill the allocated community mental health practitioner on managing the CT risk.

Case Study 2

Another disruption occurred after an individual with possible mental health problems, who had previously been referred into Prevent, was arrested **Section 38 Health and Safety**. He was remanded in custody. **Section 38 Health and Safety**. The Mental Health DS was able to provide the embedded NHS practitioner with information from Police Intelligence systems **Section 38 Health and Safety**. The practitioner was able to contact the Responsible Clinicians on this panel and obtain a report which indicated that the consultant felt the **Section 38 Health and Safety** offence was not linked to the individual's mental illness. This report was sent to the Officer in the Case (OIC) and the individual was charged with both offences. Information was provided to support a remand application and the individual was consequently remanded in custody until his trial date (5/10/17). Information regarding CT risk and the individuals past involvement with Prevent was passed onto colleagues in the NWCTU Prison Intelligence Unit (PIU) and disseminated to the Prison. Our team also made contact with mental health services in the prison to ensure they were aware of this individual.

Case Study 3

A final example of a disruption completed by the Northern Mental Health Hub involved an individual who had been referred to Prevent on several occasions in the past. Historically the case had been closed by the allocated officer as it was perceived the comments and behaviours were driven by mental illness. When the Northern Mental Health Team had oversight of the case, they worked with local mental health services to ensure that an assessment was undertaken on the individual so that this may inform the management of the case. Liaison with the referring officer highlighted that the individual had committed **Section 38 Health and Safety**. The Northern Mental Health Team continued to act as a conduit between the Prevent officer and local services throughout the assessment process, providing regular updates to the referrer and sharing relevant information with health professionals engaged with the individual's treatment. As part of the criminal justice process, the Northern Mental Health Team provided information to the Officer in the Case in order to support a remand application on the basis that there had been a significant escalation in behaviour **Section 38 Health and Safety**. The individual was consequently remanded in custody until his trial date. The Northern Mental Health Team liaised with the NWCTU prison intelligence unit to establish which Prison the individual had been detained in. Consequently, contact was made by the mental health team DS and information around the CT risk posed was shared with the Prison mental health team. A mental health assessment was conducted whilst the individual was in custody and feedback was provided to the Northern Mental Health team. This individual was deemed not to be suffering with a serious mental illness and this information was fed back to the allocated Prevent Officer making it clear that despite previous assessments and rationale, mental health was not the primary CT concern. This disruptive work allowed for an individual who had a history of noncompliance with services to be expeditiously assessed in custody. This individual has since been released from custody and the Prevent Officer has been able to utilise other tactical options in his

progression of the case in order to mitigate the CT concerns. This once again validates the significance of the benefit of having a mental health hub embedded within CT policing. It also demonstrates the advantage of building collaborative relationships with partner agencies which is integral to facilitating the sustainability of the pilot.

These disruptions are clear examples of how having an NHS practitioner embedded within a team of police officers attached to the pilot can complement the management of CT risk. The first disruption also highlights how effectively and efficiently assessing and managing the risk of individuals who have vulnerabilities of a CT nature linked to their mental health can improve the outcome of the individual by ensuring they get access to appropriate treatment with a long term risk management plan.

4. PILOT CHALLENGES

The challenges faced by the Northern Mental Health team can be broken down into 3 main areas; funding, time constraints and recruitment. However they are all intrinsically linked.

4.1 Funding

Funding was and remains a fundamental issue faced by the pilot due to the Home Office's expectation to extend the pilot to the North East region with no additional resource. Original processes have been reviewed to enable effective coverage of such a large geographical location. However, in order to achieve this, a tiered delivery model was implemented, which was based around threat, risk and vulnerability and factored in the priority status within the regions and force areas; Greater Manchester (Tier 1 force), Lancashire, Merseyside, West Yorkshire and South Yorkshire (Tier 2 forces). Whilst referrals into the Mental Health Team are assessed on their own merit and similar levels of service offered on a case-by-case basis, the tier one and tier two areas receive a higher level of engagement in terms of regular attendance on site for specific purposes such as Prevent Case Management meetings. This is challenging as the team only has one full time and one part time practitioner. Due to coverage of such a large geographical area, much time is spent travelling and consequently less time is spent on cases. If an uplift of resource was received this would enable more PCM meeting attendance (which helps to identify and mitigate risk at the earliest opportunity) and allow practitioners to dedicate more time to the effective management of cases.

