POLICING MENTAL HEALTH: CARE AND CONTROL IN THE COMMUNITY

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CONTEXT

WHAT SEEMS TO BE THE PROBLEM, OFFICER ?

- Police regularly encounter those experiencing mental distress (Chappell, 2012) estimates of up to 20-40% of police time.

- Competent but unconfident (Morgan and Cordingly, 1991; Kelleher and Copeland, 1972; Adebowale, 2013).

- Issues with the implementation of s.136 of the Mental Health Act 1983 (Curtis et al, 2013, Keown, 2013).

- Frightening for individuals (Riley et al, 2011).

- Complex dilemmas for the police.

- Issues surrounding the collaborative practice between criminal justice and health systems (Bradley, 2009; Department of Health and Concordat signatories, 2014).
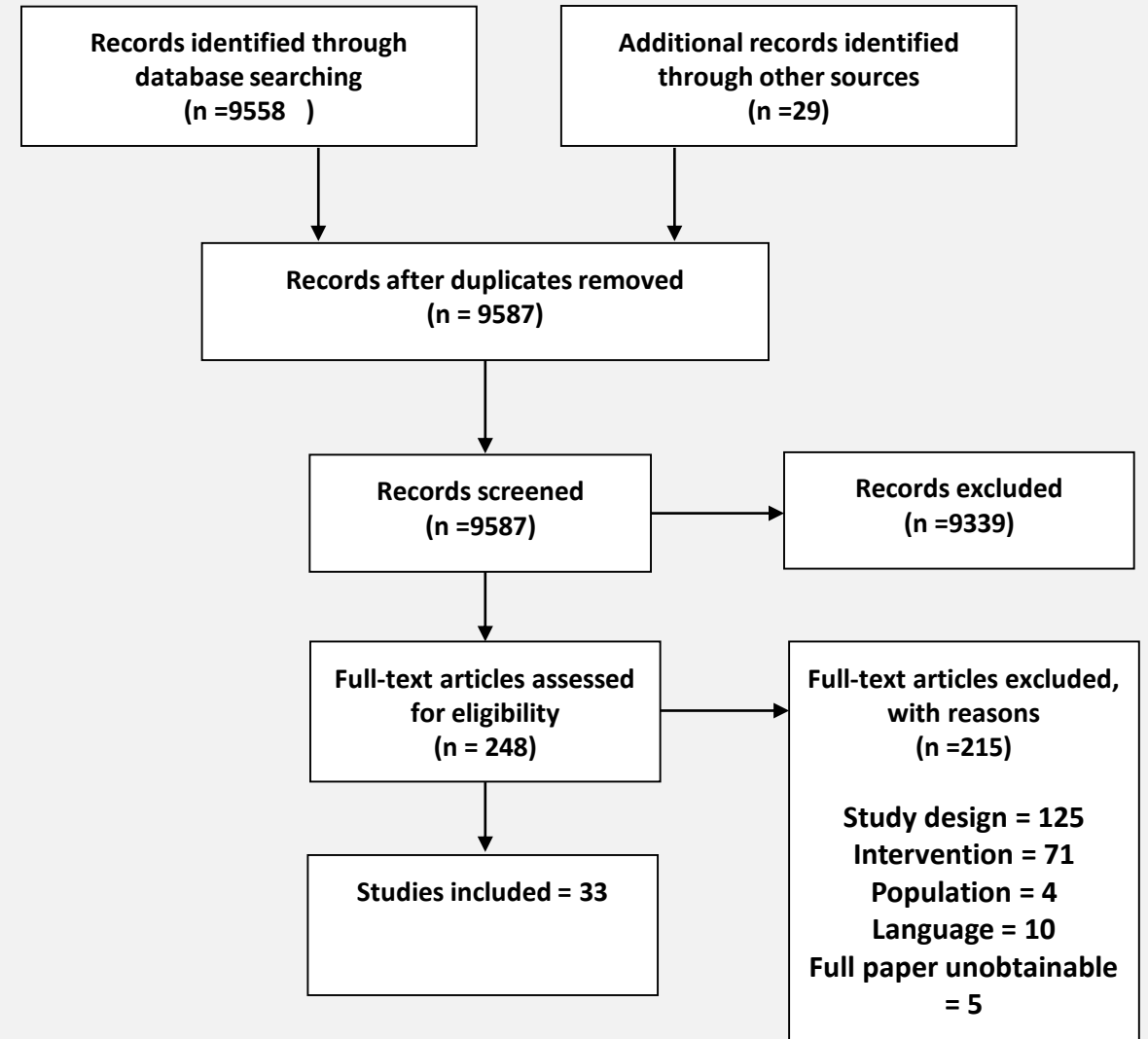
MENTAL HEALTH TRIAGE
(THE SOLUTION ?)

