“This isn’t just a case of taking someone to the hospital”: Police approaches and management of situations involving persons with mental ill health

KEELE & STAFFORDSHIRE UNIVERSITIES POLICE KNOWLEDGE FUND DISCUSSION AND POLICY DOCUMENTS

PLEASE NOTE: This working paper is a live document intended to inform and stimulate discussion and debate within the partner organisations involved in this specific research project, but also to contribute to a wider conversation involving academic and police related colleagues. PLEASE DO contact us if you have any comments or questions or would like to discuss the ideas in this document further: Please contact the lead author

Dr Samantha Weston, s.k.weston@keele.ac.uk

Keele & Staffordshire Universities Police Knowledge Fund
Discussion and Policy Documents

This working paper is one of a series published in open access format by members of the joint academic research team from Keele and Staffordshire Universities as part of a broader research project - ***Developing an Action/Work-based learning system for improved knowledge exchange, development and implementations through partnership working (Project code J11).***

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This series of discussion and policy documents is intended to inform and stimulate discussion and debate within the partner organisations involved in this specific research project, but also to contribute to a wider conversation involving academic and police related colleagues.

The views expressed in these documents are those of the individual authors and should not be regarded as representative of the views or official policies of any of the Police or related agencies that have collaborated in our research.

These documents regularly draw on research and evaluation of procedures and practices in a range of Police Forces, Offices of Police and Crime Commissioners and related partner agencies. While the project that has stimulated these documents was initially formulated in partnership with particular Police and related agencies and organisations, it should not be assumed or inferred that the discussion contained in these documents specifically relates to these partners, their policies or practices.

These documents are intended to be accessible to non-academic readers, and to provide an overview of a range of ideas, concepts and outputs from our research. We want these documents to stimulate debate and develop further knowledge exchange and production with a wider range of potential partners. If you have any comments or questions or would like to discuss the ideas in this document further, please feel free to contact the lead author cited on the title page.

Keele University

Context of this Report - Policing and Mental Health: Liaison and Diversion

This report is drawn from one strand of a PKF funded research project being completed by staff at Keele and Staffordshire Universities. This particular project developed from work conducted by our partners in the Police and OPCC in response to the growing number of people with a mental disorder that came into contact with police each year. This number will include not only offenders but also victims of crime and those who simply require help or medical care. To support policing, and following recommendations made by The Bradley Report, multi-agency initiatives include street triage, liaison and diversion in custody and courts to allow for individuals to be appropriately redirected away from the criminal justice system. Across the Force area partnerships have formed to support this multiagency response and this has produced notable reductions in the number of individuals that the police have had to deal with.

This project is intended to augment this work, to support knowledge and skills acquisition at all levels of policing to develop confident and empowered staffing solutions. In this 'Test Bed' specialist academic staff initially worked with a sample of police officers and mental health specialists working within this area to identify issues, obstacles and concerns relating to Policing and mental health. This has been delivered through a series of Knowledge Exchange Groups (KEGs) with staff working at various levels. One-to-one interviews and small group activities have also been conducted with key personnel to identify issues that might not be raised in the KEGs.

“This isn’t just a case of taking someone to the hospital”: Police approaches and management of situations involving persons with mental ill health

Final Report

Samantha Weston

Maxine Cromar-Hayes

1. Introduction

Despite being identified as a key aspect of police work (Gotfredson, et al. 2011) mental health is an area that has been neglected in police training. As reflected in the Adebowale review (2013), the police struggle to respond appropriately on an individual level to those with acute mental disorder and often find it difficult to access support from mental health services. Similarly, in the US, Wood et al (2011:6) show that the police have become "frontline workers who often come into contact with persons with mental illnesses and must respond to their needs with *whatever tools lie at hand*" (emphasis added).

