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**Working in Partnership: Police Mental Health Triage**

By

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**Declaration**

*I, the author, confirm that the Thesis is my own work. I am aware of the University’s Guidance on the Use of Unfair Means (*[*www.sheffield.ac.uk/ssid/unfair-means).*](http://www.sheffield.ac.uk/ssid/unfair-means)) *This work has not previously been presented for an award at this, or any other, university.*

**Abstract**

Police Mental Health Triage (PMHT) initiatives emerged in England and Wales (E&W) in 2012 and are partnerships between the police, and health and social care services. Within them, mental health professionals can provide advice and support to police constables attending incidents where an individual appears to be experiencing a mental health crisis. In E&W, the partnerships have predominantly adopted co-response (at the scene) or virtual (control room/telephone) models. The overarching objective of this study was to provide a rich, contextualised account of PMHT, undertaken through the application of a critical lens, to plug a gap in the hitherto largely evaluative literature. Through not only the methodological stance, but also by situating PMHT within a socio-historical context, engaging with wider debates about police partnership work, and including the previously omitted perspectives of those with lived experience of PMHT, this research is an original contribution to the existing field.

A qualitatively led mixed methods research design was adopted, with fieldwork conducted across three sites. The methodology included 214 hours of observation; 64 in-depth semi-structured interviews with stakeholders, practitioners, and service users; and a service user postal survey. A hybrid approach was taken to data analysis, with findings that drew upon the practice-orientated theory of collaborative advantage (Huxham and Vangen, 2005) and risk society theory (Ericson and Haggerty, 1997; Gale et al, 2016), through a framework of law enforcement and public health (LEPH). The research approach adopted, and methodology undertaken, have produced empirically informed findings that have encompassed both the anticipated and unintended consequences of PMHT partnerships.

The research shows the localised drivers behind PMHT included key individuals, partnership informality, and local governance structures, all of which emerged under the broader socio-political umbrella of austerity. It shows that whilst *prima facie*, PMHT partnerships were operating with a shared sense of purpose (reducing demand on police and health agencies), this was underpinned by irreconcilable interpretations of this purpose and incompatible working assumptions, particularly about risk management. Co-response models were found to have developed a purpose far beyond that for which they were intended, acting in some instances as a first responding emergency MH service in the community. Though service user perspectives showed optimism about the prospect of *any* novel addition to the crisis care landscape, this had arisen out of the flames of a profound sense of injustice about broader systematic failures of extant crisis care provision. The research provides a much-needed insight into the impact that the introduction of PMHT has had on the existing policing and crisis care landscape, depicting the rhetoric versus the reality of the partnership practice and procedures.

The findings from this study would suggest there is a clear need to focus on actually removing the mental health demand burden on the police, rather than continuing to provide a ‘sticking plaster’ over it, in the form of PMHT. The thesis includes twelve research recommendations for policy and practice. Included within these is the need for PMHT managers to avoid the temptation to continue to base the effectiveness of their partnership initiatives on singular measures, particularly s.136 data, as well as ensuring there is meaningful co-production with mental health service users in all aspects of the continued operation of any PMHT partnership arrangements.

**Dedication**

For Liv, with your everlasting strength, kindness, and love. You are so missed.

*Liv Pontin*

*12th April 1989 – 7th May 2019*

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**List of Abbreviations**

**A&E:** Accident and Emergency

**AMHP:** Approved Mental Health Professional

**APP:** Authorised Professional Practice

**BTP:** British Transport Police

**CA:** Collaborative Advantage

**CAG:** Confidentiality Advisory Group

**CCC:** Crisis Care Concordat

**CCG:** Clinical Commissioning Group

**CDA:** Crime and Disorder Act

**CIT:** Crisis Intervention Team

**CJS:** Criminal Justice System

**CoP:** College of Policing

**CPS:** Crown Prosecution Service

**CRDP:** Crime Reduction and Disorder Partnership

**CRT:** Crisis Resolution Team

**CT:** Crisis Team

**CQC:** Care Quality Commission

**DHSC:** Department of Health and Social Care

**E&W:** England and Wales

**HASC:** Home Affairs Select Committee

**HBPOS:** Health-based places of safety

**HMIC:** Her Majesty’s Inspectorate of Constabulary

**HMICFRS:** Her Majesty’s Inspectorate of Constabulary and Fire and Rescue Service

**HO:** Home Office

**HRA:** Health Research Authority

**HTT:** Home Treatment Team

**IRAS:** Integrated Health Research Authority

**IT:** Information technology

**KPI:** Key performance indicators

**L&D:** Liaison and Diversion

**MH:** Mental Health

**MHA:** Mental Health Act 1983

**MMR:** Mixed methods research

**MP:** Member of Parliament

**NPM:** New Public Management

**NHS:** National Health Service

**NICE:** National Institute for Health and Care Excellence

**NPCC:** National Police Chiefs Council

**OHT:** Out-of-hours team

**PACA:** Police and Crime Act 2017

**PC:** Police Constable

**PCC:** Police and Crime Commissioner

**PoS:** Place of safety

**PMHT:** Police Mental Health Triage

**PPE:** Personal protective equipment

**REC:** Research Ethics Committee

**SPA:** Single Point of Access

**ST:** Street Triage

**SU:** Service User

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1. **CHAPTER ONE**

**Introduction: Key Concepts, Issues, and Themes**

* 1. Introducing ‘triage’ and its application in police work

The purpose of this chapter is one of a broadly foundational nature that familiarises the reader with some of the key concepts, issues, and themes, that are referred to throughout the thesis. This research is concerned with a form of multi-agency partnership work between police and health organisations, most commonly mental health and social care services that operate within the National Health Service (NHS). While there is no single understanding or definition of partnerships, Barton and Velaro-Silva’s (2013:544) definition of partnership as several different organisations that work together towards a shared aim, serves as a good starting point. Berry et al, (2011:1) state that partnership approaches are largely built on the premise that no single agency can deal with, or be responsible for dealing with, complex community issues. The partnerships at the centre of this research are multi-agency arrangements referred to as ‘Police Mental Health Triage’ (PMHT) partnerships, though also commonly known as ‘Street Triage’ (ST) schemes.

The chapter begins by defining PMHT and providing a succinct overview of its background and purpose. It then goes on to provide some contextual background about police involvement in instances of mental ill-health and situates this study within the emerging field of law enforcement and public health (LEPH). The sections found within this chapter can be viewed as essential building blocks, each representing an aspect of the socio-legal landscape from which PMHT has emerged. The introductory chapter closes by setting out what this research has sought to achieve, as well as providing the reader with an overview of the thesis structure and what to expect from each subsequent chapter.

The word ‘triage’ originated from the French verb ‘*trier*’, which means ‘to sort’ or ‘to choose’ and emerged within a military context, whereby it was necessary to limit medical resources on the frontline to those soldiers most likely to benefit from them (Robertson-Steel, 2006). Triage has long since become an enshrined concept within physical and mental health (MH) settings to prioritise patient care according to need (Holbery and Newcombe, 2016). It is also said to result in better patient outcomes due to ensuring clinical justice and system efficiency (Fitzgerald et al, 2010). From the early 2010s, the concept of triage was adapted for use in an operational policing context, in situations involving police work where mental ill-health was the primary matter (Cummins, 2016). It is within this context that the use of the term triage in policing has become most familiar, though the notion of prioritisation according to need has been a retentive component of wider police work since the advancement of police technology in the twentieth century e.g., wireless communication, which aided the development of the first ‘information centre’ in 1934 and therefore the prioritisation of calls from the public (Williams, 2017). The strategic and operational reality is that the police are always making choices about which activities are more important than others (Police Foundation, 2022).

Though the practice of triaging within health and police organisations is thus a well-established mechanism that underpins the efficient operation of business, the familiarity of the term coined triage within policing, emerged in 2012, with the introduction of ST. There was no singularly defined operational model of ST and this generic term was used to refer to a variety of different initiatives that were emerging nationally within different police force areas, as an innovative approach to how the police respond to calls of mental ill-health in the community. As the College of Policing (CoP) definition below, alludes, the concept of ST is a form of inter-agency working with the general aim to introduce MH expertise during police encounters with those suspected to be experiencing an acute episode of mental ill-health in the community, more often referred to as a MH ‘crisis’.

*“…It is better understood as a process of inter-agency exchange which could take one of several forms, rather than a defined operating model, and aims to improve the experience of those in crisis whilst minimising restrictive practices and the use of force… it offers the potential to improve the service user experience whilst also reducing the overall resources expended in ensuring crisis care after contact with emergency services…”* (CoP, 2014)

Recent literature has seen authors choosing to use terms other than ST to describe the concept e.g., ‘Police Street Triage’, ‘Mental Health Police Triage’, or ‘Police Triage Related Incidents’ (Puntis et al, 2018; Rodgers et al, 2019; Park et al, 2019). In part, this may be due to a growing recognition that many of the MH incidents that the police attend, either during the course of their normal policing duties or as part of a partnership initiative, do not occur on the street at all (NPCC, 2022). As was the case in this research, many incidents coming to the attention of these types of partnership initiatives occurred in private dwellings whereby the key detention power the police have at their disposal in such instances, s.136 (see 1.3.), could not be lawfully used. As such, adopting the umbrella term ST appeared misleading to both its operational nature, and the variations in models that have come to exist e.g., virtual models (control room/telephone) that operate remotely. For this reason, the term PMHT has largely been adopted throughout this thesis, to consider the breadth and variation in the partnership initiatives that have developed since their inception.

PMHT schemes in E&W first emerged in Leicestershire and Cleveland police force areas, designed to operate for a 12-month trial period to improve the experience, outcomes, and access to health services for individuals at the point of crisis (Fleming and Smith, 2014; HMICFRS, 2018). In 2013, nine further police constabularies were granted funding from the Department of Health and Social Care (DHSC) to pilot the feasibility of the schemes being adopted more widely (Reveruzzi and Pilling, 2016). It was before the end of the pilot, however, that many other constabularies had started to develop this type of partnership work, with schemes that were being created according to local needs, emerging across E&W.

In 2014, Her Majesty’s Inspectorate of Constabulary (HMIC) stated that by the end of March 2015, those forces without PMHT should assess whether adopting a scheme would be cost-effective and beneficial in their area. If so, all forces should work with their local MH partners to introduce PMHT by the beginning of September 2015. By 2018, 42 out of 43 constabularies in E&W had implemented a PMHT partnership in at least one police area within their force. In recognising vast local variations in the provision, Her Majesty’s Inspectorate of Constabulary and Fire and Rescue Service (HMICFRS, 2018) recommended that by August 2019, all forces should review their existing PMHT schemes to assess their effectiveness, and the environment they were operating. This process has been disrupted by Covid-19 in many areas, but the CoP have devised guidelines, Authorised Policing Practice (APP), to help forces deliver their PMHT activity. Forces will in future be inspected in adherence to this guidance as part of the HMICFRS assessment and inspection process (the PEEL Framework[[1]](#footnote-1)).

Though only emerging in E&W in 2012, the origins of partnership work between policing and MH organisations can be traced back to the late 1980s in the USA. In 1988, the fatal shooting of a man from Memphis whilst exhibiting signs of mental ill-health, led to the development of Crisis Intervention Teams (CIT). CIT was designed primarily as a police training initiative to educate police officers to recognise the signs that someone may be in crisis (Ralph, 2010). As a police training programme, the CIT programme differs from the models that have more commonly been implemented in E&W, which are based upon partnership arrangements with MH partner organisations (Irvine et al, 2016). Deane et al (1999) distinguished between three key models of PMHT in the USA, namely, 1) a police-based police response, whereby specialist officers receive specialised enhanced training in MH e.g., the CIT model; 2) a police-based MH response whereby MH professionals are employed by the police and based within police departments; and 3) MH-based MH response, where community MH services form a specific relationship with the police, to respond at the site of an incident.

Schemes operating in E&W have predominantly adopted the third type of initiative and provide at-the-scene (co-response) or virtual (telephone/control room) advice and assistance in assessing an individual in distress. There are also some PMHT initiatives within E&W that resemble the second model, or a slightly amended version, e.g., MH professionals co-located with but not necessarily employed by the police, with the MH and police personnel located together for the duration of a given shift (Irvine et al, 2016). This research considers a range of PMHT initiatives and operating models, though it is recognised that no scheme is identical and thus the research also takes account of local variations, where they were found to exist.

* 1. Language and terminology
     1. *‘Mental (ill)-health’*

It is estimated that over a lifetime approximately 29% of the global population will live with at least one clinically diagnosed MH condition (Murray et al., 2020; Nochaiwong et al., 2021). Though the term MH has been more widely considered, it is a concept generally recognised to be influenced by the cultures that define it (Jahoda, 1948; WHO, 2004; Keyes, 2014; Galderisi, 2015). Given this research centres upon police involvement where a person is suspected of being unwell due to their mental health, the term ‘mental ill-health’ has been adopted, though the somewhat more archaic term of ‘mental disorder’ legislatively remains in place. The Mental Health Act 1983 (s.1) defines ‘mental disorder’ as any disorder or disability of the mind which it states should be construed accordingly. Within practice, the term mental ill-health has also been favoured for use within police organisations, and this is used broadly to refer to all those matters where a person’s MH is either the primary issue or a secondary fact in instances that come to the police’s attention. Mental ill-health includes mental disorders, mental illness, MH needs and many of the terms that fall within the MHA 1983 definition of mental disorder and the definition of mentally vulnerable. It also covers people who are experiencing mental distress at the time they come into contact with the police, whether or not they have been formally diagnosed or have previously received a service from a mental health organisation (APP guidance, 2022). The term mental distress as included within the guidance is commonly referred to in practice as a MH ‘crisis’.

* + 1. *‘Crisis’*

There is no legal definition of MH ‘crisis’ and within both theory and practice, there are varying interpretations of what the concept is (e.g., Erikson, 1950; Caplan, 1961; 1964; Segal, 1990; Rosen, 1997). In policing practice, APP guidance asserts that when officers are deciding whether to describe an incident as a MH crisis, they should use all available information available to them, in line with the police national decision-making model[[2]](#footnote-2) (CoP, 2020). The experience of a crisis is a very individual phenomenon, though, it is not always regarded as such by MH professionals who apply finite criteria for access to services, which are often linked with procurement and contracting processes, rather than individual needs (Lyons et al, 2009). Throughout this thesis, ‘crisis’ is a term interpreted broadly to refer to situations in which there is an urgent need for professional intervention, arising at least in part, from a person’s mental ill-health (Johnson and Thornicroft, 2008). It has been interpreted this way here, to reflect the breadth in nature of police encounters with the public, but also because it was felt to align with one aspect of crisis intervention theory which recognises how crisis is not a concept that only happens to MH ‘patients’. On the contrary, it can happen to anyone in the right circumstances (Lindemann, 1944; Caplan, 1964; Wainrib and Bloch, 1998).

* + 1. *‘Service User’*

The often-necessary assigning of a descriptive term to a homogenous group of people within research can be, as it was in this research, quite challenging. It is recognised that the spoken word often carries more weight than its dictionary meaning (McLaughlin, 2009) and so it feels appropriate here, to begin with regret, should the adopted descriptor of ‘service user’ cause discontentment to any reader. It is recognised that language is not neutral (Beresford, 2010). It is deemed important, therefore, to provide the rationale for adopting the term in this way throughout the thesis.

This research includes the perspectives of nine individuals who have lived experience of a PMHT partnership, each with identities that stretch far beyond the one that defines their relationship with PMHT or indeed wider MH services (Barnes and Cotteril, 2016). Alternative terms, including ‘citizen’ ‘ordinary person’ ‘patient’ ‘client’, ‘customer’, ‘consumer’ ‘peer’ and ‘expert by experience’ were all considered for use (McLaughlin, 2009). The different nuances that each carries in terms of the identity, relationship and power dynamic between the practitioner working within a MH service, and the person accessing that service, were reflected upon (McDonald, 2006; McLaughlin, 2009; Beresford, 2010; Christmas and Sweeny, 2016; Barnes and Cotteril, 2016). Given the small number of people within this participant group, the representativeness of the group was deemed to be less of an issue than their inclusion in the research, which was fundamental to the nature of this study (Prostle and Beresford, 2007). As such, discussions were had with each participant about perceived identity and preferred terms. The term ‘service user’ (SU) was the unanimous preference, and as such, it is how this participant group have been referenced throughout the thesis, and the term has been adopted thereafter.

* 1. The Legislation

The Mental Health Act 1983 (MHA 1983) is the key piece of legislation that covers the assessment, treatment, and rights of people with mental ill-health (NHS, 2022). Parliament passed the Act in 1959, a decade after the NHS was established, and it was later revised in 1983 to introduce the issue of consent (NICE, 2022). E&W is one of the few areas in Europe that provides specific legislation regarding the role of the police in the detention of those who appear to be experiencing a crisis (Loughran, 2018). The 1959 Act repealed the previous Lunacy and Mental Treatment Acts, 1890 to 1930, and the Mental Deficiency Acts, 1913 to 1938. Though the majority of the Act governs wider MH practice, Part X (Miscellaneous and Supplementary) contains two sections (Section.135/136) that legislate the role of the police in MH care. It will be seen how these two sections, particularly s.136, have shaped the operational policing of MH in the community. Despite varying amendments to the Act over time (e.g., 2007), s.136 remained unchanged from its passing in 1959, until the Police and Crime Act in 2017 (PACA, 2017), leaving the substantive roles and responsibilities of police constables (PCs) relatively intact until this point. The introduction of PMHT schemes has been described as a response to concerns that the police powers under s.136 were being over-used (Irvine, et al, 2015). The police detain around 33,600 people a year under s.136, and this figure has been gradually increasing since 2011 (CoP, 2015).

Though the police are involved in a range of scenarios that concern mental ill-health, those most pertinent to PMHT are instances without a warrant, where the police are called to respond to a person experiencing a suspected acute episode of mental ill-health, or extreme distress, in the community. As introduced above, such instances are governed by s.136 of the MHA 1983, though reference is made to definitions found within s.135, which is distinct because s.135 concerns removal *with* a warrant (and thus much less relevant to PMHT). The MHA 1983 is accompanied by statutory guidance provided through the MHA 1983 Code of Practice, pursuant to s.118 of the MHA 1983, which requires the code to be amended from ‘time to time’ by the Secretary of State.

S.136 concerns only the removal of mentally disordered persons without a warrant andstates that if a person appears [to a PC] to be suffering from a mental disorder and to be in immediate need of care or control, the constable may, if they think it necessary to do so in the interests of that person or for the protection of other persons, remove the person to a place of safety within the meaning of s.135, or if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety. Like for many other incidents, the police are not required to complete a statutory form when detaining an individual under s.136, with the decision to use it being a discretionary one (Borschmann et al., 2010; HMIC, 2015; Baker and Pillinger, 2020).

S.136 of the MHA 1983 was amended by the PACA 2017, for the first time since 1959, though even the wording of s.136 is not too dissimilar from the archaic legislation that the MHA 1959 repealed (e.g., the Mental Treatment Act 1930). The PACA 2017 mandated that in relation to s.136, no children may be taken to police stations as a place of safety and adults may only be taken there in ‘exceptional circumstances’; that police have a specific power to search for those detained under s.135/6 both at the point of detention and at arrival in a place of safety; that place of safety detention under s.136 can only last 24hrs unless authorisation extends this to 36hrs in specific situations; that s.136 can be instigated anywhere other than a home; and most relevant to PMHT, there is now a requirement, where practicable, for officers to consult with a doctor, nurse or approved mental health professional (AMHP) before using s.136.

Removal to a place of safety (PoS) is exhaustively defined to mean residential accommodation provided by a local social services authority; a hospital; a police station; an independent hospital; a care homefor mentally disordered persons; or any other suitable place. The MHA 1983 Code of Practice states that in all but ‘exceptional circumstances’, this should be in a health-based place of safety (HBPOS) such as a hospital, or another health setting (DHSC, 2015). The current provision of HBPOS remains variable across E&W and has been directly linked to the lack of provision and capacity (CQC, 2014). In most cases, the designated s.136 provision is inadequately staffed or has insufficient funding to operate during restricted hours. Outside of these hours, when the majority of incidents occur, police have had little choice but to transport people to an alternative PoS, such as police custody (Onyett et al, 2006; HMIC, 2013; Home Office, 2014; HASC, 2015). The use of police custody as a PoS has received unanimous condemnation due to the stigma, the association of MH with criminality, and a lack of safety, but has sometimes remained recognised as a common practice due to MH practitioner concerns regarding the risk of violence or intoxication. Progress has been made in this area, with the Wessley Review (2018:192) reporting that in 2017/18 police cells were used as a PoS 400 times in England, which was a 95% reduction from 2011/12 figures.

The purpose of removing the individual to a PoS, whether health-based or otherwise, is explicitly so that they can receive an assessment by a medical practitioner and for appropriate care and treatment to be arranged. People detained under s.136 have not committed any crime (necessarily), yet the use of s.136 is an arrest of the individual, temporarily depriving them of their liberty (Irvine et al, 2015; Kane and Evans, 2018). The average length of time for detention in a police cell under s.136 is ten hours and often occurs overnight (DHSC, 2014). Based upon this figure, this equates to 60,000 PC/staff hours per year on s.136 detentions within police cells alone (CoP, 2015).

* 1. Research Context
     1. *The policing and mental ill-health intersection*

In order to understand the socio-historical context of PMHT, as depicted in Chapter Two, it is necessary to recognise the police as only one aspect of broader processes of social control, which predominated in the eras before the birth of the modern police in 1829 (Rawlings, 2002). Social control here refers to ‘the organised ways in which society responds to behaviour and people it regards as deviant, problematic, worrying, threatening, troublesome or undesirable’ (Cohen, 1985:1). The term 'police' refers to a particular kind of social institution i.e., the police organisation today is an organised form of social control. 'Policing' implies a set of processes with specific social functions (Bowling et al, 2019). Viewing the police as an aspect of social control shifts the focus away from the 1829 inception of the police organisation being viewed as the ‘start’ of the policing of those with mental ill-health (Rawlings, 2002). The intersection between policing and MH is one that was seen as early as Anglo-Saxon times (Critchley, 1978) and has remained omnipresent since. The term intersection in this thesis refers to the deeper connection or the ‘entanglement’ of policing and mental ill-health, that has existed throughout history in a multitude of organised ways and is irrespective of the contemporary police and NHS organisations. The interface, on the other hand, refers to the more superficial relationship between the modern police and health organisations and the relationship between them, which has grown substantially from the mid-twentieth century, through to the inception of PMHT.

From its inception in 1829, the police in E&W have developed, and continue to develop, into an extensive and versatile public service, maintaining order and upholding the law, underpinned by unique powers (Police Foundation, 2022). Fifty years of policing scholarship have concluded that the police function comprises a mix of crime control, order maintenance and social functions (Millie, 2014). In contrast to the dominant imagery of the police role being one of ‘crime fighters’, commentators have described the role of the police as ‘peace officers’ ([Banton, 1964](https://journals-sagepub-com.sheffield.idm.oclc.org/reader/content/16cda515c06/10.1177/1748895812474284/format/epub/EPUB/xhtml/index.xhtml#bibr1-1748895812474284)), ‘secret social service’ ([Punch, 1979](https://journals-sagepub-com.sheffield.idm.oclc.org/reader/content/16cda515c06/10.1177/1748895812474284/format/epub/EPUB/xhtml/index.xhtml#bibr28-1748895812474284)) and ‘philosopher, guide and friend’ ([Cumming et al., 1965](https://journals-sagepub-com.sheffield.idm.oclc.org/reader/content/16cda515c06/10.1177/1748895812474284/format/epub/EPUB/xhtml/index.xhtml#bibr6-1748895812474284)). MH-related calls for service, for example, are estimated to account for up to 40% of police demand (Adebowale, 2013), though the actual figure is unknown (CoP, 2015; HMICFRS, 2018). Despite police organisations having reported a sharper increase in MH demand since the early 2010s (particularly with regard to the use of s.136), there has been a gradual increase in police involvement in MH since the 1960s.

The origins of this growth have been explained largely by the process of deinstitutionalisation (Cummins, 2010). Deinstitutionalisation refers to the relocation of people with mental ill-health from traditional MH facilities or ‘asylums’ as they were historically termed, to smaller, less restrictive, community-based care facilities, group homes and families, where independent functioning could be encouraged (Pillay, 2017). Chapter Two describes how the process of deinstitutionalisation, in and of itself, may not have generated such a rise in police demand. The process occurred, however, against a neoliberal backdrop of government ideology and accompanying policies, which contributed to a failure to develop adequate community MH provision (Perkins et al., 1999; Ruiz and Miller, 2004; Cummins, 2010). It was thus a combination of these factors, that led to the substantial increase in the police-MH interface from the 1960s.

This failure to adequately develop community services to support the deinstitutionalisation process at that time, and the impact of this on the individuals who were transferred into the community settings, is widely documented (Moon, 2000; Kelly, 2005; Wolff, 2005). Without adequate support for those with mental ill-health, MH crises within the community have become more common, effectively forcing police to become a *de facto* MH service, adopting the twin roles of law enforcement and healthcare provision in the absence of an equivalent specialised MH emergency service (Cherret, 1995; Lamb et al, 2002; Reuland et al, 2009; Reiner, 2010; Cummins, 2010; HMIC, 2015; HASC, 2015). As outlined above, s.136 of the MHA 1983 remained intact over this time, and this was a key enabler for the police in undertaking this *de facto* function.

* + 1. *The role of the police in society*

As introduced above (*1.4.1*), the multifaceted role of the police was reflected in foundational policing studies, which all considered the social role of the police alongside crime fighting, and included narratives around the policing of vulnerable populations, including those with mental ill-health (Banton, 1964; Bittner,1967; Muir, 1977; Holdaway, 1979; Ericson, 1982; Skolnick, 1982;1987; Bayley, 1985; 1974; Reiner, 1981). Thomas (1988:126) stated ‘social work as social policing is only one step removed from real policing and this must be an important factor in improving relationships between the police and social workers’. Likewise, Bittner (2001) reported that when one looks at what police actually do, law enforcement is something that most of them do with the frequency located between virtually never and very rarely. In the main, these views enforce the idea of the police function as being an emergency service, thus intervening when an emergency is public, or threatens to become public, whether that be crime, health or otherwise (Waddington, 1999).

In 2011, the Home Secretary, Theresa May, stated she was not asking the police to be social workers and their sole job was to cut crime. Her characterisation of the police as ‘crime fighters’ failed to consider either the symbolic function of police (Jackson and Bradford, 2009) or the reality that as a 24/7 emergency service they are likely to be first responders to a number of incidents stemming from a number of social issues (Bittner, 1990; 2005). In many ways, this is what the public wants and expects (Herrington, 2014). As Loader (2014:44) deciphered, ‘the bandit-catching conception of the police as crime fighters has a widespread but superficial appeal within the English social imaginary’ and it is this social imaginary that is at odds with the continued high levels of MH demand on the police in England and Wales (Abedowale, 2013; HMICFRS, 2018).

Despite HMICFRS (2018) stating concerns over the (under-evidenced) extent that the police were working over their duty in responding to MH incidents, five years prior at the time when police forces were looking at resource demand and allocation in the midst of austerity, an Independent Commission (2013) explicitly identified and described MH as its ‘core business’. In 2014, HMIC stated that when entering into an austerity climate, serious consideration should be given to collaboration with other organisations as a cost-saving effort (HMIC, 2014). Some PMHT schemes had already been operating for three years by this time, and the fact they continued to do so despite May’s seemingly politically induced narrowing of the police mandate, was suggestive that there was a genuine belief by organisations that PMHT had the ability to reduce costs for the police organisation. It should be noted however, there has never been a comprehensive cost-benefit analysis evaluation of PMHT and so there is no evidence to suggest whether it is indeed cost-effective (Heslin et al, 2016).

In the widest sense, the traditional policing responses to incidents of mental ill-health required PCs to act as first responders and to be the primary decision-makers who then connect with other agencies as and when is necessary (Morgan and Paterson, 2017). A heightened recognition of this role due to shifts seen with the social, cultural, political, and economic tides throughout history, has re-situated PCs as key sources of organisational learning, leadership, and decision-making today (Clamp and Paterson, 2013), not mere crime fighters. It has created, nationally, a much greater understanding, that PCs in their daily role act as street-level experts and will often engage with other agencies to address complex social problems (Morgan and Paterson, 2017). The implementation of PMHT is one way of formalising this recognition and is an example of practice referred to in discussions of LEPH as an emergent field of study (Bartkowiak-Théron and Asquith, 2017).

The implementation of PMHT partnerships has provided, for the first time, a formally recognised combined response (police and health) for people experiencing acute instances of mental ill-health within the community setting. PMHT partnerships sit neatly within what has emerged as a specific field of study in its own right, that of a combined LEPH approach in tackling complex societal issues (Van Dijk and Crofts, 2017). In its most simplistic form, a combined approach to LEPH is concerned with the relationship and intertwining theoretical and practical fundamentals between law enforcement and public health institutions. Both institutions can be categorised, in part, by the practitioners and organisations involved in these respective sectors, and both aim to contribute to the safety and security of the population (Van Dijk et al, 2019) e.g., the police serve as public health ‘agents’. There has been a growing recognition, that to tackle the range and complexity of the public safety challenges society faces, the police cannot be depended upon alone (Kinsey et al, 1986; Police Foundation, 2022). The term law enforcement is, therefore, used in a broad sense to refer to the sector, rather than imply that this is the core function of the police (Van Dijk et al, 2019).

* 1. Research questions, objective, and originality

The central research question that this study will address is -

***What can be understood about the origins, implementation, purpose, and delivery of PMHT partnerships, commonly referred to as ‘Street Triage’ schemes?***

Whilst the more targeted aims of the study are outlined in Chapter Four, the overarching objective of this study is to provide a rich, contextualised account of PMHT partnerships, undertaken through the application of a critical lens, to plug a gap in the hitherto largely evaluative literature (e.g. Edmondson and Cummins, 2014; Dyer et al, 2015; Wilson-Palmer and Poole; 2015; Reveruzzi and Pilling, 2016; Horspool et al, 2016; Irvine et al, 2016; Keown et al, 2016; Jenkins et al, 2017; Puntis et al, 2018; Kane and Evans, 2018). The need to develop an independent and academically rigorous evidence base around the operation of PMHT was naturally a huge driver for the research. In understanding PMHT as a purposeful social action (Merton, 1936), the research has been able to distinguish between manifest (anticipated) and latent (unanticipated) consequences of PMHT. Specifically, this framework has allowed the researcher to move beyond prior evaluative research that has focused on whether PMHT has arrived at specified goals e.g., a reduction in s.136 use.

This research delves deeper into four aspects of PMHT that previous research has omitted, largely due to methodological constraints. The first of these relates to the origins of PMHT needed to gain an understanding of both the local and broader socio-political drivers behind its implementation, thus situating these partnerships in a socio-historical context but through a theoretical lens. The second of these is how the management-based theory of collaborative advantage (CA) can be applied to PMHT partnerships, to understand the specific nature of multi-agency working arrangements within PMHT, and to what extent they have become an accepted form of police practice. In doing so, it offers an original contribution to knowledge around police partnership work, which has historically been heavily centred upon Crime Reduction and Disorder Partnerships (CRDPs). The third of these relates to the passing of the PACA 2017. The research considers the extent to which the requirement for officers to consult with a designated health professional before using s136 has given PMHT a statutory footing in practice. It considers the extent to which PMHT partnerships have become embedded practice within the police organisation and it has sought officer perceptions about whether PMHT has impacted their decision-making when attending incidents of mental ill-health outside of the partnership initiatives. In doing so, the research draws upon the theory of risk society (Beck, 1992; Ericson and Haggerty, 1997; Gale et al, 2016) and builds upon what was found in prior evaluative research, whereby contrasting approaches to risk management were found to exist between PCs and MH practitioners (Irvine et al, 2014; Edmondson and Cummins, 2014).

