SIM
Serenity Integrated Mentoring

9 BARRIERS TO SCALING

AND HOW TO RESPOND

High Intensity Network
www.highintensitynetwork.org

1 2 3 4 5 6 7 8 9

5 BARRIERS THAT DELAY
A TEAM LAUNCH

4 BARRIERS THAT DELAY
OUTCOMES

1 2 3 4 5 6 7 8 9

UNDERSTANDING POLICING HISTORY RE: MENTAL HEALTH

The police service will be 200 years old in 2029 but historically it has not focussed on mental health.
Its only in the past 10 years that the service has acknowledged that mental health crisis care is a policing responsibility.
It is only in the past 7-8 years, that police officers have been working daily with mental health crisis staff.
Its only in the past 5 years, that police officers have started to understand the difference between mental illness and behavioural health. This is still in its infancy.
Its only in the past 3-4 years that both police and mental health teams realised that some repeat crisis callers were 'unmanageable' by clinicians alone and would be best supported by an integrated care model (SIM).

The evolution of mental health crisis care is at such an early stage that it virtually impossible to make things go any faster. Imagine what it was like to have just invented penicillin and only be in 'year 2'.
That's where we are at right now with projects like SIM.

RESPONSE?

This will depend on which officers you work with. Most will be working in MH specialist posts so you wont have much trouble convincing them. They may need some support convincing their colleagues and senior managers.

ACCEPTING WE HAVE TO DEVELOP A NEW POLICE ROLE

Police officers working in the NHS? Full time?

Some senior officers are understandably struggling with accepting that **SIM is a policing role**.

Some police forces already think they spend too much time dealing with mental health patients.

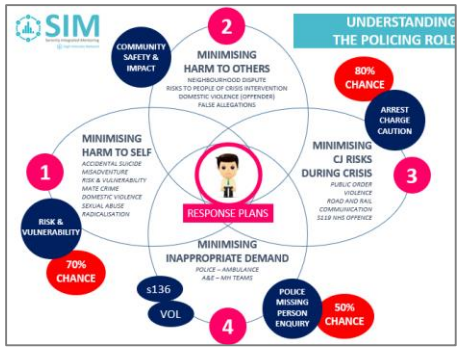
BUT…..

Prison statistics show that **80% of criminals in prison have mental illnesses**.

If 80% of people we put through the criminal justice system are also mental health patients, then policing IS a mental health related service. There is not the widest acceptance of these facts…yet.

A small number of forces will turn you away because this seems '**one step too far**' right now.

1



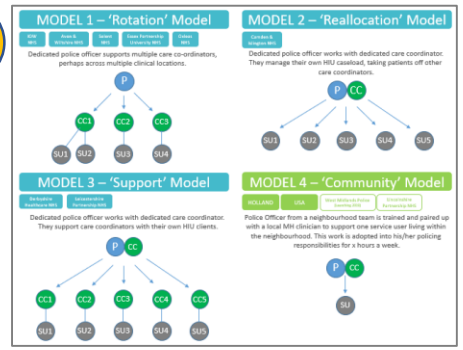
RESPONSE?

Slide 1 is the key slide in the national presentation to use, to show officers why high intensity MH patients are a risk within our communities and the policing role within the model.

SHORTAGE OF POLICE OFFICERS ON THE FRONTLINE

Like all public services, every police force in the UK has just had at least 10-15% of its officers taken away. The 'thin blue line' is even thinner than before so senior officers are **stretched for staff**.
Some police forces may say no to SIM because they don't have the staff to give to the project.
This will delay adoption unless we find creative solutions.

2



RESPONSE

1. Find external funds to pay for them (CCG/STP/PCC/Suicide Prevention budget etc). Long term funding will secure more confidence to release police staff. Try to avoid 'winter pressures' funds or similar funding ideas.
2. Do not use Police Constables but use police staff like Police Community Support Officers instead. Two teams do this
3. Build SIM skills into community teams. **Slide 2** is the key slide in the national presentation to use, to show senior officers how SIM skills can be adopted into existing community teams without the need to identify dedicated officers for re-allocation.