4.2 Time Constraints

As the pilot is only given funding for 12 months at a time, time constraints have underpinned and dictated the direction of the pilot. Furthermore, this has directly affected decisions around recruitment and also the use of screening tools such as PolQuest (see section 4.3). If the pilot had originally been funded for two years

and been split into two phases of implementation, a strategy plan could have been implemented to help build resilience to the challenges described in this evaluation. This would also have allowed for the hub to be appropriately staffed in order to effectively service the North East region.

Home Office verification of the status of the pilot and future funding is still outstanding. The team will be unable to continue the pilot's current functions if a decision is not made by December 2017 as we will have to stop accepting referrals and we will have to begin disengaging with the caseload. If the Home Office provides further funding, we need to know the level of funding to enable pro-active recruitment. Ideally this would need to be known by January 2017 to facilitate sufficient time for the full recruitment process; job advert, applications, interviews, vetting with the start date of 1st April in mind in line with the new financial year.

4.3 Recruitment

Recruitment has been another significant issue encountered specifically during the first 12 months of the pilot. Originally the pilot start date was postponed until June 2016 when the first fulltime practitioner officially joined the team. The initial team comprised of one Detective Sergeant, one Prevent Officer and the mental health practitioner. The Psychiatrist was also recruited in April 2016 to provide support to the pilot for one day per week however due to vetting and issues around devolution of the budget, she did not start until the end of November 2016. Expressions of interest continued to be advertised to fill the other full time NHS practitioner post. Despite interest being received, staffing shortages across many NHS trusts meant many NHS managers were not prepared to endorse secondment opportunities. Eventually, two part time practitioners were employed as a job share for a (0.8 FTE) post.

Time limited funding also affects the quantity of applicants due to a lack of clarity and assurance with regard to ongoing and sustained employment.

As Prevent is part of a STRAP environment, SC vetting is imperative for all practitioners. This added further delay to recruitment due to the length of time and cost vetting can incur. Unfortunately one part time practitioner left the pilot not long after starting; therefore the other practitioner agreed to work on the pilot 3 days per week as an interim measure. This has reduced the second NHS Mental Health Practitioner post to 0.6 FTE, which consequently affects the level of service which can be provided to the North East region. As mentioned previously, in order to effectively manage the risk in both regions, additional resource is essential.

5. PROPOSALS

5.1 Proposal 1 - *Prevent Support Officer*

Given the amount of administrative work and liaison with other services required within the pilot, it would be beneficial to enlist the services of an administrative support worker. The post-holder would ideally be recruited from the NHS rather than from a Police or CT background. Expressions of interest were disseminated in August 2017. This post would be funded from the mental health practitioner short-fall (see section 6). This proposal is linked to proposal two which will be an integral part of the working process of the Northern mental health hub going forward as it will help to further enable the early detection of mental health problems for people referred into Prevent. Unfortunately, there have been no applicants, largely because the current secondment opportunity ends in March 2018 and by the time vetting procedures are complete, they would only be working with us for two months. With resolution of the financial issues and delays in confirming future funding, we are hopeful we would get more interest in this post.

5.2 Proposal 2 - *Prevent & Channel Referral Screening (NW Region pilot)*

With the proposed appointment of a support officer, we want to pilot more comprehensive screening of cases. This would further allow earlier detection of mental health problems for people referred into prevent by establishing which cases are in contact with secondary mental health services. This would involve the Prevent Support officer screening all referrals into Prevent. The support officer will contact the local mental health trust(s) Prevent lead and establish whether the subject has had contact with these services in the last twelve months. If they are in current contact we will establish the details of the mental health team/consultant involved. This information will then be passed to the Prevent Officer who is managing the case and he/she can then consider the submission of a referral form to the Mental Health Team if further support is required. A referral to the Mental Health Team can still be made at any point if the referring officer is concerned about the person's mental health. The case will be allocated to one of the mental health

practitioners to progress the case (as per the current operating model). Screening all Prevent referral in this way should be an integral part of the Northern Mental Health teams working processes as it will allow for risk to be mitigated at an early stage. We will initially pilot this in Greater Manchester, Lancashire and South Yorkshire.