The final aspect that this study has been able to consider, is SU perspectives, which have, until this point, been severely and unfairly neglected in prior research. Improving the SU experience when in crisis, by providing prompt and efficient access to the most appropriate pathway of care, is regularly cited as a primary aim or purpose of PMHT partnerships (e.g., Fleming and Smith, 2014; Reveruzzi and Pilling, 2016). Extant PMHT research that includes a future commitment to the inclusion of lived experience perspectives, lest any actual inclusion, ranges from extremely limited to non-existent (HMICFRS, 2018). The national DHSC evaluation, for instance, stated that a range of qualitative material, including comments received from SUs, families, carers, and community members were analysed (2016:17), but this was not reflected in the report.

While within research it is recognised some voices can be given more attention than others, in the field of MH, the dominant stories about understanding mental ill-health and how people can best be helped have primarily been told by practitioners (Klevan et al, 2016). It is, thankfully, becoming increasingly acknowledged though that individual, rich stories can be an important source for developing knowledge about mental ill-health (Roberts, 2000). At present, however, knowledge around the level of compatibility between organisational strategy and the recipient’s experience of PMHT partnerships remains evidentially unsupported. This, it is argued, is unacceptable. The limited research that has acknowledged the omission in SU perspectives has stressed the importance of future inclusion with regard to shaping the future direction of the initiatives (Irvine et al., 2015; HMICFRS, 2018). This research has begun this process, placing enormous value on the perspectives of those with lived experience of PMHT partnerships and recognising these as vital to any interventions that concern the policing of mental ill-health. In particular, it has sought to address the perspectives of people with lived experience of PMHT, about the purpose of this kind of partnership work and the value that they perceive it to have within the contemporary crisis care landscape.

* 1. Thesis Structure

This thesis is structured into nine chapters. Chapters Two and Three provide a critical review of the existing literature that depicts *the policing and MH interface over time* and the development and nature of *police partnership work*. Chapter Two provides a historical analysis of the policing and MH interface, recognising the intersection that has existed since the thirteenth century, and reviews the accompanying interface that became substantial in the 1960s. Chapter Three is the second literature review that sets the scene for subsequent discussion of the findings in Chapter Six. It provides contextual grounding to the nature of police partnership work, introduces the collaborative advantage theoretical framework, as well as offering a 21st-century conceptualisation of PMHT through the lens of LEPH.

Chapter Four considers the *research methodology* used to address the overarching research questions. To begin with, this chapter reflects broadly upon the epistemology and ontology of the research, before discussing the methodological approach adopted by the study. The chapter pays particular attention to debates on mixed methods research, data collection and analysis techniques and ethical issues experienced throughout the research.

Chapters Five to Seven present the findings from the study. Chapter Five opens the empirical chapters and serves to further contribute to an already extensive evidence base about the historic failure to adequately implement community care and the consequences of such on the relationship between policing and MH today. To understand the origins and implementation of PMHT, this chapter offers a comprehensive overview of existing available out-of-hours crisis care provision as it was found to be at the time of the fieldwork, and reports upon the tangible reality that a decade of austerity politics had on available service provision, from the perspectives of the frontline practitioners working within it. The latter part of the chapter moves beyond *why* PMHT partnership arrangements were implemented, and towards a detailed practical look at *how* this was done in practice. It introduces the reader to a day in the life of PMHT because while the daily experiences of staff undertaking PMHT were described as variable, there were common elements to their routines across all sites.

Chapter Six reports the key findings about the partnership practice and procedures. Whilst serving the broader question of what can be understood about the purpose, operation, and delivery of PMHT partnerships, it considers the organisational and occupational milieu of PMHT police partnership work. The first half of Chapter Six considers the organisational milieu, reporting the multi-dimensional nature of PMHT and its membership; and its purpose from both an organisational perspective and that of the frontline practitioners working within it. It highlights the variances where they were found to exist; and it considers the relationship between practitioners’ perceptions of the partnership with regard to the individual practitioner roles undertaken within the most common form of PMHT, co-response models. The second half of Chapter Six considers the occupation milieu of PMHT partnerships and speaks more specifically to those research aims related to the nature of this kind of multi-agency work. It considers contrasting cultures and ideologies, and the impact they had on policing practice and decision-making processes.

Chapter Seven is the final empirical chapter within the thesis and reports the findings from a SU survey on perspectives of PMHT partnerships. In addition to the survey data, it draws upon field observation notes and interview data to offer the most notable original contribution to knowledge in this area, given the perspectives of SUs have been omitted from the limited extant research on PMHT. Much of this chapter includes references to crisis care more broadly, with a focus on how and why people came to the attention of PMHT. With this established, the remaining key themes are presented through two further sections, namely perceptions around partnership working and perceptions around interpersonal relations with PMHT practitioners.

The thesis concludes in Chapters Eight and Nine, in which the central themes presented in this thesis are discussed in relation to the overall aims and objectives of the study and the existing literature. Chapter Eight provides a much broader discussion of findings presented in Chapters Five to Seven and, in particular, pays attention to their implications for our understanding of PMHT partnerships and what can be inferred from current practices with regard to their ongoing value, purpose and the future of police involvement in MH crisis care provision. Chapter Nine provides a research overview, a summary of the original contribution to knowledge this thesis makes and closes with some final concluding thoughts.

*And it begins…*

1. **CHAPTER TWO**

**Situating PMHT Partnerships in their Socio-Historical Context**

* 1. Introduction

This chapter is concerned with situating PMHT partnerships within a socio-historical context. The introduction to this thesis outlined how a variation of PMHT (CIT) first emerged in America in the late 1980s and has remained there since (Steadman et al, 1999; Bartkowiak-Théron and Asquith, 2017; Watson et al, 2017). The goals of that partnership were to increase safety in MH crisis encounters, divert individuals in crisis from arrest, and provide links to appropriate psychiatric care (Compton et al, 2014; Watson et al, 2017). Despite sharing a similar rationale, it was not until 2012 that comparable partnerships started to emerge within E&W, and their existence was not considered commonplace here until the mid-2010s (Reveruzzi and Pilling, 2016). The purpose of this chapter is, therefore, to understand why there was a mandate for PMHT at the time it emerged within E&W, given the intersection between policing and MH predated even the creation of the ‘new’ police service in 1829 (Rawlings, 2002).

After a brief introduction to the policing and mental ill-health intersection, the first part of this chapter covers the period from 1979 through to the early 21st century, when the related interface became substantial. Its focus is on the consequences of deinstitutionalisation, intentional and otherwise, through the lens of neoliberalism. The term deinstitutionalisation refers to the process that occurred when MH provision shifted away from residential asylums, through a reprovisioning of NHS long-stay hospital beds, and to what was primarily an outpatient service (Emerson, 2004; Kritsotaki et al, 2016). It reviews how deinstitutionalisation occurred simultaneously with the start of a neoliberal government ideology and shows how such policies produced increased social and economic segregation (Savage, 2015). It is explained how this occurred at a time when deinstitutionalisation meant a large number of people with mental ill-health found themselves discharged from large MH institutions and then resettled in the community with inadequate support, which saw the police starting to ‘plug the gap’ on a much more substantial basis than it had done so prior (Cummins, 2010).

The latter part of this chapter reviews how the interface had become what I describe as being ‘maxed-out’ from the mid-2000s and so continues to review the key developments up to the implementation of PMHT, focusing primarily on the impact of austerity on society and the relevant public services. This section thus concentrates on the police - MH interface over the past two decades, leading to a position in the early 2010s when MH was recognised as core police business (Adebowale, 2013). It is argued that as a result of the interface becoming maxed-out, public sector agencies including the police and NHS were looking for innovative ways to do more with less (Solar and Smith, 2020) and PMHT was born.

Historical analyses of the policing and mental ill-health intersection and the related interface are often structured around defined periods of time. There is a danger, however, of attaching too much significance to particular dates when trying to understand history (Wincup, 2013), especially one as complex as policing and mental ill-health. In Foucault’s eminent analysis, he coined distinct periods of time as ‘*epistemes*’ which he characterised as the orderly unconscious structures underlying the production of scientific knowledge in a particular time and place (Foucault, 1965). These were (1) the pre-classical period (the Middle Ages and renaissance up to the mid-17th century); (2) the classical period (the mid-17th to the 18th centuries); (3) the modern period (19th century to the mid-1950s); and, (4) the contemporary period (from the 1950s onwards). It has been said that policing before the ‘new’ police, has often been neglected in police histories (e.g. Rawlings, 2002 on Critchley 1967), yet plenty of literature exists around the institutional response to the vulnerable from the same time (e.g., Jones, 1955, 1993; Andrews et al., 1997; Berrios and Freeman, 1991; Porter, 1989, 1991; 1981; Nolan, 1993; Parry-Jones, 1972; Russell, 1997; Scull, 1979, 1981, 1989; Garland, 1985; Showalter, 1987; Skultans, 1975; Cummins, 2020).

It was outside the scope of what was essential for this thesis, to provide a comprehensive historical account of the policing and mental ill-health intersection from its origins, which much of the above literature has done so well already. The focus of the chapter is on the more superficial policing and MH interface that exists between the contemporary police and NHS organisations. It is still important to note, though, that the origins of this interface exist within the context of a deeper policing and MH intersection that has remained omnipresent since the thirteenth century when formal state responses to mental ill-health began to develop and the policing of those with mental ill-health existed through the early forms of social control in society. Policing has thus always had a wide remit, much wider than criminal matters (Lee, 1901). While the remit of policing and the police can and does change (Millie, 2014), the policing of mental ill-health has remained a key feature within society.

The earlier epistomes, which concerned the rise of the asylum regime (institutionalisation) and how society has viewed and responded to mental ill-health through organised forms of social control prior to the contemporary police and health organisations, involved a relatively limited set of interactions between policing and health institutions and actors of the era. In addition, the policing-MH interface, culminating in this chapter with the birth of PMHT in E&W in 2012, was far from complete at the time of Foucault’s final works in the early 1980s. Much of the later research on community MH services, in particular crisis care provision (within which PMHT is most closely aligned), is situated in the ‘new’ contemporary MH landscape in the era of neoliberalism and later the expansion of this, through a decade of austerity policies (Cummins, 2010; 2012; 2019; 2020). This consequent period of time has been described as the fifth episteme, that of the ‘Neoliberal Epoch and Community Care’ era (Cummins, 2019). It was this consequent period of time, running through to the 2010s, that forms the final piece of the puzzle in understanding the context within which PMHT exists. As such, it was the fourth epistome and the subsequent era where the focus of this chapter needed to be centred, and so it begins with the path to deinstitutionalisation.

* + 1. *The path to deinstitutionalisation*

In 1944, a White Paper on the creation of the NHS recommended the inclusion of MH services within the newly proposed NHS. The NHS Act of 1948 was passed soon after, which saw the creation of the NHS come into existence in 1949. In 1953, the Percy Commission was established to develop what became the MHA of 1959. The Act included a 72-hour emergency order under s.136, which remained unchanged following the MHA of 1983 (Loughran, 2018). In 1957, the Royal Commission on MH recommended the care of those with mental ill-health should be shifted away from hospitals and into the community, depending on the ability of local authorities to provide such services. The MHA 1959 came about as a result of the deliberations of a Royal Commission on the ‘law relating to mental illness and mental meficiency’ (1954-1957). In 1959 the prior notion of ‘madness’ disappeared. Its disappearance did not signify a sudden change in psychiatric morbidity, nor the effect of a dramatic cure, it was simply that the term madness had left medical discourse (Armstrong, 1980).

The MHA of 1959 made the provision of community MH services by local authorities a statutory duty. Services were to be funded by the Treasury and community-based MH care subsequently expanded greatly. The MHA 1959 lent itself to community care in two ways. First, it proposed the movement of psychiatric treatment to wards within general medical hospitals, whereby patients would be treated on a formal and informal basis and also serve as an outpatient clinic. Secondly, psychiatry would move away from custodial care and people would no longer be admitted to hospitals because they could not take care of themselves, only if they were perceived to be suffering from an identifiable condition which could be treated, after which they would be discharged (Clayton, 1993). The 1959 MHA developed and codified the police powers in relation to managing people with mental ill-health in the community through s.136, the wording of such was not too dissimilar from that found in the Lunacy and Mental Treatment Acts 1890-1930 and the Mental Deficiency Acts 1913-1938. The interface between the police and NHS, at this point, remained limited, as community care had not yet been fully developed.

By 1954, the number of in-patients in Britain peaked at 148,100 (Tooth & Brooke, 1961) and it was 64 years since any serious consideration had been given to the laws relating to mental ill-health (Jones, 1993). The first parliamentary debate in 24 years was initiated through a private members bill due to concerns about overcrowding within psychiatric institutions and the need for modernisation (Thornicroft and Bebbington, 1989). The debate recognised that the asylums were an appalling legacy and that replacing them was not a question of a few million pounds, but a question of thousands of millions of pounds over many years (Jones, 1993). Until this point, the focus had been one of segregation and institutionalisation (Cummins, 2020), but the tide was turning.

In 1961, the UK’s new minister of hospitals, Enoch Powell, announced the abolition of long-stay mental hospitals and instigated the UK policy of deinstitutionalisation. Referring to the process of closing the asylums, Powell spoke of it being a colossal undertaking, physically and culturally. A year after Powell’s announcement, the Ministry of Health issued the Hospital Plan for E&W (1962). The primary purpose of the plan set out to reduce the inpatient population of mental hospitals, reserving hospitalisation as an option for the most severely impaired patients who were mentally ill *and* dangerous (Durham, 1989).

Deinstitutionalisation is often categorised as a two or three-step process, namely, the release to the community of all institutional patients who had been given adequate preparation for such a change; the prevention of inappropriate mental hospital admissions through the provision of community alternatives for treatment; and the establishment and maintenance of community support systems for non-institutionalised people receiving MH services (Brown, 1975). Whilst the first of those involved discharging patients from hospitals to the community, the second two concern the provision of adequate resources for good community care (Bachrach, 1976; Hoult, 1986). ‘Community care’ was thus integral to the process of deinstitutionalisation, so much so, it became the shorthand term for the new policy framework.

* + 1. *The humanitarian ‘ideals’ of deinstitutionalisation*

The deinstitutionalisation ‘movement’ first gained traction during the 1950s, and by the 1960s, had become part of the broader civil rights movement as a social, health, and human rights campaign (McKenna and Kelly, 1995; Rafferty, 1991; Pillay, 2017). The social tide once again seemingly shifted through society’s adoption of a more liberal stance i.e., both tolerance of difference and acceptance that mental ill-health could happen to anyone, rather than being a sign of shame or threat, that would previously have found someone in an asylum (Carpenter and Raj, 2012).

There was, for some, an acceptance that large institutional settings were capable of meeting patients’ basic psychological needs, butnot the higher needs of self-esteem and self-actualisation (Heller, 2015). Community care was based upon the idea that it would meet these higher needs in a way the asylum regime could not (Kelly, 1999). The notion of community care was that people would be treated, in most cases, ‘voluntarily’ at home, though the role of the community system was never really clarified (Carpenter and Raj, 2012). Fundamentally though, it was based upon the idea that people with mental ill-health could be ‘inserted’ back into networks of the ordinary (or genuine) human relationships which represent the community (Hinshelwood, 1998). Recognising the atrocious legacy of the large asylums, Pattison and Armitage noted how ‘it is widely believed that the psychiatric hospitals, many of which were built before the turn of the century, have failed as caring institutions’ (1986: 136). The paradox at the heart of community care is that it failed to overcome many of the barriers to social citizenship that it sought to end (Cummins, 2019). The reasons for such are the focus of Part One of this chapter, which begins in 1979.

* 1. Part One: The substantial interface
     1. *Introduction to the ‘substantial’ interface*

Though is widely recognised that the expansion in the police-MH interface had its origins in ‘deinstitutionalisation’, which as introduced above, saw the contraction of the institutional regime, without a concurrent expansion of community-based services (Bachrach, 1976; Cummins 2018; 2020). Deinstitutionalisation in and of itself, cannot account for the substantial growth in the police-MH interface. On the contrary, the ideals of deinstitutionalisation were admirable and were largely based on humanitarian concerns (Pillay, 2017). What can also account for the growth in the interface, was the coinciding UK neoliberal political movement from 1979 onwards, which has been described as a trailblazer for neoliberalism in Europe (Ramon, 2008).

Though this chapter has been less concerned with pinpointing developments to specific dates, using 1979 as the starting point for this part seemed just, given Thatcher’s distinctive association with this divisive form of politics (Wincup, 2013; Dorey, 2015). This part shows how forms of governance and the nature of the state, do not stand still (Carney, 2008), and thus it was the shift towards neoliberalism that saw the ideals of deinstitutionalisation flounder into oblivion, and the police organisation left picking up the pieces (Reiner, 2010; HMICFRS 2018).

* + 1. *‘Neoliberalism’*

Neoliberalism in the UK represented a major political regime shift (Duncan, 2022) and an emergence of what has been described as ‘the consolidation of a new ideological hegemony’ (Larner, 2000:9). Fundamentally, it can be understood as a return to, and also an extension of, classical 19th-century liberal laissez-faire capitalist economic theory (Maiese, 2022). As Garrett (2019) notes, the term itself is often-contested and in some cases, has been dismissed altogether (Boas and Gans-Morse, 2009; Laidlaw, 2015; Harman, 2008; Venugopal, 2015; Rodgers, 2018). The term has been criticised as one belonging to ‘the left elites’, and its political usefulness has been called to question (Dunn, 2017:435). Opponents of the term, however, have recognised the implausibility of engaging with anything more than a fraction of even the most influential sources (Dunn, 2017).

In the same vein, it must also be acknowledged that the arguments set out in the course of this thesis, exist as only a fraction of the entire writings on health and social policy, let alone all perspectives and interpretations of neoliberalism. This thesis is not intended to provide an in-depth critical analysis of neoliberalism as a whole, it simply is not possible (or necessary) to do so here, but it has been considered a useful analytical concept for understanding the developments in MH provision and the substantial growth in the police-MH interface from 1979 (Garrett, 2018; Bourdieu, 2001; Harvey, 2005; Ramon, 2008; Cummins, 2010; 2018). The concept has been approached throughout this thesis as both a policy framework, an ideology and mode of governance. Neoliberalism has been defined widely, and to avoid criticism of it being used here as a catch-all term to convey what may be perceived as discontentment with government policy and reforms, its key principles are explained as a belief:

1. that the free market is benevolent,
2. that state intervention and regulation of the economy should be minimal and
3. that the individual is nothing more and nothing less than an essentially self-interested, instrumentally rational, economic agent (Maiese, 2022).

As these principles reflect, Cummins (2018:7) notes that at the heart of neoliberal ideas, is the supremacy of the market (as the most effective means established for the distribution of resources), and a belief in liberty (defined here as freedom from the state or other interference). Its key principles thus centre upon a reduced role for the state, the introduction of market mechanisms into the provision of public services, and individualism and liberty as key political values (Cummins, 2018:3). These are reflected in cultural attitudes, as well as the new provision of services. The process of deinstitutionalisation occurred at a time when the government began to dismantle the basic institutional components of the post-war settlement and mobilise a range of policies that intended to extend market discipline, competition, and commodification (Brenner and Theodore, 2002:2-3).

It is considered below (*2.2.4*), how these principles transferred to the (under) development of community provision through policy (Perkins et al., 1999; Ruiz and Miller, 2004). The primary outcomes of such, were an underfunded system of community care from the off, along with increased economic segregation and rising inequality, which became a key mediator between political economic change and the plunging MH of the population (Burns, 2015). Together, these resulted in a large influx of people with mental ill-health into the community, and the police being the primary agency to respond to such instances e.g., using their powers under s.136 of the MHA 1983 (Teplin, 1992). Under neoliberalism, the MH/illness dichotomy defines ‘health’ as what serves the economy and ‘illness’ as what does not. This destroys the nuances of living in a complex social world, where ‘illness’ is one of the few human signals left of where society is failing us (Davies, 2022).

* + 1. *Neoliberalism and deinstitutionalisation*

Reflective of the wider neoliberal ideology, Scull (1984) described how the enactment of the policies that facilitated the process of deinstitutionalisation was driven primarily by fiscal motivation and was a cynical money-saving exercise on the part of central government (Cummins, 2019). Krauss and Slavinsky (1982) suggested that the belief that community care would be cheaper than continuing hospitalisation, no doubt influenced the government at a time when they were concerned about the rising costs of health care and the welfare system. Casting little doubt about the government’s fiscal motives (Sullivan, 1998), the accompanying document to the hospital plan, titled ‘*Health and Welfare: The Development for Community Care’* released a year after Powell’s speech, included 321 pages of detailed local authority returns on their future and was based on the idea that the state could save money through deinstitutionalisation. Community care was thus perceived as a cheaper option (Talbott, 1979; Durham, 1989; Pillay, 2017; Cummins, 2019).

Reflective of decentralisation, individual NHS organisations were left to decide which institutions to close, how they were to approach the closure, and how they were to resettle the people that had inhabited there (Ramon, 2002). Wider national guidance and support on this process were not available, beyond that concerning the financial incentive to do so (Cummins, 2016). The financial incentive was a lump sum paid per long-stay patient (resident in hospital over two years) to the housing association that was taking responsibility for their relocation, as well as the right to sell the estate on which the institution was built to private developers (Ramon, 2002). With the provision of statutory care reduced, it provided an opening for the private sector, which had become politically acceptable due to the fiscal concerns of the time (Sullivan, 1998).

A further consultative document in 1981 outlined proposals for transferring patients and resources from hospitals to the community (Sullivan, 1998). These proposals included an extension of joint financing, with a definitive statement being issued on this area in 1983 (DoH 1981; 1983). Despite this, both the HASC (1985) and the Audit Commission (1986) were critical of the realities of community care and in 1988 the Griffiths review was published (DoH, 1988). The Griffith review recommended that the government should establish a health services supervisory board, chaired by the Secretary of State for Health to decide on strategies for the NHS, as well as budgets and objectives. Griffith recommended that all regional and district health authorities should appoint general managers to take charge of services at regional and district management levels from April 1984, and the same principles should be applied to the DHSC (Edwards and Fall, 2005). Many of Griffiths’ recommendations formed the basis for Caring for People (DoH, 1989) and were incorporated into the NHS and Community Care Act 1990 (Sullivan, 1998). This reorganisation of the NHS, under the Thatcher administration, put the responsibility for community provision on local authorities.

This 1990 Act developed the idea of the split between purchaser and provider and introduced the concept of care management which created a market in residential and other community services for adults with MH and other health needs (Sullivan, 1998; Cummins, 2020). Particular reference to those with mental ill-health was in the form of the ‘Specific Grant for Mental Illness’ and the ‘Care Programme Approach’. The Specific Grant was allocated to local authorities on the basis of social care plans, which were to be agreed upon with the local health authority. The idea was for the provision of services to be operated ‘by the community’ rather than ‘in the community’ (Sullivan, 1998), with this becoming the cornerstone of MH care policy from here on in (DHSC, 1990). The remainder of Conservative governance until 1997, saw the rhetoric of improving care for people with severe mental illness, yet this was marked by a preoccupation with ‘dangerous’ people as much as it was about resourcing (Turner et al, 2015). As a result, care was increasingly provided by the private sector and informal carers, signifying the value that had been placed on the free market. The majority of adult residential care or support for people to remain living independently in their own homes was now provided by commercial enterprises (Cummins, 2019).

Individualism was also taking precedence over communalism, and local communities had largely ceased to provide care for their members (Foster and Roberts, 1999). Community care policy was in a mess, in part, because ‘community’ had become a vacuous term, meaning all things to all people (Malin, 1997). It was difficult to give the term a consistent and useful meaning, yet it was being used because of its powerful and evocative inference (Bulmer, 1987: 214). Humanitarian concerns, however, had remained within society and the wider MH movements. In 1975, Larry Gostin produced ‘*The Human Condition’*, which called for extending the human rights of MH patients and offered an in-depth critical analysis of the MHA 1959 (Jones, 1993). Two-thirds of the new provisions in the MHA 1983 were said to have been based on Gostin’s proposals (MIND, 1975). The MHA 1983 was not, however, a key driver in shaping the development of community care, but instead created the legal framework in which the policy of community care was played out in the late 1980s and early 1990s (Cummins, 2020). The 1983 Act did not alter the powers of the police in relation to managing people with mental ill-health in the community from the 1959 Act, and s.136 was described as a ‘Cinderella Section’ (Latham, 1983) because PCs and those providing medical care in police stations had insufficient knowledge of the Act and/or how to meet the needs of people in crisis.

* + 1. *An underfunded and inadequate community care system*

Leading up to 1980, deinstitutionalisation primarily involved the movement of people with the least severe disabilities to a range of often pre-existing services, such as hostels, semi-supported group homes, family placement schemes, bed and breakfast arrangements and independent living (Emerson, 2004). The provision was of variable quality (Walker, 1993) and, within the UK, the asylum was thus not replaced by a well-resourced system of community care that enabled people with mental ill-health to complete the journey from ‘patient to citizen’ (Sayce, 2000; Cummins, 2018). As the asylums shut, a fragmented, and informal system of bedsits, housing projects, day centres or, increasingly, prisons and the CJS replaced it (Moon, 2000; Wolff, 2005; Cummins, 2020). These networks as a system, have been referred to as both ‘new’ asylums and hidden institutions (Lamb, 1979; Cummins, 2019), with those with the most complex needs often finding themselves living in the poorest communities, poor quality supported housing, on the streets, or in the prison system (Singleton et al, 1998; Moon, 2000; Wolff, 2005).

The process of the movement of people from large mental institutions to the ‘new asylums’ or ‘hidden’ institutions has been termed ‘*transinstitutionalisation*’ (Barham, 1992). The care meant to be received from local authorities in many instances did not appear, as authorities were unable to invest the resources necessary because of the financial strictures imposed upon them by the government (Murphy, 1991). Once released, for example, hospitals did not make sure that people who required them received their medications (Turner, 2007). Discharged patients would often end up in marginalised areas of cities or excluded facilities ‘in the community’ (Scull, 1977). Dear and Wolch (1987) described the reality of the failed community care policies as creating ‘landscapes of despair’ for those with mental ill-health that had been ‘released’ back into society.

As Scull described in 1984, for the individual with mental ill-health, it appeared that what had changed was the packaging rather than the reality of their misery. In some cases, significant aspects of discharged patients’ experiences and identities remained the same in the community. Patients were still living with other patients in environments which were controlled by others and characterised by isolation and powerlessness (Huxley, 1993; Perring, 1993l Sullivan, 1998). The growth of ‘hidden’ asylums was not the only issue of a failure to properly develop adequate care in the community provision. Groves (1990) for instance, suggested that an ‘invisible cohort’ of individuals existed, those who had left the hospital following both long and short stays to be cared for in domestic settings. Care was then provided by relatives, neighbours, and friends, often in the setting of their own homes and often the burden of caring became considerable (Sullivan, 1998).

One of the more complex problems in examining deinstitutionalisation is the differentiation between the availability or accessibility of services, and the appropriateness of the community services where they did exist (Rose and Black, 1985). Deinstitutionalisation has shown that without sufficient resources, simply changing the locus of bad care does not create good (or even adequate) care (Borus, 1981). Walker (1993) suggested that cost had overridden the quality of care, facilitated by the Care and Community Act of 1990 which had effectively created a mixed economy of care in the community (Sullivan, 1998). The concept of community care implied merely a change in the locus of care, and in the methods and financing of its delivery (Goldman et al, 1983). What has since become evident, is that whilst the change in the locus of care should have been in the community, a properly resourced appropriate, and adequate system of community care never materialised (Kelly and McKenna, 2004).

* + 1. *The impact on the police*

The changes in MH policy surrounding the era of deinstitutionalisation ultimately dictated the future of the policing and MH interface (Massey, 2016). The lack of adequate MH provision, particularly during out-of-standard working hours, saw PCs not only as gatekeepers to the CJS but also increasingly to the healthcare system as well (Borschmann et al., 2010; HMIC, 2015). Deinstitutionalisation put huge and almost instantaneous pressure on the police role (Teplin, 1984; Rogers, 1990; Cummins, 2006; Clifford, 2010). As the institutions closed, the police found themselves confronted with a new phenomenon, the presence of large numbers of people with mental ill-health for whom there was no longer a residential-based MH service, and frequently, no sufficient community system either (Chappell and O’Brien, 2014). Those with mental ill-health have been described as ‘another category of neoliberalism’s victims’, and on the grounds of public safety, left the police with a huge burden of responsibility (Bowling et al, 2019:107).

Care in the community had effectively shifted the duty of care away from psychiatry and mental health providers and towards the police (Green, 1997; Peez et al, 2003; Clifford, 2010). There was a natural correlation between the rise in the number of people with mental ill-health now living in the community, and the increase in the number of police contacts between them (Engle and Silver, 2001). The police responsibility in this regard had altered significantly as a direct result of the closure of the institutions (Arboleda-Florez and Holley, 1998) and the relationship in the interface between the police and mental ill-health quickly shifted to being a much more substantial one. The term ‘street level psychiatrist’has been used to capture the role that the police, almost totally unwillingly, were being drawn into playing from that time onwards (Lipsky, 2010).

* + 1. *Social inequalities and criminalisation*

Reflective of the neoliberalism principle of individualism, the concurrent welfare reforms that were passed also had implications for the number of people in the community with mental ill-health and thus also contributed to the substantial growth in the police-MH interface. The result of welfare reforms increased economic segregation and the implications of such meant not only the rise in the number of people within the community with mental ill-health after deinstitutionalisation but also the wider CJS-MH interface e.g., penal policy and the prison system. Police activity has always borne most heavily on the economically and socially marginal elements, whose lives are lived largely in streets and other public places. Such powerless groups have been named ‘police property’ (Cray 1972; Lee 1981; Bowling et al, 2019) and there has been no shortage of testimony that British society is characterised by deep social and economic division, where increasingly large numbers of the residuum have become marginalised through the institution of policing (Young 1999, Crowther 2000, Reiner 2000).

It is beyond the remit of this chapter to consider in any great depth the related yet distinct aspects of the wider CJS, where much of the literature focuses upon social inequalities e.g., advanced marginality theory (see Wacquant, 1999; 2008a; 2008b; 2009a; 2009b). Where inclusion is made, it is within the context of the increased role of the police in society post-deinstitutionalisation and how this contributed to the growth towards the substantial police-MH interface. As a starting point, it should be noted that mental ill-health is more common in more unequal societies and thus, the rolling back of the welfare state from 1979 onwards disproportionality affected those with mental ill-health (Patel & Kleinman, 2003; Pickett and Wilkinson, 2007; 2009; 2010).

The retrenchment of the welfare state through neoliberal policies has been said to have resulted in marginalised communities being denied access to decent housing, education, and employment opportunities (Wacquant, 2008a, 2008b, 2009a and 2009b; Cummins, 2020). As introduced above, due to inadequate funding and development of community MH provision during the process of deinstitutionalisation, those who had previously resided within the institutions quickly became part of such ‘marginalised’ communities. After the asylum regime, those with mental ill-health who were most likely to end up homeless were those discharged from admission wards in local hospitals without adequate after-care, and not those long-stay patients who were more carefully considered (Leff, 1997). Poverty and mental ill-health are inexplicitly linked, and the debate has now shifted towards which aspects of poverty and deprivation are the strongest drivers, rather than whether they are in fact linked (Lund et al, 2010; Burns, 2015).

