ROBERT GORDON UNIVERSITY ABERDEEN

# Black, white and Grey- Supporting an understanding of the pathways and interface between police, those in mental health distress and emergency health services.

Inga Heyman
Principal Supervisor Prof. Catriona Kennedy

Secondary Supervisors Dr. Steve Smith.
Dr. Sheelagh Martindale

# Study background

- Practice experience
- Why mental health distress (MHD)?
- 'Grey' area of practice
- Complex and resource intensive

# Study aim

To understand the pathways and interface between police officers, health service practitioners and those in mental health distress who initially present to, and are returned to, police services for subsequent management following mental health assessment.

# Literature review

- Focused in Australia, USA and Canada. Differing legislation.
- Focused on custody or triage models of care.
- Inconsistencies in terminology regarding mental health distress
- Reporting mainly on issues of severe and enduring mental health issues
- Gaps-
  - interface between police/health,
  - police and those in MHD,
  - influences such as alcohol and violence on this pathway
  - Scottish legislative context.

# Research questions

1. What are the pathways in help seeking support for those in MHD coming to police attention?

2. What is perceived as a positive/ negative outcome within these pathways?

3. For whom do the pathways work or not?

4. What are the interface, barriers, and facilitators, for those involved in these pathways to achieving a positive outcome?

5. What are the implications of these study findings for practice, policy, theory, education and research?

# Embedded exploratory case study

Viewed this event through the lens of police, Person Who Experienced Mental Health Distress (PWEMHD)and health services.


Based in a large city in Scotland

Ethical approval

**3 phases.**

Phase 1. Police and health strategic managers and key personnel. Semi-structured interviews (n=12)

Phase 2. In-depth investigation of three cases- PWEMHD, Police and health staff involved in case - semi- structured interviews. Initial pilot study. Exploration of police and health files relating to each case.

Phase 3. Focus groups x3. Police only, health only and mixed group of both. Interview structure partially influenced by Phase 1 and 2

Template analysis

# Cases- phase 2

- Range of pathway start and end points
- Public area, home
- Interviewed- PWEMD, police and health staff involved in each case

# Case 3

Lady called 999 numerous times due to a domestic incident. Intially refused police entry or called police off. Hx of problematic alcohol use.

Police attended home – highly intoxicated and threatening self harm. Call to Out of hours medical services . Police asked to transport her to health services for assessment at however, lady refused to leave home. Request for Dr. home visit. Police remained in attendance (three hours), unable to stand down due to threats of self harm.

Seen by Dr.in home who advised unable to assess due to intoxication. Advised to take to place of safety. Lady would not leave the home. Police exhausted all options to secure a family member to keep her safe. Limited options and no one willing to take her.

Forced to consider custody as a place of safety and required to charge with wasting police time to ensure safety. Officers did not wish to cuff but lady became violent in police car and tried to open car doors.

Placed in custody over night. In morning related no longer wished to harm self.

# Through the lens of the PWEMHD

- No recollection of seeing Doctor due to intoxication.
- No understanding of why, if suicidal, she would be locked in a cell. Why not hospital?
- Hand-cuffs and locked in cell highly traumatic due to Hx of childhood and adulthood violence, and sexual trauma- tied up. Locked in.
- Embarrassed that neighbours will have seen police, wish there were someone other than police attend
- Unwillingness to phone the police again in domestic incident following cuffing and cell environment– even when being assaulted by partner
- Highly appreciative of NHS alcohol services but wished they were more joined up with police so they knew her history

# PWEMHD

- *‘There is a side of me that is different when I have had a drink…. I understand why the police react the way they do… I can be a pest with a drink….but locking me up …that’s wrong. It’s about what I have been through in the past….if I am suicidal like they say, why put me in a cell?’*
- *‘The police kindly took me home the next day. I had the police drop me at the top of the road. I did not want the neighbours to see me’*

# Through the lens of health services

- Triaged at health out of hours
- Needed to be assessed but other competing emergencies
- Very common presentation. No major psychiatric illness
- Too drunk to assess. Need to be sober- breathalyse. Need to reactive. ‘Health hands tied’.
- Place of safety – not health service. Fire risk. Medico-legal issues
- ? Need for home intervention team (as in other areas). Regionally specific.
- Police should be part of the assessment. Good communication with police
- Minimal understanding of police limited resources
- This group will always be at risk.
- Need to look at other services developed to look after these presentations. Social problem not health or police.
- Third sector organisations involved to support wait for sobriety. Not police or health

# Through the lens of the police

- Good relationships on whole with health but frustrated by lengthy wait times. Described as ‘babysitters’.
- Difficult position for police when refusal to leave home for medical assessment.
- Police can not leave. Need to just wait for Dr. arrival. Expectation by health that police responsibility
- Health inconsistencies in relation to level of intoxication for assessment
- In this case, no place of safety options except cell block
- Extremely frustrating and uncomfortable for officers to charge to keep safe. Relationship change (negative) with PWEMHD
- Uncomfortable cuffing PWEMHD
- Bring in additional officer to constant supervise in cell.
- highly resource intensive for police

# Pathway

- Pathway fractured and limited
- Alcohol and violence has a major impact on the pathway direction and for all involved
- Legislation impacts highly on pathway- barrier
- Does not particularly work well for any party when alcohol involved
- Police risk averseness and duty  alters direction
- Police picking up the majority of this area of work when someone is intoxicated

# Interface

- Good relationships between services yet, lack of understanding of resources available in both services
- Time taken for health to respond altered presentation, health questioning police request for assessment
- Diminishing resources in all services –tensions
- Lack of collaborative planning in practice for PWEMHD presentations.
- Consider better use of public funds through collaboration
- Stigma and discrimination associated with police involvement for PWEMHD

# Discussion

- International and national inconstancies in approach to MH assessment when under the influence.
- Gaps in legislation to support this group and organisations.
- Whose problem is it?
- Disconnect when tested against care pathway theories.
- Reliance and expectation on police services
- ? Models that divert from emergency health services and inclusive of third sector organisations.
- Can technology (e.g. body worn camera) inform the police interagency communication on the pathway?
- Resource implications
- Shadowing opportunities between services
- Advance nurse practice roles

# Thank you

Inga Heyman
School of Nursing and Midwifery
Robert Gordon University
Garthdee Road
Aberdeen
AB10 7QG
i.heyman@rgu.ac.uk

ROBERT GORDON UNIVERSITY ABERDEEN