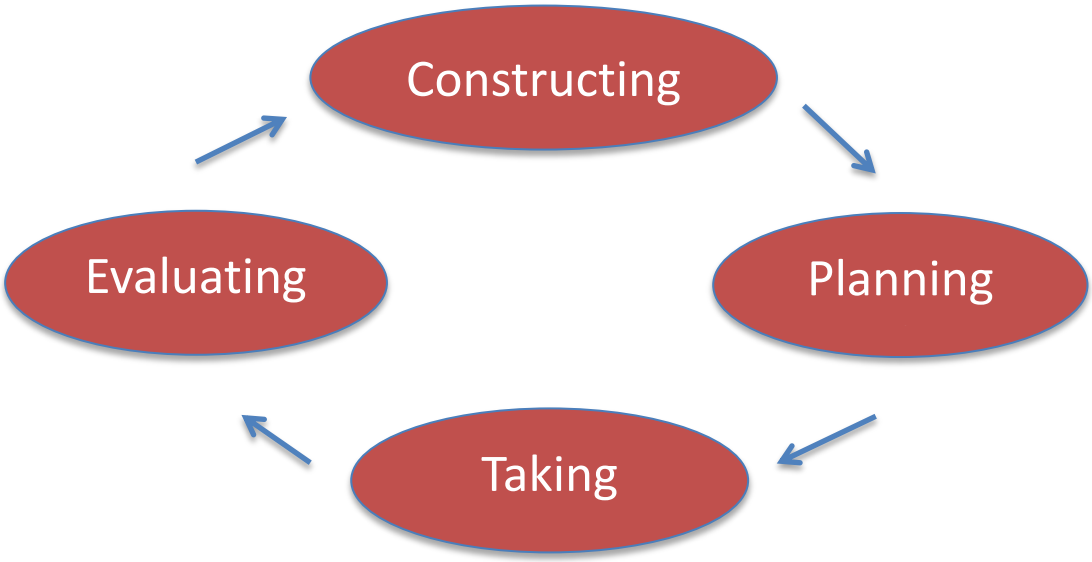
Section 136 of the Mental Health Act 2007 has become a fundamental tool for police officers when managing situations involving persons with mental ill health (Turner, et al. 1992). Yet nationally, questions have been raised about the extent to which police officers should be called upon as 'the service of first resort' (HMIC, 2017:8). Similar concerns have also been raised at a local level. The Office of the Police and Crime Commissioner covering Staffordshire commissioned a review to identify the frontline impact of mental health issues and found that demand on the police to support people with mental health needs living independently was increasing (2013).

Against this backdrop have been significant cuts to mental health provision and other services that may have otherwise addressed the issues presented by people with mental ill health. This context means that police officers need some core skills to carry out their role and to ensure that vulnerable people receive appropriate care.

The project reported here aimed to involve officers, and other related personnel, directly in devising training and knowledge related to mental health, as an alternative to imposing externally generated innovation.

Through the use of three Knowledge Exchange Groups (KEGs) and 12 one to one interviews, we were able to engage staff at all levels to identify the issues and challenges faced by both police officers and other related personnel, and the possible solutions that are rooted in their day to day experiences. Using the principles of Work-Based and Action Learning (see figure 1), the KEGs were designed to encourage operational staff to share experience and operation knowledge in order to 'frame' operational challenges and think about potential solutions. The one to one interviews, on the other hand, were designed to explore how the issues identified were currently negotiated.

Figure 1: The Action Research Cycle



The report is organized into two main sections. The first, section 2, reports on the findings of the project and offers some suggestions for the future. The second, section 3, evaluates the methods used to collect data as a knowledge exchange technique.

2. Findings

The first KEG consisted of a range of professionals including police officers, mental health staff, and commissioners of services. The police officers in the group were asked to identify an issue or challenge faced by them relating to mental health and to present this to the rest of the group.

A number of challenges were identified but many related to their roles and responsibilities in relation to calls received from inpatient facilities. Police officers reported being called to assist mental health staff with patient on patient or patient on staff assaults, or missing patients. In the event of an assault, police officers have a duty to respond through crime investigation. However, questions were raised about the capacity of the patients in question. Police officers acknowledged that if it was found that the patient had no capacity to commit a crime the investigation may be cancelled.