Many of those who were moved from the asylums without an adequate alternative system of support became homeless (Lurigio et al., 2004), and this increased their likelihood of coming to the attention of PCs on patrol (Soderstrom, 2007). The term ‘*criminalisation of the mentally ill’* was first utilised by Abramson in 1972 (Lord and Bjerregaard, 2014). Abramson (1972) described this process whereby post-deinstitutionalisation, individuals with mental ill-health unable to access continued support within the community, would come into contact with the police. The criminalisation hypothesis advances that people with mental ill-health are overrepresented in the CJS because of the lack of resources available in the community and the lack of safety net provided by a properly resourced welfare state (Rachlin et al, 1975; Swank & Winer, 1976; Whitmer, 1980; Morgan, 1981; Lamb & Grant, 1982; Teplin and Pruett, 1992; Peterson et al, 2010; Lamb and Weinberger, 2001).

In relation to criminality, because the police responsibility to protect the public was primary, *parens patrie* concerns (those about caring for someone unable to care for themselves, e.g., with s.136), were less likely to occur where offences had been committed, regardless of the persons mental ill-health (Teplin, 1984; Engel and Silver, 2001). The role of the police changed when their general workload expanded due to officers being called upon to investigate a greater number of community complaints, disturbances and crimes concerning people with mental ill-health that had previously resided in the institutions. There was thus now a huge number of people that had made the transition from asylum to the community, then fell into the ‘cracks’ of the failed system, e.g., those who were considered too dangerous to be accepted for community treatment, but not dangerous enough to meet the threshold for in-patient provision.

One outcome of such, first described in the USA, was a process coined ‘mercy bookings’ (Teplin, 1984). This referred to the arrests of people with mental ill-health for minor charges, used by the police to try to protect people in the absence of available community MH provision (Lamb et al, 2002). Turner (2007) described how the disproportionate use of arrest for people with mental ill-health could be attributed to such mercy bookings. Due to the limited exclusionary criteria for people with mental ill-health, the CJS became the institution that would rarely say no. People rejected as inappropriate for the MH system were readily accepted by the CJS. Sadly, penal institutions have been said to have become ‘front-line MH providers’ (HRW, 2003: 16), representing the ‘MH institutions of the 21st century’ (White & Whiteford, 2006: 302), with those who are unwell accessing these institutions through their interactions with the police.

* + 1. *A failed experiment*

Although the humanitarian underpinnings of deinstitutionalisation were admirable, the process has been coined ‘the largest failed social experiment in twentieth-century America’ (Torrey, 1995:1612), a sentiment also echoed throughout the UK (Warner, 1989). The reality of deinstitutionalisation was that the asylum proved to be a persistent establishment, and the anticipated rapid closures were delayed as efforts to construct alternative community facilities stalled during the expenditure crises of the 1970s (Busfield, 1986; Carpenter and Raj, 2012). Issues surrounding the development of care in the community had been increasingly observed by people from the late 1960s, most notably by Titmuss (1968), who asked whether community care was indeed a fact or fiction. Community care had become an example of political rhetoric, which was undisputedly so far removed from the practical reality of the system of care that existed (Sullivan, 1998).

Rose (1979:461) and many others assess the practice as, at best, merely an ill-advised neoliberal political movement of the 1960s. Gruenberg and Archer (1979:485) concurred with this view, in that the crisis which resulted from the community care policy ‘attests to an abandonment of the mentally ill, and that community psychiatric services fail to meet the needs of many patients discharged from-state mental hospitals’. The concept of ‘care’ itself had, at best, paternalistic connotations and, at worst, involved negative assumptions that a full, independent life might not be possible. It was, therefore, an intrinsically weak and limiting paradigm that was also problematic when it was promoted (Carpenter and Raj, 2012). The ideals of community care, properly resourced and community-based to support individuals when unwell, has been said to have been lost in a world of managerial doublespeak and risk assessment (Cummins, 2016:28).

* 1. Part Two: The ‘Maxed-out’ interface.
     1. *Introducing the ‘maxed-out’ interface.*

This section considers the period from the mid-2000s through to 2018, two years after the national pilot of nine PMHT schemes had been published (Reveruzzi and Pilling, 2016), and the starting point for this research. Whilst the preceding section introduced the neoliberal mandate that accompanied the deinstitutionalisation era, the focus of this section remains broadly on the same theme. It considers the drastic extension of neoliberal governance, through a series of public service reforms enacted under the coalition government’s austerity agenda from 2010, which shifted the police-MH interface from being substantial to one that effectively became ‘maxed-out’ and thus, requiring action.

The term austerity stems from the Greek word ‘*austeros’*, which itself has a long-embodied connotation, given it describes a bitter taste that makes the tongue dry (Sparke, 2017). Ironic, perhaps, given it has been shown that austerity is regressive, impacting most on the poor, thus widening socio-economic inequalities (Ball et al, 2013; Stukler et al, 2017; Cummins; 2020). Austerity has thus disproportionately affected those with mental ill-health, in addition to the policies themselves leading to higher levels of depression and anxiety amongst those subjected to them (Cummins, 2018). Mental ill-health has a large impact on many aspects of people’s lives e.g., housing, education, and employment (Silva et al, 2016), and so when those people need help or action, the impact also extends across many budgets (McDaid and Knapp, 2010).

The fundamental argument presented through this section is that the further retraction of the welfare state, along with budget cuts to the police organisation and reduced investment in NHS MH services, denied people of essential forms of social support while also eliminating the very systems that people need during an economic crisis (McDaid et al., 2013). This created the perfect storm for an expansion of the police-MH interface, the result of which was a shift towards agencies adapting to ‘do better with less’ (Solar and Smith, 2020) through an increased focus on ‘partnership, co-funding, and co-production (Grifths and Kippin 2013:12), within which, PMHT emerged. In the midst of the other social transformations, the neo-liberal turn undoubtedly and significantly also affected the politics of the police (Bowling et al, 2019). As such, the changes in patterns of policing at that time, including partnership work, can also, to a large extent, be understood as a consequence of the ‘destabilising and criminogenic effects of neoliberalism’ (Reiner 2010:32).

There are simply not enough words in the thesis to provide a comprehensive historical analysis of every service and policy development within both policing and MH provision, though brilliant accounts exist elsewhere (e.g., see Cummins, 2020). The socio-political context of this time (1997-2010) is considered more in the following chapter with regard to the development of ‘joined-up’ working. It would be fair to say, however, that through each of what may have been considered as key legislative and policy developments otherwise omitted from this chapter, the police-MH interface remained substantial through them all, that is, until 2010 when this interface ramped up even further.

* + 1. *The austerity agenda*

The global financial crisis of 2007–2009, commonly referred to as the ‘banking crisis’ (Clarke and Newman 2012), and the economic recession that followed, have been described as the most ‘severe, unpredictable, complex, systemic, and international crisis’ since the Great Depression of the early 1930s (Malliaris et al, 2015: 4). It was the response to the crisis which instigated a cataclysmic growth in the police-MH interface in a way not seen before. The government’s response to the banking crisis under Gordon Brown did show glimpses of a return to Keynesian politics, through large government expenditure spent bailing out the banks that were deemed ’too big to fail’ (Acharya and Yorulmazer; 2007). This was in addition to a reduction in VAT and increased capital spending (Cummins, 2018).

Reminiscent of 1979, however, the coalition government elected in 2010 sought to take a fundamentally different approach, one which remained present with the succeeding governments of Cameron (2015-16) and May (2016-19). Far from questioning the Thatcher legacy of holding down public spending and reducing the size of government, the coalition broadly pursued fiscal austerity within a wider agenda of reducing the size of the state (Sowells, 2014). Whether fiscal constraint and contraction were the appropriate remedy to the financial crisis is open to debate (e.g., Davidson, 2009; Krugman, 2012; Skidelsky and Wigstrom, 2010) but one outside the remit of this chapter, with a need of keeping the focus on the repercussions of the adopted ‘remedy’. The approach pushed for a model of central-local governance that relied heavily on improving the quality of services while keeping costs down (Lowndes and Gardner 2016; Solar and Smith, 2022).

During Chancellor George Osbourne’s debut ‘emergency budget’ speech to the Commons in 2010, he identified there were six-billion pounds of public service savings to be made, in order to help combat the £156 billion in the national deficit that he had inherited. He claimed his approach supported a strong enterprise-led recovery, and that the government had laid the foundations for a more prosperous future (Guardian, 2010). It was this speech that unveiled a huge package of public sector reforms that would impact the police, welfare system and NHS, concurrently. It has been argued that despite austerity being a deeply political project (Krugman, 2015), the government tried to depoliticise the package of reform by presenting neoliberalism as a ‘technical rational economic exercise’ (Cummins, 2019:3).

The term austerity, meaning severe restraint, has thus become a common name for the neoliberal policies of public-service financial cutbacks and the pro-market discipline that followed (Sparke, 2017). Fundamentally, the Coalition’s hope was that through the mechanisms of the so-called ‘Big Society’ project, the private sector, volunteers and community groups would step in to fill the voids created or exacerbated by fiscal constriction and reduction (Bullock and Millie, 2012). In relation to public sector reform, reducing expenditure through fiscal austerity is based upon the premise of it achieving two things. The first is an expansion of the neoliberal principle of individualism, in that by encouraging individuals to take increased responsibility for their actions (e.g., through Universal Credit (UC) and disability benefit reforms), demand will reduce. Alternatively, they turn to the voluntary sector to help out those who cannot be ‘responsible’ for themselves (e.g., food banks).

The second concerns an expansion of decentralisation, in that ‘doing more with less’ i.e., applying economic pressure to the public services, would produce necessary institutional reforms and make the operation of local services more efficient (Solar and Smith, 2022). In what has been referred to as ‘polycentric governance’, this idea is perceived as a mechanism for decentralising governance to create negotiated solutions through inter-agency working (Osborne and Gaebler 1992; Ostrom, 2010). The focus of policy was thus on the need to reduce what was perceived as an expensive and inefficient centralised state, to reduce the UK’s national financial deficit (Solar and Smith, 2020).

In the UK, public expenditure overall was reduced from 44% of GDP in 2010, to 40% in 2015, but the reduction in spending was not distributed equally amongst government departments (IFS, 2015). Half of all the cuts in spending fell within the welfare and local government budgets (Centre for Welfare Reform, 2015). These areas accounted for 25% of overall government spending, thus austerity meant a 20% cut to available welfare provisions (Cummins, 2018). This occurred concurrently with a 27% reduction in the budget of Local Authorities (Local Government Association, 2013). The police receive their funding annually through a central government grant and through policing precepts in council tax receipts (Brown et al, 2019). Central Government funding to police forces had reduced by 30% in real terms between 2010–2018 (HASC, 2018). During this time, police forces made combined savings worth over £ 1.5 billion (HM Treasury, 2015).

In terms of the NHS, for the first time in a decade, investment fell across MH crisis resolution, early intervention, and assertive outreach services by £29.3 million between 2010/11 and 2011/12 (Docherty and Thornicroft, 2015). This is despite MH care receiving only 13% of total NHS spending when it accounted for 28% of the total burden of disease (NHS Spending Centre for Economic Performance, 2012). Echoing Osbourne’s sentiment from the emergency budget, in a speech on the economy shortly after, Cameron insisted that, ‘we are all in this together, and we will get through this together’ (Cameron, 2010: 5). If we were able to retrospectively adjust the sentiment of this promise, to reflect the actual impact of the decade of austerity, it might instead have read, ‘we’re all in this together, unless you are part of an already marginalised community, poor, from a BAME background, disabled and/or experience mental ill-health.

* + 1. *Austerity and the welfare system*

One of the key ideas in the neoliberal attack on the welfare state is that it creates dependency (Cummins, 2018:4). The Welfare Reform Act received Royal Assent on 8 March 2012. The intention of the welfare reform was not only to save money but to ‘make work pay’ through the introduction of UC (Department for Work and Pensions, 2010). UC replaced six of the main means-tested benefits and tax credits for working-age claimants, with a single benefit that would be paid monthly to people out of work and to those in low-paid work (Sainsbury, 2014). Also introduced was a programme to reassess the eligibility of 1.5 million claimants of the main out-of-work disability benefit Disability Living Allowance.

With these reforms, came a new and much tougher sanctioning regime (where benefits are stopped for a set period for failure to comply with requirements) which has had severe consequences (Mattheys, 2015). Sanctions, alongside benefit delays of six weeks before receiving first payment, and financial difficulties related to the bedroom tax and abolition of council tax relief, have been attributed to what has been described as an explosion in the use of food banks (O’Hara 2013). Between 2008/09 and 2020/21, the number of foodbank users increased every year, from just under 26,000 to more than 2.56 million (Trussel Trust, 2022). The Wessely Review (2018:53) indicated there was a corresponding rise for some indicators of hardship, including rates of benefits sanctions, with rising MHA 1983 detention rates. Many individuals were affected by multiple welfare reforms, and it was those on the lowest incomes who were most heavily affected (Mattheys, 2015). The Welfare Reform Act 2012 thus reduced the adequacy of some benefits, capped the total amount of benefits someone could receive, and reduced the amount of rent that was covered by housing benefits for tenants with a spare room, otherwise known as the bedroom tax (Bar et al, 2016).

The Marmot Review (2010) identified a clear link between poverty, inequality, and poor MH. During the austerity era, cuts to local government budgets were shown to hit the poorest parts of the country hardest (Taylor-Robinson and Gosling, 2011; Crawford and Phillips, 2012; Taylor-Robinson et al., 2013; Whitehead 2014; Matthews, 2015) and local authorities saw widespread reductions in the number of people able to receive state-funded social care support. The result of which can be seen through the 30,000 people with mental ill-health who have lost their social care support since 2005, following a £260m shortfall in funding due to cuts to local authority budgets, which was a relative fall of 48 % (Fernandez et al, 2013). This is only one example of how austerity has had harmful impacts on vulnerable people, increased poverty, and reduced the social safety nets that were previously in place. Whilst the sentiment of making work pay seems logical for those able, the reforms have distinctly disadvantaged those unable to work due to disability, including those with MH conditions.

As well as heightened economic segregation as a result of the welfare reforms, and a disproportionate impact on those with mental ill-health, the impact of the reforms themselves have also been said to have led to an increase in mental ill-health in the community (Bar et al, 2015:324) The reforms, they argue, have led to rising numbers of people with low levels of education, out of work, with mental ill-health, and these factors are known to lead to an increase in social exclusion, as well as demand and reliance on social welfare systems. This is particularly worrisome since lower socioeconomic status is a potential factor in suicidal behaviour (Platt et al. 2017).

It has also been considered how society had not yet ‘recovered’ from the impact of the recession, at the time the welfare reforms had started to emerge. Rises in unemployment since the financial crash have been linked to a rise in suicides and an increase in other adverse MH outcomes (Heller, 2015; Hawton et al., 2015; Spence et al., 2014). Luo et al (2011) found a historical increase in suicide rates during times of recession and a time trend analysis found evidence that linked the increase in suicides in E&W with the 2008 financial crisis (Reeves et al, 2012; Heller, 2015). Since 2010, there has been a 23% increase in prescriptions for anti-depressant medication in the UK (O’Hara 2013). This is symptomatic of a growing situation in which people increasingly feel unable to cope and the dominant discourses around MH, in which the social and structural determinants are marginalised in favour of a focus on the individual (Morrow 2013). Around 21% of the population of the UK lived below the government’s official poverty line, and virtually all of the welfare reforms were targeted at this group of people (Duffy 2013).

* + 1. *Austerity and the police organisation*

The scale of the budget cuts to policing was also unprecedented and required police services to reconsider their priorities (HMICFRS, 2014). The announcement of austerity led quickly to widespread public and political debate regarding what the police service could realistically deliver in the face of fiscal constraint, the implications for the frontline officers and ultimately for crime control ([Millie and Bullock, 2012](https://journals-sagepub-com.sheffield.idm.oclc.org/reader/content/16cda515c06/10.1177/1748895812474284/format/epub/EPUB/xhtml/index.xhtml#bibr25-1748895812474284); 2013). The nature of these debates is considered in Chapter Three when providing a conceptualisation of 21st-century police partnership work and the introduction of LEPH as an emergent field of study in 2012. The focus here is much more practice-based and reviews what the implications of austerity have tangibly been on the police organisation since.

Cameron introduced an agenda of mixed resource allocation, doubling down on the idea that the police needed to do more with less. The rhetoric in response to this was that the ‘front line’ would be protected (e.g., HMIC, 2011; 2012) with the front line defined as ‘those who are in everyday contact with the public and who directly intervene to keep people safe and enforce the law’ (HMIC, 2011: 6). [Between March 2010 and March 2018,](https://www.gov.uk/government/statistics/police-workforce-england-and-wales-31-march-2018) the police organisation in E&W lost 21,732 officers (Home office, 2019). In addition, the number of police community support officers (PCSOs) fell by nearly 40% during this period, from 16,688 in 2010 to 10,139 in 2018. In addition to reducing staff numbers, forces took other cost-cutting measures such as selling capital assets including property and land (Millie, 2012), spending less on large-scale projects e.g., IT transformation, and making efficiency savings (Brown et al, 2019). With the closure of police stations and a reduction in the opening hours of those that have remained, there has been a reduction in interaction with the public, resulting in the remaining points of contact becoming saturated by the same, or even increasing, levels of demand (Solar and Smith, 2020). A HASC Report in 2018 reported that neighbourhood policing had been eroded and that forces had lost at least a fifth of their neighbourhood policing capacity since 2010.

Distinguishing the police from those seeking welfare support and access to crisis care provision, is that the police are rarely in a position where they cannot respond to a request for help. Using falling crime figures to legitimate the cuts (Cummins, 2018), May told the Police Federation to stop ‘crying wolf’ about the impact of the financial cuts on rising demand, accusing Federation leaders of ‘scaremongering’ over the effect of cuts while crime was falling (BBC, 2015). The impact of these cuts, however, has been damning. HMIC (2018:10) found almost a quarter of forces were not meeting enough of their demand or were managing it inappropriately. Officers themselves were found to have the perception that their employers were struggling to balance the numbers of officers and staff, with the demand on the organisation (Elliot-Davis et al., 2016).

The Police Federation (2019) also reported how 89% of PCs who responded to their survey, said there were not enough officers to manage the demands faced by their team during a shift. In some cases, forces were found to be putting vulnerable people at serious risk of harm as officers were not able to routinely identify vulnerable people. In other forces, they found that staff were holding thousands of emergency calls in queues, largely because officers were not available to respond to them (HMIC, 2018). In some cases, officers were not actively reassessing the urgency of the calls during the delay (HMIC, 2018:10). The National Audit Office (2018) also found there were signs that forces were finding it harder to deliver an effective service and concluded that the Home Office did not provide value for money in the way it was overseeing the police system.

The consequence of this was that not only were the police faced with constraints on their own resources but where other services were reduced (e.g., welfare and crisis care), then people with a range of problems called on the police, thus demand for their service simultaneously increased (Cummins and Edmondson, 2016). The issue underpinning this was two-fold, in that as well as the effects of social reform resulting in increased police contacts with those with mental ill-health, officers were left unable to dedicate as much time to such cases, which was said to increase their likelihood of using s.136 rather than less invasive measures (Loughran, 2018). Officers were left frustrated at the lack of alternative provisions (Martin and Thomas 2015), with s.136 said to have become used as a suicide prevention strategy (Menkes et al, 2022).

Incidents involving mental ill-health are costly to the police organisation. It has been estimated that police interventions involving individuals with mental ill-health illness use up to 87% more resources than interventions involving non-persons with mental ill-health (Charette, Crocker, and Billette 2014). Professor Louis Appleby told the Angiolini Review in 2017, if all the people with MH issues were removed from police custody there would almost be no need for police custody suites to exist (2017:46). Police accounts revealed that austerity was hindering a practical compromise on the nature and form of service provision, and this was creating higher demand on an already struggling police force (Solar and Carlos, 2022). Sir Peter Fahy, Chief Constable of Greater Manchester described MH in 2014, as the number one issue for most frontline PCs (HASC, 2014).

The overall number of police incidents with a mental ill-health aspect rose by 33% between 2011 and 2014 (Quinn et al. 2016). In terms of s.136 use, there was another rapid acceleration from 2007 (Home Office, 2014). In 1984, for instance, there were 1,959 detentions under s.136 in hospitals and this had increased to 17,008 in 2013/14. The Home Office review into the use of s135/6 (2014) reported that the increase in s.136 could partly be accounted for by the reduction in police stations as a PoS (and a lack of prior data on such), and the additional investment in HBPOS from 2007, which saw the number of s.136 detentions made in hospitals in England double in the following five years. Despite a range of reasons being put forth to explain the rise, the government itself has failed to recognise the impact of its 2012 austerity reform package on the rise in police contacts with those experiencing mental ill-health.

* + 1. *Austerity and the NHS*

The DHSC budget (March 2010) contained a commitment to £4.35 billion in efficiency savings within the NHS savings over a two-year period. A promise was made, however, that this would not affect front-line services. Instead, the savings would be reliant on measures such as smarter procurement practices; being more energy efficient; making better use of property; reducing staff sickness; as well as reining back on the national health information technology programme (McDaid and Knapp, 2010). In 2011, the Coalition Government’s MH strategy for England (‘No Health without Mental Health’) was published. It placed new emphases on service provisions, such as person-centred care, well-being, recovery, the involvement of SUs and increased access to psychological therapies, though these lacked a historical context (Turner et al, 2015). It set six key targets, including improvements in safety, patient-centeredness, recovery, and physical health. This emerged, however, at the same time as considerable structural change in the NHS, related to the ‘Nicholson Challenge’ which was to hold overall expenditure steady (Docherty and Thornicroft, 2015).

The promise of this not to affect front-line services, unfortunately, did not equate to reality. Despite upon re-election, Cameron stating ‘I want to put the record straight loud and clear. They said we would cut the NHS. We haven’t and we won’t’ (PMs Office, 2015), his insistence was certainly questionable. The Wessely review (2018) reported how in the last decade, the average spending per person in contact with secondary MH services had reduced, and there was some indication that the number of times someone had contact with their community team had also reduced. It also reported on a reduction in real terms spending in adult social care, which it states would have impacted Local Authority based social care MH services, mostly concentrated in community care.

Although health, pensions, and education were considered ‘protected’ expenditures (all three amounted to 44% of government spending on services by 2015), the health sector has since faced the most austere cutbacks in the post-war period (Parliament, 2015). The UK saw the closure of over 1700 MH hospital beds between 2011-2013, leading to warnings that the demand for crisis services was far outstripping supply (McNicoll 2013). The NHS was making real-term reductions in investment in MH services, which exacerbated the situation in a sector that was already subject to chronic underinvestment stemming from the deinstitutionalisation era (Thornicroft and Docherty 2014).

Crisis care, in particular, was in crisis (O’brien et al, 2018). Beresford (2013) produced a devastating critique of the position of MH services. He noted that there was a seemingly ever-widening gap between MH policy documents, which consistently promised the completion of a MH revolution, and the reality of service provision (Cummins, 2018). Areas such as hospital admissions had seen a rising trend, and bed availability, particularly in MH units, was ‘increasingly limited and the financial position of NHS providers is also worsening, indicating that some were struggling to cope with the reduced prices paid for services’ (Parliament, 2015).

* + 1. *Decentralisation, polycentric governance, and the move to joined-up working.*

Underpinning austerity, was the notion that putting economic pressure on public sector organisations would see changes in the forms of service delivery, resulting in new forms of governance that could produce better quality services, for less (Curristine, Lonti, and Joumard 2007). As a result of austerity, the UK public sector shrunk to the lowest among major economies (Taylor-Gooby, 2012) and all organisations were looking to do more with less. The pressure to end siloed policies and improve service delivery through networks and partnerships between a range of public and private agencies had become considerable (Pricewater Cooper, 2007; Solar and Smith, 2022). In light of the increasing level of MH demand, it was assumed that ‘the collaboration between MH service providers and the police had become critical’ (Normore, Ellis, and Bone 2016:2). The police-MH interface had ‘maxed out’; organisations could no longer keep doing as they had always done, and enhanced forms of partnership working became inevitable.

The extension of decentralisation became obvious through the passing of the Police Reform and Social Responsibility Act 2011, and a series of subsequent policies that attempted to create local networks e.g., the police and the NHS working with newly established organisations such as the Office of the Police and Crime Commissioner (PCC) and the Clinical Commissioning Groups (CCGs). In February 2011, the ‘No Health Without MH’ strategy emerged. Reflective of the desire for local networks, the government stressed its view that action at local and national levels to implement this strategy will only be effective if there is sustained partnership working across all sectors (HM Government 2011:68). Shortly after, the DHSC had initiated the process of conducting a review of the Code of Practice, pursuant to section 118 of the MHA 1983, which had last been revised in 2008. The revised code was published in 2015 and sought to provide stronger protection for patients as well as clarify roles, rights, and responsibilities. With the focus firmly on extending the notion of polycentric governance, between 2013-2018, there were a number of key reviews and reports (Table 2.1), as well as an independent commission into Policing and MH.

**Table 2.1: Overview of key reviews and reports 2013-2018**

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| [**The Adebowale Report**](http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_05_13_report.pdf)**(2013)** – Independent Review into policing and MH in London. |
| **A criminal use of police cells (2013)** - HMIC / CQC / HMIP review of police custody as a PoS |
| [**A Safer Place to Be**](https://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf)**(2014)** – CQC Report into health-based Places of Safety. |
| [**Crisis Care Concordat**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf)**(2014)** – Cross-government concordat in England to improve MH crisis care. |
| [**Victim Support Report**](https://www.victimsupport.org.uk/sites/default/files/At%20risk%2C%20yet%20dismissed%20-%20full%20report.pdf)**(2014)** – At Risk Yet Dismissed. |
| **Review into the use of s135/135 (2014)** – DHSC and Home Office joint review |
| [**Policing and Mental H**](https://publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/202.pdf)**ealth (2015)** – Home Affairs Committee report. |
| [**Crisp Report**](https://www.rcpsych.ac.uk/pdf/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf)**(2015)** – Independent Review into inpatient MH beds for adults. |
| [**Right Here, Right Now**](https://www.cqc.org.uk/sites/default/files/20150630_righthere_mhcrisiscare_full.pdf)**(2015)** – CQC Thematic Review of Crisis Care. |
| [**Five Year Forward View**](https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf)**(2016)** – NHS England. |
| [**The Angiolini Report**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf)**(2017)** – Independent Review of Deaths/ Serious Incidents in Police Custody |
| [**The Future of Policing Report**](https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/515/515.pdf)**(2018)** – HASC report. |
| [**Picking Up the Pieces**](https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/policing-and-mental-health-picking-up-the-pieces.pdf)**(2018)** – HMICFRS report |
| [**The Wessely Report**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762206/MHA_reviewFINAL.pdf)**(2018)** – Independent Review of the MHA 1983. |

It was through a central-local relationship, based on policy networks and partnership boards, that the police were to become a leading role in the co-delivery of MH services (Solar and Smith, 2011). On June 27th, 2013, the first four police forces were announced as part of the national ST pilot. The policing minister at the time, Damian Green, stated that these pilots would help ensure people with serious MH issues are given the appropriate care and support while ensuring PCs’ time is freed up to fight crime. They were said to show the good partnership work going on between health services and the police to ensure people with MH issues are dealt with by the right emergency service (DHSC, 2013).

* + 1. *Situating PMHT with concurrent developments*

Reflective of the wider recognition that the police-MH interface had become ‘maxed-out’, Table 2.1 shows there were at least 14 key reports and reviews between 2013-2018, which referenced the ‘need’ for PMHT and/or increased police-NHS partnership work. The Independent Commission on MH and Policing sought to review the work of the Metropolitan Police in relation to how officers interacted with people with mental ill-health (Adebowale Report, 2013). The report stated that it should be viewed through the lens that MH is part of the ‘core business’ of policing (Adebowale, 2013:6), as well as recommending that there needed to be more effective interagency working (2013:9). The Commission recognised the extensive MH demand on the police organisation, reporting that there were in 2012, there were 21,741 more MH related calls than there were for robbery, and 47,203 more than there were for sexual offences (2013:12). The Commission estimated around 600,000 MH calls a year to the Met, and at least 20% of police time was being spent dealing with incidents of mental ill-health, but up to 40% if wider work with vulnerable people was included. In relation to partnership work, it stated that there seemed at times to be boundary disputes, a lack of coordination and a sense of buck-passing driven by the need to manage limited resources in some cases (2013:22).

In 2013, a joint review (*a criminal use of police cells*) examined the extent to which police custody was being used as a PoS under s.136. It found that it was indeed still being used as a primary or secondary PoS and cited insufficient staffing and available beds at HBPOS for being half the reasons for such. Though it found all areas had joint policies and protocols in respect of s.136, the standard and breadth of those policies varied. It found that not all areas had a clearly defined multi-agency strategic framework, and without such, it was difficult for the police and health partners to work together effectively to ensure compliance with the Codes of Practice in all cases of s.136 detentions. They also found that, on occasion, there was a lack of clarity about who was the lead person within the health service for s.136 work.

The Crisis Care Concordat (CCC, 2014) a year later, was described as a shared agreed statement, signed by senior representatives from all the 27 organisations involved. As the mission statement included below reflects, it aimed to consolidate ‘what needs to happen when people in MH crisis need help – in policy-making and spending decisions, in anticipating and preventing MH crises wherever possible, and in making sure effective emergency response systems operate in localities when a crisis does occur’ (2014:1). The CCC was introduced as a framework for networked governance, yet in line with the decentralised approach, this relied on the local authorities to execute the strategy encouraging them to agree on their priorities and processes to assess to MH crises (solar and smith, 2022). Mind was tasked with overseeing and administering the implementation of the national CCC, for two years. Mind had commissioned the McPin Foundation to evaluate the implementation of the Concordat at the local level, but the CCC has since been overseen by the DHSC, the HO and NHS England. The CCC commitment was as follows:

*“We commit to work together to improve the system of care and support so people in crisis because of a MH condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first. We will work together, and with local organisations, to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a MH problem to move towards Recovery. Jointly, we hold ourselves accountable for enabling this commitment to be delivered across England”- (CCC, 2014)*

The announcement of the ST pilot in 2014, stated that the innovation was based upon initial reports from established schemes in Leicestershire and Cleveland, which described that it could help to keep people out of custodial settings and reduce the demands on valuable police time. Within the CCC, the ‘original’ Leicestershire ST vehicle was presented as a case study, in which it was claimed that the scheme dealt with 120 cases a month, had led to a 33% reduction in s.136 detentions, and the average time to help people when they are detained had reduced to five hours. The aim of the schemes as outlined in the CCC was to allow MH professionals to provide on-the-spot advice to PCs who were dealing with people with possible MH problems. It noted that this advice could include an opinion on a person’s condition, or appropriate information sharing about a person’s health history (2014:23). The aim was also stated as being to help PCs make appropriate decisions, based on a clear understanding of the background to these situations which in turn, should lead to people receiving appropriate care more quickly, leading to better outcomes, and a reduction in the use of s.136 (2014:23).

A review around the use of s.135/6 was announced by the then Home Secretary, Theresa May, to the Police Federation conference in 2013. In the foreword to this review, May stated that ‘the ST pilots that we launched in nine police force areas are showing promising signs, the number of people being detained has fallen by an average of 25% across all pilot areas, and all areas are recording a reduction in the use of police stations for MH detentions (2014:4). Alongside this review, the HASC held an Inquiry into Policing and MH. It reiterated, again, the limited nature of MH crisis care, particularly at night, referring to the police as ‘the de facto first aid response to mental distress’ (2014:7). It reported that in Cheshire, there was an 80% reduction in the use of s.136 in the first six months of ST. Instead of being detained, people were referred to other care, for example, 15% were referred to substance misuse services. In Birmingham and Solihull, there was a reduction in the use of s.136 by 50% over a 20-week period. The review stated that it was important that the scheme was fully appraised against a range of clear success criteria, including an analysis of the relative merits of different models of provision, and the results published. In particular, it would be important to understand why the number of s.136 detentions had fallen in some areas but not to the same extent in others. It recommended that the Government give a clear commitment that funding will be made available for schemes which have been proven to be cost-effective (2014:20).

