Mental Health and Demand upon Policing

York Health, Housing and Adult Social Care Policy and Scrutiny Committee

26th March 2018

The Police and Crime Commissioner (NYPCC) and North Yorkshire Police (NYP) are deeply committed to caring about vulnerable people, and to improving the response to their needs, with a particular focus on reducing harm to people at greater risk. Our vision in respect of mental health is threefold:

- Those people coming into contact with NYP, whose mental health is a presenting issue, get the earliest possible intervention at the lowest appropriate level to help promote recovery
- Improve services, reduced demand and keep people safe, well and avoid inappropriate contact with NYP as a consequence of poor mental health
- Reduced repeat calls for service where mental health is a component, by focusing on identifying unmet needs and working with others to address them

To achieve these objectives, it is vital to have an improved understanding of the scale and nature of the issues being faced. Mental health issues affect all aspects of life and no single agency can hope to address its complex nature alone. Although it is often seen as a health issue, its consequences impact upon every public service. The police service often encounters people at the highest level of risk and need, where other services appear unable to provide the requisite assistance. Described below is our combined response to those specific questions raised within your originating report sent to PCCs & Chief Constables and our endeavours to set-out the evidence and narrative to portray an insight into the challenge being faced, both locally and nationally.

General data on mental health demands

Mental health forms a core part of policing business (*Adebowale, 2017*) through the police duty to preserve life. Estimates indicate that 20-40% of operational policing demand includes some component of mental

health issue. This is entirely consistent with figures from the Adult Psychiatric Morbidity Survey[1] showing that around 17% of people over 16yrs old have a common mental disorder, and supporting evidence that a similar proportion are symptomatic but do not fulfil full diagnostic criteria (*McManus et al 2009*). It is important to remember that people affected by mental health issues will fall within all categories of involvement: as victims, witnesses, suspects and other contacts (such as missing persons, suicidal people etc.).

In addition, there is extensive evidence that:

- 90% of the prison population have one or more mental health conditions, and 70% have two or more (*Singleton et al., 1998*)
- Women with a mental health condition are 10x more likely to be a victim of crime than the general population (men are 7x more likely) (*At Risk, Yet Dismissed, MIND, 2013*)
- Mentally ill people are four times more likely to be a victim of violence than the general population, and 25% have been attacked in the past year (*Lancet, 2012*)
- Around 45% of people with a serious mental illness were victims of (any) crime in the preceding year. Nearly a fifth (18%) were victims of an assault; and 23% were victims of a household theft or criminal damage (*At risk, yet dismissed, MIND, 2013*)
- Mental/emotional health was the most common main concern in ChildLine counselling sessions in 2016/17 (ChildLine delivered 295,202 counselling sessions in 2016/17 - a 55% increase since 2009/10).
- Approx. 80% of missing people are experiencing some form of mental illness (*Gibb & Woolnough*, *2007*)
- Following its pilot research during 2015-16 with 1,500 young people, where mental health issues were an over-riding concern, the North Yorkshire Youth Commission included mental health as a priority for further research which was undertaken during 2017-18. Over 3,000 young people have been engaged during this time and the North Yorkshire Youth Commission continue to work with North Yorkshire Police to influence their approach in this area, this

[1] https://digital.nhs.uk/catalogue/PUB21748

has included being involved in the Connect training project for frontline officers.

It is therefore perhaps helpful to consider the issues associated with policing and mental health through the lens of the "i4R Model", developed by NYP in 2016 as part of the "Connect – Mental Health Partnership" with the University of York, College of Policing and Tees Esk and Wear Valleys NHS Foundation Trust and sponsored through the Police Knowledge Fund (report enclosed). The model identifies five key areas where agencies can improve in respect of vulnerability:

- ***Identification*** of vulnerability, through training, raising awareness, enhancing partnerships and developing screening tools
- ***Recording*** of relevant information in a terminology that is commonly understood between (and accessible by) partners
- ***Response*** using appropriate internal and external resources in an intelligent way, to ensure the lowest appropriate, least restrictive intervention at the earliest possible opportunity
- ***Referral*** to agencies able to provide the correct, longer-term support and management
- ***Review*** to ensure residual risks and needs are understood and effectively managed, and that there is identifiable ownership of responsibilities

Identification

As the police and many other commissioned services (e.g. Supporting Victims – North Yorkshire's equivalent to Victim Support, provided by an in-house team) are not experts in mental health, it is extremely difficult for officers to consistently identify whether someone with whom they are in contact is experiencing mental health issues.