DIFFERENT FORMS OF 'INNOVATION SABOTAGE'

This does not happen often but it does happen; a small number of organisations (or more usually individuals within an organisation) will sabotage an external organisation's idea, work or proposal. It must be stressed that 'sabotage' is a problem experienced by most innovators. It was widely discussed at the *NHS Innovation Accelerator w*orkshop attended by the NHS' top 37 innovation teams in this month. Sabotage can come in many forms but the overall goal of sabotage is *'resisting a new idea to retain control of something - or a status of someone - or maintaining the status quo'.*

Examples of sabotage reported by innovators at the NIA workshop included:

- *Automatic objection or counter argument when presenting your innovation.*
- *The saboteur deliberately involving themselves to ensure specific outcomes (including to ensure the complete failure of adoption).*
- *Adopting the idea but disassociating from the innovator. Re-labelling the innovation as your own, ignoring the benefits of professional networks. Avoidant behaviour when challenged.*
- *Creating misinformation about the proposed innovation.*
- *Refusing to meet or communicate with the innovator.*

We appreciate that this is not a nice subject to discuss but it is important to be aware of, if you are involved in scaling & adoption related programme management.
This type of behaviour has already been encountered within this project.

RESPONSE?

Seek advice from trusted peers. There are a number of options:

1. Empower the saboteur – ask them to co-lead the project with you. Allowing the saboteur to take part-credit may mean that the innovation is successfully adopted.
2. Bypass the saboteur by seeking support in other areas, by an 'adoption champion' or at a higher management level.
3. Create professional pressure on the saboteur to adopt from peers.

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DECISIONS TAKE TIME

The decision to take a police officer off the streets and put them into NHS teams takes time.
It can take up to **4 separate visits** to a single area to meet all the **6 possible stakeholders** with the decision making power to get a combined decision. Often decisions slow or stall completely because we haven't **busted the common myths** about SIM. Sometime we also have to wait to fit the introduction of an innovation into a local time or financial work stream. The average time it is currently taking from first visit to launching a team is **1 year**.

ESSENTIAL STAKEHOLDERS

Police Force

NHS Provider

OPTIONAL STAKEHOLDERS

Police Crime Commissioner (PCC)
CCG MH Commissioner
STP or ICS MH Lead
Crisis Care Concordat Board

RESPONSE?

Do not assume that all of the 6 possible stakeholders are needed to make the decision. All you need is the NHS Trust and the Police Force to agree and if the police donate the officer, you don't even need any funding decisions. Involving the other 4 stakeholders maybe unnecessary to get going. See who you need to get going and involve the least number of decision makers.
If you do need multiple stakeholders at the table plan all meeting dates in advance so everyone can make it and press home to all how Important attendance is.

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Once you have navigated past the pre-launch barriers, there are now 4 factors that may slow your ability to show positive results. They are:

ENGAGING WITH BEHAVIOURALLY COMPLEX PATIENTS

Once launched, it can take a lot of time and effort for a team to engage a patient with any new, joint model of care.
Many patients have an understandable **fear of the police** so it can take weeks to build their trust.
We also find that patients with the this clinical profile can **naturally push against** any change as they often don't have the confidence, self esteem or the personal skills to **cope with change**. Many patients **resist being cared for** in different ways and may have a selection of behaviours they have used before to **delay, block or sabotage real change**.
In Surrey this year, a patient finally engaged with their team after whole 1 year of visits.
You cannot rush trust so we cannot rush results.

RESPONSE?

1. Do not set out telling commissioners that this project will produce 'quick wins'. It won't.
2. Do not use temporary funding – this project needs time to embed.
3. Do not use the word 'Pilot' as this loads long term commitment on short term statistics.
4. If possible, recruit the right managers and frontline staff who will stick with the project for atleast 2 years.

