EMPAC Roundtable:
Policing mental health

Research Insight report

September 2018

Authors - EMPAC

“We can’t beat a person into good health”

Contents

Background 4

Method 4

Objective 5

Policing context 6

Just do it: crisis led change 9

How did we get here?: tactical change without strategic forethought 11

Re-visioning the future: what if we to start over? 14

Next steps 15

Background

As part of the *East Midlands Police and Crime Research and Development Plan*, the important topic of policing and mental health was highlighted as a key workstream. Detective Chief Superintendent Chris Davison, of Lincolnshire Strategic Partnership, Dr Claire Davis, of the University of Leicester, Professors Melanie Jordan and Kerry Clamp of the University of Nottingham, and EMPAC, planned an event to stimulate insight, innovation and future research. Thanks is also due for planning advice from Inspector Michael Brown, who is seconded from West Midlands Police to the College of Policing as national coordinator for policing mental health. The University of Nottingham offered to host a roundtable in September 2018 and thanks is due in particular to Dr Jordan for organising the logistics of the event.

A contextual opening statement was given by Detective Chief Superintendent Chris Davison, and then DCS Davison facilitated the event with A/Professor Kerry Clamp.

The topic is of pressing concern to Chief Constables and Police and Crime Commissioners within the EM region, and beyond, as a matter of capacity, capability, efficiency and agility for current and future needs. The intention of the Roundtable was to offer insights and innovation to inform both regional and national thinking on policy and practice.

Method

The roundtable informal, action-orientated approach has been used successfully in other settings (such as national security consortiums with academia in Australia) and builds upon the existing collaborative partnership of EMPAC across the region. Within the EMPAC region, the approach was first promoted by Professor Rob McCusker. The basic origins are as a form of democratised conversation – with no 'top table' hierarchy – but rather an open and eclectic problematisation to critically challenge and inform new ways of thinking about key topics. A number of academics from HEIs were involved, across several academic disciplines (i.e. Policing, Criminology, Behavioural Psychology, Health and Social Care, Psychiatry, Business) a mix of policing professionals from OPCC, Custody, Reactive, Analytical, Corporate Services, Vulnerability and those working in strategic partnerships with local government and Community Safety Partnerships.

Specifically, an adapted facilitated focus group[1] method was utilised using a semi-structured conversation topic focus with strategic and tactical questions to provoke discussion (see appendices).

The focus on mental health (see appendices) was framed by wording provided by the Roundtable planning team to stimulate the need for practitioners and academics to tackle the challenges and opportunities by working together. There was a clear link between the method of the roundtable

[1] Bloor, M., Frankland, J., Thomas, M., & Robson, K. (2001) - for focus group methodology

seeking research-mindedness insight into mental health needs and the roles that various state agencies could and should play.

Objective

The Roundtable approach was a tangible way of working in partnership between policing professionals, industry and academic researchers to discover new ways and challenge conventional thinking. The opportunity for the roundtable, given the mix of delegates, was to seek diverse views, establish what is already known and encourage fresh thinking from across the involved partners, with a research 'known unknown' outlook at the centre. The interconnection of differing sorts of data, whether called intelligence, information or evidence are all forms of knowledge which a proactive research outlook can assist to expand.

The objective of the event was to:

Based on current policing challenges in how we understand, manage and predict policing demand, seek insights and innovation using a joint approach between policing professionals and academic researchers to improve policing capacity and capability and inform policy and practice.

The structure of the event's process was in five stages[2]:

1. **Policing context**

a. How do we begin to understand the demand being placed on the police service?

b. What are the drivers for the change in policing functions around mental health?

[2] At the roundtable, the contextual opening statement was delivered by Detective Chief Superintendent Chris Davison. Additional table prompt questions were distributed (see Appendix).

c. Has the role of policing grown whilst other services have withdrawn service provision?

d. Is the role of policing around mental health legitimate given its coercive role in society?

2. Definitions

a. what do we mean by mental health?

b. what is the role of the police?

3. Innovation

a. If we had the opportunity to start again, how would you organise services?