The presentation of a person in distress, or in need, can have compound causes and the police cannot be expected to accurately determine the underlying causes without expert advice from the outset. However, there are strong indications from a number of data sources that the number of people encountered by police who have one form or another of mental health issue is increasing. The reasons underpinning this are complex and undoubtedly include an element of better awareness by officers. However, the rising trend in detentions under s.136 Mental Health Act 1983 (MHA) over recent years strongly points towards this

relating to increased prevalence, rather than simply being an artefact of improved identification.

Recording

- *Incidents*

The primary mechanism for police recording of incident-specific data in relation to mental health is set out by the Home Office through National Standards for Incident Recording (NSIR). This clearly defines that a "Mental Health Qualifier" must be used "*to endorse an incident involving a person who has, or appears to be suffering from, a mental disorder or mental impairment including learning difficulties*". This seems completely unambiguous, but has been interpreted in several ways, with vigorous debate on how this should be applied.

In essence, there are two opposing viewpoints:

- The first, and literal, interpretation is that an incident should be marked with a Mental Health Qualifier if there is the simple involvement of any person, whether as victim, suspect, witness or other contact (such as being a missing person, suicidal person, someone detained under s.136 MHA etc.) who has or appears to have a mental health issue. This approach recognises that police are not mental health professionals and cannot diagnose someone's condition or how that might affect their behaviour.
- The counterview is that there must be a causal link between the person's mental health condition and their involvement in the incident.

In 2015, NYP officially adopted the former position, as it would be a logical fallacy to expect police to attribute causality to a person's involvement based upon their underlying mental health, and there is no necessity in the NSIR definition to do so. Furthermore, the involvement of a person with mental health issues (regardless of whether those issues may be related to the incident) may determine that a modified response is required to take account of any vulnerability.

- *People*

Police systems can use a range of "Warning Markers" to denote risk or need-based information about a person, and the pertinent markers in this instance are MENTAL DISORDER, SUICIDAL or SELF-HARM. The presence of such markers helps officers to identify potential

vulnerabilities or risks relevant to the subject's presentation. This information is also available to our Supporting Victims team, and factors into their need assessment process and whether they refer victims into the mental health services commissioned by the PCC (such as mental health triage nurses within the Force Control Room or counselling services) or into existing NHS mental health services.

There are very rigorous (and arguably archaic) requirements before these markers can be applied to a person's Police National Computer (PNC) record, including a requirement for a diagnosed condition. A mental health diagnosis is sensitive personal data and subject to rules of patient confidentiality and is therefore unlikely to come into the purview of police. Forces are able to use local records management systems to record Warning Markers, but there are no defined standards for when markers should be applied. There is a fundamental lack of consistency, which NYP has sought to address by creating a set of definitions and requirements for utilisation, which could easily be adopted as a national standard to address this deficit.

- *Partner Systems*

NYP and NYPCC commissioned services have invested considerable resource in engaging in operational integration with partner agencies to assess information and intelligence relating to potentially vulnerable people, in order to manage their calls for service with the lowest appropriate intervention from the most relevant service at the earliest possible juncture. Although great strides have been taken, with mental health nurses embedded in NYP's police control room and able to access police and NHS data, this journey is far from complete.

Operational integration in this way is a highly effective technique for improving services and outcomes for vulnerable people, but is beset with frustrating challenges. NYP and NYPCC have invested to provide this functionality, despite it being of equal benefit to NHS partners in helping patients. Perhaps the most frustrating, is the matter of information governance, which is rife with ambiguity and impediment and is likely to become more difficult with the introduction of the General Data Protection Regulations in May 2018. It has been stated that public services should be brave in their approach to sharing information about vulnerable people, but bravery is no substitute for a clear, practical legal framework to enable operational information sharing to help keep people safe and well.

Response

The toolkit for police officers when engaging with mentally-vulnerable people is very limited, and often coercive. Largely, s.135 & s.136 MHA are the only available powers to intervene and they have significant limitations. The optimal solution is to integrate police, health and social care services in an operational response capability, but this is frequently (and erroneously) seen as being a benefit to policing, rather than a benefit to vulnerable citizens.