In March 2016, the report into the national pilot of ST schemes was published (Reveruzzi and Pilling, 2016). It reported that all but two of the nine schemes had resulted in a reduction s.136 detentions, though data for one scheme was not available. It reported an average reduction of 21.5% (15.5% to 27.5%). In addition, it reported that more people were placed in HBPOS compared with police custody and those in police custody spent less time there than indicated by previous reports, as well as providing some insight into factors that may make for better outcomes e.g., joint ownership of the schemes. The report recommended that the schemes should be made available 24/7 and that a national curriculum and associated training materials for PMHT staff should be developed, along with enhanced MH training for all PCs. The Angiolini report (2017) a year later, recommended that successful local MH policing pilots and initiatives, particularly PMHT (and L&D schemes) should be sustainably funded and rolled out nationally, as far as possible, those in MH need are dealt with through medical and community-based pathways, not through police detention.

In 2016, the NHS Five year forward review outlined its mission, and though not referring to PMHT, included several tangible forms of triage for those in crisis. By 2023/24, for instance, it stated that NHS 111 will be the single, universal point of access for people experiencing MH crisis. There will also be an increase in alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute MH pathways. It described how they would introduce MH transport vehicles, introduce MH nurses in ambulance control rooms and build MH competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a MH crisis. Finally, it stated how MH liaison services will be available in all acute hospital A&E departments and 70% will be at ‘core 24’ standards in 2023/24, expanding to 100% thereafter (2016:73).

By 2018, PMHT schemes had been in operation for around five years but concerns around their operation and the potential implications of such were starting to emerge. In evidence given to the HASC in 2018 (*The future of policing*), their value was questioned due to observations that the majority of MH incidents did not require the police at all. It was noted in that evidence that most of those who had contact with PMHT schemes, were already known to local MH services. There was a warning that such schemes might be increasing MH demand on the police, with other professionals now viewing the police as an easy-to-access nurse-led service, even when the interaction itself did not require the police. The committee concluded that PMHT schemes might be promoting further reliance on the police as the first point of call for individuals who witness or experience a crisis. PMHT was described as a gateway to healthcare for those in desperate need of help. The Committee remarked how ‘this is an extremely poor use of public funds and one of the worse examples of cost shunting between public services’ (2018:51). A joint thematic inspection of the criminal justice journey for individuals with MH needs and disorders (November 2021), reported that where they found actual deployable triage vehicles or MH ambulances, these were commonly under review, were being withdrawn or had recently been withdrawn. This is reflective of the concerns raised by the HASC report, and the current research will engage further with these debates in Chapter Eight.

Two months after the HASC report (October 2018), the Wessely Report was published (December 2018). This reported the outcome of an independent review of the MHA and led to the first amendments to s.135/6, since 1959. In his foreword, Simon Wessely outlined the case for change, with concerns found in previous reviews leading up to legislative reform (Cummins, 2020). The review reported that there had been a 40% increase in detentions in the period 2005/06 to 2015/16 and were 49,551 detentions under the MHA in 2017/18 (DHSC, 2018: 44). It recommended that the Home Office, in liaison with the National Police Chiefs Council (NPCC) should publish data on police use s.135/6 on a quarterly basis, as close to real-time as possible, and should include new data on delays so that opportunities for in-year improvements are not missed. Though PMHT was not discussed at length in this review, it did include Northumbria’s ST as a case study of good practice. It reported how the average monthly number of s.136 detentions in the 12 months before the scheme was 71,205, falling to 18 over the four months following. The PACA 2017 reforms to s.136 came into effect on December 11th, 2017. The Wessely review did not seem to consider the concerns around PMHT that had started to emerge within the HASC review, focusing instead on the almost entirely positive features of these schemes identified in all of the earlier reports on PMHT.

* 1. Conclusion

This chapter has covered a lot of ground with regard to the relationship between policing and mental ill-health over time, yet still only remains a snapshot of the available literature that depicts their socio-historical context. Though the earlier epistemes (Foucault, 1965) were unable to be considered in depth within this chapter, it’s recognised that those were concerned with the rise of the asylum regime and how society viewed and responded to mental ill-health through organised forms of social control from the 13th century to the 1950s. It was noted that despite an omnipresent policing and MH intersection, this era involved a relatively limited set of interactions between police and MH institutions and actors of the period. The argument made through the first part of this chapter, is that deinstitutionalisation in and of itself would not have failed, had it been adequately resourced and facilitated at the time and had the intentions been only to respond more humanely to mental ill-health, rather than to make cost savings and roll-back the state. The impact of deinstitutionalisation and the accompanying neoliberal political mandate drove substantial growth in the police and mental ill-health landscape for two key reasons.

Community care was never adequately funded or implemented, and so those requiring the same level of ‘support’ that they received in the asylum setting, were often left without care that met their needs and they were often not adequately prepared for life in the community. Secondly, the constriction of the welfare state saw numbers of vulnerable people in the community become increasingly vulnerable. Both increased the number of people in the community with mental ill-health and a system of provision unable to care for these people. The only 24/7 service consistently available to respond so such people, was the police. The ‘care in the community’ policy ideals that accompanied deinstitutionalisation became little more than a fantasy, never adequately funded nor their proper implementation facilitated. Had they been, it is prophesied that whilst the police-health interface may have seen an expansion, it would not have been so significant that more than half a century later, it was the subject of a doctoral thesis about an innovative way to manage unprecedented MH demand on the police organisation.

Where bed reduction for MH patients is responsibly managed, it has been shown that the overall costs of community-based care are similar to those of hospital services for long term patients (Thornicroft et al, 2016:282). There are several cost drivers which do not make community MH care a cheaper model, including safety standards, clinical efficiency controls, professionally trained staff, appropriate facilities, and equipment, all of which must be in place in very much the same way they feature in hospitals (Pillay, 2017). This is indicative that fiscal considerations took precedence over humanitarian concerns in the 1960s, and by enacting care in the community as a money-saving exercise, it was not awarded the resources to be adequately implemented. As a result of deinstitutionalisation occurring concurrently with a series of neoliberal reforms, the interface between the police and people with mental ill-health thus became a substantial one. The police became the *de facto* response to mental ill-health in the community in the absence of an alternative, described as undertaking the role of ‘MH interventionists’.

Through the latter half of the chapter, it was seen that from 2010, the UK saw an extension of the neoliberal mandate under the Coalition government, in response to the global banking crisis, itself a product of neoliberal free market fundamentalism. The damage that nearly a decade of austerity has done to MH services is apparent in a number of areas including, the pressure on inpatient beds, out of area placements, the response to individuals in crisis, the increased use of the MHA 1983, the position of the CJS as a default provider of MH care and the personal toll that policies such as UC have inflicted, including on people’s MH (Cummins, 2018). This was reflected in 2016, when the United Nations damned the impact of austerity, and specifically mentioned the provision of poor MH care, alongside related issues such as the increased use of foodbanks and homelessness. The police are spending considerable time on mental ill-health, firstly because of increased demand, but secondly because the police are dealing with issues of mental illness in ways that exacerbate rather than resolve the problem, hence producing a situation where people with MH issues continually become the subject of police attention. As a consequence, demand is often complicated to control and the interface between policing and mental ill-health became effectively ‘maxed-out’.

As the decade of austerity measures was layered on top of what was already a chronically underfunded MH system, the impact of such on the police became unmanageable using their existing ways of working. Austerity forced public sectors, including the police, to ‘do more with less’ and shifted attention towards polycentric governance and joined up working. It was here that PMHT emerged as an innovative response to deal with rising MH demand on the police organisation. There is limited available academic evidence that relates specifically to PMHT, though it has been referred to widely and positively across policy reports and reviews since 2013. Though concerns started to emerge in 2018 about the potential of PMHT to increase demand on the police organisation, rather than reduce it, this has received little attention since. It is hoped that this thesis will provide a useful corrective to this by shining a more critical light on the promises and pitfalls of PMHT and the partnership work that is at its core.

1. **CHAPTER THREE**

**Partnership working: a method of policing complex social issues.**

* 1. Introduction

Partnerships within multi-agency settings have been described as a practice involving several different organisations that work together towards a shared aim (Barton and Velaro-Silva, 2013:544). When a partnership involves multiple partners, typically representing diverse interest groups, a partnership can also be referred to as a collaboration, which, Huxham and Vangen (2005:4) describe as any situation in which people are working across organisational boundaries and towards some positive end. PMHT partnerships can thus be understood as one specific form of multi-agency collaboration, and the one that is the area of study and at the core of this thesis. The purpose of this chapter is to review the extant police partnerships literature, situate this within the context of what can be understood about (in)-effective multi-agency partnership work more broadly, as well as to offer a 21st-century conceptualisation of PMHT partnerships.

The first part of this chapter draws upon the wider police partnerships literature, given that which relates to PMHT, specifically, is scant. It highlights how many of the early constraints associated with police partnership work have shifted to a position where they are now generally considered accepted wisdom in policing practice (Crawford and L’Hoiry, 2017:638). To understand (in)-effective partnership work, the second part of the chapter draws upon the management-based theory of collaborative advantage, forming a basis to later analyse and interpret the specific nature of the partnership work found within PMHT arrangements. The nature of police partnership work has shifted far beyond that of a crime reduction sphere with the growing recognition that MH is a core aspect of police work, meaning traditional sector boundaries are being increasingly amalgamated (Dees and Anderson, 2003).

Reflective of this shift, the final part of this chapter conceptualises the development of PMHT partnership arrangements by introducing the framework of LEPH, though, this section also considers the challenges it has faced in relation to re-negotiating the role of the police in society (Millie and Herrington, 2014). LEPH is a theoretical approach still in its infancy but an area of study that is quickly becoming used to situate more recent partnership arrangements e.g., those concerning vulnerable populations, that have emerged as a response to doing more with less (Solar and Smith, 2022).

* 1. Part One: situating police partnerships in their socio-political context

In this section, I explore the development of *formalised* police partnerships as a result of the Crime and Disorder Act 1998 (CDA 1998) and locate their development in the wider social-political landscape of the time. This era (1997-2010) was largely omitted from the previous chapter in relation to policing and mental ill-health, as the focus there was upon portraying how the police-MH interface throughout that time had remained substantial until the start of austerity, after which it became ‘maxed-out’.

The reality of contemporary policing involves working with other agencies in a range of different ways, from the ‘simple’ diversion of cases to other agencies to the more sustained partnership arrangements such as PMHT, that have a targeted approach to the planning, design, and implementation of long-term problem-solving strategies (O’Neill, 2014). Despite much attention being given to police partnerships post-1998, it is a practice with a long history e.g., joint investigations into child abuse were undertaken in hand with social services, with the mobilisation of what was considered an inter-professional matrix necessary to protect vulnerable children in the 1980s (Garrett, 2004). The police working with other agencies was not in itself therefore, a novel concept, but it is the mid-nineties that the literature marks as the start of a formalisation agenda for police partnership work (Skinns, 2005).

As formalised police partnerships became prominent in 1998, their operation was later supported by the rollout of neighbourhood policing in 2008, which provided a more obvious and facilitating context for multi-agency crime prevention work (O’Neill, 2014). This was due to the nature of neighbourhood policing, which placed a heightened emphasis on the value of what had been considered ‘soft policing’ functions, i.e., all those social matters beyond crime control (Innes, 2005), including that of collaborative community projects. The notion of ‘soft policing’ is thus considered further below (see 3.3.6.2) in relation to police culture, as ‘soft’ policing activities were also reported as having become more accepted within the police organisation in the wake of community policing reforms (McCarthy, 2013).

* + 1. *The ‘Third Way’ and the professionalisation agenda*

When New Labour came to power in 1997, they explicitly adopted much of the neoliberal inheritance bestowed upon it by the outgoing Conservative government (Smith and Morton, 2006). In the early years of Blair’s premiership, public investment seen in education, health, and welfare provision did, however, seem removed from the doctrines of neoliberalism (Toynbee and Walker, 2011; Cummins, 2018). Labour’s approach to police reform during its first term of office was governed more by wider agendas, embracing the public sector as a whole, rather than any particular concern with the organisation of policing. One of these was the policy of ‘joined-up government’, and the other was the best-value agenda (Savage, 2003). It has been argued that New Labour was distinct from the previous government in that it was a ‘hybrid regime’ (Hall 2003: 19), a ‘social democratic variant of neoliberalism (Hall, 2003:22). This third way discourse provided by New Labour, meant neoliberalism did, however, remain ever-present, though in a modernised unitary perspective (Fox 1966: 3).

One of the central themes of the Third Way was ‘partnership’ (Collins; 2001). New Labour’s crime reduction approach continued with the existing emphasis on the police role being one of crime fighting, albeit in a somewhat modulated form (Savage 2007: 185). Blair’s ‘tough on crime, tough on the causes of crime’ (New Statesman, 1993) mandate appeared as an extension of the previous government’s failure to recognise the social role of the police and indeed the substantial interface that existed between policing and mental ill-health. This was evident in New Labour’s flagship legislation, the CDA 1998, which mandated Crime and Disorder Reduction Partnerships (CDRPs). This Act is widely recognised as the first statutory framework for police partnership work involving local authorities, fire services, health and educational authorities and other agencies, which were collectively aimed at reducing crime at the local level and improving community safety (Savage, 2003). These were at various levels of governance, but with local authorities at the core of which, had the primary responsibility for the overall crime reduction strategy (Savage, 2003).

There were many perceived advantages for organisations, practitioners, and society to be gained by the police working in partnership with other agencies. Skinns (2008) identifies some of the key arguments for police partnerships, highlighting for instance, that working with outside agencies is considered to contribute to the managerial goals of efficiency and effectiveness and is believed to provide a way of doing more with less. Evidence of the further extension of the neoliberal ideals during the austerity era can be seen through the perspective that partnerships may create opportunities to reduce duplication, break down working barriers for practitioners, build trust between agencies, allow for information sharing and maximise practitioners’ skills, capacity, and knowledge (HMIC, 2014).

Beyond this, partnerships were seen to provide an opportunity for a different kind of accountability, by empowering partners to provide checks and balances on each other and enhance the legitimacy of the CJS, as well as possessing the potential to reduce the chance that social problems will fall between the gaps of different social institutions (Skinns, 2008). From a policing perspective, the key benefits of partnering include the prospect of sharing some responsibilities with other agencies and other services in the community (Mazerolle and Ransley 2005, Corsaro et al. 2009). In so doing, police and partner agencies would be better placed to respond to people in a cost-effective and collaborative way (Braga et al. 2001, Rosenbaum 2002, Penfold et al. 2004). There have, however, been several high-profile cases that highlighted instances where police partnership work has failed, notably the Laming Inquiry which excoriated the police and other agencies handling of the Climbie abuse and murder case (Home Office, 2003a), as well as the Bichard Inquiry into the Soham child murders (Bichard, 2004).

* + 1. *The shift to ‘accepted wisdom.’*

Much of the literature on early police partnerships depicts the challenges encountered, with police partnerships being far from readily accepted within the organisation (Sampson et al, 1988; Pearson, 1992; Crawford, 1994, 1997). This was the preoccupation of much of the research conducted around the time of the CDA 1998, lots of which failed to interrogate the meaning of ‘success’ within partnership work (Dick, 2018). Pearson et al (1992) identified difficulties for PCs moving beyond task orientation, towards a more deliberative and cooperative set of practices typical of partnership responses. In turn, hostility towards more welfare-orientated agencies, frequent interagency conflicts, as well as struggles for the police in relinquishing some of their authority and control all presented problems at that time. The police were often accused of dominating partnerships and using them for their own ends (Edwards, 2002). Poor communication is also known to hinder effective multi-agency work and threaten the effectiveness of any partnership (Davies, 2021), something many of these issues reflects.

Bullock et al (2016) detailed common operational issues encountered in police partnerships, such as data sharing, mixed agendas, lack of focus on projects, lack of project ownership and a lack of experience in problem-orientated policing. Similarly, the concept of ‘mission creep’ has been described as a process through which the scope of the duties of those working within police partnerships have significantly expanded, including an expansion of the role of PCs when they become involved in a given partnership (Corbett, 1998). Prior police-probation partnership literature, for instance, found that where mission creep occurred, this had the potential to produce unwelcome consequences, by saddling participating officers with more responsibilities than they can realistically handle (Murphy, 2005).

The Police Reform Act 2002 was amended in 2014 to extend the membership of CRDPs to Primary Care Trusts amongst others, as responsible agencies in developing and delivering the wider crime reduction program. The fact that the types of responsible agencies had to be modified in law, even after the rollout of CRDPs, was suggestive that partners had not fully engaged with the partnership process or were seeking the expertise of other agencies voluntarily (Crawford, 2006). Despite Health Authorities being named as a responsible agency in police partnerships, the focus remained very much on crime reduction and so did not seek to address the issue of police involvement in MH where it occurred in the absence of crime. CDRPs were said, however, to have presented a clear opportunity for the MH needs of individuals coming into contact with the police to be considered when pursuing a coordinated multi-agency response (The Sainsbury Centre, 2008).

It has now been over two decades since police partnerships were mandated by the CDA in 1998, and recent research has suggested that perceptions of partnership working have changed, with it now being viewed in a more positive light by the police (O ‘Neill, 2014; O’Neill and McCarthy, 2012; McCarthy, 2011, 2012; Mawby and Worrall, 2011). A reason for such is that partnership working has become institutionalised into the police organisation, and it no longer has the same introductory flavour it once did. That is not to say, however, that such partnerships now exist without issue, and the hesitancy and constraints within the development process have been duly noted (Crawford and Cunningham, 2015). The literature is now largely suggestive, however, that the police do support and embrace partnership working, both at operational and strategic levels. Within policing today, for instance, the emphasis is on evidence-based policing, joined-up strategies, monitoring and evaluation, performance targets, and more business-like policing for continuous improvement in efficiency and effectiveness (Bowling et al, 2019). Partnership work thus sits nicely within many of these contemporary strategic visions of the police organisation.

Whilst there is now a seeming agreement about the importance of partnership work, local interpretations, and implementation of it have meant it still often lacks national consistency (Skinns 2005, 2008; Hughes 2006). In part, this is due to the notion of constabulary independence (Mawby and Wright, 2005; Yesufu, 2021), and the localised nature of police management priorities within ‘high policing’ (Brodeur, 1983). Crawford and L’Hoiry (2017) argue that many of the difficulties highlighted in the early scholarship of police partnerships remain stubbornly persistent today. Even a decade after partnerships were formalised, Skinns (2008:312) noted how it is only in theory that all elements of partnership working can work – that it can create new opportunities, that trust can be built, information can be shared, and that resources, skills, capacity, and knowledge can be equally distributed. There is no question that partnership work can be difficult, in practice. Researchers who have dedicated their working lives to understanding effective partnership work, have stated that even they do not seek to promote collaboration, concluding with a message to practitioners and policymakers alike of, ‘don’t do it unless you have to’ (Huxham and Vangen, 2005:13).

* 1. Part Two: Understanding (in)-effective partnership work.

There has been much interdisciplinary research looking at what does and does not make for a successful or effective partnership (e.g., McCann 1984; Gray 1989; Mattesich and Monsey 1992; Kanter 1994; Winer and Ray 1994; Das and Teng 1997; Faerman et al. 2001). The meaning of the term ‘successful’ however, depends upon the kind of study being conducted, the purpose of doing so, and methodological stance e.g., though success can be gaged by assessing particular outcome measures, it can also be drawn from studies, like this one, seeking to understand specific mechanisms behind effective partnership work in a particular context (McCarthy and O’Neill, 2014). As outlined in the introductory sections to the thesis, part of the originality of this research comes from its explorative nature, deviating from the prior evaluative research on PMHT and signalling a distinct move away from the reduction in s.136 being accepted as the primary measure of ‘success’ for PMHT partnerships.

This research draws upon the work of Chris Huxham and Siv Vangen, both of whom have backgrounds in management science and have produced a theoretical basis for understanding partnership work in a way also capable of informing practice. Its premise is a themes-based theory of collaboration, with themes having been drawn from extensive partnership practice research conducted over the last two decades. In the preface, they describe partnerships that are capable of tackling social issues that would have otherwise fallen through the gaps, as having achieved collaborative advantage (Huxham and Vangen, 2005). There is no doubt that police responding to people in crisis, is an exemplary ‘social issue’ as referred to by Huxham and Vangen. This research considers the nature of partnership work within PMHT and whether they are operating in a way conducive to achieving such an advantage.

* + 1. *Introducing Collaborative Advantage (CA)*

CA is concerned with the creation of synergy between collaborating partners (Huxham and Macdonald 1992; Huxham 1993; 1996; 2003; Huxham and Vangen, 2005). The idea is that CA will be achieved when something progressive or advanced happens through a partnership, such as attaining an outcome that neither partner organisation could have produced on its own. CA provides what has been described as a useful guiding light for collaborative partners (Huxham, 2003), and thus an agreeable basis upon which PMHT schemes can be analysed. The related term ‘collaborative inertia’ was developed after the original theory of advantage had been devised. It emerged out of cases where partnerships had appeared to produce very slow or negligible outputs, despite all agencies seeking CA (Huxham, 1996). In its simplest form, the theory seeks to explain why partners who embark upon partnership work do so with CA at the forefront of their vision, yet so often end up with collaborative inertia.

The authors identify themes or ‘mechanisms’ for enabling CA. The issues are not performance factors, but aspects of the nature of collaboration that may arise and need to be managed (Huxham and Vangen, 2005). The themes overlap (see Figure 3.1), with many of the issues underpinning one theme, cross related to the others.

**Figure 3.1: Key themes within the theory of CA**

Text

Description automatically generated

(Huxham and Vangen, 2005)

The research underpinning CA has concerned a wide variety of partnerships, both private and public sector e.g., education and community services. It is unclear whether the police were a partner in any of the underlying research of the theory, though the theory has since been considered by Crawford and L’Hoiry (2017) in their work on safeguarding children (where police were a partner). Aside from this, much of the literature on police partnerships has been preoccupied with broader crime reduction agendas and has tended to focus on the early constraints and limitations of police partnership work (*3.2.2).*

Although the more recent police partnerships research has provided a much-needed ‘update’ to knowledge and understanding of police partnership practice post-1998 and beyond, it has not drawn upon CA explicitly. There are, however, commonalities with some of the themes that were identified within prior policing research which considered ‘success’ factors in the context of a partnership e.g., trust, style, identity and operation, and diversity (McCarthy and O’Neill, 2014). Whilst each theme is introduced and described below in the context of the CA framework, where overlap has been found with existing police partnerships literature, this has been incorporated so the review is as relatable to the context of PMHT partnerships as it can be, in the absence of much pre-existing PMHT research.

* + 1. *Establishing Common Aims*

In place of discussing the common aims of a partnership, the theory of CA refers to common wisdom (Huxham, 2003). Common wisdom spans wider than just agreeing on the aim(s) of the partnership, as wisdom also indicates an agreed ‘understanding’ about the purpose of a partnership more broadly. Related to this, a shared sense of commitment and purpose was also outlined as a prerequisite for effective police partnership working in the safeguarding children partnerships (Crawford and L’Hoiry, 2017). Typically, partners embarking on a collaboration set out to establish common, or at least compatible, agreed, or clear sets of aims as a starting point. In practice, however, the diverse organisational and individual agendas make it difficult to agree on aims in practice and often many begin action without the aims being set in stone (Huxham, 2013).

Professionals from partner agencies often have differing, and sometimes incompatible, tacit assumptions about the problem and ways of working, yet a shared belief in a common goal and underlying philosophy has been identified as a key contributing factor to establishing successful partnerships when there is a diverse range of partner agencies (Rosenbaum 2002, Stern and Green 2005). The destination may thus be shared, but the means of getting to may vary. The emphasis on evidence gathering and prosecutorial zeal of the police has been perceived by those across all non-police agencies to sit at odds with the processes and values of partner agencies (Crawford and L’Hoiry, 2017), for example. There is a need for mutual respect for different types of contributions. Shared understanding does not mean that all the partners necessarily agree on the problem or hold the same view of it. Rather, it demands that the partners understand each other’s positions well enough to have meaningful dialogue about the different interpretations of the problem and to exercise collective intelligence about how best to seek to resolve it (Huxham and Vangen, 2005).

In addition, goals may vary between those of each individual organisation and those of the individuals within the partnership. While some of these goals may be explicit, many will be assumed by one partner but not necessarily recognised by another, and many will be deliberately hidden (Huxham, 2003). There is also the issue of how committed each partner is to achieving common wisdom. CRDP research discussed how the various agencies had different internal pressures, plans and priorities to meet with often limited resources, and so where an agency did not see crime as part of its core business, it was difficult for that agency to muster enthusiasm and commitment to the project (Hughes and Rowe 2007). Without a commitment to achieving the aim of the partnership, it is even more unlikely that there will be common wisdom, as wisdom is broader than simply setting out an aim.

In partnerships where progress against their aims is to be measured e.g., through a quantifiable percentage reduction, this may be hard to achieve where partner organisations have their own targets which must also be measured. Achieving CA may be challenging where there are competing measures and targets outside of the partnership and different ways of managing performance. New public management (NPM) is the term used to describe how management techniques from the private sector came to be applied to public services and are recognised as a fundamental component of neoliberal ideology.

As part of the NPM approach, key performance indicators (KPI’s) linked accountability to results (Hood, 1995) and were a product of the decentralisation of responsibility (Gray and Jenkins, 1995). The objectives of performance indicators have been summarised as threefold: achieving greater control over public expenditure and greater value for money; improving managerial competence in the public sector; and bringing about increased accountability (Carter et al, 1992). NPM is also associated, however, with creating unintended behaviours across the public sector, including within police and health settings (Bevan and Hood, 2006; Guilfoyle, 2012; Tendler, 2007; Monro, 2008; Seddon, 2008; Loveday, 2006, 2008). An example of which, was when the police were found to be routinely underreporting crime data, described as letting the victims of crime down (HMIC, 2014).

In relation to partnerships within the LEPH sphere, it has been said that a modern public sector not preoccupied with the pursuit of results and influenced by NPM is now difficult to imagine (Van Dijk et al, 2019). This section has highlighted that although the common aims within a partnership may be identical between agencies, the ways in which success is measured may differ and this can inadvertently drive organisational intervention in conflicting ways (Van Dijk et al, 2019). The notions of success and effective outcomes may vary depending on where in the partnership process you sit. Often the most important outcomes are the hardest to measure (Van Dijk et al, 2019) and the temptation to value only what can be measured needs to be avoided.

* + 1. *Power, ownership, and leadership*

The mechanism of power in CA is understood by identifying where and how power is enacted in inﬂuencing the way in which the collaborative agenda is negotiated and undertaken (Huxham, 2003). Power can be exerted in varying ways and at varying stages of a partnership. Huxham and Beech (2002) refer to these occasions as ‘points of power’ which together form the ‘power infrastructure’ of a partnership. The terms power and ownership are not necessarily synonymous in nature, but the issue of control or ownership may be a point of power. Understanding both are important, as relations between partners, at times, can be undermined by perceived imbalances in authority and power (Crawford and L’Hoiry, 2017).

The most obvious point of power may be viewed in financial terms. Those who fund a partnership, either partly or wholly, may be perceived as having more power than partners who do not. It raises questions such as whether the partnership is there to benefit primarily the investor and whether the main investor should have a greater claim in terms of aims and outcomes. There is no uniformity for funding of PMHT partnerships, aside from the initial thirteen DHSC-funded pilot schemes in 2013 (Reveruzzi and Pilling, 2016). Irvine et al (2014) in a local PMHT evaluation, noted how the multi-agency nature of the client group raised broader questions such as which organisations the service should be available to and who it should be funded by. It noted that these were ongoing questions that need to be addressed in a real and non-theoretical way by those involved in providing and funding the service. Although funding is significant, it is only one of many points of power which occur in practice, especially in situations where partnerships are funded equally by all agencies.

Alternative points of power may include naming the partnership (which may impact what it does); deciding who should be invited; setting an agenda; chairing meetings; meeting premises and so forth. At the bare minimum, most partners will ordinarily have the power to exit, if not immediately then at the end of a fixed term membership. The power infrastructure continually adapts as the points of power change, neither remain static at both micro and macro level (McQuaid 2000; Mayo and Taylor 2001; Huxham, 2003). Operationally, identifying and understanding the varying points of power in a partnership will allow participants to judge where others are inadvertently (or consciously) exerting power, where others may view them as exerting power or consider how explicitly to exert power. Responding to all of these, however, requires a willingness to accept that manipulative behaviour is appropriate, which some would argue is against the spirit of collaboration altogether (Huxham, 2003).

In some CRDPs, research has shown that they served more of a purpose for the police than other partners (McCarthy and O’Neill; O’Neill 2014), assisting the police meet their organisational goals. Therefore, it may be in the interests of the police to take ownership of the partnership agenda, irrespective of overruling other partner members. The police have historically been central in driving forward the agenda of the partnership and delivering its objectives (O’Neill, 2014). Research has shown that the police are often the dominant player in multi-agency partnerships and on occasion, this has been explicitly encouraged and shaped by their ‘can-do’ approach (McCarthy and O’Neill, 2014). This domination could further be attributed to the perception that the police are experts, knowledge brokers or specialists in all things crime, plus they are the main custodians of crime statistics. As Hughes (2007) elaborates, some agencies such as social services, probation, and education, saw the exclusive, enforcement- driven, crime reduction approach favoured by the police as an anathema to their ways of working, which tended to be more inclusive, liberal, and orientated around community safety (Garett, 2004).

In CRDPSs where there have been less clearly defined roles, the ownership of the partnerships has become a contentious issue and there have also been uncertainties among participants about their own roles and responsibilities and the division of labour (Skinns, 2008). Culturally, Hough (2006) also highlighted how the police often operate with simplistic notions of crime control and that this could disenfranchise partners who were used to more holistic views of social problems and who sought to avoid quick, uninformed decisions about how to address them. While the police partnership ‘domination’ has previously been criticised (Pearson et al, 1992), more recent work has suggested this may not be as problematic as it seems (e.g., O’Neill, 2014). The police by nature of their organisation are more able to respond quickly to events as they unfold, as well as make decisions and follow tasks up in a timely manner than their partners might be. The police might end up chairing or leading partnership groups in some areas and this might be a benefit as the police can provide leadership that is needed to keep partnerships running (O’Neill, 2014).

Strong leadership was noted as a major factor in driving forward improvements in partnership work by providing strategic direction that professionals felt a mutual commitment towards (Crawford and L’Hoiry, 2017). It seems somewhat self-explanatory that good public sector leadership is crucial in ensuring efficient collaboration between the collaborating partners, especially where problems span across all agencies and require input from each (Herrington, 2015). Nowhere is the importance of shared leadership more evident than at the front line, which is the practical interface between practitioners. Frontline professionals must make decisions about how best to interact and partner with each other. To effectively achieve this collaboration, they must draw on their shared loyalty to positive health and safety and security outcomes for the community (Van Dijk et at, 2019).

There has been little evidence found of a consistent or unproblematic cascading of the operation of partnership relations from managerial to frontline staff, with managerial and frontline staff having been found to experience partnership relations differently. The cultural barriers between managers of different organisations are less evident than they have been found to be at the frontline level of partnerships, as they share similar lived experiences of managing (large) public sector organisations and workforce. As a consequence, relationships between partners tend to be more easily established and consistent at managerial levels (Crawford and L’Hoiry, 2017).