4. What next?

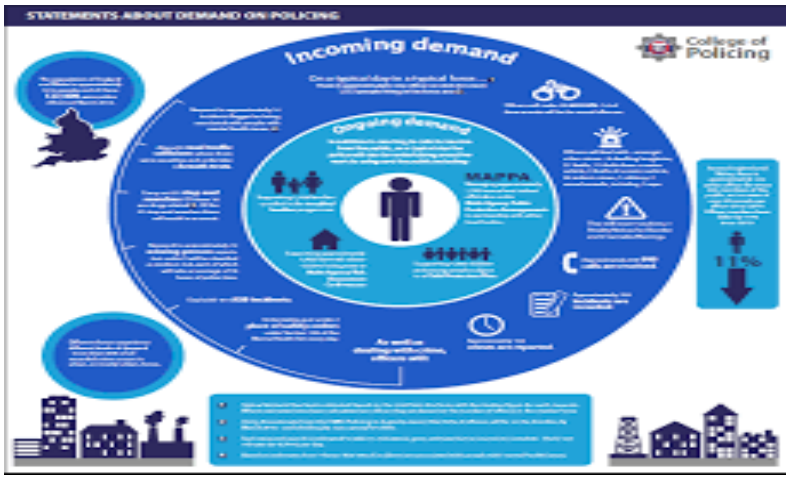
a. What do we need to do next to help inform policy and practice?

5. Respondent validation

a. Delegate interaction post-event for data and thematic interpretation validation

Policing context

Demand for policing has increased and this is arguably linked to an expansion of the role and scope of policing. Many services have made efficiency changes and as a result there are fewer preventative interventions and more responding to crises linked to mental health.



The fundamental context laid out for the roundtable queried not so much is policing 'doing things well (in terms of compliance and inspection) but rather is the current and trajected policing of mental health the right thing to do in the first place? Was the role of the police in being a prime responder to mental health matters a legitimate use of the service, particularly given the coercive nature of policing? The roundtable sought to stand back from 'doing things well' to challenge *what* policing and others should be doing. The opening context asked for a conversation to explore to what extent had policing slid into doing more and more around mental health amidst a vacuum of other service provision, and with that slide what implications were there for the police service,

other state services and indeed the public. The urgency was also that that the current trajectory was not standing still but continuing to move policing even further towards mental health response, even though some statistical measures (i.e. use of section 136, MHA) showed a reduction in the use and recording of powers. The opening context was that the shift in the role of policing had been a form of sleepwalk that had not been validated with the service or the public, but rather out of a form of crisis necessity which was now becoming increasingly normalised. The contextual appeal was to seek a safe space to reflect on why things were happening, outside of the compliance pressures of 'just doing things'.

Further prompter questions to stimulate discussion amongst delegates were shared:

What do we mean by mental health and should the police even undertake "mental health work"?

What are the ramifications for police staff as a result of working in this field?

What work do the police do in the realm of mental health?

What is working well and where are the opportunities for improvement?

What should mental health services in society be and/or look like?

What should the role of the police be in society?

What should the role of the police be in relation to mental health?

What research questions could academics explore in this realm?

What evidence does the police need to further its frontline work in relation to mental health?

How does what we envisage marry with, or not, current practice?

What needs to change and how might this be achieved?

What resources do the police need to address mental health fully?

Are members of the police comfortable and equipped to undertake "mental health work" and should/how might this be improved?

Key discussion themes

Questions helped stimulate discussion where the first overarching theme explored just what do we mean by mental health; what definitions, moving or fixed, are at play? Has mental health become a generic symptom where the causes are linked to several growing societal ills? Is the crisis over mental health *about* mental health or a crisis of public service capacity to cope?