SECURING BEHAVIOURAL CHANGE FOLLOWING ENGAGEMENT

Once a patient has been engaged, then starts the task of moving them from a behaviourally risky state of mind to a safer, more stable and responsible mind-set. These patients mostly struggle with **Emotionally Unstable Personality Disorder**. This can only be diagnosed if there is evidence of emotional instability in childhood or adolescence. Therefore these patients have been **thinking and reacting in heightened emotional states for most of their life.** SIM IS THERFORE DELIBERATELY SLOW IN ENCOURAGING DIFFERENT OUTCOMES. We have to tackle each behaviour one at time and 'shape change' from Behaviour 1 to Behaviour 2 over time using a model of support called 'Contingency Management'.

e.g. How do you ensure that a patient who goes to a multi-storey car park every week to get help doesn't do this anymore? How long do you think is reasonable to expect them to switch to another coping mechanism you are recommending that is safer and doesn't involve such extreme behaviour? A week? A month? 3 months?

How long do we wait until we start using 'blue skills and consequences' to ensure this happens?

We cannot make them change so we cannot make them safer in a matter of days. We have to lead and mentor them to **their own decisions**. This takes time.

RESPONSE?

1. Measure outcomes with as many qualitative data sets as quantitative. Our HIN Data Portal launching in Spring 2019 will help you do this. *e.g. clinical progress, risk reduction and patient safety, self harm, feedback from the patient and their family etc*

999 RESPONDERS WILL TAKE TIME TO TRUST THE NEW RESPONSE PLANS

The biggest challenge of all is not to meet the patients, build their trust and write response plans. The biggest challenge is actually making police and ambulance responders have the confidence to follow these plans. **Police culture is massively risk averse** – officers often operate in fear of prosecution and investigation – SIM methodology will be asking them to make decisions that they would **not normally make**.

e.g. Imagine you are a police officer and you dealing with a patient on a multi-storey car park. You would never have considered any other decision other than to take them to hospital but the SIM response plan you are reading is telling you to take the patient home. Would you do this? If you don't, you will be 'rewarding them' with what they used the behaviour for in the first place (to get into a hospital bed) – so you are actually encouraging them to repeat the same behaviour again!

This is culture change on an epic scale. It may take 6 months for a SIM trained officer to gain the trust of his or her colleagues, for them to follow what he/she is recommending.

RESPONSE?

If the police service are struggling to accept this as a new way of working, then get Paul to speak to the Professional Standards Dept of the police force concerned.

Reassure all people that the training course will give the SIM staff the confidence to do this.

FINANCIAL SAVINGS ARE A BY-PRODUCT OF CARE QUALITY

There is a lot of scope for significant cost reductions and efficiency improvements but much of this cost saving is indirect reductions in demand such as freeing up resources and releasing staff– not direct 'cash in pocket' savings

Preventing a suicide or accidental death saves £1million

Preventing a motorway being closed for one hour saves the economy £1million.

The cost of a police deployment, an ambulance deployment, an A&E attendance, a MH assessment and 1 day in a MH bed is £2300.

We can only eliminate the need to use these services if we can secure behavioural change.

This is achieved by radically improving care intensity and care quality.

Surrey Police estimate that for every £1 spent, they have prevented £3 of officer time.

SIM is not an innovation that produces 'quick win' cash savings within an April to March NHS time frame.

Despite these barriers, the take up of SIM has been significant.
Not one NHS Trust has said no in 3 years.
The future is bright and SIM is without doubt an innovation that totally justifies AHSN support.
AHSNs are already providing immense value to our innovation.
It is important that we collectively decide how to measure AHSN value over the next 18 months.
This project will save and change lives in your area.

You are now part of a national team that is leading one of the biggest clinical and cultural changes in NHS and Policing history.
The challenges you will face are unique.

We hope that being part of this project will be one of the most memorable phases of your career.
We really appreciate your support.
THANKYOU