- A more streamlined, coordinated, reactive approach to crisis care.

- Implemented across England and Wales since 2012.

- Different models implemented depending on the needs of the locality.

- The co-response of mental health professionals and front line police where an individual is perceived to be experiencing mental health crisis, and comes to the attention of the police , or non-crisis situations where an individual is an enduring concern to the police. This can be in a public or private place.

- Generally pre-arrest.

- Aims to enable individuals quicker and more appropriate mental health/ other types care. Can still result in criminal justice action.

- Mental health professionals can be control room, office or 'street' based.

WHAT IS KNOWN ABOUT MENTAL HEALTH TRIAGE ?

- Systematic scoping review (Park et al, 2019).

- Few 'robust' studies.

- Little known about the effectiveness or cost effectiveness.

- Mixed qualitative evidence, under theorized.

- Nuanced triage models across and within OECD countries.

- We need to know more about how triage schemes work in their local context...

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│ Records identified through│    │ Additional records identified│
│   database searching     │     │   through other sources  │
│      (n =9558  )         │     │        (n =29)           │
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        │ Full-text articles│───────▶│ Full-text articles excluded,│
        │ assessed for      │        │      with reasons        │
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        │    (n = 248)      │        │                          │
        └──────────────────┘        │  Study design = 125      │
                 │                   │  Intervention = 71       │
                 ▼                   │  Population = 4          │
        ┌──────────────────┐        │  Language = 10           │
        │ Studies included │        │  Full paper unobtainable │
        │      = 33        │        │         = 5              │
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METHODS

- Realist approach. "…a programme is its personnel, its place, its past and its prospects" (Pawson and Tilley, 1997, p.65).

- Aim: To understand the processes and mechanisms of mental health triage in the northern police force under study.

- Broadly ethnographic approach (43 interviews/ 27 observations) comparing two sites in the northern police force. Police officers/ triage practitioners/ key informants/ service users/ carers took part– hard to recruit the latter two !

PRELIMINARY FINDINGS

PROACTIVE & REACTIVE WORK

- Site 1 – emphasis on proactive, slower time work as well as reactive.

- Multiagency team (unique to the area) and Safer Neighborhood teams.

- Emergent. Discretion of practitioners, 'flexible working'.

- Professionals meetings and improved service links.

PROACTIVE COMMUNITY WORK

- **Processes and mechanisms of proactive work**
- ➤ Police community work.
- ➤ Noticeable or changes in behaviour.
- ➤ Assessment and feedback between professionals,

- **Context**
- ➤ Relationship building.
- ➤ Unique multiagency team.
- ➤ Practitioner conceptualisations.
- ➤ Legal context.

CARE AND CONTROL IN THE COMMUNITY ...

Privacy.

Consent.

Maintenance of individuals in the community.

Policing mental health.

Triage as a pragmatic response to a bigger issue ?

CASE EXAMPLE

- Police community support officers had become concerned about an individual due to 'odd behavior' and changes in the living conditions of the individual.

- Arrived at the accommodation and got consent to come in and talk- including me.

- PCSO expresses concern when we got inside that the living circumstances had seriously deteriorated.

- Discussion of mental health with nurse (paranoid ideas/health/ mood)/ social factors (bereavement/ housing/ social care/ isolation) criminal justice risks.

- PCSO and support worker discuss living situation and explore the accommodation.

- Nurse, PCSO, support worker (and me) discuss the case after.

- Immediate outcome – help to tidy flat, liaison with GP to explore the current care and other services to paint more of a picture of what was going on. PCSO gets permission to make a welfare referral.

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