Just do it: crisis led change

The definition should be a medical one on assessment and diagnosis grounds, not the slide into accountancy.	The police get into unlawfully detaining people. There is no power to keep people in custody pending assessment. There's power under Section 136 in a private place. Bending the law is not in the public interest.	I think the definition is not person centred but agency centred, based on demand and capacity. Then you get agency ping pong.	The police are detaining because health are not putting in place 136 detention suites. In the sense of detaining this simply means acting like a holding bay until someone in health can see them.
The definition of mental health is so wide it can mean different things to different people.	Mental health in reality is often a mix of underlying factors. The big joint endemic factors here are homelessness, relationships, substance abuse and mental health.	There's a spectrum between mental health and a morph into 'crime' issues. But the default position seems to be throw the police at it.	Mental health should be about assessment and treatment in a health care setting and a move away from detention in a cell alongside criminals.
When there is a crime and mental health in one situation even when the crime has been looked at the police are still left holding people pending assessments.	It's not on for the police to be guarding someone for 48 hours until someone decides if it is mental health.	Even if we can't define what it is we can be sure poor mental health is not a crime.	Is it appropriate for the police to be having to decide if a case is mental health or not? The definitions are effectively situational judgements.
There is a core of people who have that toxic cocktail of homelessness, mental health and so on where proactive services could be targeted more to stop the revolving door. Addressing the causes rather than the crisis symptoms of mental health.	There needs to be more of a joined up 24/7 service to assess much more quickly what is mental health and far quicker response from health to begin treatment.	HMICFRS seem to think the police have to decide if any one case is crime or mental health there and then. It's apparently not possible for a mental health specialist to make a timely decision, so it's devolved to someone with less knowledge.	There's a sliding definition for mental health depending on the scenario and cynically I would say if the health office is open and has any capacity. It doesn't help to have definitions acting as thresholds – a depressed person trying to jump off a building for example. Surely there are health issues there?
It can be misleading to consider mental health yes or no – there tends to be episodes and cycles.	Do we include depression? Learning needs? There needs to be a lot more upskilling in health too about this.	There seems to be more clarity over if it's mental health or not after the event, but that doesn't help at the time, during crisis.	It seems mental health has become a bit of a broad label for vulnerable people in a state of vulnerability who need some support to stop it deteriorating.

It's not just policing who have had a rise in demand about mental health – it's EMAS and A & E too. It's just that we are managing the crises from a single agency approach too much.	The key difference between the agencies is how they interpret 'dangerousness'. Health call on the police at any sign of conflict for example. So, there is a working difference between compliant mental health that fits in with going along to the GP by appointment and awkward mental health that gets into crisis at 2am on a Saturday morning.	The Section 135 duty on the police is where risk of violence is so unmanageable. But even then, this should be led by health professionals. It remains mental health even if protective factors for staff are needed.	I think service users will tell you it's very hard to get seen by a mental health professional. That's why we have people going to extreme and committing crime to get noticed to get seen. The bottom line is mental health services are effectively rationed, using ever shifting threshold definitions. The issue then doesn't go away it's simply others like the police and society who have to pick up the pieces.

How did we get here?: tactical change without strategic forethought

This additional theme explored, in the context of mental health, was what is the role of policing? The key point here was a 'can do' operational culture that leaned towards action, yet like any service, with a limited capacity. As well as exhausting capacity, there was a subliminal shift in the role of policing towards mental health response, which due to the actioned orientated nature of policing culture was simply not considered. The inspection regimes also failed to drive home the point that policing was being changed on the hoof with little indication of moral, social or legal considerations being taken strategically.

Police leaders are trying to do their best. Always trying to do things better. But this is a hang on a minute 'why are we doing this' question. The police are so busy being compliant the big questions around 'why' never get on the table.	I've seen such changes as police MH triage cars, nurses in police control rooms and custody blocks. I've not seen so many additional 136 provision secure beds and places of safety in hospitals though. Who's owning this?	The police at the end of the day are the coercive arm of the State. There are powers invested there, to take life if necessary, that no other service has. Is it appropriate that coercive service is responding to mental health?	Are the Police best placed, equipped and trained to be responding to mental health matters more and more? I would say the police are responding more to mental health than mental health specialists. How can that be the right balance?
Cynically, is this simply about the police being 24/7, answering the phone and being willing to be out there why they are doing all sorts? And being criticised then for doing things imperfectly. If the Government is seeking to professionalise policing then do just that and stop this 'all sorts' mentality. Get mental health professionals dealing with mental health and police doing professional policing.	The police are busy complying and performing for HMICFRS but there is very, very little independent thought about what and why which functions policing should be doing.	There are all sorts of problems out there in society. Deprivation for example. We don't have deprivation triage cars, yet!	There are many messages about what is appropriate for 999 and what is appropriate for an ambulance. Whilst I appreciate that, that dividing line just pushes things into the miscellaneous basket and policing seems to have to pick it up. Mental health is nearer health than crime surely? Why can't we be open about that?
HMICFRS could help by stop doing single agency inspections of agencies over what are clearly holistic issues in society. Is it really a sound strategic decision to inspect in a silo?	It's like mental health professionals have positioned reactive constables to be the lower tier response of their service and only to act as the specialists further down the referral route.	We need to understand more about what is working well and not. We need a joined-up conversation that does not simply look at the police role. The current default is police are last, and first resort.	Police do their best but are not the experts.
Policing is so 'can do' it puts itself at risk in work around mental health – limited knowledge can get us into violations.	A big risk here is the police get better at doing the wrong thing. Then health specialists	The more respond to managing mental health demand you'll find demand will grow. There'll have to create	We should have perhaps another 24/7 agency for mental health if the health service can't cope.