Mental health crisis services are frequently not commissioned to provide an urgent response to people experiencing mental distress in the community, with a 4hr response being a common target for the highest priority cases and, outside of crisis situations, lower priority cases/prevention often being inadequately resourced. As a consequence, there have been a number of innovative solutions (inc. "Street Triage") commissioned by police / PCCs to address this commissioning deficit. Whilst these provide extremely valuable assistance, they are frequently primarily resourced from policing budgets, rather than those held by partners. Moreover, when health and social care partners do contribute, the funding is often short term, meaning the sustainability of such services can be deeply problematic, often with PCCs stepping in to make up shortfalls. This in turn can put pressure on partnership relationships.

Historically, the police take an incident-based approach to business, rather than adopting a person-centred model. This has resulted in a focus on responding to symptoms, instead of identifying and addressing causes. Every contact with the police is a result of unmet need, but this is often lost in the emphasis on risk, which is largely centred on risk to the organisation in the event of an adverse outcome. There is suspicion that the prevalence of mental distress in policing situations is so high that many staff across all services have become desensitised to it, tuning-out mental illness as a distracting complication that clouds the issue in hand, rather than potentially being the underlying cause of to the situation facing them. Given the overwhelming evidence that indicates the linkages between mental health issues, substance misuse and criminality, there is a compelling argument to take a different approach to traditional criminal justice solutions in addressing behavioural issues.

There is excellent evidence that links the presence of adverse childhood experiences (ACEs) and earlier-life trauma to mental health issues (*Dube et al. / Preventive Medicine 37 (2003) 268–277*). Similarly, there is further evidence that approx. 25% of the prison population has ADHD

(*Young et-al, A meta-analysis of the prevalence of attention deficit hyperactivity disorder in incarcerated populations, Psychological Medicine. 2015*) – whether diagnosed or otherwise – and that people who are untreated have significantly increased susceptibility to criminal, suicidal and / or antisocial behaviours. Effective treatment has been demonstrated to reduce criminality in this population (*Lichtenstein et al., 2012*). To an extent, this has already been acknowledged by the introduction of Mental Health Treatment Requirements, but the uptake rate of <1% of eligible cases due to issues with probation services has been pitiful.

An alternative may be to allow the consensual psychological assessment of people entering police custody for the first time, along with a screening for ADHD, in an effort to identify potential causal factors underlying their behaviours. This would incur cost at the front-end, but the whole-system savings and improved quality of life (let alone reductions in future offending) have potential to provide a considerable return on investment. In financially straitened times, there is limited discretionary spend available for innovation. However, this is an under-explored area which may be worth researching.

<u>Referral</u>

As already stated, every contact with police is as a consequence of unmet need, but the organisation's processes translate this into assessment of risk. In doing so, much of the emphasis is centred on risk to the organisation, which can result in factious approaches instead of emphasis on addressing exigency.

Every year, police generate many thousands of social care referrals for children and adults nationally. However, there is little academic evidence of the effectiveness of this process, or the motivation for referrals. This is reflected by discussion with professionals within NYP. The propensity to attribute blame to public services when adverse incidents occur has led to illogical attitudes to risk. It is recognised that referrals do not necessarily result in a change to the levels of risk or need for the subject (*HMIC - In harm's way: The role of the police in keeping children safe, p.68, July 2015*), but there are apocryphal indications that staff belief submitting a referral acts to transfer some risk from the officer to the recipient. Such efforts to transfer risk, rather than address needs, are contrary to the interests of all concerned.

Moreover, often a person is passively “signposted” to another service but it then rests on the individual to take up that service. Analysis of our Street Triage data indicates 88% of those seen over a 6 month period (April 2017 – Sept 2017) were known to TEWV, 11% were not known to TEWV and that 45% of those known to TEWV did not have an active care plan in place, so it is highly likely that many do not access services successfully, thus failing the person and perpetuating the problem for all concerned. There is also clear evidence from the Pathways Project that when people are actively supported into appropriate services, the outcomes can be far more positive for both service users and service providers.

Data Integrity

Police IT systems have been largely designed to fulfil crime investigation and intelligence requirements, rather than to deliver performance data on mental health and vulnerability. This presents significant challenges in extracting and analysing information. Despite crime constituting just 17% of police demand (College of Policing, 2015), systems have yet to adapt to the changing nature of policing.