Some of the issues raised by both police and mental health staff culminated from the differing definitions used by the respective agencies. Police personnel reported frustrations about reports of missing persons from inpatient facilities raising questions about the risks posed by these individuals:

> "Quite often we get a phone call, so and so has gone missing from a ward, and straightaway the word missing is used which activates all sorts of stuff and it isn't always as big a drama as it could be. There are occasions where an individual who's got maybe complex issues and behavioural risks that we need to find this person as soon as, but there are others that have been let out on a section 17 leave at 3 o'clock and it's now

> 3:30pm. Are we really going to class them as missing because if they were alright to go out at 2:30 what's the problem at 3:30?" (Police officer)

These frustrations were also acknowledged by senior mental health staff admitting that the police are often called upon to assist in situations that may not be classified as the responsibility of the police service:

> "I know we get it wrong sometimes, I think quite rightly the police get frustrated with us about missing people… Sometimes I cringe when I hear in a liaison meeting that we have phoned the police because the person might be on a section and are refusing to come back but we haven't got any concerns about them then we ring the police to say bring them back. You know, the police are not a taxi service". (Senior mental health worker)

Also dominating discussions about challenges confronted by police officers was the increasing expectation to respond to people with low severity mental health, i.e. those people who may not be in crisis but might be regarded as vulnerable in the absence of appropriate support services and networks. Police officers complained about the increasing volume of calls being received by people who are known to mental health services but are not experiencing crisis:

> "We obviously have people who ring off on a daily basis, who suffer very low level mental health issues". (Police officer)

The one to one interviews provided an opportunity to explore the issues raised during the KEGs in more depth, which raised a number of wider issues effecting police work and potentially creating the challenges identified by police officers.

2.1. Austerity and the displacement of community mental health care

Many of those interviewed expressed humanitarian concerns for the people who were requesting help and support and although resources were not always referred to, the narratives of officers relentlessly move to the inevitably conclusion that services are suffering from dire under-funding:

> "Because the public sector is being tightened, where someone might fit the criteria for more [mental health] support a year or two years ago they don't fit that criteria now so they are not getting the support they need, and if they've not got family around them then that person can become quite isolated". (Police officer)

It is within this climate that those in need of support are displaced from community mental health care to emergency services:

> "I would say there are issues. Resources without any question... when you think how many acute inpatient beds we used to have and how many we have got now... so we have got more people being supported within the community... people don't disappear, what we do is move it into somewhere else and I think that's what we are seeing. I'm sure the police will that they what they deal with now is more health and social welfare than crime" (Mental health commissioner)

> "I think it depends on the time of day or night or what day it is in terms of what happens. I don't think the pathways are very clear for relatives who are trying to get people help so people normally access our services at a point of crisis, and that would be A&E or being picked up by the police" (Mental health practitioner)

2.2. Role of the police as mental health interventionists

Against this backdrop police officers are increasingly expected to respond to the increasing demand caused by a shortage in mental health provision. The police officers interviewed reported how their role and responsibilities with regards to the management of situations involving people with mental ill health was much more than simply "taking someone to the hospital" (Police officer). Police officers expressed concerns about the increasing need to assess risk and make decisions based upon this assessment, despite not having the appropriate skills to make this type of assessment:

> "You try and interact with the subject don't you? name a lead you, ' oh I'm under the care of so and so at the moment or I have...' ' talk us through why you're feeling like this. It might be that they've been on the phone to us saying that they need some help or they might have been on to crisis or the community mental health team, saying I'm struggling at the moment, I'm going to take a an overdose. We then get a phone call and we turn up. So we've got a little bit of background and they're quite happy to open the door to us and we're thinking have you taken anything? Do I need to think about an ambulance? If I can get you an ambulance then maybe I can get you referred up there? That's one avenue but if they are like no, no I haven't taken anything then you've got a situation in the property, which way do you go on that? and sometimes it can take hours..." (Police officer)