	step back even further saying leave it with you.	another agency at this rate to respond to crime.	
There is so much time spent – wasted – over individual cases; holding for assessment, tying resources up, the risks involved, the availability of beds etc on a daily basis; often 'out of hours'. Yet there is less strategic discussion about alternatives to that daily chaos.	Demand for mental health is increasing. Does that mean society is getting more unhealthy? Or is this about the societal issues such as poverty that are increasing?	The definition is blurred because there is so little early intervention we're all just responding to catastrophic failure and trying to work out what it is once it's become a crisis	It's like somewhere somehow society has got commodified so that it's a 'go away and sort yourself out' until crisis point and then the 21st century equivalent of the workhouse. It's Dickensian.
We shouldn't look at mental health in isolation from society. It's not an imaginary ill health and it's grown exponentially. Society has fractured to an extent and the State shrunk just to be a buffer zone around crisis.	We've seen new hospitals built and still no space for a joined up social care, mental health or even enhanced security provision. It's like the buildings represent the silo thinking.	One the one hand there is a merging of functions, but you might also see it as an abuse. For example, EMAS requesting ARVs to attend incidents for them as they carry a defibrillator.	It's a muddled and tense public service out there. Hospital A & E prioritise EMAS to turn their units around as soon as possible yet have police sat waiting for hours and hours.
Health have decided not to staff 136 suites knowing police will have to pick it up. But it's not about a dispute between services – it's because of the cuts to services.	We've got the very unfortunate combination of revolving doors in terms of repeated crisis cases and closed doors from any prevention and proactive health service.	We need to understand that NHS Trusts too have limitations over current powers, such as to detail people. The law around mental health needs looking at.	We all know a person waiting at a hospital for assessment, if left by the police, can then walk off and then becomes a high risk missing person. One crisis feeding another crisis.
Saying there are fewer 136 cell detentions is not addressing the point of how many hours police are sat with the same people at hospital. Just measuring the cell statistic is missing the overall point.	We need to review what the whole region is doing across partners too to see what is working better and spread better practice. We have to think proactively about these constant crises, not just live in the eye of the storm 24/7.	A person with mental health in police detention needing help – what do the police do, rush in there with shields and restraints to hold them down. We can't beat a person into good mental health. Police have coercive powers but mental health matters should be led by health.	We also need to understand that whilst we might say mental health needs to be owned by health, there is no magic bean in psychiatry. This is not as simple as putting mental health in a box and saying job done.
Mental health is one of those needs in society that seems to have caused friction and division between blue light services. That's regrettable as it's caused by central	Hospitals maybe needs to have a widened security function rather than calling on the police so much. They seem to afford people to police their car parking	When can the police ever say 'no'. We just do without questioning enough. There's a duty to protect life, and there might be a cry for help. But who is the best	All public services have had to change what and how they do things. With lots less being done we are seeing a series of crisis issues that what is left of the services are struggling to cope with.

Government cuts and that gets missed in the divide and conquer of austerity.	charges because it's income generation.	agency to help? And who are willing?	The implications and ramifications of salami slicing huge cuts weren't thought through. Maybe this roundtable should be about financing public services. The metal health crisis is possibly a by-product of that issue.

Re-visioning the future: what if were to start over?

Here, innovations about how the problems being discussed could be eradicated were encouraged. The notion was to explore and reframe a de-problematised environment as an alternative way of thinking about the issue to see if the solutions could be worked towards other than seeking to fix the perpetual demand crisis piecemeal.