In relation to mental health, the focus of performance measurement has historically been around the utilisation of powers of detention under s.136 MHA. However, this makes up only a tiny fraction of policing activity in respect of mental health. NYP is assessing the feasibility of introducing a vulnerability screening tool as a preface to all form-based encounters. This would greatly enhance the evaluation of needs and risks, provide much better management information, assist in making meaningful referrals, and consequently provide higher-quality services to vulnerable people.

Current data for s.136 MHA tends to focus upon throughput. In NYP, the volume of s.136 MHA detentions is very small, but the collective resource requirement that sits behind each incident is much greater. Using police and partner data, NYP is seeking to identify the actual impact of s.136 MHA upon policing in terms of risk (transportation and retention at the suite), resource (the total resource deployment to allow the s.136 MHA detention) and repeats (trend analysis).

An initial snapshot of 4 months data shows that in NYP, staff were involved in taking 95 different individuals on 114 occasions to a Health-Based Place of Safety, which included 19 repeat visits with one individual being transported 6 times. For 46 of those 114 occasions a

police vehicle was used to transport the individual. Whilst it is not at present viable to break-down the specific actions of each of the police resources used, it can be noted that a total of 505 resources were deployed on those 114 occasions for a total period of 1,019 hours. The intention is to use this approach to build a more complete picture of s.136 MHA on resource demand, and options upon how NYP can seek to reduce demand through alternative pathways.

Given the deficits in data-capture mechanisms, and the broad range of circumstances that can present to police, NYP is seeking to understand mental health demand in a different way, by calculating the additional resource requirements required to deal with incidents where mental health is a presenting issue. The last two months data relating to incidents where mental health presents most frequently (Concern for Safety, Missing Persons, Domestic Incidents, Anti-Social Behaviour, Nuisance and Violence) has been analysed. This has allowed differentiation (in terms of operational resource hours) between incidents with and without Mental Health tags on NYP's command and control system.

It is apparent that in each of the areas analysed, the total police resource time spent is greater when mental health is a presenting issue. This can then be translated into an actual policing resource cost that reflects the additionality linked to mental health. Whilst this is limited to only the initial deployment of policing resources, an initial estimate for NYP for these five areas equates to an additional resource cost of around £500,000 per annum (Table 1).

Table 1: Data in hours, and converted to approximate cost. Note: Data for January 2018 shows increases in recording of mental health-qualified incidents, following an audit of the month's data.

Concern for safety												
Month	Volume	Volume tagged MH	Resource	Resource tagged MH	Hours spent	Hours spent MH	% volume MH	% Resource MH	% hours MH	Av response time non MH	Average Reasponse time MH	Estimated additional cost MH per mth
Dec-17	1101	279	2696	857	2224:00	1016:00	25.3%	31.8%	45.7%	1:05:50	3:38:30	£21,921.43
Jan-18	1041	470	2543	1259	2215:00	1262:00	45.1%	49.5%	57.0%	1:40:08	2:41:06	£16,785.71

Missing Person												
Month	Volume	Volume tagged MH	Resource	Resource tagged MH	Hours spent	Hours spent MH	% volume MH	% Resource MH	% hours MH	Av response time non MH	Average Reasponse time MH	Estimated additional cost MH per mth
Dec-17	162	38	537	210	931:00	424:00	23.5%	39.1%	45.5%	3:07:47	11:09:28	£9,500.00
Jan-18	164	51	518	255	798:00	476:00	31.1%	49.2%	59.6%	2:50:58	9:20:00	£11,839.29

Domestic Incident												
Month	Volume	Volume tagged MH	Resource	Resource tagged MH	Hours spent	Hours spent MH	% volume MH	% Resource MH	% hours MH	Av response time non MH	Average Reasponse time MH	Estimated additional cost MH per mth
Dec-17	500	54	1280	170	1335:00	195:00	10.8%	13.3%	14.6%	2:16:48	3:36:40	£2,565.00
Jan-18	498	132	1104	327	1166:00	367:00	26.5%	29.6%	31.5%	1:36:16	2:46:49	£5,657.14

Violence												
Month	Volume	Volume tagged MH	Resource	Resource tagged MH	Hours spent	Hours spent MH	% volume MH	% Resource MH	% hours MH	Av response time non MH	Average Reasponse time MH	Estimated additional cost MH per mth
Dec-17	545	35	1765	133	2286:00	184:00	6.4%	7.5%	8.0%	3:51:25	5:15:26	£1,812.50
Jan-18	515	106	1469	371	2104:00	592:00	20.6%	25.3%	28.1%	2:56:09	5:35:06	£10,070.00

