SIM TEAMS – CORE 'FIDELITY FEATURES'

	ESSENTIAL	PREFERRED BUT NOT REQ	NOT REQ
Service users on the programme: have demonstrated high levels of behavioural intensity to such a degree that an integrated support team using a police officer has been chosen to enhance care and reduce risk.	■	☐	☐
Protected time: The project has identified police officers and mental health staff whose time is protected to work together with identified service users more intensively.	■	☐	☐
Combination of clinical and behavioural input: The success of the model is based on providing the service user with the right combination of clinical care and behavioural intervention.	■	☐	☐
High quality, co-produces response plans: The primary objective of this model of care is to **co-produce response plans** that define what the service user will/wont be expected to do when in crisis and what they can/cannot expect from 999 & healthcare teams.	■	☐	☐
Staff selection: Both NHS and police supervisors have assessed the staff operating this model of care as being personally and professionally suitable for the role.	■	☐	☐
Diversion/wellbeing: The team not only focusses on the crisis itself, but also supports and promotes lifestyle changes and helps the service user to address and solve key problems and needs that contribute to poor mental health.	■	☐	☐
Cost reduction: The team's role is not only to find healthier ways of coping with a crisis but to identify and reduce unnecessary use of emergency and other critical care services; to achieve either direct cost savings or to reduce avoidable resource usage.	■	☐	☐
Clinical knowledge: Some degree of clinical training input for non-clinical staff is provided. This includes training about both mental and behavioural health so that clients can be safely supported using this integrated approach.	■	☐	☐
Full-time role: Police officers and MH staff supporting this cohort of service user perform this work in a dedicated, protected role, (where demand levels would justify this).	☐	■	☐
Continuous Professional Development: Staff that operate in these specialist roles have a programme of continuous professional development to build skills and confidence.	☐	■	☐
Police powers: The staff member from the police service has to be a police constable with arrest powers.	☐	☐	■
Location of intervention: The team meets the service users within public service buildings.	☐	☐	■

OTHER MH PARTNERSHIP MODELS THAT DIFFER FROM SIM

CONTROL ROOM TRIAGE

A mental health clinician based in a Police or Ambulance control room with access to NHS patient records. These clinicians help to assess the risk during the initial call screening and can speak to the individual on the phone to see if all deployments can be prevented. Control room triage is not SIM because it is a crisis **response** model – SIM is a crisis **prevention** team.

STREET TRIAGE

A ST projects employs a mental health clinician who works alongside police response teams. They deploy with police officers to the crisis incident and usually have remote access to NHS patient records. These clinicians help to assess the risk during the incident, they speak to the individual and will advise the police officer as to whether they need to use police powers under s136 of the MH Act to detain the person and take them to hospital. Some ST teams will try to engage when the patient is not in crisis (usually by home visits) but because they are primarily a response team, their ability to meaningfully engage to prevent more crisis calls is be very limited so they are not considered the same as SIM.

HIGH INTENSITY USER GROUPS

These are meetings (usually monthly) between police, ambulance, A&E and MH teams to identify frequent users of service (usually via data). They then agree what care to provide the next time the patient calls. These are important meetings to have in any high intensity patient management pathway but **should only be used to identify** service users that need more support or a different response.

Well run HIUGs will prioritise clinical care and then allocate a case worker/team to meet with the service user to identify ways in which the crisis calls can be handled more effectively and how the patient can stay safe. They will plan care with the patient (SIM is an example of this type of team).

Poorly run HIUGs will write a response plan without ever speaking to the patient with a heavy focus on demand reduction. Often the patient does not even know the response plan exists. Poor HIUGs often create risk and at times can even increase the risk – *e.g. not involving the patient may trigger feelings of neglect, worthlessness and abandonment. This may trigger the patient to go into crisis*. Most HIUGs are not SIM as they do not manage the patient face to face.

LIAISON AND DIVERSION TEAMS

These teams use a mental health clinician working within the criminal justice system. They are often located within police custody blocks or court buildings speaking to people who have been arrested/charged, trying to identify undiagnosed or untreated mental and behavioural health issues, with the aim of diverting the offender away from the CJ system or by advising prosecutors and courts about the health of the suspect/defendant.

Well run L&D teams will maintain contact with the individual after they have left the CJ system.

Poorly run L&D teams have been criticised for being 'glorified referral teams'. L&D teams are not SIM because the vast majority of people in police cells are not the same cohort of patient as those repeatedly using 999 services in crisis.