We would be in an environment where services were funded enough so that they could be available and accessible early to stop the spiral of decline.	There should be a move away from managerialism and state interference in public services. The public fund the service – it's public services not Government services. The public want early help, reduced bureaucracy and resourced locally delivered services that care.	We've discussed roles and functions and definition but we could have an environment where the blue light services are more as one and leave behind the division and divides. But is a universal, jointly managed, blue light service any better that properly serviced police, fire and ambulance services or just another efficiency saving?	That alternative future has social care and health as one. There is better flow of data, joined up around the person in like a health passport. Professionals know the context quickly and can intervene early.
We should get a future where the police are operating in their legitimate legal and moral role. It's undermining the legitimacy of policing using them as a form of Securicor for the NHS.	There is a new concordant between health and policing agreed by the NHS and NPCC. We need to be looking at that - more trials and more evaluation.	We can get more informed and base commissioning on evaluation. There has been some evaluation of triage in Northamptonshire and we need to build on that for a broader join up across blue light services across the region.	The health service is so complex, there are different bits doing different functions. Not only does policing need to work closer with health and social care the NHS itself needs to get a more joined up approach.
We would have a stronger evidence base of what works. Triage cars and nurses in control rooms. We need more evaluation. Some claims made by street triage are misleading, they don't solve issues they displace and refer and displace.	It's a link into what we need to be doing locally. We do need to jointly sit down with partners to have a full and frank discussion about services – maybe by looking at this from the service user's perspective.	There could be a 4th service with powers to address mental health. For policing it's a but like the role of the Highways Agency, to stop policing resources parked on motorway hard shoulders or escorting lorries	There needs to be much more early intervention, diagnosing much earlier and resourcing intervention before crisis point. Ironically prevention is cheaper than cure yet all the prevention work seems to have gone.
There should be mandated information sharing around mental health – driven by central Government.	A good model would be a crisis care service hub, to pull together work on homelessness, alcohol, mental health. This could be multi-agency staffed.	You know people will say that's pie in the sky because there's no money for it. Well you know what, we can't afford response and it doesn't work anyway. So, we need to challenge those who seem to stick to a status quo of failure.	The future needs to be less selfish, less efficient and more focussed on the quality of people's lives. Having gfbhna greedy morality of dog eat dog means we have a lower tier in society who are written off, criminalised and demonised. The future needs to be more humane.

Next steps

Like other roundtables, this event on mental health proved to be a start of something rather than a ‘fix’. As with all research process where you think you are starting at is often not where inquiry takes you. In this instance, the question over mental health moved to a question over roles and the need to work together with partners in a more holistic fashion. There was an assertion that joint problems needed joint working: the silos of responsibility and remit did nothing for long term legitimacy or accountability for public outcomes.

There was interest in more research to explore and confirm what works best in resourcing mental health issues across the region, which could be offered as a national model.

Joint approach	At the next event we need directors of health, EMAS, social care leads and mental health services to be here for a joined-up conversation	We need to – together – think about our roles. Do we want pseudo cops and pseudo nurses in public services? Do we go for a core function approach and have territory disputes between us?
Voice	For the next event, there should be representation of users of services, not just professionals who deliver them.	We need to focus on high intensity users, to expand the NHS and NPCC agreed co-ordinated approach idea: to target the most vulnerable. We need trials and evaluation to inform future commissioning of public money.
Early holistic intervention	We need to get beyond crisis response. We need to have more community focussed identification and diagnosis and treatment. This needs to link holistically to the mix of homelessness, relationships, alcohol, poverty.	Just measuring 136 cells use is misleading we need to think holistically where all our various resources are being used at every stage in reality to inform just what is it currently costing us. We could chart that from existing client episodes.

Appendix

Prompt questions distributed across the Roundtable for delegates:

What do we mean by mental health and should the police even undertake “mental health work”?

What are the ramifications for police staff as a result of working in this field?

What work do the police do in the realm of mental health?

What is working well and where are the opportunities for improvement?

What should mental health services in society be and/or look like?

What should the role of the police be in society?

What should the role of the police be in relation to mental health?

What research questions could academics explore in this realm?

What evidence does the police need to further its frontline work in relation to mental health?

How does what we envisage marry with, or not, current practice?

What needs to change and how might this be achieved?

What resources do the police need to address mental health fully?

Are members of the police comfortable and equipped to undertake “mental health work” and should/how might this be improved?

What’s next for academic research in this realm?

Reference: EMPAC Policing Mental Health 5918

ISBN: None

The views expressed in this report are the authors' and do not necessarily reflect those of Lincolnshire Police.

Internal circulation only.

Any enquiries regarding this document should be sent to us at: john.coxhead@empac.org.uk

This document is formatted in compliance with Social Science Research in Government.