ASB Nuisance												
Month	Volume	Volume tagged MH	Resource	Resource tagged MH	Hours spent	Hours spent MH	% volume MH	% Resource MH	% hours MH	Av response time non MH	Average Reasponse time MH	Estimated additional cost MH per mth
Dec-17	930	23	2188	67	1025:30	48:00	2.5%	3.1%	4.7%	1:03:04	2:05:13	£821.43
Jan-18	949	53	1966	145	964:00	114:00	5.6%	7.4%	11.8%	0:53:44	2:09:03	£2,366.07

Annual cost extrapolated from data

	Concern for safety	Missing persons	Domesic Incident	Violence	ASB Nuisance	Total
Dec-17	£263,057.14	£114,000.00	£30,780.00	£21,750.00	£9,857.14	£439,444.29
Jan-18*	£201,428.57	£142,071.43	£67,885.71	£120,840.00	£28,392.86	£560,618.57
Average	£232,242.86	£128,035.71	£49,332.86	£71,295.00	£19,125.00	£500,031.43

*Jan included some data cleansing of incidents application of tags were applied

The PCC and NYP are clear that the above data is only what has been possible to evidence to date, but that the actual amount is likely to be much higher, and that therefore this estimate of cost is an absolute minimum. This is mainly restricted by the ability and practicality of officers assessing a mental health need and recording this as part of their report as outlined above. NYP's approach is to refine and develop this approach in order to identify methods of how we can more effectively manage and reduce this demand.

Identifying the split between legitimate and non-legitimate mental health demand

There are various ways to define the split between "*legitimate and non-legitimate demand*" on policing; some of which involve value judgements. Therefore, it would be useful to consider the meanings of the terms.

The primary role of the police is the protection of life and this is reinforced by Article 2 European Convention on Human Rights (ECHR). As a principle, if there is no immediate threat of harm to any person or to property, or a crime in progress, then it should not be a police responsibility to manage calls for service in respect of identified mental distress. However, it is often impossible to establish whether that is the case without actual attendance.

North Yorkshire Police's position in this respect is clear:

> *As a principle, the police should not be the default response for patients experiencing mental distress. Officers are not mental health experts, and their involvement can have a seriously detrimental effect on the patient's mental state by giving an appearance of criminalising them. Our primary responsibilities are the protection of life and property, prevention and detection of crime and maintaining order.*
>
> *However, there are many situations involving mentally distressed people where there is a potential for harm that requires a policing intervention, or where it is not immediately apparent that there are mental health issues involved. Indeed, policing powers can often be the only available means to safely resolve an incident. We must exercise these powers in a sensitive, safe and proportionate way, involving healthcare professionals to ensure the safety and wellbeing of patients throughout.*
>
> *Police officers responding to an incident involving someone with mental health issues should prioritise the welfare and safety of all those involved, including the patient, and seek guidance from healthcare professionals at the earliest opportunity.*

A Police Officer's legitimacy in mental health cases is predicated on the need of an individual and the lawful authority of the Police in line with legislation. Their legitimacy in cases related to s.136 MHA is most often, therefore, without question. However, whilst there has been much emphasis on police use of s.136 MHA, it is arguably far more common

for police to encounter people in distress in their home where no such power exists. There is therefore a crisis of legitimacy in the use of police in relation to mental health issues and crises occurring in someone's home, where the need may be undeniable, but the lawfulness of their actions is in doubt.

It was posited in the Sessay case (*R (Sessay) v South London and Maudsley NHS Foundation Trust [2011] EWHC 2617* (QB)) that the Mental Health Act was effectively perfect legislation, and while that may be true from a legal perspective, its practical application - if someone who is non-compliant but has mental capacity, in their home and in need of care - is woeful.

In many areas, including North Yorkshire, the difficulties of securing the intervention of Approved Mental Health Professionals[2], magistrates and legal advisers out-of-hours mean it is practically impossible to obtain a s.135(1) MHA warrant in a timeframe that enables effective and lawful action to keep someone safe. This creates a dilemma for officers, whose sworn duty to protect life and obligation under Article 2 ECHR conflicts with the absence of lawful authority to intervene in someone's home if they have capacity.