Police officers also talked about their role in safeguarding and welfare, particularly with regards to those people experiencing low severity mental health. In an effort to reduce the number of calls being processed in the control room one officer described how he had made regular arrangements to visit people who might be described as 'frequent callers':

> "The control room, if they are able to might have a little chat with them on the phone and that's it they will go on their way again. I have got a couple on myself I go and try to see them a couple of times a week". (Police officer)

This police officer also described various examples of the type of support he has provided to people requiring mental health support, ranging from help with accommodation, utility bills, and cleaning:

> ""there is this particular person who comes in, has been one of our highest callers, some of the agencies that were dealing with him did let him down getting rehoused and we have had to step in a little bit. Some of our PCSOs have gone in and helped him clean his flat, they have helped him with some bills they have done things like that. He now knows that if he rings the police someone will go and speak to him and tell him what he needs to do. When it comes through the control room now it's flagged that he has got

> mental health issues and it is myself that goes to see him and then I update the incident of the last incident to notify when I am going to see him next, so if he calls they will say " OK Gary but Bill is coming out to see you next Tuesday so you can wait till then"... and that has actually reduced his calls quite dramatically, just by doing that and I've done him a flowchart as well“ (Police)

2.3. Over-reliance on ‘individualised knowledge’

In an effort to overcome the issues and challenges identified, police officers have made efforts to work closely with mental health staff. Common strategies used by Staffordshire police have included the implementation of regular joint meetings between frontline police officers and mental health practitioners, and the development of protocols to raise awareness among mental health practitioners working at inpatient facilities as to when the police should be called. Yet many of these strategies, as acknowledged by those interviewed, rely heavily on ‘individualised knowledge’.

Regular joint meeting between frontline police officers and mental health commissioners have helped to develop close working relationships where informality and trust are common features:

> “Well I think the relationship is very good. I think there is scope to improve it. It's very good in the sense that we have got our local liaison officer and there's a PCSO as well. We have a monthly liaison meeting but there is a much more informal relationship as well where [local liaison officer] contacts me I contact him, he'll pop down if he can, we can have a conversation on the phone I can leave him a voicemail if he's not on shift and he's very often a source of information for me”. (Senior mental health practitioner).

> “Before, things would just fester, it just goes on and on and it’s never resolved, it's never brought to anyone's attention, it just starts to become a moaning tool almost. We highlighted that that's not healthy from all sides and there’s a need to get into a discussion and thrashing it out, whereas before it was go unresolved. A problem that was never resolved is talked over usually in a matter of a day. It's been flagged up and the next day we're talking about it, we are resolving it, and we are understanding it. Nobody slams the door in my face and I don't get told to clear off. They don't trust me just because of who I am or because of what I'm wearing they trust me because they know the individual that's working with them...” (Police officer)

However, as one police officer suggested, staff turnover in the police service and mental health sector presents as a threat to these working relationships:

> “The problem that we have on both sides ourselves included we have such a high turnover of staff at the associated coal face and in our control room. We're trying to get our control room to be part of some of the meetings because some of the decisions that we make at a strategic level will occasionally get lost in translation when it hits the boards itself, which makes it even more difficult when agency staff are being used” (Police officer).

Police officers also acknowledged the difficulties in communicating strategic decisions to frontline staff:

> "and the thing is we can have a very good relationship with our level and then it can be I wouldn't say shattered but it can be weakened by a third party which is out of control room which is the middle party getting involved in it. we can normally resolve most things can't we, afterwards? but if we can get to the point where we don't have to resolve things... it makes it a lot easier" (Police)

2.4. Recommendations

Among those attending the KEGs the need for supporting roles was acknowledged. Particularly positive comments were made about the crisis team and street triage used across Staffordshire. However, in the absence of these services feelings of discontent among police officers were common. To overcome this problem it was suggested that the training of police officers should be a main priority for Staffordshire police. Currently, the knowledge about mental health is gained from 'on the job' experience:

> "Ultimately anything that we learn mental health wise in this job is learnt on the job with no structure, no information. That's fine because if the person you're picking it up from has got it right then brilliant but where are they getting it from? a lot of its legacies from when they were taught by their tutor constable maybe 20 years ago and they've been doing it the same way, but that might have been before the Mental Health Act so actually there're things that they have learnt, ways of dealing with it or even illegal ways of doing it because they just don't know" (Police officer).