* + 1. *Trust*

Trusting partners, whether it be that they aim for CA, are competent, are invested, or some other issue seems a somewhat obvious starting point in ensuring a good working relationship. Friendships and relationships between people in everyday life are to a large extent based upon an element of trust (Das and Teng, 1998; Lane and Bachman, 1998). Despite this idealist view, even partnerships outside of the policing sphere initially have been found to contain a higher level of suspicion than trust (Huxham, 2003). One way in which inter-agency tensions express themselves is in ‘distrust’ and mutual suspicion between personnel from differing organisations (Crawford and L’Hoiry, 2017). The notions of suspicion and cynicism have been identified as core characteristics of police culture (see *3.3.6*), which early police partnerships research identified was particularly problematic for the effective operation of police partnerships (Pearson, 1992; Sampson, 1998; Reiner, 2010). By the same token, other agencies have also been found to view the police with suspicion, primarily due to their law enforcement powers, which could be a barrier to achieving CA (Garrett, 2004; McCarthy and O’Neill, 2014).

As with CDRPs, often collaborations are legislated, or policy will dictate which organisations must partner with each other, taking some element of choice away about whom organisations should work with. To an extent, this was the case with the initial DHSC triage pilots, as these were not legislated and there remained an element of autonomy when the police organisations were chosen, with whom they would include in their initiative, though at an individual, not organisational level. The CCC, as the overarching framework, for instance, had 27 signatories and so there was the expectation that at a minimum, the NHS would be a necessary partner. With legislated partnerships, there may also be the issue of whether the most appropriate partners have been identified as key actors (Huxham, 2003) and whether these actors are there because of a genuine commitment to the partnership, or because they have to be there.

Research has shown a key feature of trust relations perceived by officers was the consistency of agency representation (McCarthy and O’Neill, 2014). This was viewed as crucial in allowing time for understanding each agency’s motives and goals behind their engagement in partnership working (Berry et al, 2011; McCarthy and O’Neill, 2014). It makes sense that if trust is to be built, there needs to be consistency in the people involved in partnerships. Partners with prior experience in partnership working have been highlighted as a feature of successful project outcomes, due to knowledge of the practical delivery of the collaborative agenda (Huxham and Vangen, 2005). If people have been involved with partnerships prior, they are more likely to have knowledge of the roles, responsibilities, and occupational cultures of the partner organisation. Maintaining stable relationships, however, has previously been subject to a range of practical obstacles, notably different patterns of working, particularly around weekends. Officers have been found to express frustration about other partners working standard office hours, and noting that dealing with complex social problems doesn’t just happen Monday to Friday (Crawford and L’Hoiry, 2017).

As McCarthy and O’Neill (2014) have noted, the importance of getting to know individuals involved in a partnership can be aided by face-to-face contact and co-location arrangements. Bringing multi-agency teams together in the same physical location, often jointly managed, serves as a means of forging what Crawford and L’Hoiry (2017) discussed in relation to emergent communities of practice. Whilst co-location is not essential for effective partnership work to occur, co-located teams have been shown to help foster dynamics within the collaboration. An initial reluctance on the part of the affected staff has been previously reported, though this was overcome by the practical benefits of day-to-day interactions (Crawford and Cunningham, 2015), such as the building of interpersonal trust relations between colleagues from different agencies (Crawford and L’Hoiry, 2017).

* + 1. *Membership Structures, roles, and responsibilities*

Within CA, the membership of a partnership is said to influence what the partners are able to achieve together, as well as the role(s) that each takes. The theme of membership has three aspects to it, that conceptualise the difficulties associated with it. These are ‘ambiguous’, ‘complex’, and ‘dynamic’ relationships (Huxham and Vangen 2000b). The partnership’s research underpinning CA theory highlighted how often members were unclear about who they were in collaboration with e.g., those who were central in managing the partnerships often could not list the membership of their partnership without referring to formal documentation (Huxham with Macdonald 1992; Huxham 1993; Huxham, 1996). This ambiguity could be attributed to the varied role of the individuals within a partnership, who were described as ‘wearing more than one hat’, much like PCs who may be involved in multiple initiatives or have varying priorities at any one time (Zakimi et al, 2022). There was also a lack of clarity about whether it was the individual person from an organisation or the organisations that were members of a collaboration, or indeed both.

The lack of clarity about who partners are is often compounded by the complexity of the partnership arrangements in practice (Huxham, 2003). The research underpinning CA found that as partnership working increased, there were more people at partnership meetings, often doing different things which covered different aspects of their job. This raised questions about where the line was drawn between their role in the partnership and other responsibilities (Huxham with Macdonald 1992; Huxham 1993; Huxham, 1996). This points to potential ‘dangers of collusion and merger’ which may result ‘not in good collaboration but in a form of incorporation of one service into the other’ (Thomas, 1986:126).

There is also an inherent dynamic at the heart of any partnership since the membership should deﬁne its purpose, but equally, the purpose should indicate which members are needed (Huxham, 2003). The turnover of key staff out of particular teams or localities has been shown to severely disrupt relationships that have built up over time. This ‘churn’ of personnel was also recognised by police as particularly problematic in terms of the loss of human capital, through expertise and skills that have been built up in a particular specialism (Crawford and L’Hoiry, 2017). The relationships between individual partners are often argued to be essential to getting things done. This makes them highly sensitive to changes in someone’s employment, even if these are merely role changes within one of the partneriing organisations.

* + 1. *Occupational Cultures*

Within CA, the variance in occupational cultures has frequently been cited as problematic in relation to a successful collaboration (Huxham, 2003; McCarthy and O’Neill, 2014; Crawford and L’Hoiry, 2017). In partnerships such as PMHT, that fall within the LEPH arena, the importance of the relationship between LEPH, does not mean that law enforcement work is the same as public health work, let alone that the police agencies and public health agencies share important features in their culture and methods (Anderson and Burris, 2017). Occupational culture is widely defined but can refer to the values shared by colleagues in an organisation, which become manifest through the occupational practices within that environment (Johnson et al, 2009). Paoline and Terrill (2014:5) define it as ‘the attitudes, values, and norms that are transmitted and shared among groups of individuals in an effort to collectively cope with the common problems and conditions members face’.

Unlike that of MH crisis care, police occupational cultures have generated substantial interest in the policing field from the most seminal research, through to the most recent (Banton, 1964; Skolnick, 1966; Westley, 1970; Cain, 1973; Punch, 1979; Holdaway, 1983; Loftus, 2009, 2010; Cockcroft; 2015). Research has offered varying terms to describe police culture, some prefer the term ‘police subculture’, while others choose ‘occupational culture’, ‘organisational culture’, ‘cop culture’ or ‘canteen culture’ (Bacon, 2014). All suggest that PCs have a set of norms, beliefs and values which influence their behaviour (Loftus, 2009). Reiner described police culture as ‘the values, norms, perspectives and craft rules which inform police conduct’(1992:109); Chan (1996) as the ‘informal occupational norms and values operating under the apparently rigid hierarchical structure of police organisations’([1996](http://www.oxfordscholarship.com.sheffield.idm.oclc.org/view/10.1093/acprof:oso/9780199560905.001.0001/acprof-9780199560905-bibliography-1#acprof-9780199560905-bibItem-290): 110), and Holdaway (1983) as a residual core of beliefs and values, of associated strategies and tactics relevant to policing, as a principal guide for the day-to-day work of the rank-and-file officer (1983: 2).

The guiding principle of police culture (s) (Bacon, 2014) is that underpinning the role of the police are specific, informal values that impact how and what the police do in their day-to-day duties (Cockcroft, 2013). Reiner (2010: 118-132) identified ‘core characteristics’ of police culture, which included a sense of mission; action-oriented behaviour and cynicism; suspicion; isolation; solidarity; pragmatism and authority; masochism; prejudice and conservatism. The works from which these characteristics derived have been said to have been so timeless that they have today assumed the status of something approaching sociological orthodoxy (Loftus; 2010).

*Police pragmatism*

Despite research challenging the cultural manifestations within policing (Waddington, 1999; Slansky, 2007), Loftus (2007; 2010) depicted them as consistent but altered by the 21st-century policing landscape, including within the embedment of partnership work. O’Neill and McCarthy (2014) considered how police culture has been ‘renegotiated’ through partnership working and PCs now welcome working with other agencies that historically may have been viewed with suspicion as ‘outsiders’. They noted that culture, especially the concept of pragmatism, has facilitated partnership work in their studies, not hindered it. Given the police are often called upon to address a variety of problems and are expected to do so quickly, they tend to rely on pragmatism, that is, on methods of working that ‘make sense’ or show a practical value (O’Neill, 2014). Pragmatism is often associated with a kind of ‘conceptual conservatism’ (Crank 1997).

As Reiner wrote ‘PCs are concerned with getting from here to tomorrow (or the next hour) safely and with the least fuss and paperwork, which has made them reluctant to contemplate innovation, experimentation, or research’ (Reiner 2000: 101). Pragmatism is often attributed to a ‘hands-on’ mode of experience which treats ideologies, principles, and theories of policing with scepticism (McCarthy, 2013). The police hierarchal and command control structure also lends itself to a style of working which favours a task-based response, as opposed to the deliberation and debate style often found within partnership work.

‘Meeting overload’ was described as an undesirable aspect of police partnership work, which was said to have been influenced by the police being a traditional task-focused organisation e.g., officers resented the number and length of meetings they were required to attend. Once partnerships became commonplace within policing, they were able to provide the kind of pragmatism that PCs tended to seek. It was found that PCs who worked closely with partners embraced the potential for medium-long-term problem-solving (O’Neill and McCarthy, 2014). This was a departure from previous conceptualisations of pragmatism, in that the police were not just looking to get ‘from here to tomorrow’ but were more likely to invest the time and effort required in attempting to ‘fix’ the often-complex social issues at the heart of the partnership.

In conceptualising the re-negotiation of police culture through partnership work it was reported that the majority of reasons officers gave in support of partnership working were outcome-based (McCarthy, 2014). Through the merger of information shared between agencies and the pooling of resources to tackle certain issues, the belief among officers was found to be that underlying social problems can be more effectively tackled by working with other partners. Officers were described as recognising the limits of their own expertise in dealing with certain social problems, alluding to the remit of other agencies e.g., children’s services, as being more effective in understanding the complexities of issues such as child delinquency.

*‘Real police work’: The concepts of hard, soft, and empathic policing*

The concept of ‘soft policing’ can be defined as ‘the non-coercive aspects of police-led social control encompassing the provision of a visible presence of authority, persuasion, negotiation and community interaction’ (Innes, 2005:157). There has been a historic animosity by officers towards ‘soft policing’, whereby such aspects of their role were perceived as a departure from ‘proper’ or ‘hard’ images of police work, associated with masculine ideals of crime fighting (Holdaway 1983, Fielding 1994, Herbert 1997). Those soft-policing tasks, however, require PCs to possess what has been termed ‘soft skills’ such as displaying a level of emotional intelligence, in order to undertake their role effectively (Millar and Butler, 2019). Emotional intelligence has been defined as the capacity for recognising our own feelings and those of others, for motivating ourselves and for managing emotions effectively in ourselves and others (HayGroup 2011:4). Policing requires officers to adopt many different roles and attitudes in the course of undertaking their duty. These include listening and providing empathy, qualities often associated with the role of counsellor or social worker, as well as conveying authority and enforcing the law (Millar and Butler, 2019).

Amongst a mix of cultural elements at work, pragmatism has been said to be the biggest factor in the adoption or rejection of ‘soft’ policing activities by frontline PCs (McCarthy, 2013). Prior research has widely reported the ways in which the occupational culture of frontline officers has tended to value the conduct of ‘hard’ policing functions e.g., pursuing ‘real’ criminals and public order policing, over the less coercive aspects of the job (Holdaway 1983, Irving et al., 1989; Fielding 1994; Martin 1999, Miller 1999, Herbert 2001; Westmarland 2001). Activities concerning crime-fighting, for example, were those categorised as ‘hard’ policing functions, in as much as they are all founded upon the direct implementation of a coercive form of power (Innes, 2005).

This contrasts with the task of officers responding to people with mental ill-health in the community where those ‘soft skills’, such as empathy, are necessary. Empathy is not an emotion, rather it is how we share another’s emotions. We can choose to empathize, and our emotional response to empathy is compassion (Oxley, 2011). Empathy is widely perceived by officers as having a place within policing practice (Millie and Hirschler), yet it may be confined to ‘soft policing’ tasks. In criminological and social-psychological research on procedural justice (e.g., Alexander and Ruderman, 1987; Lind and Tyler, 1988; Hough et al, 2010), it is suggested that the police gain legitimacy when people are dealt with fairly, that ‘fair procedures can act to reduce generally the level of conflict and dispute’ (Lind and Tyler, 1988:82). The notions of fairness, empathy, and compassion have been notably absent from the prior PMHT research, most likely due to the omission in SU perspectives. This critical approach thus presents a new opportunity to reconsider the current understanding of these not only within policing, but within a partnership context, given the intervention not only involves partnership work but is a partnership that concerns an aspect of their role itself that is also historically considered to be a ‘soft policing’ task.

*The lacuna in the knowledge of occupational culture within MH practice*

When looking comparatively at the policing literature, occupational cultures within the NHS mental health organisation, let alone out-of-hours crisis care provision, have received nowhere near the same level of consideration in the extant research. Most prior research on Crisis Resolution Teams (CRTs) has focused on efficiency and the impact on hospital admission rates (Johnson, 2005a; 2005b; Karlsson et al., 2011; [Wheeler et al., 2015](https://journals-sagepub-com.sheffield.idm.oclc.org/reader/content/16cbbcdcb5b/10.1177/1473325016668962/format/epub/EPUB/xhtml/index.xhtml#bibr26-1473325016668962)). Even at the wider mental health organisation level, culture has been primarily referred to in relation to organisational stresses and reducing staff turnover, or risk and patient safety (e.g., Peterson and Wilson, 2002; Higgins et al, 2016). MH nurses have, however, been found to perceive their role primarily as risk managers (Downes et al, 2016), yet also that the practices they take in managing risk are perceived by them to be limiting in their ability to form therapeutic relationships with the people in their care (Slemon et al., 2017). As risk is the predominant characteristic of culture within the MH organisation, this is considered below.

An independent inquiry into crisis care provision by Mind (2011) reported that people in crisis overwhelmingly wanted to be treated with humanity, that is in a warm, caring, respectful way irrespective of the circumstances in which they come into contact with services. The report does not directly reference this in relation to occupational culture within crisis care provision but indicated that mental health services may have lost touch with basic humane principles when dealing with people in crisis – through evidence given regarding a lack of human contact, a lack of respect often bordering on rudeness by staff and a reliance on force. Collectively, they stated this does not produce the relationships and conditions that help people recover from the crisis. Similarly, people in crisis may feel an enhanced feeling of safety when practitioners demonstrate care towards them, which has been shown through expressions of empathy and kindness directed toward them (Culter et al, 2020).

The concept of compassion fatigue (CF), however, has been found to reduce a MH practitioner’s ability to feel empathy towards people in crisis and their families (Jenkins & Warren, 2012). The concept of CF was first defined as a unique form of burnout that is inherent in caregiving work (Joinson, 1992). The term CF was later adopted by Figley (1995:34) and described as a state of exhaustion and dysfunction, biologically, physiologically, and emotionally, as a result of prolonged exposure to compassion stress. Other commentators assert that CF may be better understood as moral distress (Forster, 2009), or as empathic distress fatigue (Klimecki & Singer, 2012). CF has also been referred to as the end result of prolonged, cumulative exposure to stress and trauma (Ainsworth & Sgorbini, 2010; Coetzee & Klopper, 2010; Figley, 1995, 2002; Marshman et al, 2021). A systematic review into CF in MH nurses has reported that resources are urgently needed for education and workforce development to address CF where it occurs and that interventions are needed to address the physical, cognitive, and emotional demands of MH crisis care work to ensure practitioners have the capability to provide sustainable compassionate care to the people who seek help (Xie, et al, 2021).

While it has been more challenging here to identify core characteristics of crisis care practitioner culture in the same way these exist within policing scholarship, the literature has shown that the discourse in the MH field has been on risk, patient safety, and the efficiency of services through the retention of staff. The possible impact of shared cultures within police partnerships is often overlooked (Crawford and L’Hoiry, 2017), despite there often being important common cultural characteristics that cut across occupational boundaries (Nash and Walker 2009) e.g., the role of humour (Charman, 2013). As such, this research presents an opportunity to consider these within the context of PMHT.

* + 1. *Risk*

Police perceptions and responses to risk are a feature of police culture, though risk is not typically seen as part of the orthodoxy on police culture, and it was notably absent from Reiner’s core characteristics of police culture (Reiner, 2010: 118-132). The theme of risk within CA is considered in two related but distinct ways. The first relates to the initial taking of risk that is necessary to initiate the collaboration. If partners are able to take enough risk to engage in collaboration, then trust between partners can be built thereafter. It is proposed that by starting with some modest but realistic aims that have a likelihood of achieving success, then trust will be reinforced, and the partnership will have built the foundation for more ambitious collaboration (Huxham, 2003). The focus in this section, however, is on the second aspect of risk, which involves the bringing together of different working practices and organisational approaches to risk management. This is also related to trust because for CA to occur, partners need both trust and the ‘wisdom’ to understand on a broader level that different partners may have different or even contrasting approaches to managing risk.

It has been over three decades since the emergence of literature on the ‘risk society’ (Giddens, 1991, Beck, 1992, Beck, 2000), which shaped an expanding study around the sociology of risk and a recognition of the need to understand risk in the context of everyday lives (Lupton & Tulloch, 2002, Zinn, 2008). In a risk society, governance is privatised and dispersed across numerous individual institutions. The onus is placed on organisations and individuals to be more self-sufficient and to look after their own risk management needs. This emphasis on self-governance is underpinned by the interconnected discourses of morality, rights, responsibility, and accountability (Ericson and Haggerty, 1997). Considerations of risk and risk management are said to have flourished across public sector organisations since the 1990s (Kemshall, 2002, Power, 2004), including in police work (Heaton, 2010).

Risk management has been described as an activity that involves the evaluation of risks, and the development, selection, and implementation of control measures that change reduce, or eliminate the probability or consequences of a harmful action. It refers to the process of looking into the future (short or long term) and identifying what can go wrong and then taking action to prevent it (Girod, 2013). Garland (2003) refers to risk in policing as a measure of exposure to danger, of the likelihood and the extent of loss though recent attention has been upon the aversion of risk and the growing perception that a risk-averse culture significantly limits the ability of public sector organisations to achieve their goals (Heaton, 2010).

Risk aversion has been highlighted as a reason underpinning the rise in s.136 use (Thomas and Forrester Jones, 2019). Officers have been said to operate in fear of a ‘death in police contact’, the consequence of which is highly risk-averse behaviour and a high degree of compliance with force policy, even where the officers judge this as inappropriate. This inhibits officers from exercising their discretion and finding other ways to deal with those in crisis and makes detentions inevitable (Ericson and Haggerty, 1997). In cases where officers have perceived there could be a threat to life, the only way they could discharge their responsibility for this was to pass the responsibility to someone else. Whereas in previous times this may have been police custody, the move towards reducing custody as a place of safety has seen a shift of this responsibility towards health professionals e.g., hospital or ambulance staff. The impact of this recent shift has seen the police being described as inadvertently operating a new ‘patient pathway’, providing direct access for people in crisis to health services and to a MH assessment (Thomas and Forrester Jones, 2019), with the police being increasingly relied upon as an emergency MH service (Dodd, 2016). This knowledge is based upon a small-scale study in one force, and thus provides a useful starting point to consider risk within a PMHT decision-making context.

Within policing, apart from the threats to individual officers posed by risk, a further set of risks revolve around the threat to the organisation’s reputation in the event of failure (Heaton, 2010). The Adebowale report (2013) was highly critical of police responses in MH death cases and highlighted significant problems in joint working between social workers, NHS staff and police forces. It is unsurprising that given consent for policing is heavily reliant upon public confidence, owing to the potential negative consequences that taking risks might have on reputation, the police have developed a risk-averse culture which is reflected in their processes and decisions (Heaton, 2010).

In terms of PMHT schemes, it has been noted in a local evaluation that officers were working on a worst-case scenario basis when coming into contact with someone in crisis and were unable to ignore such a risk (Irvine et al, 2014). In contrast, the MH nurses were found to draw upon their prior experience of assessing those who were mentally unwell and the likelihood that the person would harm themselves. Unlike the police, they talked about ‘therapeutic’ or ‘positive’ risk-taking (Irvine et al, 2014:8.2). This meant the MH practitioners did not always intervene to prevent an individual from acting on certain behaviours and whilst the police were surprised by this, they stated they would not alter their own practice as they did not feel equipped to do so (Irvine et al, 2014). The promotion of positive risk-taking has been proposed as an essential tool for health and social care staff, but little is actually known of the dimensions and value of this approach (Robertson and Collinson, 2011). In other words, just as MH and police agencies are culturally independent, this includes when they are identifying and managing risk.

Risk in MH care is often used to refer to the possibility of an adverse event, outcome or behaviour arising from the unwanted actions of the SU (Dixon, 2001, 2015): notably the risk of harm to self, others, or both, and may include self-harm, suicide, or violence (Ahmed et al, 2021). Risk-taking is, however, necessary in every aspect of MH where the primary purpose is that of improving SUs’ quality of life (Ramon 2004). Though not too dissimilar to the approach understood in policing, it is important to remember that mental ill-health is only one aspect of the police role. MH clinicians working in emergency crisis assessment teams or MH triage roles, on the other hand, are routinely required to make rapid and accurate risk assessments as part of their core function (Sands et al, 2012).

There are few examples that can be found in the UK literature of standardised approaches to positive risk-taking (Robertson and Collinson, 2011), though there are three broader approaches to assessing risk in MH care where positive risk-taking may sit. These are unstructured clinical judgement, actuarial methods, and structured clinical judgement (Doyle and Dolan, 2002). Unstructured clinical judgement typically involves professionals making judgements based on their clinical experience, opinion, intuition or ‘gut feeling’. Actuarial methods provide the assessor with a statistical means to combine information and calculate risk (Godin, 2004), though the subjective nature and poor predictive accuracy of these approaches mean they should not be used on their own in practice (Quinlivan et al, 2017).

Structured clinical judgement involves the use of a standardised risk assessment tool to aid a professional in their clinical judgement (Doyle and Dolan, 2002). While clinical risk management tools have been shown to be effective in some MH settings, this cannot be said to be the case in the crisis care environment where the emphasis is on rapid assessment and management of risk. MH practitioners in these circumstances have little scope to complete paper-based risk assessment tools, and often decisions are undertaken in unpredictable environments or public places, in time-pressured circumstances (Johnson et al. 2005). Consequently, decisions must be made with speed and thus are more informed by clinician knowledge and experience (Sands et al, 2012), falling under the unstructured clinical judgment approach to risk management.

As well as exploring the implications of the broader approaches to risk management within PMHT partnerships, this research will also draw upon the concept of ‘risk work’, developed by Gale et al (2016). The concept of risk work is defined as ‘working practices framed by concepts of risk—a concept synthesising and developing insights from the sociology of risk and uncertainty’ (Gale et al, 2016: 1047). This approach to analysing risk practices has three components that were drawn from a narrative review and synthesis of the existing risk literature. These are: (a) translating risk into different contexts; (b) minimising risks in practice; and (c) caring in the context of risk.

The first of these, translating risks into different contexts, is concerned with how probabilistic risk based on population-level data needs to be translated to individual cases, and how individual risk often needs to be converted into auditable data for organisational use. The key challenge within this is the desire for safety and certainty within what are often inherently uncertain situations. Translating risk has been described as a fundamentally social process, and different methods of implementing interventions may have unintended consequences for those who access them. The theory recognises how health workers have to draw on other (non-probabilistic) forms of knowledge about risk in the translation process. A variety of terms have been used in the literature to describe this, including how practitioners rely upon ‘tacit knowledge’ (Wood et al., 2003, Scamell & Stewart, 2014, MacLeod & Stadnyk, 2015); ‘broad, practical experiences’ (Williams, Alderson et al. 2002); ‘intuition’ (Warner & Gabe, 2004), and ‘intuitive expertise, and embodied knowledge’ (Godin, 2004).

The second component of risk work concerns minimising risks in practice. This involves activities such as encouraging or supporting behaviour changes in SUs, the administration (or not) of medication and other healthcare interventions or developing new policies or procedures. Where the responsibility lies for risk is dependent, at least in part, on policymakers’ and professionals' political views and interpretation of the evidence on social determinants of health (Delawarde, Saïas et al., 2014). The minimisation of risk is thus an interesting concept to be explored within the context of PMHT where officers and MH practitioners come together with potentially different risk management approaches.

Finally, the third component of risk work, caring in the context of risk, can be difficult to reconcile with the other aspects of risk work. Compassion is widely recognised as being core to quality health care (DHSC, 2012; Cleary et al., 2015; NHS England, 2018), yet when MH practice requires upward accountability to ensure that the organisational transfer, this has the potential to threaten the trust within the practitioner–patient relationship (Brown & Calnan, 2013). Equally, risk minimisation might challenge practitioners' commitments to enhance patient choice or control (Hall et al., 2012). Gale et al (2016) also note that what actually counts as a risk is dependent on social, political, and ethical constructions (Thomas, 2015) and reflects on the nature of the power relationship between patient and practitioner, in which, for example, practitioners retain control over a patients care (Zayts & Sarangi, 2013, Arribas‐Ayllon & Sarangi, 2014). This is to be considered in the present research with regard to the tangible effects of austerity as reported by frontline MH practitioners working in the crisis care setting of PMHT.

* + 1. *A moral imperative*

In bringing this part to a close, even a brief discussion of each theme highlights the obvious complexity of multi-party and often multi-location partnerships, especially those involving the police. Huxham and Vangen in their concluding thoughts about CA in partnership working, state that it is necessary to learn to live with the complexity and manage it. Though they provide several reasons why partnership work may be necessary, in the case of PMHT, there is a ‘moral imperative’ (2005:7). That is, there is no alternative to working in partnership with regard to managing the maxed-out policing and MH interface, and the issue of collaboration in the case of PMHT has thus become a moral concern. This rests on the belief that important issues facing society – mental ill-health, poverty, crime, drug abuse, conﬂict, health promotion, economic development and so on – cannot be tackled by any organisation acting alone. These issues have ramiﬁcations for so many aspects of society that they are inherently multi-organisational, and collaboration is essential if there is to be any hope of alleviating them (Trist, 1983).

With or without PMHT, the police will often remain the first responder to a person in crisis and it is recognised now that ensuring the most appropriate response is likely to require the skills and resources of MH and social care agencies (Horspool et al, 2016). This is the basis of the moral imperative behind the need for partnership work in this area. The police and MH services have both failed to adequately achieve these things in a silo, as had they done, the need for PMHT may not have emerged (Horspool et al 2016; Irvine et al, 2015; Reveruzzi and Pilling, 2016; Cummins and Edmondson, 2016). Working together in partnership is challenging, and fragmented systems and processes are often the results. In the case of PMHT, this leads to poor experiences for the police, health professionals and the public (Murray et al, 2021). Despite the complexities, collaboration is not, however, a hopeless quest. Even if inertia may have set in, it is possible to resuscitate certain partnerships. There are ways to unravel the web of complexity; not completely, not in perpetuity, but in part and for the moment (Huxham and Vangen, 2005), and this is what this research seeks to achieve.

* 1. Part Three: A 21st-century conceptualisation of police partnership working.
     1. *Introducing Law Enforcement and Public Health (LEPH)*

This final section succinctly considers the theoretical underpinnings of how PMHT can be understood within the context of a relatively new field of study which encompasses LEPH combined. The combined approach is distinct from that which has gone before, where both fields have been developed well, but in silo (Van Dijk and Crofts, 2017; Van Dijk et al, 2019; Punch and James, 2017). The Global Law Enforcement and Public Health Association (GLEPHA) was formally established in 2017, growing out of the impetus built by the Australian-based, Centre for LEPH, established by Professor Nick Crofts in 2010. The First International LEPH Conference was held in Melbourne in 2012 and these conferences have continued around the world every two years since. It was this conference series that cemented the international push for a Global LEPH Association (GLEPHA, 2022), yet its global emergence would not have been possible if it were also not a framework that had become so popular after the financial crash throughout the austerity decade in E&W, and beyond this into the ‘covid-era’.

As well as austerity undoubtedly generating a need for change in the approach to police practices (Solar and Smith, 2022), the increasingly recognised notion of ‘vulnerability’ within policing, has simultaneously bridged the gap between policing and healthcare (Herrington, 2012). The emergent LEPH field seeks to bring together those in police and health practice touch points, with a growing recognition of the extent to which policing and public health share common ground (Murray et al, 2021). The ‘touch point’ considered here, is the contact that officers have with people experiencing a MH crisis within the community setting, and the way in which PMHT partnerships as an intervention may impact this. Since the PACA 2017, this touch point also includes the statutory requirement for officers to consult with a health professional prior to the use of s.136.

As shown in Chapter Two, the maxed-out interface between policing and mental ill-health had accelerated the need for partnership working in this area (Christmas & Srivastava, 2019). Van Dijks and Crofts (2017) talked about there being a re-definitional process taking place regarding the remit of LEPH, though they did not explicitly place it or explain it within the wider social context in terms of the effects of austerity policies on those most vulnerable. The swift acceleration of LEPH and the recognition of it as an area of study in its own right, does mean, however, that there are few studies which have explored partnership working from a LEPH theoretical lens (Enang et al., 2019; Shepherd & Sumner, 2017). Consequently, there is relatively little empirical evidence about combined public health and policing interventions (Murray et al, 2021). The current research seeks to contribute to this scant evidence base, providing some well-overdue insight into PMHT as one form of partnership work that exists within the LEPH arena.

* + 1. *Defining LEPH*

Health is defined by the World Health Organisation (WHO) as ‘a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity’ (WHO Constitution, 1948). The term ‘public health’ refers to ‘the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society’ (Acheson, 1988, WHO). Public health is wholly inclusive of MH and despite a historic disparity between physical and MH, the rhetoric in the UK advocating for parity of esteem between the two continues to develop and remains present (Naylor, 2016; Fedock, 2017; Thornicroft, 2011; NHS England, 2016). Law enforcement has been defined as ‘the organised and legitimate effort to produce or reproduce social order, evident in rules and norms, to enhance the safety and security of society’ (Van Dijk, et al, 2019). Although the membership of PMHT partnerships varies between localities, the commonality is that they all involve the public police, who are the most symbolic representation of law enforcement, despite much policing being undertaken by other agents (Roycroft, 2014; Van Dijk and Crofts, 2017).

The chapters thus far, have shown that the intersection between LEPH is a tale (almost) as old as time, yet recognition of the need for a combined field of study encompassing LEPH has only come to the forefront of academic policing studies over the last decade or so, synonymous with the austerity era. At the core of LEPH, is the idea that there should be societal concern about the issues each raise, there should be more involvement in these matters within law enforcement and there should be strong cooperation between LEPH agencies (Punch and James, 2017). It is based upon concerns that the siloed operationalisation of vulnerability in current policies is counterproductive. It addresses the layers of universal human vulnerability and situational vulnerability presented in every law enforcement or public health encounters and requires the abandonment of siloed policies and practices (Bartkowiak-Theron and Asquith, 2017).

A starting point for understanding LEPH can be seen when considering that one of society’s highly valued freedoms is the avoidance of ill health, injury or unnatural and untimely death. It is the common domain of both public health and law enforcement agents to protect people from these fears, by varying means (Van Dijk and Crofts, 2017). Similarly, policing academics have described the notion of individual freedoms and how the police’s role in public security, social order and safety is necessary for them to be upheld in a sophisticated democratic society (Brodeur 2010; Reiner, 2010). The police can therefore uphold these individual freedoms by acting as public health agents, in a different but complimentary way to health professionals.

Part of the difficulty within LEPH, and perhaps owing to the delayed acceptance of the concept, has been the inadequate characterisation and legitimisation of the role of law enforcement agencies in the protection or promotion of public health. Most law enforcement agencies have not constructed their identity in this way, despite having an active and integral role in many aspects of public health (Anderson and Burris, 2017). Whilst much police activity has been directed under the guise of public safety and security, much has actually always been about the preservation of life and duty of care e.g., compulsory seat belt and cycle helmet legislation. The only motive for the police’s role in enforcing the law on such issues is one of public health and safety and the preservation of life.