Such circumstances were reportedly witnessed by Sir Paul Beresford MP in 2014, which led to his submission of a Private Members Bill on 15th October 2014 requesting amendments to s.136 MHA. The Bill was unsuccessful, and although there were amendments to the MHA in December 2017, this critical omission of a power of detention in a person's home remains. The anomalistic effect is that officers retain the duty to act, but without any lawful authority. Officers are duty-bound to provide assistance, which can result in mentally vulnerable people being criminalised – or potentially requiring restraint by officers – as a means to get them help. Authorised Professional Practice on Mental Health, published by the College of Policing, tacitly acknowledges this paradox by intimating that officers may have to rely upon "*the doctrine of necessity*", which relates to extra-legal actions by state actors, and is a wholly inadequate solution to an everyday issue. This must be addressed at the earliest opportunity to provide officers with the legal basis to fulfil their responsibilities and ensure that people in distress are treated with dignity and respect in a prompt and lawful manner.

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[2] Out of normal hours, there are usually only 2 social care professionals / AMHPs covering all social work demands across the entirety of the county, provided by the Emergency Duty Team.

Other health and welfare-related demands which fall outside core police functions

The question of what is a core police function is critical to understanding this issue. Overall, and in addition to duties prescribed in legislation or common law, the role of the police is broadly defined as:

- protecting life and property
- preserving order
- preventing the commission of offences
- bringing offenders to justice.

This is a broad spectrum that is capable of interpretation to include almost all potential deployments. Therefore, it is arrantly difficult to quantify what might constitute activity relating to non-core functions.

Once frequently cited example is the issue of remaining with mental health patients at hospital whilst they await assessment, lest they decide to abscond before being seen. Some people regard this as a flagrant misuse of police time, however it is a function that no other involved party is empowered to fulfil. Preventing someone who may have suicidal ideation or acute healthcare needs from going missing is central to protecting life, and there are no other services with policing powers or capabilities competent to undertake that role.

The case of Webley (*Webley v St George's Hospital NHS Trust & Anor, Court of Appeal - Queen's Bench Division, February 14, 2014, EWHC 299*) articulated the police duty of care in this respect, which is broadly described as requiring a competent, capable, willing and able person who has been briefed of relevant risks to accept a transfer of responsibility to their care. There are very few circumstances where these responsibilities can be carried out by others, unless the person is either detained under the MHA, lacks capacity or is already an in-patient.

Police officers are regularly put in a position where they transport patients to hospital, where ambulance attendance cannot be secured in a timely fashion. Again, one may argue that this is encompassed within the duty to protect life, but each instance is contingent upon the facts of the situation. Obtaining empirical data in this respect is fraught with difficulty, and ambulance service performance information may not be wholly congruent with policing data.

As a consequence, NYP is endeavouring to improve recording of requests for ambulance attendance, so that there is independent information available to assist in evaluating operational performance. As

part of this approach, we are working to establish a tri-service protocol in partnership with Yorkshire Ambulance and North Yorkshire Fire and Rescue Service to understand and manage demand in a more integrated way.

Unlawful Detentions in Police Custody

There have been occasions where a person was held in police custody for the purpose of assessment under the Mental Health Act, in circumstances where there the grounds for detention had lapsed. Changes to s.136 MHA in December 2017, which now mean that it may be a tactical option to detain a person whilst already in custody, should largely address this issue. However, there are still occasions where a person is at such an elevated level of emotional arousal that there are no secure health-based facilities to safely continue the patient's detention for assessment and / or treatment other than police custody.

Only forensic mental health units provide such a level of security, but there are no pathways for patients into forensic mental health direct from custody. These services are commissioned by NHS England, who similarly do not operate an accessible out-of-hours facility to help resolve operational issues with highly vulnerable people. Again, this is a critical deficit in health commissioning, where the police have no option but to be responsible for the risks of caring for extremely unwell patients.

Partnership Working

In North Yorkshire, there are for the most part, excellent working relationships between the PCC, police and health partners, but effectiveness is constrained by fragmented service commissioning, which has created an environment where agencies compete against each other not to deliver services. Additionally, there are significant challenges in accessing and reconciling data from the multitude of involved agencies to evaluate outcomes for people. The reliance on "exclusion criteria" to justify why agencies will not provide help to extremely vulnerable people is seen as unconscionable. The complexity is increased since there is no single authority with the ability to unify commissioning and delivery of services in a whole-system approach (*Smith & Solar, 2017*).