Suggestions for improvement to training included the adoption of a more multi-agency approach:

> "It's quite nice when it's multi agency because everybody has their perspective from their organisation" (Police officer).

Many police officers also suggested the need for input from service users:

> "it's that personal experience that is missing from the training courses, there is just a PowerPoint thing that they go through about capacities... they have no scenarios, they had no this happened, this is what the police did, and this was the result. No sort of horror stories, you know, some things have ended badly. Can we not share some of these experiences that people have had just to give a little bit of awareness, to cement training because training is yes you do need to know this stuff but personal experience and personal knowledge is a lot better because we're not dealing with criminals, we're not dealing with people who have that constant engagement with police, and know how to respond and deal with police, we're talking about people who have had no contact possibly for 50 years of life and all of a sudden you've got somebody in body armour and with tasers coming at you". (Police officer*)*

> "one thing I looked at following your course was the training and whether we have any external input and that is no. Those new officers coming in have got no experience of dealing with mental health whatsoever. They have had the training but they've got no ... we must have videos of people in a mental health crisis from city centre CCTV cameras but we did not show any of them. A new officer wouldn't know the difference between

> someone who is off their face on drugs, drink, legal highs, or having a mental health crisis...they wouldn't know the difference". (Police officer)

Also consistent among the expressions of police officers was the need to develop knowledge about who to contact when they are confronted by a person experiencing a mental health crisis:

> "For mental health s135 and s136 training, having looked at it, it was almost aimed at teaching you how to suck eggs. You know, recognising someone in the street that doesn't look very well. Do I really need that? Come on, I got this job for a reason not because we decided to walk in off the streets to the police station one day and said give us a job. We've got something about us, we've gone through a selection process, you think I really need 20 minutes looking at some pictures of somebody that doesn't look very well because that should be second nature you shouldn't be teaching that you should know it almost. I want to know what things I can do, what I need to do with them and who is going to help me and fundamentally what powers I've got. Once I have got all of those things in place no problem at all" (Police officer).

> "My biggest challenge will be who do I pass it to next if it's not an emergency, who do I pass it to and how long are they going to be? I would say that's probably it for both myself and the response officers because we are an emergency service and we are there to prevent injury to them and anyone else and once you've got that under control we are the experts, we can talk to someone, we can put some referrals, in but really we need to make sure that that person is safe and get that help they need" (Police officer).

The need to prevent harm when confronted by situations involving persons with mental ill health was consistent among the expressions of those attending the KEGs and those interviewed. It was thought that if police officers were trained sufficiently enough to have the confidence and ability to deescalate a situation the need for specialist secondary care services, which are associated with higher costs, may be avoided. This approach reflects the public health approach being adopted across other areas of policing. For example, drawing on the work of Laws (1996, 2000) and rejecting the traditional reactive responses, attempts are being made to address sexual offending from a public health perspective, making way for more forward-looking approaches towards preventing sexual- and other forms of violence. Central to this reframing is the shift in definition of the problem from the vantage points of containment, surveillance, monitoring and management to an approach which anticipates and solves problems in a broader context and involves key stakeholders. The primary approach, then, is one of inclusion and reintegration rather than exclusion, where strategies are implemented to retain individuals in the community by managing out, reducing or limiting problematic behaviour rather than excluding them from the situation. Applied to the area of mental health, officers would need to be trained and work closely with other health and social care services to undertake pro-active outreach work with at-risk groups. As evidenced in this report, examples of this type of work are already taking place across Staffordshire but need to be formalised through the implementation of clear training packages and identification of officers willing to carry out this type of work.