As part two of this chapter recognised, a political mandate focused upon the police as ‘crime fighters’, has not reflected what the public demand on the police has been since the 1960s and deinstitutionalisation. In relation to policing and mental ill-health within the LEPH sphere, police judgement has always been required when trying to define a boundary between illness and criminality (Taylor et al, 2014), as highlighted prior. The importance of LEPH is becoming increasingly recognised in many sectors across the CJS, particularly with regard to recognising the intertwined relationship between substance misuse, MH and the CJS. There is now widespread recognition, for instance, that factors beyond drug use and offending, such as social exclusion (Seddon 2006) and access to employment and stable accommodation (NTA for Substance Misuse 2009) must also be addressed. LEPH is thus being increasingly recognised as a potential way forward, not only theoretically, but in practice to address an array of complex social issues, including providing appropriate responses to those experiencing a MH crisis.

* + 1. *Challenges to LEPH*

The rapid global acceleration seen in the understanding and acceptance of LEPH as a new field of study since the initial LEPH conference in 2012 has been quite remarkable. This conference came two years after the announcement of austerity in the UK, which had led to widespread public and political debate regarding what the police service could realistically deliver in the face of fiscal constraint, the implications for the frontline, and ultimately, for crime control ([Millie and Bullock, 2012](https://journals-sagepub-com.sheffield.idm.oclc.org/reader/content/16cda515c06/10.1177/1748895812474284/format/epub/EPUB/xhtml/index.xhtml#bibr25-1748895812474284); 2013). As shown in the preceding chapter, PMHT emerged shortly after May’s 2011 speech that had signified a politically induced narrowing of the police mandate, to focus only on crime. At the first LEPH conference, there was a feeling of real uncertainty over whether austerity would be an incentive for organisations, both policing and health, to return or stick with what they viewed as their core tasks, at the detriment of multiagency approaches (Millie and Herrington, 2014; Van Dijk and Crofts, 2017).

Such rumblings around what austerity would mean for the role of the police in society, however, continued into the second LEPH conference in 2014 with a plenary debate between Professor Andrew Millie and Dr Victoria Herrington on how wide the police’s remit should be. Feeding into the broader issue of the extent to which the police *should* be responding to people with mental ill-health goes somewhat further than how they could do what they were already doing better or more efficiently through partnership work. This debate arose from Millie’s work (Millie, 2012; 2013; 2014a; 2014b) which had itself informed Lord Stevens’ independent review of the future of policing in England and Wales (2013). His argument centred upon the potential opportunities for policing to recast its role in society as a result of contraction enforced through austerity, and for the police to reconsider being involved in a range of non-crime issues. Austerity was viewed as an opportunity, therefore, not only to revisit the role of the police but also to discuss which tasks may be better suited to other non-policing providers (Millie, 2014a).

Millie (2014b) conceptualised policing as being on a continuum between narrow policing and wide policing, depending on the range of functions adopted by police personnel. His argument was based on the position that policing had become too wide and needed to be narrowed, but not to the extent of May’s statement as the police being ‘no-nonsense crime fighters’. Though recognising the police do have a role in areas not directly related to crime, his proposal was that there may be other agencies that are better suited. By reconsidering where it is and is not suitable for police involvement, he argued there was the possibility of the ‘de-policification’ of wider social policy. De-policification referred to where the police’s roles and responsibilities have expanded to cover other non-traditional duties over time. He proposed that the police should maintain partnership arrangements but not have to take the lead in such work on wider social problems. He recognised that should the police have passed on responsibilities during fiscal restraint then others may not have been able to fill the gaps immediately, but proposed over time the result would be a narrower, more focused police service. He put it simply, ‘the police do not have to be doing everything’.

It seems that the fears at the 2012 and 2014 LEPH conferences were, for policing in E&W at least, unfounded (Van Dijk et al, 2017), given the rapid acceleration of PMHT schemes emerging up and down the country shortly after, and the simultaneous development of a law enforcement and mental health special interest group within the GLEPHA. While the growth in LEPH appears to signal the arguments calling for a narrowing of the police role have been decimated, it is vital to revisit these debates in light of the emergent evidence base on specific LEPH interventions, such as PMHT.

* + 1. *A policing and medicine analogy*

The word medicine comes from the Latin word "medeor," to cure. Medicine means the art of preventing, curing, or alleviating the diseases of the human body and like policing, is primarily suited to providing acute treatment for individuals in critical distress (Anderson and Burris, 2017). In relation to PMHT, closer analogies may be drawn between policing and medicine, with public health remaining at a broader level. The public health vision is towards prevention at the population level, ideally by addressing the generalised causes of risk and vulnerability. In contrast, medicine and policing dedicate most of their energies to addressing the acute needs of individuals and have relatively little capacity to change the upstream structural factors that produce them (Anderson and Burris, 2017).

It has been recognised that MH crises are more often than not preventable and avoidable, and that prevention is better and cheaper than a cure (HMICFRS, 2018). In the Metropolitan Police for example, in 2017 a total of 8,655 calls were made to the police by just five individuals with mental ill-health, at an estimated cost to the police of £70,000. Had these five individuals got access to the appropriate care and support, then the likelihood of these calls continuing would decrease and the cost savings would be significant. In the UK, the 2016 statistics show government expenditure on healthcare was £152.2 billion (79.4% of total healthcare expenditure) of which only £8 billion (5%) was spent on prevention and £97 billion (60%) on cure and rehabilitation. There is however a growing movement towards prevention being better than the cure (NHS England, 2014; General Practice Forward View, 2016).

Like with chronic diseases, police can only manage symptoms, but cannot cure the underlying pathology. The police cannot address poor housing, poor education, early life trauma or employment issues. In a US study on hot spot policing, officers described feeling they were little more than a plaster. As Wood et al (2014) identified, however, plasters are temporary but helpful, nonetheless. Much of the medical system is, for instance, based upon temporary measures, such as medicating pain prior to a less temporary procedure with longer-term impacts for a person.

Often perceived to be a consequence of multi-agency working, the blurring of roles and fluid boundaries between professional groups, such as that of the police undertaking a MH care role, has been interpreted as reflecting wider societal shifts (Reiner, 2000). Previous predictions have been made regarding how further embedding of partnership work may lead to accelerations in the ‘de-differentiation of expert positions and skill boundaries within state health and welfare organisations’ (Leonard, 2000: 106). There has been little research, however, that has since considered this in relation to LEPH partnerships, particularly PMHT partnerships. The current research considers this, as well as the policing-medicine analogy with regard to the wider debates around the necessity for PMHT partnerships and the future of policing-MH relationship and partnership working more broadly.

* 1. Conclusion

The purpose of this chapter was to review the existing police partnerships literature and situate this within understandings of (in)effective multi-agency partnership work more broadly, as well as to offer a conceptualisation of PMHT partnerships. Part I has shown how, in the last two decades, we have seen police partnerships develop far beyond those of the legally mandated crime reduction partnerships of the mid-to late1990s. These developments have occurred concurrently with an ever-growing and more complex policing landscape (Skinns, 2008; O’Neill, 2014). The complexities in policing which have become more prevalent in recent years, with the changing nature of the role in response to an expansion of the neoliberal agenda e.g., NPM principles, have both presented a further reconfiguration to the policing field.

Due to the innovative nature of PMHT, there is limited evidence of these specific collaborative working arrangements, hence the need for the current study. The chapter has therefore considered evidence from the wider extant police partnerships literature, much of which has centred upon crime reduction through the CRDPs that were introduced by the CDA in 1998. Although PMHT is concerned with distinctly different issues to CRDPs, it has provided a useful starting point to later consider what can be understood about such issues in the context of LEPH, where crime is not the focal point. This research is able to begin from a basis of understanding, that though not without issue, police partnership practice is now both culturally and practically accepted across the organisation.

Part Two has drawn upon the management-based theory of CA. Consideration of the key themes of common aims has highlighted the complexities associated with effective partnership work. These themes offer a framework upon which to later analyse the nature of multi-agency working with PMHT partnerships and the extent to which they are capable of achieving CA. CA and successful partnerships do not arise spontaneously. They need to be forged and supported at all levels by people committed to realising the benefits of collaborative working. How these tensions play out in the future will depend on the extent to which commitments to long-term benefits that derive from inter-agency teams are protected and secured (Crawford and L’Hoiry, 2017). Even those partnerships that have already been subject to ineffective relationships within the partnership e.g., not producing the desired results are capable of being bought back to life if partners are prepared to ‘nurture, nurture, nurture’ them (Huxham and Vangen, 2005). Finally, Part Three of this chapter has examined PMHT and its alignment with LEPH. It has also discussed how narrowing the LEPH field to consider the analogy of medicine and law enforcement, rather than the wider notion of public health and law enforcement, may also be useful to understanding the police-health partnerships working relationships within PMHT.

Ensuring a person’s safety, providing prompt access to emergency MH support, improving working relationships, reducing the use of s.136 and providing a better experience for those experiencing a MH crisis are all identified as things which are seen as more attainable by working in partnership. Early studies on police partnership work, however, have highlighted the issues surrounding the longevity of a partnership arrangement, given early partnerships were often short-term with limited funding attached to them (Blagg et al, 1988; Liddle and Gelsthorpe, 1994). Despite the advances in police partnerships over the previous two decades, and the rapidly growing acceptance of a LEPH approach, there remains a feeling that echoes this sentiment, that PMHT may be a temporary and piecemeal initiative (Punch and James, 2017).

As an emerging practice, within an emerging field of study, there is a clear need for the development of an independent and academically rigorous evidence base to underpin its operation and shape its future direction. That is not to undermine the importance that the limited localised and/or evaluative research has had thus far in its contribution to knowledge, only to recognise that there is much more to be done. It is hoped that this thesis fills this gap in knowledge. This research is tentatively adopting a LEPH lens, though the findings will provide a valuable opportunity to contribute to this debate. By drawing on theories of CA, risk society and LEPH, it is hoped this thesis makes an original contribution to knowledge by providing a rich theoretically informed approach to understanding the specific nature of PMHT partnerships.

1. **CHAPTER FOUR**

**Research Methodology**

* 1. Introduction

This chapter outlines the methodologies adopted for this study, as well as the research approach, theoretical position, research strategy, data collection methods, and the data analysis processes that were undertaken. Attention is paid to each of the three data collection methods, which were engaged through a two-stage approach that reflected the mixed methods data sequence assumed for the study (QUAN 🡪 QUAL). Stage one of the research involved a self-report servicer user postal survey (predominantly quantitative, though with some open-ended questions), whilst stage two involved the remaining qualitative data collection methods, namely observations and interviews. As the research data was triangulated (Denzin, 1978), the data analysis processes are considered together, following the research phase sections.

Given the sensitive nature of the research for those with lived experience of PMHT, the potential to cause further harm to a group of people who may already have experienced such was the paramount consideration throughout. Research involving human participants is a privilege that carries with it important responsibilities (Hyman, 1999). Ethics can be considered a practical or professional morality that enables boundaries for the work of research to be played fairly (Stewart, 2011). It is about conducting research in a way that goes beyond merely adopting the most appropriate research methodology and ensuring that it has been conducted in a responsible and morally defensible way (Gray, 2018). Ethical issues are considered at various points in this chapter and across both research phases. The guiding ethical regulatory framework for this study was the NHS Health Research Authority (HRA). This regulatory body stipulated that all research instruments, including consent forms and information sheets, should follow the HRA template and so these were reviewed independently by an NHS Research Ethics Committee (REC) and an NHS Confidentiality Advisory Group (CAG).

* 1. Research Objective and Questions

As the introductory chapter to this thesis stated, the central research question that this study addresses, is:

*What can be understood about the origins, implementation, purpose, operation, and delivery of PMHT partnerships, commonly referred to as ‘Street Triage’ schemes?*

When devising the central research question, it was noted that PMHT had been in operation for less than a decade, and there was a scant evidence base around their operation in E&W (Massey, 2016:60). To reflect this, the formulation of a broad central research question allowed the researcher to treat it tentatively and develop more specific aims as the research progressed (Bryman, 2018). The overarching objective at the commencement of this research was thus to provide a rich, contextualised account of PMHT partnerships, undertaken with the application of a critical lens, to plug a gap in the hitherto largely evaluative literature. To achieve this objective, the following research questions were developed:

* How did PMHT initiatives emerge locally, what considerations were given as to their purpose (s), and what were the key socio-political drivers underpinning their necessity?
* Has the implementation of PMHT altered the role of the police and its officers when responding to instances of mental ill-health in the community, particularly their use of s.136?
* What is the specific nature of multi-agency working arrangements within PMHT partnerships and to what extent have they become an accepted form of police practice?
* What are the perspectives of people with lived experience of PMHT about the purpose of this kind of partnership work and the value of it to the contemporary crisis care landscape?

Emergent research within the LEPH arena has recognised how evaluations of the achievement (or lack thereof) of formally stated partnership aims may not reveal the actual implications of the intervention or action in practice (Murray et al, 2021). Additionally, as highlighted in Chapter Three, the aims of a formal partnership arrangement may not be clearly stated, or even yet established, thus making such outcome evaluations problematic. HMICFRS (2018) recommended that all forces should locally evaluate their PMHT schemes for effectiveness, as well as conduct a snapshot exercise of their MH demand. In relation to the local evaluations of PMHT, the report stated that the CoP was to devise practice guidelines to help forces benchmark their triage activity. As highlighted in the introductory sections of this thesis, part of the originality of this research comes from its critical lens, rather than an evaluative approach to understanding the nature of PMHT. As such, this research has not been conducted in collaboration with any of the participating police organisations for the purpose of locally evaluating their individual initiative. The reason for such was not to be uncooperative with the forces seeking to evaluate their schemes, but rather, to be able to produce this research as the first wholly independent study of its kind in E&W.

Unlike previous evaluative work, this research does not seek to report upon numerical outcome measures, conduct any costs-benefits analysis, or attempt to measure the success of PMHT based upon how many schemes claim to have generated a reduction in s.136 use. Instead, it provides a new offering in our understanding of the specific mechanisms behind PMHT, and this is underpinned by how those within the system itself have perceived the impact of both the austerity measures and the introduction of PMHT on their working practices and/or experience. In adopting a critical approach to the research area, it has been possible to consider any unanticipated consequences of PMHT as the purposive social action (Merton, 1936), in particular, through the inclusion of SU experiences.

Unanticipated consequences of purposeful social action (the action being PMHT) are essentially the unforeseen consequences of an act that result from a variety of sources or circumstances. In general, unanticipated consequences result from the actor’s limited ability to predict and/or control the outcome of an act (Merton, 1936). While predicting and controlling the outcome of any social action with complete success is unrealistic, there are certain factors that, if controlled, can reduce the element of the unknown. Minimising the potential of negative unanticipated consequences requires full consideration of these factors and proper appreciation for the threats they pose. It is important to note, however, that just because a consequence is unforeseen does not necessarily mean that it is adverse; in fact, both anticipated and unanticipated consequences may either be positive or negative (Murray, 2021).

* 1. Research Approach
     1. *Mixed Methods Research (MMR)*

MMR has been referred to as the third ‘methodological movement’, ‘research community’, or ‘paradigm’ (Johnson and Onwuegbzie, 2004; Doyle et al, 2009; Teddlie and Tashakkori, 2009:4). Whilst still in its infancy, this type of research has emerged as an alternative to the dichotomy of quantitative and qualitative traditions (Teddie and Tashakkori, 2009:4). As ‘a new star in the social sky’ (Mayring, 2007:1) MMR has been explained as when the researcher collects both types of data and integrates the two, allowing for interpretations to be drawn based upon the combined strengths of both qualitative and quantitative methods (Creswell, 2014:2) As this approach has come into its own as a methodological movement, newer explanations also discuss the combining of quantitative and qualitative approaches at all phases of the research process (Creswell and Plano-Clark, 2018:2). Johnson and Onwuegbuzie (2004), for instance, talk about MMR as the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts, or language into a single study.

The approach taken to MMR in this research has been to classify the mixed methods in terms of the *priority decision,* and the *sequence decision* (Morgan 1998; Creswell and Plano-Clark; 2011). The priority decision is about deciding which method is the principal data-gathering tool, or whether they carry equal weight. Unlike MMR which favours quantitative methods as the priority, with a strand of qualitative data incorporated somewhere else (Morse, 2003), this research favours a primarily qualitative approach (Hesse-Biber, 2010:64). In taking this approach to the research design, the quantitative component plays a relatively auxiliary role when considered as part of the wider methods framework (Howe, 2004: 54; Howe, 2003).

Although auxiliary, a mixed methods approach was necessary as one data source would have been insufficient to address the central question of the thesis (Crewswell and Plano-Clark, 2018:7). The second classification, the *sequence decision*, is about deciding which method precedes which, or whether the data methods are concurrent. Data can be collected either *sequentially* (i.e., one data collection method follows the other) or *concurrently* (i.e., both data collection methods are collected at the same time. Based on a pragmatic rationale relating to the nature of the central research question and the aims of what this study sought to achieve, the decision was made by the researcher to adopt a two-stage sequential approach to data collection. The first phase was that of the predominantly quantitative data collection technique, a postal questionnaire, which ran exclusively prior to the other data collection techniques. The second phase consisted of the remaining two qualitative multi-methods (observation and interviews) running concurrently.

* + 1. *Epistemology and ontological considerations*

Epistemology is about ‘how we know what we know’ (Crotty, 1998: 8) or ‘the nature of the relationship between the knower or would-be knower and what can be known’ (Guba and Lincoln, 1998: 201). Epistemology is closely linked to ontology which, broadly speaking, refers to ‘the study of being’ (Crotty, 1998: 10) or ‘the nature of reality’ (Lincoln and Guba, 1985: 37). Ontology focuses on questions such as ‘whether or not a social reality exists independently of human conceptions’, ‘whether there is a single shared social reality or multiple context-specific realities’ and, ‘whether social behaviour is governed by immutable or generalisable laws’ (Snape and Spencer, 2003: 11).

Here the epistemological approach adopted is that of pragmatism, primarily because the inclusion of a quantitative data collection technique into an otherwise qualitative study subscribes to neither only the positivist nor constructivist dichotomy, and pragmatism recognises how that is okay. Much like those who formally linked MMR to pragmatism (Tashakkori and Teddlie; 2003), it is argued here that a strict alliance to either a positivist or constructivist epistemology is unnecessary and can be abandoned where MMR is necessary to address the central research questions. As Braun and Clarke (2006) recognised, the theoretical framework and methods should match what the researcher wants to know, and the researcher should acknowledge and recognise these as conscious decisions, as was the approach taken here. Dichotomising approaches to research ‘mask the reality that there can be many different combinations of methods’ (Yin 2006: 41). The researcher, who over the previous decade has widely utilised qualitative research methods in her social research, and (if adhering to the status quo) would have continued to align with interpretivist approaches, accepts the epistemological position here as ‘*scaffolding, not an edifice*’ (Crotty, 1998).

Some of the key thinking behind pragmatism includes practical usefulness being the main measure of truth; guidance of action as the top priority of science; and an ecological view of knowledge (Lushin and Anastas, 2011). Pragmatists value the usefulness of knowledge and avoid excessive generalizations (Lewis, 2006; Rorty, 1982). The focus of pragmatism is thus on the consequences of the research (Rorty, 1998); the importance of what is to be answered over the methods necessary to do so (Tahakkori and Teddlie, 1998) and using multiple methods of data collection to inform the study (Creswell and Plano-Clark, 2018:37). Hence, pragmatists focus not on whether a proposition fits a particular ontology, but whether it suits a purpose and is capable of creating action (Rorty, 1998). In taking this approach, it is possible to embrace the strengths of both positivist and interpretivist approaches (Maxcy, 2003: 52). Given the priority decision in the current research is qualitative, much less appreciation was awarded to the positivist orthodoxy, yet its value was not undermined. Pragmatism was an attractive epistemological approach when taking the research design into account, in particular the necessity to include a quantitative survey which, in turn, would enable access to a ‘hard to reach’ population. Achieving this sought to enhance the overall value of the research by producing an original contribution to knowledge in this area.

* 1. Research sites and settings
     1. *Selection and rationale*

Previous categorisations of PMHT models were outlined in Chapter One (Deane et al; 1999; Putis et al, 2108; Park et al, 2019) and were a useful tool when broadly categorising each research site by the operational model(s) they had adopted. The fieldwork was conducted across three research sites that incorporated elements of each of the key models of PMHT that have commonly been adopted across E&W. Research participants included employees of the police and NHS (in a wide range of roles and ranks), as well as people with lived experience of PMHT partnerships. Bowling (2010:19) advocated that the role of the social scientist is not to produce policing research that only applies to a specific city, but to produce work that can be generalised enough for explanatory lessons to be drawn elsewhere. To this effect, whilst this research recognises local variations within each site, it sought to identify the broader themes that could be applied to the field more widely. The sampling design used here was therefore primarily based on typical sites (Scneider, 2006).

Each research site consisted of at least one model of PMHT and, for two sites, the model of partnership in existence at the time of the research was the second type of PMHT partnership model that had been implemented in that area, meaning most staff could speak broadly about both the previous and current models. Two research sites belonged to the same police force area, but with different NHS partners. This was to enable an exploration of how even within one police force area, there were varying partnership arrangements with different partners. The three research sites have been assigned the pseudonyms **Northfield**, **Eastbrook**, and **Hilltop**.

Northfield and Eastbrook were located in two districts of a large metropolitan force, with different managers and processes in each district. Hilltop was in a second police force area, much more rural in nature, which operated a PMHT model that spanned the force-wide area (primary control room model).

Hilltop was operating a police-based MH response with MH professionals, employed by, and based within, their police control room. Northfield and Eastbrook were operating a MH-based MH response whereby community MH services had formed a specific relationship with the police, to respond at the site of an incident (mobile crisis team/co-response models). In an earlier model utilised by Eastbrook, they had operated a semi-police-based police response, whereby they trained specialist officers who had received specific training in MH, but who then was working within a MH-based MH response model (mobile crisis team/co-response). That model had, however, ceased to operate in 2016 and was replaced with the new model on a trial basis in 2019, at the time of fieldwork. Table 4.1 provides an overview of the demographical area of each site.

**Table 4.1: Demographic area of research sites and key site information**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Northfield** | **Eastbrook** | **Hilltop** |
| **Type of demographic** | City | Town | Rural Town |
| **Total population** | Nearly 600,000 | Over 260,000 | Nearly 200,000 |
| **County population** | 1.4 million | 1.4 million | 800,000 |
| **ST hours of operation** | 4pm-12am M-F  4pm-2am S-S | 4pm-12am | 6pm-2am |
| **ST days of operation** | 365 days a year | Monday and Thursday | 365 days a year |
| **ST operating base** | NHS office (community) | NHS office (hospital) | Police control room |
| **Type of ST model**  **Frontline team**  **Designated s136**  **Suite** | Co-responder & phoneline  PC & MH worker  Yes (2 beds) | Co-responder & phoneline  PC &MH worker  Yes (one bed) | Control room and phoneline  MH worker, paramedic & SW  Yes (2 force wide beds) |

Notes: ST = Street Triage; PC = Police Constable; MH = MH; SW = Social Worker

Figure 4.1 offers a visual depiction of the complex overlap between each partnership, by presenting a further geographical breakdown of the partnerships and highlighting the local and surrounding area provision, including the designated s136 suites and Accident and Emergency departments.

**Figure 4.1: The geographical layout of sites, surrounding areas, and service provision**

Chart, diagram, radar chart

Description automatically generated

* + 1. *Northfield*

Northfield was a metropolitan city with a population of over 500,000 people, served by two general NHS hospitals. Only one of these, Northfield General Hospital, housed an A&E department (including a hospital MH liaison worker) and some of the city’s designated MH provisions (and inpatient facilities). This MH provision, referred to locally as ‘The Centre’, was a self-contained building adjacent to Northfield general hospital, which was in the process of refurbishment to include a new psychiatric decisions unit (PDU). The Centre contained the city’s designated s136 suite (2 x available beds), with separate entrances and exits to other areas of the hospital and centre. Other notable MH provisions across Northfield included an additional standalone MH inpatient facility, Northfield NHS Trust Headquarters, and several community MH buildings that housed varying aspects of Northfield’s community provision. One such community building was used to house Northfield’s 24/7 MH crisis care provision, which included a Single Point of Access (SPA) telephone service (8 am-8 pm) and the out-of-working-hours team, where the PMHT MH worker was based. The building itself was self-contained in Northfield NHS Trust premises, not much bigger than a large, converted house which was spread over two floors. The building was approximately twenty minutes from A&E (and the adjoining s136 suite) and was situated close to the city centre.

Northfield’s PMHT scheme had existed since late 2013 and was staffed by workers from Northfield’s out-of-working-hours MH provision office, referred to locally as the ‘Out-of-Hours’ team (OOT). This site deployed a co-response model, with one officer and one MH worker going to MH incidents in the community, together. It also operated a 24/7 phoneline, whereby officers could contact the SPA line to speak with a MH worker directly.

* + 1. *Eastbrook*

Eastbrook is a metropolitan town with a population of over 250,000 people, served by one general hospital, Eastbrook General Hospital. Locally, this PMHT was also referred to as ST and existed as a co-response model with one PC and one MH worker. It operated from the Eastbrook NHS Trust OHT office, which was situated within a MH inpatient unit. The MH unit was self-contained premises but within the site of Eastbrook general NHS hospital building. The PMHT arrangements in Eastbrook resembled those of Northfield, in that it is the same model of operation and had PMHT as a duty, rather than a separate clinical team. The MH workers in Eastbrook did not all work in the same OHT, with some staff coming from wards, community services and elsewhere in the Eastbrook NHS Trust to undertake PMHT duty. Although Eastbrook first implemented a model of PMHT in 2014, the arrangements in place at the time the fieldwork was undertaken, were operating on a trial basis. At the time the fieldwork in Eastbrook took place, the arrangements had been in place for nearly three months and partners were seeking an extension for a further three months.

Prior to the trial arrangements, there had been significant changes in terms of provision from when PMHT was first implemented here in 2014. In part, these changes can be attributed to an internal evaluation conducted by the Eastbrook NHS Trust. The first pilot operated for 24 months beginning in 2014, but Eastbrook was excluded from the pilot for the second year. This pilot was initially proposed in response to the CCC and due to what the Trust identified as limited access to effective MH crisis provision outside ‘normal’ office hours in this area, and the impact this was having on Northfield Constabulary and the communities it served. The initial operating hours were 6 pm to 2 am seven days a week and covered a much larger geographical area than was the case at the time of the research. This was due to Eastbrook NHS Trust covering three main areas, and Northfield Constabulary covering two of those. The initial pilot, therefore, consisted of a standard police patrol car, staffed by one PC and one MH worker (the same as the at the time of the research model of operation), but spanned two geographical areas rather than the one that it operated in at the time of the research. The original pilot was funded by three health partners and the police. Figures for the police are unknown, but health estimated a cost of £120,000 split equally between partners for the duration of the pilot.

* + 1. *Hilltop*

Unlike the other two sites, Hilltop was a county with a population of over 750,000 people and was a place of geographical and social contrasts. It had a number of heavily built-up areas and large, sparsely populated rural areas. It was estimated that 27% of the population lived in very rural areas. This model differed in that it was the county-wide provision, by way of a 24/7 phoneline and police control room model. Within the police control room, there was what was referred to locally as the MH ‘hub’. The hub operated within the police control room vicinity but was located in an adjoining office to the main control room. Whilst the main control room was large in size, with many rows of police dispatcher desks situated on two sides of the open plan office-type room, the hub resembled a small meeting or classroom, which was accessed via a door from the main police control room. The Hub had been in operation for eighteen months and was in the process of establishing a health-only response to incidents by way of an ambulance.

When a call arrived at the control room and dispatchers identified there may be a MH element to the call (either in part or whole), the dispatcher would ‘link’ the Hub worker into the call to provide any additional information from the persons MH medical record, if they had one. Health and Social care staff had been specially recruited to work in the Hub, and the process of recruiting paramedics was also underway, at the time of the research.

* 1. Phase-one data collection (Quantitative)
     1. *Service User (SU) questionnaire*

To help understand PMHT from the perspectives of people with lived experience of the partnerships (in a SU capacity), questionnaires were sent to individuals in Northfield, who in 2016 had a ‘*Police Street Triage*’ incident recorded in their MH medical record. The questionnaire was distributed by Northfield’s third-party mailer in August 2018. Self-administered questionnaires are one of the main instruments for gathering data using a survey design (Bryman, 2016:220). Gray (2018) described them as a research tool whereby people are asked to respond to the same set of questions in a pre-determined order. Their popularity generally stems from some of the inherent advantages they carry, such as the potential to generate a quick inflow of data; the level of convenience afforded to the respondent (e.g., completion at a suitable time); the straightforward analysis of closed questions; their anonymity for participants; and the lack of interviewer bias (Gillham, 2007).

Whilst qualitative data methods have been identified as the *priority* decision in this research, the quantitative method came first in the *sequence* decision (Hessie-Bieber, 2010:65-66). The questionnaire was deployed first to primarily cast a recruitment net, with the goal of identifying the specific population of interest that would otherwise be hard to reach (purposive sampling). The population of interest here was people with lived experience of a PMHT partnership. Such participants may be considered ‘hard to reach’ because unless the person was explicitly told at the time of the contact, and additionally comprehended the fact that they were being seen by PMHT, it may be unlikely that they would know or could recollect what PMHT is. Thus, rather than put the onus on the SU to identify if they were seen by PMHT, the questionnaire allowed for direct access to this group of people.

An alternative to the questionnaire was considered, which would have involved asking NHS community MH staff to identify if any of the SUs on their caseload had a recorded triage incident and then offering them the details of the study. However, given that at the time of the research the NHS research ethics system reinforced the gatekeeping role of front-line staff, this may have worked to bias samples in favour of ‘amenable’ SUs and exclude others from having their views and experiences represented (Allbut and Masters, 2010). The survey and the acceptability of recruitment methods were discussed at a SU network group held by the host site for the project, and feedback also suggested that the survey was preferable to alternative recruitment strategies discussed. This group also piloted the survey and suggested slight amendments to the wording of a statement, as well as highlighting where ambiguities may arise in the data due to the ability to interpret the survey statements in different ways, based on individual experiences.

The questionnaire applied the most widely used type of rating scale: the Likert Scale (Cummins & Gallone, 2000; Page-Bucci, 2003; Mathers et al., 2009; De Vaus, 2014;). The Likert Scale required individuals to decide on their level of agreement with 60 statements (see appendix 4). A 5-point scale was used, with answers ranging from “strongly agree” to “strongly disagree” (Page-Bucci, 2003). Due to the exploratory nature of the research, statements were broad and varied in nature. The SU questionnaire was used to collect data on perceptions of fairness and treatment; the appearance and practicalities of delivering PMHT; partnership working; distinctions between different types of staff within the PMHT team; the role of the police in MH crisis care more generally; the purposes of PMHT; and risk management procedures.

At the end of each section, there was a box for additional open-ended comments. All respondents provided further information in these boxes to expand upon why they had provided a particular response to a statement. At the end of the questionnaire, there was also a larger space for any additional information the respondent would like to include. Again, this was used widely by all respondents and assisted in the analysis of the quantitative data. In addition to the questionnaire data gathered, recipients were able to give permission for the researcher to contact them on the details they provided (if provided), to be invited for an interview at a later date.

* + 1. *Identification of Eligible Recipients*

The Information Governance Manager at the NHS Trust identified the eligible participants through an electronic search of their patient recording system. As Table 4.2 shows, in 2016, there were 704 ‘Police Street Triage’ incidents recorded by MH workers from the OOT.