5.3 Proposal 3 - *PolQuest*

Originally, as described in the Northern Mental Health Pilot Operational Implementation Policy V4, we planned to pilot PolQuest in two Greater Manchester divisions for cases with no secondary mental health care services involvement identified. This pilot aimed to enhance the early identification of mental health problems for people referred into Prevent for individuals who are not currently known to mental health services. However due to lack of funding and time constraints we have decided to postpone this proposal.

The Secretary of State for Health Jeremy Hunt is currently writing a policy that those referred into mental health services where there are counter terrorism concerns will be seen within 7 days of a referral being submitted. This policy is due to be released in September 2017 and should add value to the case management process and improve outcomes for individuals with mental health problems who are deemed vulnerable to radicalisation.

5.4 Realistic coverage of the North West and North East Regions

In order to address the mental health need of referrals and effectively manage and mitigate risk in both regions, we feel that attendance at PCM meetings and the implementation of a screening process to establish secondary mental health service contact are essential functions.

At the time of writing this interim evaluation, there have been **1637** referrals into Prevent since April 2017 (North West **638**; North East **729**). Our staffing model assumes that around 40-45% of Prevent referrals will hold a mental health component as a primary feature (GMP MH pilot, 2017). Our proposed staffing model represents a multidisciplinary safeguarding mental health team split into NHS staff and Police staff posts:

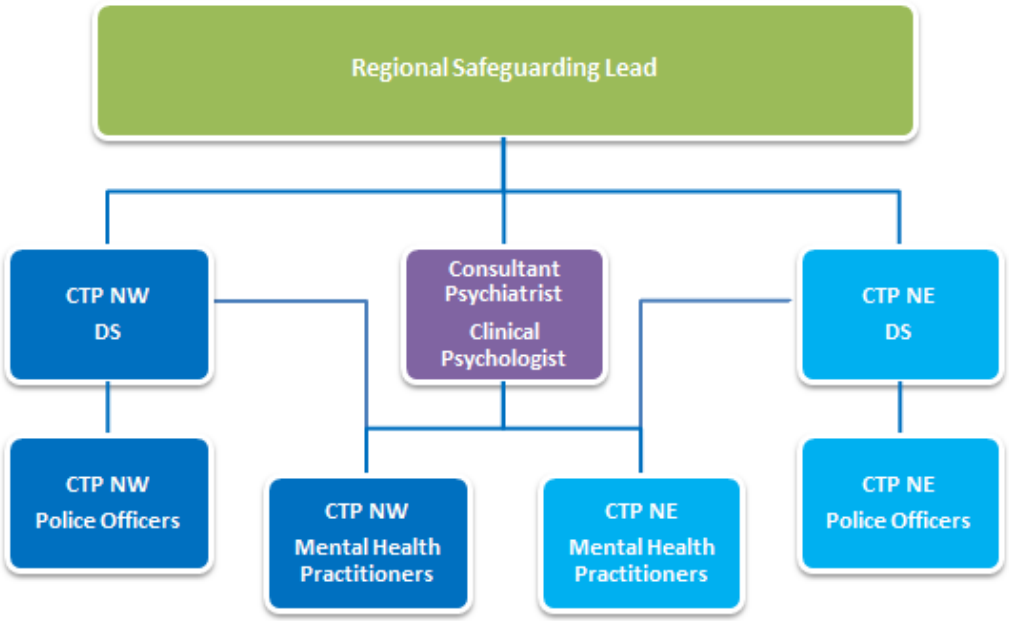
NHS Staff Posts

- I x consultant psychiatrist 2 days per week
- 2 x clinical psychologist up to 2 days a week
- 5 x MH practitioners (1 x Band 7/8 2 x Band 7 2 x Band 6)
- 2x Admin staff

Police Staff Posts

- Regional Safeguarding Lead/CTPNW Detective Inspector
- 2x CTPNW Sergeant
- 4 x mental health police officers

A full breakdown of costings can be found in the Northern Mental Health Team Pilot bid document. Below is a representation of what the proposed governance and command structure would resemble.



6.

CONCLUSIONS

There is clear emerging evidence that embedded mental health provision adds value to CT policing by enabling effective and efficient assessment and management of risk posed by individuals with mental health, learning disability and other developmental problems, who are vulnerable to radicalisation. It has also allowed for imperative relationships to be built with NHS partners who actively support risk management plans suggested by the embedded NHS practitioners in order to manage CT risk.