The Police and Crime Commissioner has commissioned a Mental Health Force Control Room (FCR) Triage service in its entirety since 2016,

which consists of Mental Health nurses monitoring calls and providing advice and support to staff and officers on the ground when they are interacting with a person in mental distress or crisis and triaging accordingly. The PCC also funds Mental Health Street Triage (ST) teams in York and Scarborough, which work on the front-line with NYP, attending live incidents where mental health is an influencing factor. This means a person in distress is assessed by a mental health professional at the scene of an incident and where appropriate given the relevant support and aftercare.

In York, there is a partnership agreement between NYPCC and TEWV that (where resources allow) Street Triage supports NYP in managing its demand around Mental Health. The ability of ST nurses to build rapport with individuals in crisis and de-escalate situations has been evidenced through feedback from officers and through academic evaluation by University of York (*Irvine, Allen & Webber. 2016*).

TEWV Street Triage and FCR Triage nurses have remote access to patient records, enabling them to establish the risks and vulnerabilities of individuals coming into contact with police and to respond accordingly. The impact of these services on diverting individuals away from Criminal Justice can be seen through the reduction of custodial detentions under s.136 MHA. Being able to receive advice from FCR nurses and knowing that Street Triage teams will soon be in attendance supports officers to feel more confident in managing mental health-related calls. The volume of incidents supported through these initiatives show that in quarter 1 and 2 of 2017/18, the FCR nurses triaged a total of 1,282 Mental Health related occurrences; Scarborough Street Triage teams triaged 308 Mental Health occurrence and York Street Triage 153 occurrences.

Although there is some evidence to suggest these services positively impact on s.136 MHA detentions, there is still a gap in our understanding of their impact on other emergency services (e.g. the impact on A&E attendance, ambulance service and Crisis Teams). It is also unclear of the impact on the individuals who come into contact with the Street Triage and FCR Triage teams and what this has meant for them in terms of increased care and support. The partnership agreement with York is also a challenge due to lack of resources (i.e. staffing issues), meaning delivery of the service has been inconsistent. NYP is currently working with CCG and TEWV colleagues to review service specifications and outcome/impact information.

The PCC and NYP are also working closely with Together for Mental Wellbeing - a national charity - addressing the underlying causes of vulnerability and mental distress with the aim of improving the collective response to excluded individuals experiencing mental distress coming into contact with the police and / or emergency services. This “York Pathways Project” is a multiagency approach to supporting those with complex needs, and brings partners together to collectively consider how to manage risk and offer support. With effect from April 2018, PCC will be commissioning this service in its entirety with a focus on those placing the highest demand on NYP in York. Evidence to-date suggests that the service has reduced demand across blue light/emergency services with one year post referral information identifying reductions in contact for Crisis (70%), Police (28%), Ambulance (21%), and Emergency Department (21%).

North Yorkshire has a large and diverse geography and the PCC and NYP are trying to work with partners through the Crisis Care Concordat (CCC) to develop a consistent approach to addressing this demand across the County. This has proved challenging due to differing priorities, but partners are committed to introduce governance that includes joint chairing arrangements between the PCC and CCG. There are also a number of other partnership initiatives the PCC and NYP are involved in to support this demand and improve the response to vulnerable individuals coming into contact with the police, including alternative places of safety, of which there is one in York (Save Haven) commissioned through TEWV to be open out of hours, 7 days a week for individuals in distress or nearing crisis.

Concluding Remarks

In recognition of the importance of evidence-based approaches in mental health, NYP has developed excellent relationships with academia:

- The N8 Police Research Partnership3 is a collaboration of 8 northern research universities and 11 police forces, with which NYP has worked closely to enhance understanding of mental health and policing. At NYP’s request, the topic of policing and mental health is being considered as the key research theme for 2018.
- Through the Police Knowledge Fund, NYP, University of York, College of Policing and Tees, Esk and Wear Valleys NHS

Foundation Trust undertook the £1m Connect – Mental Health research collaboration to provide a clearer understanding of the issues, and to develop training for staff.

- PhD studentship with University of York to evaluate Mental Health Triage in North Yorkshire.
- A rapid evidence synthesis of police-related mental health triage interventions, conducted by University of York

In recognition of this, following a recent PEEL Effectiveness inspection NYP was cited by HMICFRS for good work in respect of mental health. However, there remains much to be done and both NYP and the Police and Crime Commissioner are committed

Annexes

Annex 1 – Urgent Care Services available in York and Selby