**Table 4.2: Number of Recorded ‘Police Street Triage’ Incidents in Northfield**

|  |  |
| --- | --- |
| **Year** | **N** |
| 2014 | 392 |
| 2015 | 660 |
| 2016 | 704 |
| 2017 | 795 |
| 2018/19\* | 1004 |

Notes. N = number of recorded ST incidents; \*2018 through to February 2019

Despite there being a total of 704 incidents recorded in 2016, there were only **347** eligible participants to receive the questionnaire. This lower figure takes account of multiple incidents involving the same person throughout that year. The search also eliminated people who were now either deceased or whose records had indicated there was no recorded last known address for the person. All 347 eligible participants from this mailing list were sent a questionnaire pack containing a letter of invitation; a participant information sheet; the questionnaire; and a prepaid envelope for return. This recruitment pack was posted to participants on behalf of the researcher by Northfield NHS Trust using their third-party mailer so that the personal information of those seen by the PMHT team was not shared with the researcher. In addition, the questionnaire was also distributed by the local SU network email list to all members with the option to reply via email.

Though the limitations of the survey are discussed in Chapter Nine, it is noted here how the eligibility of the 347 people sent a survey is disputed due to Northfield’s recording system. It is also recognised more broadly here, that one of the most damaging limitations is that surveys by postal questionnaire typically result in lower response rates than comparable interview-based studies (Baruch and Holtom, 2008; Bryman, 2012). With postal questionnaires, it is also naturally the case that some people who are in the sample will refuse to participate, and with the added uncertainties of eligibility in the current study, the actual response rate can only be estimated.

Of the 347 participants who were sent the questionnaire, 25 returned it, 22 of which were completed and able to be used in the analysis. Had all 347 participants been eligible, this would equate to a **6.3% response rate.** Had a hypothetical 100 of the 347 had direct contact with the team (either in person or over the telephone), this would equate to a 29% response rate which is much more aligned with similar studies involving MH patients (CQC, 2018). All returned questionnaires were from the NHS postal survey and no responses were received from requests to participate in the survey sent to the SU network.

The questionnaire was not administered in the remaining two sites, due to the high third-party mailing costs. Despite acknowledging potential shortfalls of the questionnaire, at the time of the research, no other evidence existed that reports the views of people with lived experience of PMHT in this capacity. Consequently, the significance of the questionnaire data should not be dismissed. The returned questionnaires offered valuable insights into the perspectives of those with lived experience of not only PMHT, but their experiences of crisis care more broadly. Given all survey respondents stated that this was the first time they had ever been asked about their experiences of PMHT, their perspectives were even more vital, regardless of their generalisability. The results of the questionnaire also informed the development of the interview schedules, highlighting issues that could be addressed in the follow-up qualitative study. Finally, conducting the quantitative study first created options for enhancing the validity and reliability of the qualitative findings, as well as for exploring contradictory results found between the quantitative and qualitative studies and between different types of participants in the research.

* + 1. *Ethical considerations*

In order to identify recipients and distribute the questionnaire, access was required to confidential patient data which is strictly regulated by the NHS Act 2006 s.251. An application was made to the NHS CAG Panel under Regulation 5 of the Health Service Regulations 2002 to process patient identifiable information without consent, for the purpose of this research. This was approved on 02/03/18 for a period of six months, with the survey identification/distribution concluding in June 2018.

Consideration was given to the amount of time that should have elapsed before contacting potential participants for involvement in this research. It was anticipated that SU participants may have been potentially vulnerable, in the sense that they had on at least one occasion experienced mental ill-health, however, the questionnaire was sent retrospectively, and consent was not being sought at any point from participants who identified as being in immediate MH crisis or who lacked capacity. In addition, they were afforded protection by the rigorous regulatory framework guiding this study. The year 2016 was chosen so that only people with lived experience of PMHT over twelve months from the start of the data collection period were contacted.

The rationale behind the questionnaire was that the recipient was under no obligation to do anything with it upon receipt (Gillham, 2007). As with any questionnaire, the sender is unable to predict the individual circumstances of the receiver at the time of receipt (e.g., if they were experiencing a subsequent crisis) and there could have been many factors that influenced their decision whether to take part (Bryman, 2018). The questionnaire was designed with both open and closed questions and so it gave recipients the opportunity to only include the information they wanted to share. It was clear on the information sheet that participation was voluntary, and participants should feel no obligation to complete any aspect of the questionnaire that they did not feel comfortable with.

The questionnaire also guaranteed anonymity (Gillham, 2007; Bryman, 2018). Although it provided the opportunity for participants to leave their details if they were interested in taking part in a follow-up interview, it was anticipated that some participants may have felt comfortable providing written responses but would not feel comfortable speaking with a researcher or identifying themselves to anyone in person. The methods in this research, therefore, considered varying perspectives that people may have and sought to prevent harm by leaving the choice to participate and indeed their level of participation up to the recipient of the questionnaire. In order to further safeguard participants, for postal questionnaires, the invitation to participate and participant information sheet also contained information on what to do if receiving the questionnaire had affected them at all.

* 1. Phase-two data collection (qualitative)
     1. *Observation*

The concepts of ‘(pure) observation’; ‘participant observation’; and ‘ethnography’ are terms often used interchangeably (Baker, 2006), yet are very much distinct concepts. Ethnography has become a favoured descriptor for studies involving any aspects of observation and informal interview methods because, in practice, researchers undertaking this approach do more than simply observe (Bryman, 2012). A traditional ethnography is generally characterised by deep immersion and thick description, and whilst there were elements of this, the current study was not intended to be a traditional ethnography. Instead, it adopted an ethnographic approach to exploring the processes and mechanisms of PMHT. An ethnographic style and design can thus be categorised 1) by its objectives, which are to understand the social meanings and activities of people in a given setting, and 2) by its approach, which involves close association and/or participation with this setting (Brewer, 2000). The purpose of this approach was to be able to utilise the interviews and observation techniques to provide a fairly complete picture of a particular group, setting, or institution (Weitzer, 2017), namely PMHT.

The study employed observation but drew upon principles of ethnography e.g., immersion when examining the cultural aspects of the social setting. This provided a useful means of studying PMHT from the perspective of both the police and the policed, here in the context of MH. As policing is reformed, transformed, debated, and challenged in the twenty-first century, ethnography is able to facilitate the exploration of a world that still requires close, in-depth examination (Jackson, 2020). Observing the operation of PMHT partnerships was thus deemed key to addressing the central research objective, as ethnographic approaches have proven unparalleled for understanding the internal workings of the police organisation (Skolnick 1966, Bittner 1970, Westley 1970, Cain 1973, Rubinstein 1973, van Maanen 1973, Punch 1979, Holdaway 1983) and MH settings (Goffman 1968, Altschul 1969).

* + 1. *Observation hours and settings*

Whilst each research site varied due to factors such as those depicted in Table 4.1, opportunities were sought within each site to observe the fundamental elements of each PMHT partnership where they did not all occur in one place. Table 4.2 shows how the observation settings included the operating bases of PMHT (both NHS hospital premises and crisis team/MH out-of-hour provision offices); as a passenger within the PMHT police vehicle; the police control room (including a MH ‘hub’); and attendance at a series of multiagency meetings that were relevant to PMHT. Where PMHT duty ended at 12am, the researcher would often stay the remainder of the worker’s shift (until 2 am) to observe what happened when the duty had officially ended and this also proved a good time to ask questions of the practitioners, conduct interviews and debrief on the duty that had just ended.

Northfield was the first observation site, and soon into the process, it became evident that due to the amount of time staff spent in the operating base, the majority of observation hours would take place there. Even where observations were conducted through ‘ride-a-longs’, the researcher was meticulous about what actually needed to be observed to address the central aim of the thesis. It was not necessary, for instance, to at any point purposefully observe someone in crisis, given knowledge was not being sought about this (nor would this have been morally acceptable to the researcher). The focus remained on understanding the operational delivery of PMHT, which could be effectively achieved without the researcher being an extra presence at a crisis incident. SU accounts obtained later in phase two, by interview, were able to supplement the overall PMHT process, in a more ethically considered way. Unlike some of the seminal observational policing studies that involved anything from six to twelve plus months spent observing in the field, recent research can involve the researcher spending much less time in the research site (Holdaway, 1983; Hobbs, 1988; Innes, 2003; Fassin, 2013; Grey, 2018). Table 4.3 shows how a total of 214 hours of observation were untaken across the three sites, with the bulk of these hours (168) being undertaken at Northfield.

The observation in Northfield was conducted over a period of three months and included at least one shift with each member of the MH staff from the OHT (who also undertook PMHT duty). Both weekday and weekend shifts were observed, some partial and some in full. One full additional shift was observed in both Eastbrook and Northfield, though several other shifts were observed at these sites, in part, when the researcher attended the sites for other purposes e.g., meetings and interviews.

**Table 4.3: Number of observation hours conducted at each research site and setting.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Type of observation setting** | **Hours** | **Site Total Hours** |
| **Northfield** | Street Triage operating base (NHS out-of-hours/crisis team office) | 140 |  |
|  | Multi-agency meetings (held at NHS headquarters) | 4 | 168 |
|  | In the Street Triage vehicle | 24 |  |
| **Eastbrook** | Street Triage operating base (NHS hospital premises) | 10 |  |
|  | In the Street Triage vehicle | 10 | 20 |
| **Hilltop** | Police control room | 10 |  |
|  | MH ‘hub’ (MHPT room next to control room) | 10 | 24 |
|  | Multi-agency meetings (held at police headquarters) | 4 |  |
|  |  |  |  |
|  | Total observation hours |  | 214 |

The operating models adopted within Eastbrook and Hilltop meant more observation hours would have provided little added benefit when addressing the central research questions of this thesis. Instead, attention was given to ensuring that sufficient interview data could be collected. In Hilltop, the control room model of PMHT which had no frontline partnership element to it (in terms of people), meant one observation shift was sufficient to understand the technical infrastructure (the triage/information ‘tree’) that underpinned its operation, gather key information, and grasp its overall operation.

In Eastbrook, the co-response partnership that was being trialled during the fieldwork had been modelled upon Northfield’s co-response model, and so again, one full shift was also sufficient to determine that it was operating very similarly to Northfield and further observation there was unnecessary. The researcher was offered an open invitation to continue fieldwork in Northfield and Eastbrook (beyond the agreed timeframes) if she wished and ‘for as long as she wished’. The researcher considered the value of generating more observation hours and decided at this point in the observation she was not seeing anything new and had reached data ‘saturation’ (Fusch and Ness, 2015).

* + 1. *Going into the field*

Going into the field of study means introducing oneself continuously, saying why you are there and generating trust (Hammersley & Atkinson, 1983). Building rapport is important, as once established, the participants consider you as one of them, without actually being so, and thus someone who is not a threat to them. In a policing context, it has been described how considerable efforts are needed in fieldwork to break down perceptions of researchers by participants as ‘management spies’ (Reiner, 1991; Loftus, 2009). This was something encountered infrequently amongst PCs because the researcher would have appeared to them to ‘belong’ to the NHS organisation, given the researcher was on NHS premises and sat within the team. The researcher felt she was met on a couple of occasions with suspicion from both police and health practitioners about whether this project had the potential to disband the operation of PMHT. In responding to this, it was possible to take advantage of her student status and reassure staff that the purpose of the project was primarily one of her personal motivations, i.e., to receive a doctorate.

Where it was felt that suspicion existed, a conscious effort was made to offer the staff member a drink or accompany them on a cigarette break later in the shift. It was during these informal times that practitioners were able to get to know the researcher better and often they would ask questions about mature student life, with some expressing their own desires to return to higher education. Making use of informal breaks to break down trust barriers was not confined to easing suspicion, it was during these times that the researcher felt some of the frankest conversations occurred with practitioners. There seemed to be an ‘air of honesty’ when they walked down the stairs to exit the building, the researcher knowing that when a practitioner started to whisper as they left the office that they were willing to share something they didn’t want ‘on record’ or known within the office setting, and this ‘air of honesty’ swiftly closed again when they re-entered the office setting.

Goffman’s (1959) analysis of social life as a theatrical performance and the metaphorical ‘front and backstage’ analogy, offers a useful conceptual and metaphorical toolkit for making sense of the inconsistencies and interactions that may have occurred between the formal and informal aspects of organisations (Bacon, 2016: 78; Manning 1997, 2008). That said, the researcher did not feel frontline practitioners were on a ‘front stage’ at all during the observation period. The researcher was shocked at how little practitioners seemed to be bothered by her presence, how quickly she was welcomed to their backstage world, and how freely they spoke about issues one might consider controversial or at least thoughts that one might expect that staff would want to be contained within their team of confidants. This differed with middle management and above, where the researcher was seemingly not allowed ‘backstage’ at any point, at least until the opportunities arose for 1-1 conversations with staff at that level of the partnerships.

Waddington (1992:212) discussed the well-known observer effect in relation to this work. The researcher did reflect often during fieldwork upon whether what she was observing at the frontline was actually the backstage view at all (as it appeared), or whether the seemingly ‘warts and all’ appearance were in fact staff performing how they thought they should present, which in all honestly raised questions about whether this was actually as bad as it was appearing in many ways and for many reasons. At times, it seemed too difficult to comprehend that what the researcher was observing was anything other than a backstage view. Each time the reflections came to the same conclusion, that given the amount of time spent in the field at Northfield’s frontline, staff would be hard-pressed to perform on the frontstage for the number of hours spent with them, and indeed the informal conversations that took place on informal breaks were what staff may describe as being ‘backstage’ conversations, in that they were between them and the researcher and not for the ears of the whole team.

* + 1. *Becoming one of the team*

The researcher gave thought to her ‘impression or image management’ (Hobbs, 1988:6; Goffman, 1990) whilst in the field. There was nothing that distinctly identified the researcher from the NHS practitioners and given the plain clothed dress code was one of ‘smart casual’, the researcher seemingly blended into the observation setting in a way that may not have occurred had medical practitioners been wearing a uniform. Whilst in the offices, the researcher would take a laptop and set-up on the desk next to the PMHT worker and ensure she had something to be working on in the background. This was to avoid standing out from the rest of the office, minimise her presence and avoid putting pressure on staff to ‘entertain’ her. Eavesdropping became the researcher’s best friend, as she was able to blend seamlessly into the office setting, whilst being alert to what was happening around her.

The researcher rarely made written notes in the presence of practitioners but did use the note function on her phone to record important information verbatim, if possible. Field notes were written when she left the building, for example, to collect food. More often than not, the researcher had food with her and used the half hour away from the office to record as many of the mental notes she had made as possible. This was primarily because it felt awkward writing about people in their presence as if the researcher were actually a ‘management spy’ as discussed above. Whilst many of the ‘scribbled’ field notes would probably have been illegible to an outside eye anyway, they were essential to ensure key observation data were not forgotten. The observation notes were typed up coherently as soon as possible after a shift had ended, and where this was the following day, having the ‘scribbles’ helped.

From the outset and in line with the ethnographic approach taken, the researcher decided that the fieldwork would involve ‘observing, listening, formulating a few questions, engaging sometimes in mundane conversations and, ultimately, trying to comprehend what was going on’ (Fassin 2013: 24). Despite the researcher’s best efforts to adhere to the above, undoubtedly, as when any person is placed within a team with few staff for any prolonged period of time, it became increasingly difficult to stay passive the more accepting the team became of the researcher and the more she was treated like one of the team. For instance, staff had adopted her nickname and she entered the office one day to see this had been written on the staffing board, with one practitioner jovially explaining that they didn’t want her to feel left out. Although perhaps more cynically this was to do with alerting all staff to the visitor’s presence, it certainly did not feel so and had not been written there previously by management.

Whilst becoming ‘one of the team’ helped develop trust, it was also problematic for a few reasons (Rowe, 2005) and the researcher was also all too aware of the issues surrounding ‘going native’ (Jackson, 2020; Punch 1979; Loftus 2009). It used to be that if a researcher ‘went native,’ she was professionally doomed, assumed to have lost some necessary distance and objectivity and criticized for deluding herself that doing so was even possible (Turner 1993). In the current study, however, the researcher reflected upon the need to continue to develop the trust of practitioners, with her own morality, when this came into question.

On one shift, for instance, a practitioner asked the researcher if she could answer the phone if she was on another call and take details of the incident. The researcher was hesitant and explained that she could not really get involved with incidents and note-taking but understood the worker’s predicament and said she was prepared to take the name and number of the PC and explain that the worker would ring them back as soon as she was off the phone. The researcher did undertake that function on that occasion, which happened to be one of the busiest shifts observed for the OHT, but this was resolved later in the shift with the practitioner apologising for asking the researcher to help.

The second problematic issue with being treated as ‘one of the team’ was the extent to which the researcher was to be complicit in aspects of the occupational culture that was observed. In terms of policing research, there have been reflections on the challenges of being drawn into illegal activity as part of participant observations in relation to research with criminals (Hobbs 1988, Pearson 2012, Rowe, 2007), yet in the current research it was the not the police organisation raising such challenges. There was a fine line that had to be drawn (that the researcher never expected to have to draw) between maintaining the privileged position of having ‘backstage’ access to out-of-hours MH provision and maintaining personal integrity at all times. Whilst this was at times difficult, it was resolved to the best of the researcher’s ability by reflecting upon the different courses of action that could have been taken where such scenarios arose. These reflections were recorded and as such, there was a written record of why decisions were made at the time as advocated by Miller and Bell (2002: 67). The most consistent conclusion to these scenarios was that such instances highlighted why the research being undertaken was of vital importance. It was deemed positive that the researcher was able to remain in control of her own thought processes and conduct herself in a way that another person undertaking the same work may not have.

* + 1. *Interviews*

An interview is a verbal exchange in which the interviewer attempts to acquire information from and gain an understanding of another person, the interviewee (Gray, 2018). The interviewee may be invited to talk about their own attitudes, behaviours, beliefs, or experiences (Rowley, 2012). At the root of interviewing, is the intent to understand the lived experiences of other people, and the meaning they make of that experience (Steidman, 2013). Cohen and Manion (2011) point out that the interview can serve several purposes. First, it can be used as a means of gathering information about a person’s knowledge, values, preferences, and attitudes. Second, it can be used to test out a hypothesis. Third, it can be used in conjunction with other research techniques, such as surveys, to follow up on issues. This study employed interviews based on the first and third of these purposes. This research consisted of 64 interviews across the three sites, a breakdown of which can be seen in Table 4.4

Interviewing the frontline staff who work on PMHT could produce an understanding of the beliefs, attitudes, and feelings of staff, which was important, but it could also be seen as capturing only one piece of the puzzle (Massey, 2016: 61). Front line staff may be conducting the work, but they are often powerless in decisions about the allocation of resources, workloads, and joint-working (Massey, 2016: 62) and so it would have been problematic to focus only on these individuals in addressing the research objectives. For this reason, the researcher was keen to capture the perceptions of the people who do ultimately make the decisions about this work, including representatives from MP’s, the CoP, NHS MH Commissioners, Police and Crime Commissioners (PCCs) and strategic management in the police and health organisations.

**Table 4.4: Number of interviews conducted and interviewees.**

|  |  |
| --- | --- |
| **Role** | **Interviews**  ***N*** |
| Street Triage MH Worker | 12 |
| PCs undertaking Street Triage duty | 20 |
| Police Sergeant | 2 |
| Police Inspector | 1 |
| Force Strategic Lead for MH (Superintendent) | 1 |
| MH Force Co-ordinator (Civilian Role) | 1 |
| College of Policing Lead for MH | 1 |
| Police and Crime Commissioner | 2 |
| Shadow Policing Minister | 1 |
| Hilltop Paramedic | 2 |
| Police Control Room Dispatcher | 5 |
| Police Control Room Manager | 1 |
| MH SUs  Carers | 9  2 |
| MH NHS Commissioners (CCG) | 1 |
| Street Triage MH Manager | 1 |
| Founder of the first ST scheme | 1 |
| NHS MHA Manager | 1 |
| Total | 64 |

* + 1. *Interview Recruitment*

Unlike the survey, purposive sampling was adopted for interviews as the researcher did not seek to interview participants on a random basis (Bryman, 2018:408). Purposive sampling is related to the research purpose and the idea is that the research questions should indicate which ‘units’ need to be sampled. The term ‘unit’ here refers to the people who would be able to assist in addressing the research questions. A mixture of snowball and opportunity sampling was adopted for both practitioner and SU interviews. The decisions around whom to interview were largely based on individual knowledge of PMHT, such as people with direct knowledge of the schemes. SU interview recruitment is discussed further below, but all but one participant came from the survey respondents. One participant was recruited from the SU Network group, in response to an email. News releases were also published by the National SU Network and the Disability Network. The researcher also posted on sixteen available SU groups on social media in an attempt to recruit SUs from Eastbrook and Hilltop and this was shared on other social media platforms by people other than the researcher. As suspected, and depicted above, the most successful way of recruiting this hard-to-reach population, was through the survey.

For participants that fell under the group ‘other relevant people’, emails were sent directly to individuals from the organisations. The researcher was not expecting a response from the Shadow Policing Minister for instance but was of course overjoyed that she recognised the value of the research and was happy to participate. Police and Crime Commissioners, Health Commissioners and Strategic Management Practitioners were also recruited via direct email. Practitioners working on PMHT were recruited primarily on shift, where interviews often took part. Due to some PCs not basing themselves at the PMHT operating base, there was a disparity in police and health practitioner numbers. In an attempt to even this out, the researcher did on three occasions travel to the police station and recruit from there, successfully.

* + 1. *The interview*

A semi-structured interview style was favoured over structured, non-directive, focused, informal conversational or problem-centred interviews (Gray, 2018), however, there were elements of the latter five present in the interview style. The defining characteristic of a semi-structured interview is its flexible and fluid nature (Mason, 2002) which encourages and allows participants to provide an account of the values and experiences meaningful to them (Stephens, 2007:205). Adopting this interview style awarded the researcher flexibility in her questioning, whilst being aware of the key issues she wished to discuss. It meant the ordering of the questions could be changed and the interview flow could become directed by the interviewee, through probing and seeking expansion upon a previous response. The interview schedules (Appendix 5) consisted of ten carefully thought-out questions with sub-questions noted for probing. Although this may not seem many, Rowley (2012) recommended no more than 12 such questions, to allow the researcher to probe efficiently to ensure the key themes are covered in the interview.

As with many semi-structured interview techniques, it was necessary for the interview to improvise and develop new questions based on a respondent’s answer (Wengreaf, 2001). In improvisation, Arskey and Knight (1999) suggested varying the question order to fit the flow of the interview, varying the phrasing of the question to help the interview seem natural, letting the interview seem to go off track and building trust by putting something of the interviewer’s self into the interview. In the SU interviews, for example, the researcher did on occasion disclose that she too had shared experiences and part of the reason for this research was to give others a voice.

Elements of non-directive interviews were also present, in that the researcher was unsure what respondents would say and therefore she allowed respondents to talk freely around a subject area and would ask for clarification on something they had said to ensure accuracy in the interpretation. Like in a focused interview, the researcher could bring the interviewee back to the semi-structured questions if respondents drifted too far away from a theme and although semi-structured, the researcher favoured an informal conversational approach in her interviewing technique. This was to put the respondent at ease and allowed the researcher to intertwine the semi-structured questions in a conversational manner. The first question posed in the interview may be considered to adopt a problem-centred style, in that the researcher took an open approach to elicit stories and narrations that were structured by the interviewee (Scheibelhofer, 2008) and the researcher would then be able to decide which line of questioning to follow based upon aspects of their narrative. Reflections of the interview process can be found in Appendix 8.

* + 1. *Ethical considerations*

*Informed Consent*

For consent to be ethically *and* legally valid, participants must be capable of giving consent for themselves. All participants in the study were considered capable of providing consent according to the description of ‘capable person’ as defined by the NHS HRA guidance (2019). All participants were over the age of 18 and so no parental consent was required. Similarly, consent was not sought at any stage from participants who were known to lack mental capacity. Informed consent refers to the idea that research participants should be fully briefed about the research that they are participating in (Skinns et al, 2016: 186) such as ‘its purpose, methods, demands, risks, inconveniences, and its outcomes’ (Israel and Hay, 2012: 502). To ensure informed consent can be gained, participants should be given information about research funding, confidentiality, what would be required of them, and the right to withdraw without consequence (Skinns et al, 2016: 186). All participants were provided with a participant information sheet containing such information (Appendix 2). This was provided prior to the interview via email, as well as a hard copy provided in person at the interview which the researcher verbally discussed its content with the participant prior to commencing the interview. The researcher’s email address and that of her primary supervisor were also included, and participants were invited to contact the researcher if they required any further information or had any questions.

In addition to informed consent, consent should be given freely and voluntarily (Skinns et al, 2016: 187). Whilst this could be ascertained with ease for lived experience interviews due to people attending an agreed location of their own accord at a mutually convenient time, extra consideration was given to practitioner interviews due to the location and timing of the interview being at their place of employment during the course of their shift. Experience had shown that despite permission to interview staff being granted at the highest organisational levels, individual staff consent may be given reluctantly, or staff may not be particularly forthcoming (Norris, 1993:129). Fortunately, in this study, staff were very forthcoming, with several expressing their will due to it getting them out of the office for a while, with their manager’s permission. It was assumed after the process of verbally explaining the information sheet therefore, that if the participant agreed and stated they understood the nature of the research and signed the consent form to state as such, that informed consent had been obtained voluntarily, and the interview could commence.

For observing practitioners, according to HRA guidance (2019), individuals in this research setting were not deemed to be research participants and it was not possible to gain consent from each individual observed. In instances such as this, as per the HRA guidance, the rights and privacy were protected for those observed or otherwise involved in some way in any research activity for which it was not proposed to gain individual consent, by not recording any identifiable information about these individuals. Once access had been negotiated in each site, police and NHS PMHT managers distributed the information sheet to all staff via email prior to the researcher’s arrival. This informed them of the project and the reason for the researcher’s presence. Staff practitioners could have informed their management if they objected to my presence, but this did not arise. Fetterman (1989:134) maintained that ‘ethnographers must be candid about their task, explaining what they plan to study and how they plan to study it’ and this was the approach taken in this study. For observation of multi-agency meetings, the chair of the meeting circulated the information sheet to members, prior to the meeting. At the beginning of each meeting, the researcher verbally explained the research and her reason for her attendance. There were no objections from any practitioners about the researcher’s presence in either the operational delivery of PMHT or the multi-agency meetings.

*Potential Harms*

The term ‘harm’ can embrace a very wide range of issues, ranging from physical to mental and emotional harm (Gray, 2018:75). Research may be harmful, for example, if it causes a participant to be embarrassed, ridiculed, belittles or generally subject to mental distress (Sudman, 1998), or if it produces anxiety or stress to participants or produces negative emotional reactions. It was not expected that the processes in the research would cause harm to staff participants and no instances of harm occurring have been made known to the researcher. Should any police or MH practitioner participants have experienced distress because of involvement in this study, they would have been advised to contact their occupational health department or line manager in the first instance. If any distress became evident during interviews with staff participants, the researcher would have reminded staff participants that their participation was voluntary and that the interview could be terminated immediately. It was anticipated that staff participants would have a higher level of resilience than the average person to the potentially sensitive issue of MH crisis care due to their occupation and experience in the field. On this basis, the risk of harm or distress to staff participants arising from their participation in this study was deemed minimal.

In relation to people with lived experience of PMHT, additional precautions were taken to prevent harm or distress to these participants. It was anticipated that asking SUs about their experience of their MH crisis may prompt an emotive reaction. Naturally, their participation in the research may cause them to relive a difficult time in their life. Interview location was key in considering how best to minimise such risk, given the reported secondary traumatisation caused by individual experiences of NHS crisis care. Whilst NHS premises were available, a third-party MH support group venue was also sourced. For both sites, there was professional support available should it be required as there was at least one MH professional on both sites. Participants were given the option to bring another person to the interview with them, for instance, a family member or friend. The researcher acknowledged that different people may respond in different ways and was mindful that some people would find this beneficial. This option was provided both verbally on initial contact and on the information sheet, prior to attending the interview.

Upon contacting participants for the interview, the researcher conducted a preliminary screening exercise to ascertain the suitability of participants for interview. This included whether they had a GP or MH worker and whether they were under NHS Trust care at that time, or whether they might have identified as being in an immediate MH crisis. Aside from a circumstance where someone identified as being in an immediate MH crisis, this screening was not necessarily to exclude these participants but to instead make sure the researcher was aware of any potential vulnerabilities that required her to utilise any further mitigations from harm, based upon individual need.

Prior to interview, participants were informed that they should alert the researcher if they wished to stop at any time. If the researcher had believed the participant was experiencing any visible signs of harm or distress, the researcher would have terminated the interview. The information sheet also contained information about who to contact in a MH emergency, as well as the additional safeguard of their being a trained MH professional at each location. Participants were also advised both on the information sheet and in person, that should they suffer any harm or distress after the interview had finished, then they should contact their GP or MH worker in the first instance if they have one. There were no instances of visible harm or distress that occurred during interviews.

There was deemed to be a low risk of physical harm to the researcher throughout this study. The sites in which the researcher was based included NHS premises but were limited to the office and administration space and excluded hospital settings. Therefore, the researcher familiarised herself and adhered to the health and safety regulations in place for each site. Psychological harm to the researcher was deemed medium risk due to the potentially distressing nature of the research. To manage this risk, the researcher met with her supervision team at regular intervals during the entire study period, to ensure her welfare was protected. Maintaining regular supervision meetings was an opportunity for the researcher to reflect on the demands of the process in a confidential setting and raise any data collection issues that may have arisen. It also enabled the supervision team to continually monitor the researcher’s welfare and should either party have raised any concerns about this, the researcher would have been able to access professional support from The University of Sheffield Student Services Department.

*Confidentiality and Anonymity*

Anonymity refers ‘to the protection of the specific identities of individuals involved in the research process, whereas confidentiality refers to the promises not to pass to others, specific details pertaining to a person’s life’ (Hopkins, 2010: 62-63). All participants were informed that their participation in the research was confidential, and that all identifiable participant data would be anonymised. Research tools and materials had been marked ‘*confidential when complete’* (consent forms and returned surveys) and were stored in a locked cabinet in line with the Data Protection Act 1998 (study conducted pre-GDPR) and the relevant University of Sheffield policies. This office was located on the University of Sheffield premises and access to the room was by security code only. As soon as practicable after the event, interview audio files were transcribed verbatim, ensuring the removal of all identifiable data by assigning in-text pseudonyms before the deletion of audio files. Each transcript was then assigned a code e.g., Northfield Nurse 3. Due to there being a limited number of PMHT workers in each site (or only one role per organisation e.g., MHA Manager), anonymised data alone may have been insufficient to fully protect the identity of participants where their employers were known. As such, the identity of their respective participating organisations was also anonymised by way of the research site pseudonyms.

There were, however, three exceptions to this, in which maintaining complete anonymity was impracticable and so express permission was sought from the individuals by way of a consent form and verbal agreement (Tong, 2016: 114). The CoP Lead, the founder of the first ST scheme, and Shadow Policing Minister have all been identified by role only, due to their unique perspectives on PMHT. Some methodological and analytical approaches have been directly undermined by too stringent attempts to anonymise data (Hallenburg, 2003; Plummer, 2001; Elliot, 2005) and the researcher felt here that for the methodology to make sense, it was necessary to disclose these participating organisations whilst maintaining the individual’s anonymity.