The Northern Mental Health team has regularly supported investigation and intelligence officers across the Counter Terrorism Unit in managing risk linked to mental health and extremism. This has led to not only the early detection of mental health problems for people referred into Prevent but has also led to the early detection of mental health problems for subjects of interest and enabled safeguarding strategies for mental health to be implemented. More recently, the mental health hub has also provided safeguarding strategies for live CT investigations to ensure that those being charged and remanded on bail have appropriate support in place if mental health is deemed a primary component of the Counter Terrorism risk. Consequently, active involvement in safeguarding interventions and disruptions has demonstrated the importance of the pilot. Not only has an improvement in the level of engagement and communication with mental health service providers been observed, but have also been able to manage and understand the risk vulnerable individuals may pose to themselves or others, whilst improving outcomes, recovery and wellbeing for the individual through the established collaborative relationships with partner agencies. A further success identified is early

identification of unmet need in vulnerable individual's, which has enabled appropriate interventions to be implemented in an attempt to mitigate the counter terrorism risk that the individual may pose. The disruptive work also demonstrates how having an NHS practitioner embedded within a team of police officers attached to the pilot can complement the management of CT risk. Sustainability has also been a priority, and we have worked closely with NHS partners in order to encourage the development of specialist skills by upskilling mental health practitioners in managing CT risk in people suffering with mental illness.

Although many benefits are identified in this evaluation, one clear advantage of the embedded mental health provision includes the attendance of Prevent Case Management (PCM) meetings in all high risk areas. This enables Mental Health Practitioners to have oversight of, and triage all cases being opened to the Prevent team. Early intervention supports the mitigation of risk and enables early detection of mental health problems for people referred into Prevent. As mentioned previously, if additional resource is provided essential attendance at all PCM meetings in all areas, along with the implementation of a screening process to establish secondary mental health service contact will enable further mitigation of risk at the earliest opportunity.

As part of the next interim evaluation (March 2018), we aim to further evaluate the success of the Northern Mental Health hub by looking at comparisons between effectiveness of the pilot the North West and the North East regions given the different levels of service provided. What is clear already is that in comparison to the North West, we have received a significantly lower number of referrals from the North East region which may be attributed to the limited presence we are able to facilitate across the region. We also aim to compare the Northern Mental Health Hub with the other Mental Health pilot sites in order to establish best practice and inform the implementation going forward.

Since the last interim evaluation, a proposal document completed by the Regional Lead has been submitted. This features a staffing model and the budgetary requirements to secure the effective future direction of the pilot. This bid facilitates safe working practices to enable early detection of mental illness to facilitate mitigation of CT risk, whilst improving efficiencies by avoiding repeat referrals into NHS and Police services via the use of a multi-dimensional approach.

APPENDIX

1. Feedback form template

Northern Mental Health Team - Feedback Survey

Date completed:

For each item identified below, choose the number from the rating scale that best fits your judgment of our service. This form can be printed and given to a member of Northern Mental Health Team or it can be emailed through to our mailbox- (Northern.MentalHealthTeam@gmp.police.uk)

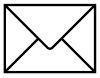
Survey Item	Scale Negative ↔ Positive				
1. Did we respond in a timely manner?	1☐	2☐	3☐	4☐	5☐
2. Did we meet the expected outcome of your referral? (Please give reasons for your answer)	1☐	2☐	3☐	4☐	5☐

3. Did you find having access to specialist advice/intervention helpful? (Please give reasons for your answer)	1☐	2☐	3☐	4☐	5☐
4. Do you feel we were able to support you in the management of the subject? (Please give reasons for your answer)	1☐	2☐	3☐	4☐	5☐
5. If applicable; did our attendance at the contact visit help in your management of the subject? (Please give reasons for your answer)	1☐	2☐	3☐	4☐	5☐
6. Do you feel we were able to improve information sharing between health and the police? (Please give reasons for your answer)	1☐	2☐	3☐	4☐	5☐
7. Has the Northern Mental Health team helped to improve knowledge and understanding about mental illness within the case management? (Please give reasons for your answer)	1☐	2☐	3☐	4☐	5☐
8. In your opinion did we have an impact on the reduction of risk concerning this subject? If yes please explain in the box.					
9. Do you consider there to be a need for the Northern Mental Health Team?	YES ☐		NO☐		
10. Do you have any other comments? We welcome all feedback.					

COUNTER TERRORISM POLICING

Northern Mental Health Team

0161 856 2368



Northern.MentalHealthTeam@gmp.police.uk