3. Evaluating the methods used as a knowledge exchange technique

One of the main advantages that emerged from the use of KEGs as a source of information and knowledge production was its changing membership. Each of the three KEGs attracted different

personnel, expertise and experiences presenting as a good practice example of inter-professional learning and collaboration. In the absence of a dominating voice or agency, multiple agendas were discussed and actions attached.

This type of membership, however, does have its drawbacks. As membership was fluid, it was difficult to capture change and actions taken forward between the various KEGs. Therefore, it became necessary to capture evaluation in other ways. During the course of the project and emanating from discussions had during the KEGs it became apparent that evidence of 'behind the scenes' activities were taking place. Examples of these included the involvement of service users in both police training and the training of student paramedics.

3.1. The involvement of services users in police and student paramedics training:

There is indisputable evidence that people with mental health conditions are stigmatised by society. Such stigmatisation has the potential to infiltrate public sector establishments which can in turn impact on the quality of service received by people with mental health presentations. As reported earlier, many of the police officers attending the KEGs emphasised the need for service user experiences to be part of their training but acknowledged too was how paramedics also find it difficult to understand the rationale of people's behaviour when related to mental health conditions. To address these concerns, and as a result of a collaborative effort between Staffordshire police and the North Staffordshire User's Group, an advertisement has been placed in the North Staffs Voice for Mental Health calling for people to talk about their experiences of being treated under section 136 and asking if anyone would like to be involved in training the police and/or becoming involved in undergraduate paramedic education (Figure 2):

Figure 2: North Staffs Voice advertisement for service user volunteers

Opportunities for Involvement:

Below are three separate opportunities for you to be involved which will lead to improving services for others in the future. Please get in touch with Carole on **(01782 683043)** if you would like further information, or want to get involved.

Have you been treated under a **Section of the Mental Health Act** recently?
This is an opportunity to speak to someone about your experience, so that providers can look at how to improve.

Have you used the **ambulance service** recently – for mental or physical health reasons?
This is an opportunity to be involved in training paramedics at Staffordshire University.

Would you like to be involved in the training of **Police Officers** to raise their awareness of mental health problems?

3.2. Perceptions of participants

Other forms of evaluation were sort in the guise of impact and pledge statements. Impact statements are personal and do not necessarily align themselves to an action but have the potential to present as opportunities for change. Six impact statements were given in the final KEG:

1. Enlightening.
2. Useful to gain insight into other services, the pressures and expectations and limitations they are faced with and how this interfaces with my own service.
3. Allowed me to see that there is a bigger picture to all the services involved in mental health.
4. This is the first meeting I have attended, think it is a good opportunity to get everyone form partner agencies talking.
5. More service user input on training.
6. The KEG has made me think about my role in terms of police liaison and how I maximise the impact of this.

Pledge statements are more aligned to action or something that has an intention. Five pledge statements were made:

1. To review our local protocols in light of the recent MOU – "The police use of restraint in mental health and learning disability settings".
2. To take forward questions that arose around the police and crime bill.
3. To ensure involvement is meaningful.
4. To learn more about the services out there and where it fits within my role.
5. To understand the bigger impact on other professional and not to get frustrated.

From an external position, the KEG was assessed as being successful. The inter-professional nature immediately broke barriers and created opportunities to learn from one another, with the overall aim of making the experience better for the police, aligned services and individuals coming into contact with the police. When considering the future there were discussions in the group about undertaking research with regards to trying to establish more funding from commissioners with respect to the triage system. There was also an expressed interest to take a closer look at adolescents' experiences of mental health and their contact with the police, as anecdotally there is concern that contacts with the police will rise due to lack of child and adolescent funding in the NHS as well as the pressures and effects of social media.