* 1. Data Analysis
     1. *Triangulation*

Triangulation is described in the literature as an approach where the researcher uses either multiple methods, several theories, different data sources (in time and space) or different independent researchers in order to strengthen the study’s credibility (Denzin, 1978). The term triangulation in this section refers only to data triangulation, i.e., the point at which and strategy used to integrate two sets of methodologically distinct research findings. In other words, this means retrieving data from multiple sources and then comparing across the data sources (Miles and Huberman, 1984; Mathison, 1988; Ryen, 2012; Thagaard, 2013). The development of data triangulation within MMR has naturally strengthened over time (Caracelli, 1993; Fetters et al, 2013; Fielding, 2012) and broadly speaking, is understood to be a process which can occur at either the interpretation stage of the study (when both data sets have been analysed independently), or at the analysis stage of the study (both data sets are analysed concurrently). Here, both of these statements are true.

Phase-one data was initially analysed alone because this was used to develop the direction that phase-two could take. The phase-two data (qualitative) was triangulated at the analysis stage of the project. Once the phase-two data analysis was complete, the researcher then returned to the phase-one data and the phases were again triangulated at the interpretation stage. Using triangulation, researchers are said to have the opportunity of gaining a better and broader understanding of the phenomenon under investigation (Miles and Huberman, 1984: 235). This was certainly the case here, whereby phase-two data were able to contextualise that from phase-one, which otherwise may have appeared to suggest alternative findings from that stage.

* + 1. *Phase-one data analysis (quantitative)*

The data gathered by the survey were analysed via a process of examining the returned surveys for correctness and completeness, careful coding, inputting data into a database in (SPSS) and performing an analysis of descriptive responses where appropriate, according to frequency distributions and descriptive statistics. The frequency distributions were those of responses in each of the five categories (Strongly Disagree, Disagree, Agree, Strongly Agree, Not Sure) to see whether there were any high-frequency responses, indicating a very strong negative or positive response. Given the low number of returned surveys, there were few statements which demonstrated such. Given the lack of any high-frequency responses to ‘strongly agree’ and ‘strongly disagree’ and the low number of returned questionnaires, responses ‘Strongly Agree’ and ‘Agree’ responses were combined into one category and ‘Strongly Disagree’ and ‘Disagree’ as another. Presented in the summary tables throughout Chapter Eight, there are therefore three types of response - ‘Agree’; ‘Disagree’ or ‘Not sure’.

* + 1. *Phase-two data analysis (qualitative)*

In accordance with Braun and Clarke's (2006:6) 6-step approach, all qualitative data gathered during this research were analysed using thematic analysis. They define this process as ‘a method for identifying, analysing, and reporting patterns (themes) within data’. Boyatzis (1998) characterised thematic analysis, not as a specific method, but as a tool to use across different methods. This approach to data analysis was therefore suitable for the interview data, fieldnotes; qualitative survey comments; and the multi-agency meeting minutes.

Interview data had been transcribed verbatim by the researcher, which enhanced the familiarity process (Riessman, 1993) and meant the researcher could be aware of written sections where the transcription process would have otherwise created difficulties in capturing the spoken word in text form, due to sentence structure (Meadows and Dodendorf, 1999). The researcher then repeatedly read over interview transcripts to achieve data familiarisation prior to conducting line-by-line, part data part theory, driven coding of each transcript. Whilst the coding process was at the outset led by broad themes identified in the literature, noted by the researcher during interviews when listening to recordings or during the transcription process, subsequently, a data-led approach was applied to the transcripts and field notes.

* 1. Conclusion

This chapter has outlined the epistemological and ontological positions underpinning the research, along with the research method processes and analysis undertaken. Attention has been paid to each aspect of the data collection, namely observations; semi-structured interviews; and a SU postal questionnaire. In total, 214 hours of observation were undertaken, 64 interviews were completed, and the SU survey received 22 responses. The research process and overall approach to research utilised in the current project have been discussed. A mixed methods approach has been used to achieve the aims and objectives of the study, as it allowed for both breadth and depth of understanding to be achieved with regard to the relatively innovative phenomenon of PMHT. This chapter has thus provided reasoned discussion and justification for the data collection techniques employed and methods used to analyse and integrate the collected data and finally, has detailed some of the key practical and ethical issues encountered by the researcher while undertaking the research. Together with Chapters One and Two, this chapter has hopefully provided a foundation for the discussions which follow. The findings of the study outlined in Chapters Five to Seven of this thesis provide a detailed exploration of the implementation, purpose and delivery of PMHT partnerships, commonly referred to as ‘Street Triage’ schemes.

1. **CHAPTER FIVE**

**A portrait of challenging times and the emergence of PMHT partnerships**

* 1. Introduction

Four months after completing the fieldwork for this study, Boris Johnson was elected Prime Minister and in September 2019, the newly appointed Chancellor, Savid Javid, announced that the government had ‘*turned the page on austerity’* and outlined what he described was to be the fastest increase in spending for 15 years (BBC, 2019). Chapter Two provided a history of community MH service development and detailed the growth in the police-MH interface, against a neoliberal backdrop of conservative policies from 1979. The literature depicted how an extension of this ideology through the commencement of the austerity agenda in 2010, had further increased economic segregation and widely impacted police and MH service capability. Drawing upon interview data, field observations, and minutes from multi-agency meetings, this chapter presents key findings that serve to further contribute to this already extensive evidence base.

These findings are drawn from a critical point in time, in that they take account of the full impact of a decade of austerity, but prior to the coronavirus pandemic which took hold in the UK some six months later. The findings in this chapter speak primarily to the research aim of understanding the implementation and purpose of PMHT and provide a foundation upon which to be able to consider the more intricate nature of the PMHT partnerships themselves. It is necessary to dissect the inner workings of what crisis care actually looked like in practice, away from what it was purported to be according to the official ‘party line’. This chapter does so, in order to understand why despite a professedly functioning 24/7 system of MH crisis care, there was such high MH demand on the police, that necessitated PMHT. As shown prior, it was this demand on the police which was said to have created the need and/or desire for the creation of PMHT, and these findings provide the context to this. The latter part of the chapter moves beyond *why* PMHT partnership arrangements were implemented, and towards a detailed practical look at *how* this was done in practice.

* 1. Introducing the 24/7 system of crisis care: rhetoric vs reality

Despite it being reported in March 2020 that less than half of all NHS MH trusts were operating any form of 24/7 crisis care provision (NHS England, 2020), the research sites in this study fell within the ‘operating 24/7’ minority category and are thus deemed to be providing more extensive provision than in other parts of the UK. The research sites provided their 24/7 crisis provision primarily via single point of access (SPA) telephone numbers, which were publicised on their respective websites as offering 24/7 crisis support. To access the SPA number there was no referral necessary, and it was accessible to anyone directly in crisis, GPs, families/carers, PCs, social workers, housing/voluntary/charity sectors, or anyone else who had a reason to need access to a MH professional within their locality.

The quote below reflects the position of every frontline practitioner (police and health) interviewed, who unanimously indicated that the existence of a SPA telephone number alone was less than adequate 24/7 crisis care provision, despite ‘*ticking the box*’ to meet the national targets of providing such. The relevance and usefulness of this SPA provision were deemed questionable if there was ‘*little to no’* capability beyond an initial phone call to respond to MH crisis situations in the community setting.

‘…*my fear about the five-year review telling the NHS they should provide 24/7 crisis care is that MH trusts like mine will say, “well, we’ve got that already as we’ve got a SPA”. So, we’ve got somebody on the end of a phone line and that is your crisis response. That’s completely inadequate and again it illustrates that health services aren’t keeping up with the reality of what’s happening on the street and that’s not good. What I want to see is at 2 o’clock in the morning when PCs are called to a private address, when we’ve got no powers to control that scenario, when someone’s in crisis, is to be able to call out the MH team and get them the genuine professional response they need at that time*…. (PC 2, Eastbrook)

There was disillusion that research (including this study) or future reports detailing the failings of existing crisis care would ever be enough to generate positive change and ‘*fix it’* or ‘*do anything worthwhile’* i.e., extend the capability of crisis care provision to provide any community-based emergency intervention beyond the current SPA system. It was also repeatedly highlighted by MH practitioners how ‘*even getting to the point where we have a 24/7 phoneline’* appears to be hailed as a great success for community crisis care provision, leaving many questioning ‘*where is the rest of it?’* As the quote below reflects, this was founded upon the basis of ‘*we’ve heard it all before’* in relation to innovative reform or tangible future investment in crisis care provision.

*‘…I’ve been talking about this for years, and I’m still talking about the same stuff. There’s public documents and independent reports that fill my shelves, that come out every year or so, that are all saying the same thing. It’s not me saying it. It’s charities saying it, it’s independent bodies that are reviewing crisis care, making the same recommendations that were made 10-15 years ago. How many reports do we need before change actually happens? …’* (PC 1, Eastbrook)

The reason for their disillusionment was the identification that it would take significant monetary investment into MH crisis care specifically and to ‘*start over*’ with the existing operational models. Both these options were perceived as ideals rather than real possibilities. MH practitioners repeatedly reported they were ‘*doing what they could with what they had*’, which is a very different mentality to being able to work for a health service that could meet the needs of society.

What was considered previous major reforms to crisis provision were deemed by those who had been in employment long enough to remember them, as ‘*doing the wrong thing righter’*. The Crisis Resolution (CR) and Home Treatment teams (HT) introduced in 2000, for instance, were intended to provide short-term crisis support to people in the community, who would otherwise require hospital admission. Practitioners reported that these teams operated in their sites between 5-7 days a week during office hours (sometimes extended), at the time of the research. Access to these teams was not available outside of their standard operating hours in any research site, and even during operation, each CR/HT team had stringent eligibility criteria attached. This was another area where the rhetoric of available provision was shown to vary significantly from a system that provides 24/7 wraparound MH provision, with the reality of this in practice found to be inadequate in meeting the needs of those experiencing a MH crisis in the community setting. The quote below highlights this disparity, with the CCG upholding the ‘party line’ of their being tangible alternatives to hospital care available 24/7, thus serving as a justification for the closure of inpatient hospital beds and other configurative action discussed below, as a result of austerity constraints.

*‘…I think it’s so important that we recognise that somebody can absolutely be on an acute pathway of care and having the same interventions that are needed if you are physically in a hospital bed, whilst being at home with intensive treatment through a Home Treatment team and I think that’s what’s important. We’re not saying people aren’t on an acute pathway, it’s about not necessarily needing to be in a bed…’ –* (MH Commissioner, CCG, Northfield)

Indeed, there was widespread recognition amongst the MH workers that hospital should be, in all circumstances, an absolute last resort and admission to hospital did not align with the least restrictive working practices set out in the MHA Code of Practice (2015). Not one practitioner thus disagreed with the rationale of acute care pathways in the community. This, however, is a distinct issue to there not being enough resources, both for in-patient and community services, to feasibly achieve adequate community MH crisis care provision which would provide a hospital alternative and reduce police demand. The quote below reflects the widespread desire shown by health staff for attaining the ideals of a functioning and adequate community alternative to hospital:

*‘…we don’t want people carted off to A&E or custody, we need more staffed specialist units, we need more crisis houses, more hospital beds, we need more community interventions and treatment. If people need to be in hospital, it’s because there is no other option. Hospital should always be the last option, because let’s face it, they just contain people, that’s all they do, and keep people safe in that context. They don’t give them therapy, they don’t try and teach them anything, give them psych education…’* (MH Worker 8, Northfield)

The SPA was advertised respectively by each NHS research site webpage as a frontline NHS triage service, being able to make referrals, carry out assessments over the phone or face-to-face, to find out how they could help and then use that information to signpost them to a service who could best meet their needs.  A subsequent internet search found this to be a common descriptor of purpose for all NHS Trusts found to be operating a SPA system for accessing crisis provision. During working hours, the SPA was staffed by a duty MH nurse or social worker. Out of working hours is where you found the teams that most closely resembled that of the traditional CRTs. These were Eastbrook Crisis Team, Hilltop Crisis Resolution Team, and Northfield Out-of-hours Team.

Whilst on the surface it, therefore, may have appeared that the level of provision a person in crisis received depended on whether they were experiencing a crisis in or outside of working hours, this was true only to the extent that in working hours the SPA worker had a wider pool of professionals and services they could ‘signpost to’. Most frequently this was observed to be the caller’s designated MH worker, if they were already known to services, or their GP if not. It did not mean that if a person experienced a crisis during working hours that they would have enhanced access to specialised or different services which accepted instantaneous referrals from the SPA only, because like all other services operating within each of the research sites, these were accompanied by waiting lists or as was the case with CR/HT, a criterion which included that the person would otherwise need to be admitted to hospital.

Like the other sites, Northfield had previously been called Northfield Crisis Team, before changing to the ‘Out-of-hours Team’ (OHT) as part of a whole service reconfiguration. All sites had undergone various forms of service reconfiguration in the decade prior to the research, the most recent of which was Northfield which had been in place less than 4 months at the time of the research. Eastbrook was actively undergoing another reconfiguration at the time of research. The purpose of these reconfigurations was cited in multi-agency meeting notes as part of the process of continuously reviewing services to ‘provide better care to meet the needs of the local population’. The reality, as reported by frontline practitioners, was that such reconfigurations were perceived as ‘*no more than a money-saving exercise’*, ‘*another way to close services and beds*’ or as another health worker put it, ‘to *put us further up shit creek than we already are if that’s even possible’*.

As part of Northfield’s latest service reconfiguration, there was now a period of cross-over between the frontline day and night community MH staff, aiming to enable better communication between in and out of working hour practitioners. This was perceived as a positive aspect of the reconfiguration, as reported by staff, though other negatively perceived aspects of the reconfiguration were centralising the various community MH teams, selling off the estate, and dispersing some of the existing MH outreach teams who had previously offered a preventative service. The ‘ideals’ are reflected in the quote below from the CCG, who generally reported the whole restructuring of out-of-hours crisis provision as a positive process.

‘…*from a primary care perspective, if a GP rings at 6 pm there is capacity and an appropriate facility for the crisis teams to respond and to internally hand over so it’s not a cold cut off for any one team saying we are the day team here until 6 pm and the crisis team deal with anything after. I think that’s been a really important reconfiguration and restructure*…’ (Northfield MH Commissioner, CCG)

The broad findings reported in this introductory section have highlighted the perception that reconfigurations to community services were a far cry from the drastic monetary investment and actual radical overhaul which respondents felt would be required to operate a ‘*true*’ system of 24/7 crisis. There was a very observable disparity between the rhetoric and the reality of organisational responses to the austerity constraints placed upon them. The remainder of this chapter uses the empirical findings to add depth to the issues reported thus far and includes the chronic understaffing of out-of-hours crisis provision, difficulties in access to s.136 provision, and the availability of inpatient facilities when needed.

* 1. Three is the magic number (unless it’s for staffing allocation)

As reported above, the ‘crisis teams’ (an umbrella term used to encompass each of the old CRTs) and other services designed to provide alternatives to hospital care, such as HT, operated in a silo as individual teams. Within working hours there was a greater opportunity for more direct and faster communication between teams, such as phone calls and email responses. Out of working hours, the crisis teams were reliant upon email correspondence which had a slower response time due to parties working alternate hours.

The reality of staffing for all out-of-hours community provision was found to be a very small team of frontline individuals. The highest number of people observed to be working at any one time in any of the research sites’ out-of-hour MH provision, was four. Most consistently, however, this was three, made up of one or two Approved MH Professionals (AMHPs) from the community AMHP team who worked a mixture of days and nights and a mixture of other MH workers. This team operated 24/7, again indicative of the ideal that each site offered 24/7 crisis care, but in the main, the AMHP team were a functioning daytime service as the majority of the team worked within office hours. During the day there were marginally more staff to cover the geographical area of the Trust. The other one or two members of out-of-hours MH staffing came from a total pool of between 10 and 12 people (site dependent), though in Northfield the four people were made up from different designated teams e.g., 1x AMHP, 1x Hospital Liaison worker, 2x CT workers. In Eastbrook and Hilltop, out-of-hour provision differed in that there was one team for the entire out-of-hours provision, and this included AMHP’s employed for the purposes of fulfilling all roles and responsibilities required out of working hours for the Trust’s whole geographical area. As the quote below reflects, the out-of-hours team in those sites were also responsible for MH assessments in police custody.

*‘…on an out-of-hours basis the AMHP role comes from the crisis team, so we have taken on a multi-function role. Up until a month ago we were the hospital liaison team [see below], the community crisis team and also the AMHP service …We’ve had a separate custody team for about 15 years, but it was a very small team of 2 workers Mon-Fri 9-5, so yes, we’ve always been the custody team as well and still are out-of-hours…’* (MH Worker 3, Eastbrook)

Another national target set out in the NHS Five Year Forward View (2014), was that 70% of all acute hospital settings would provide MH liaison services staffed to key commissioning standards by 2023/2024. All sites in this study had implemented MH hospital liaison, but to varying degrees and each again had a criterion attached to it. For instance, in all sites a person could only access this team if they were referred by the general hospital, meaning even if a person self-presented in A&E they would not necessarily be seen by the MH practitioners from that team. The implementation of these services was reported by staff to alleviate some of the demand stemming from their out-of-hours role within A&E, though others reported that there was no ‘*new team, it’s just with a different name’*. It was observed in Eastbrook, for instance, that the MH practitioner (an AMHP) identified to be working within the hospital liaison team, was also the same person conducting MHA assessments within the community, and police custody for a whole police district area.

The reality around the position of out-of-hours MH provision after observing the sheer volume of work and responsibilities that such a small number of people were tasked with undertaking on behalf of large geographical locations during one 10–12-hour shift was bewildering. There was widespread acceptance and understanding from staff that viewed the system as ‘*normal*’ and ‘*that’s just the job if you choose to work out-of-hours*. The lack of parity with physical health was stark. No A&E department, for example, would have less than four physical health care professionals on duty after 6 pm to cover the same geographical areas as the sites in this research. The fieldnote below reflects many of the conversations had with practitioners about how staffing out-of-hour provision has always been perceived as problematic, but austerity has pushed this to breaking point through the local reconfigurations that had occurred sporadically, across all research sites since 2010.

‘…*Just spoken with an AMHP about what provision is available out-of-hours and where he fits in to that. He described it as “abysmal”. He tells me he has been a MH worker for over thirty years and never has his role been so stretched due to the new teams and functions but with no staff to fulfil them. He feels he alone fulfils three of those teams off the top of his head…’* (Fieldnote, Eastbrook)

The lack of available staff out-of-hours was also recognised by PCs, who expressed frustration at being the de-facto response to MH crises in the community. This was not because they indicated they did not wish to attend MH incidents, but because, for most, they perceived that they were only doing so because of a failure to plan and invest in MH services. The quote below was reflective of many accounts given by PCs at all levels of the organisation, who expressed concern or thought it was ‘*barbaric*’ that in 2018/19, there was no functioning emergency MH service to respond to MH crises that occurred outside of standard working hours.

‘…*If you have a crisis team and you’ve only got one nurse on duty, I mean first of all why have you only got one nurse on duty? If you [NHS] can accept part of your role as a healthcare provider is that you’re running a crisis team that might need some more people at an unpredictable time, it’s pretty reasonable to think somebody is going to ring tonight that needs crisis support and if that is going to be a visit to a house then how are you ever going to do that if you have one nurse on duty? You’re almost planning to fail to meet demand by only having one nurse on duty because that immediately means you have to find demand from elsewhere to cover your back, which means you advise the caller to get to A&E and if they refuse you either ring an ambulance or the police*...’ (PC, seconded to the CoP)

The words from the officer above neatly conclude the issue of staffing, which is ultimately linked to financing. It is entirely foreseeable, knowing what is known, that there will always be a need for out-of-hours MH crisis care provision. With all the best intentions of developing teams and services that could have the capability to operate in emergency settings out-of-hours, but with so few people to fulfil them, this research paints a bleak picture of the ‘black hole’ in out-of-hours MH service provision and helps to contextualise the resulting dependence on newer initiatives like PMHT partnerships. Whilst all sites in this research could on paper be hailed as providing 24/7 crisis care provision, the reality was found to be a fragmented and understaffed offering of too few people filling multiple roles.

* 1. The ‘old’ Crisis Resolution Teams (CRTs)

As reported above, the CRTs (including HTs) were operating primarily a daytime service, and it was observed and reported how these teams during the day worked in separate silos, with both undertaking different roles, offering different levels of provision, and fulfilling different functions. Already this chapter has started to paint a picture of what the existing MH crisis provision landscape was, and why there remained a ‘gap’ to be filled by PCs, and thus a perceived need for PMHT. Returning to the idea of ‘wraparound’ MH crisis care and the fact all sites in this study would be categorised as being one of the NHS Trusts offering 27/4 crisis support, it was necessary to consider what the parameters of this support were out of these working hours.

Despite the SPA being in operation 24/7, the caller was not automatically put through to the team out-of-hours. They were greeted by an answering machine and asked to leave a message stating their name and date of birth. The staff then picked up the messages as and when they could and triaged them according to perceived need within a four-hour target period. This allowed them to check their systems prior to returning the person’s call. When asked about why this was the case, the answer was always that there would not be enough staff to answer the phone when calls came in and so it was easier to create a ‘working list’ of people to return calls to over the course of the night. They recognised this may take some time and was rarely instantaneous, and as the quote below reflects, the most commonly observed action from the SPA line was the health practitioner advising the person in crisis to ring a third-party charity line such as the Samaritans, Re-Think, or Mind (where these were in local operation).

*‘…The two staff on out-of-hours, their role is to either talk to somebody and deescalate it or to direct them to rethink 24-hour helpline for people who are distressed but not psychiatrically distressed, having a bad time or whatever, they’ll be picked up by them and supported in that sense*…’ (Eastbrook Head of Services)

This demonstrates how the 24/7 crisis care provision even in areas that had met the government benchmark, was in practice less than simply ensuring that the phone is answered when a person sought immediate help. Despite being the service with the supposed capability to offer 24/7 crisis support, the teams themselves did not view their role as having the capability to respond to MH ‘emergencies’ or indeed that forming a part of their fundamental role at all:

*‘…The thing is, the crisis team isn’t there to respond to a crisis, they are not an emergency service, they’ve got a 4-hour response time, that’s not an emergency response. If people need an emergency response, they should go to A&E like they would if they were critically ill. (*MH worker 5, Hilltop)

In addition to MH practitioners, PCs also recognised the shortfall in there being any ‘MH emergency’ response beyond a phone call, expressing concerns about the standard four-hour response time target for health workers to respond to a MH crisis. They frequently referred to what they imagined would happen if the police worked to the same time scales for MH calls, and overwhelmingly concluded it would lead to deaths:

*‘…If you’re wanting to kill yourself, a phone call in 4 hours probably isn’t going to cut it, and then where do you go from there? If you can’t get medical assistance when you’re in that state, it’s a resourcing issue and then people ring us or go to A&E...*’ (PC 4, Hilltop)

The expectation from the public around what the function of the crisis team is, versus the reality of provision and what it was capable of providing to people in crisis, was also talked about by staff extensively. Staff understood SU’s sense of frustration leading to an assumption that they as a team are ‘*inept*’ in their role, do not understand MH, or choose to do nothing to help and take such a ‘*refusal*’ personally. As the worker identifies below, this was particularly challenging when a person declares they have made plans to end their life:

*‘...A lot of people think the crisis team is a blue light service, they think well we’ll call them, and the crisis team will be able to come to you right away, when the reality is that usually it’s one person in an office trying to deal with the calls for the entirety of the city. It needs communicating to people. We get a lot of people who have suicidal thoughts and have plans to end their life, but I’m a human, albeit a trained one in MH, but I can’t solve that from the other end of the phone...’* (MH worker 4, Eastbrook)

The inability of out-of-hours crisis care to provide a real-time emergency MH response was seen across all sites, highlighting that this was not isolated to any one site. On the contrary, as highlighted above, many areas are not yet operating any form of out-of-hours crisis care provision. Most of the interviewees who discussed issues relating to resourcing, provided the same ‘solution’ as they saw it. This would be to staff an out-of-hours team in the same manner as a police station, effectively creating an emergency MH response team.

‘…*We need a well-staffed presence available to respond. I think actually going to see people rather than having to bring them to A&E, where you can see them in the community. I do feel that a double-headed assessment with another MH worker is best practice, shared decision making. We need to avoid the whole circus of bringing people to hospital to be able to see someone in the middle of the night. If there is a well-staffed fast response that would be a good way to go. Again with transport, ambulances should be used for serious paramedic responses and when we’re using ambulances to help the police with a 136 who’s not self-harmed in any way to take them from the side of a bridge to a 136 suite I just scratch my head and think we’re going crackers here it’s a bonkers decision when we clearly have ambulance waiting times for people who need an emergency care to get them to A&E very quickly*…’ (MH Worker 3, Eastbrook)

It became increasingly evident, even after the first observation shift undertaken in Northfield, that the police were the closest agency able to provide the emergency response that people so often sought necessary to keep them safe. The police were the team with the means to travel on blue lights and attend an emergency incident, with the means to secure transport for that person to hospital, albeit often this remained a police vehicle. Whilst it was observed and reported that rarely did each police shift have the full levels of intended staffing (due to sickness or staff shortages), there was still always at least double the number of PCs on one station night shift, as there were out-of-hours MH workers for the whole force district area.

* 1. Places of safety (PoS)

Chapter One reviewed the place of safety provision across E&W and showed whilst progress has been made, significant issues remain regarding availability, accessibility, and staffing. All sites had designated HBPOS referred to as the s.136 suites as set out in Chapter Four. Each s136 suite was based within existing MH inpatient provisions, some in standalone MH units or hospitals and some attached to MH wards in general hospitals. In those s.136 sites embedded within the existing MH units, each suite had a separate entrance/exit and the s136 suite was a standalone area which was clearly labelled outside as the s136 suite and existed as the designated place of safety to assess people who had been detained under s136 of the MHA.

To summarise the s.136 provision depicted in the previous chapter, Northfield had two available s136 beds in one suite and Eastbrook had one bed in one suite. Hilltop’s hub as a control room model covered the whole police force area, rather than specific districts in a police force area like Northfield and Eastbrook which were covered by the same police force area. Therefore, there were two designated s136 places of safety identified within the Hilltop area that could be accessed depending upon which district the officer was from, each with one bed. Despite Northfield and Eastbrook being different NHS Trusts, the location of the s136 suites meant that for some residents of Northfield, the Eastbrook suite was actually closer in distance to them than that of Northfield and vice versa. This caused frustration, because whilst officers from Northfield were required to take people to Northfield’s suite because it was their local, on many occasions this meant travelling much further than the nearest place of safety was to them geographically, thereby taking in some cases up to twice as long to travel to than it otherwise would:

*‘…It’s a major problem, it’s more of a problem here than it’s ever been. We monitor now where a person is being picked up because they should be taken to their local 136 suite. If they’re picked up in Northfield, then they should be taken to Northfield’s suite and so on. If that suite is full, then what happens is the police tend to go to the nearest available one which for Northfield is Eastbrook and Northfield is shut far more often than here. It is relying on the police to transport somebody across the city and up the motorway and how safe is that, so occasionally we do get people queuing in the car park but ideally, they should wait and be seen where they are, because what happens is our AMHPS and our doctors for Eastbrook are then assessing Northfield patients and they don’t know anything about them….’* (Head of Services, Eastbrook)

It is shown below, how a lack of available inpatient MH beds in Northfield meant an ‘*unfortunate*’ practice had developed, whereby staff had ‘*no option’* but to temporarily admit inpatients into the bed within the s.136 suite until they could source an inpatient bed within the main hospital wards (nationally). Where the s.136 suite was being used for this purpose, the suite was then ‘full’ for patients who may subsequently be detained under s.136 and require that place of safety, much to the frustration of surrounding areas. The quote below is reflective of this issue, though when put to the Commissioners, there was a denial that this practice could be happening but stated they would welcome this research upon completion.

*‘…It’s been an absolute disaster for about 9 months, although Northfield seem to have sorted their shit out a little bit now, but they have been absolutely appalling. Northfield had a practice of providing no s136 service to the point where the AMHP there would clock off, and I know this for a fact as I know the team, I was in the pub with them the other night. They would clock off duty and say call me if there’s a community assessment because our 136 suite is out of action due to either it been decided by the nurse on duty that the staffing was so low or that there’s been broken furniture or something, or more commonly, the fact the trust have shut down so many beds means they have just been admitting people into the 136 bed. It was every bloody day for months and months...’* (AMHP 1, Eastbrook)

It was never observed that there was ever any suggestion in Northfield that the AMHP had ‘clocked off’ and certainly did not appear to be common knowledge if this had ever been the case. I had been conducting fieldwork there the week the worker referred to. During my time there in the field, however, the AMHP was only ever seen at the start of the night shift as it was presumed the rest of the evening, they were out conducting assessments elsewhere. When the police had taken someone detained under s136 to a suite that was not their local one, staff at the receiving suite would regularly ring the local suite to establish why, and one of the key reasons given was there were no staff members available to physically open it:

*‘…I would then ring Northfield to ask why it is unavailable and for a long time it was because they couldn’t staff it. Well, we manage to staff ours even though ours is a stand-alone unit and theirs isn’t. Then it just became month after month that they would admit people into those beds. Those beds weren’t ringfenced basically, it was deemed to be an appropriate way to manage their resources and for us it seemed like a complete lack of respect for their own client group and certainly for the neighbouring authority, us. We ringfence our suite for a 136 service and then we end up being theirs. This means our suite is out of action for the people of Eastbrook. The situation is rotten to the core…everything about it stinks…’* (MH Worker 1, Eastbrook)

As reflected below, the lack of available staff to keep Northfield’s 136 suite open was recognised also by the MH staff in Northfield itself, with their frustration mirroring that of their colleagues in the surrounding areas:

‘…*I can see why surrounding areas get really pissed off with us, because we’re a big city and we should be able to operate two 136 beds*…’ (MH Worker 1, Northfield)

Whilst there was a lot of emphasis in Eastbrook about Northfields ability to keep their 136-suite open, the Head of Services at Eastbrook reported how their site too was often closed due to staffing:

*‘…Each individual 136 suite is not staffed individually because it’s not used all the time, so it pulls the staff off the units to support it. Then we have to meet safe staffing levels as well, so if were not able to meet safety staffing levels and open the 136 suite then we might have people up at the general hospital or 1-1 up there or if the seclusion suite is open or we have particular issues on the ward or we’ve got an under 18 in our care because they have to have a 1-1 all the time, if we really can’t open the unit and keep it open and safely staff the unit then we have an escalation process and only the director can decide that’s its closed*….’

In practice, it was observed to be the responsibility of PCs to locate a s.136 suite that was open and willing to accept the person they had detained. Officers reportedly found themselves ‘embroiled’ in what appeared to be a cat-and-mouse chase to find any available provision that was willing to accept them:

*‘…we often have issues with the 136 suites being full, but then when we go to a different suite, they say well they’re not full they’re understaffed, which I appreciate isn’t your problem it’s NHS funding. Same with everywhere, they’ve got no funding, got no staff, but then it adds to us a journey time of over an hour for a round journey etc., so that’s something to mention, sometimes with MH jobs an hour of PCs time is added to because we’ve got to travel to a 136 suite elsewhere in the county…’* (PC 4, Northfield)

The demographics of the sites chosen for this study have made it possible to understand how the issue of finding an adequate place of safety impacts upon the amount of time PCs spend with a person detained. Practitioner interviewees noted the knock-on effects of one site in a police force area not having access to their local place of safety, contributing to a lack of provision in each surrounding NHS Trust. The chain of attending the closest available ‘open’ suite would continue until it had gone full circle and the original suite was open again, or indeed there was no designated s136 place of safety open or available at all within a 120-minute radius.

Whilst the above has centred on the relationship between the provision in Northfield and Eastbrook in detail, again this was not an isolated issue to these sites, as Hilltop reported exactly the same issues with their surrounding areas. The incident recalled by the Hilltop PC below follows an account of when they had detained a man under s136 and had already waited over two hours at the side of a dual carriageway, with the man in the back of a caged police van [handcuffed due to him trying to self-harm], repeatedly telephoning the hub, and then driving around to find a 136 suite that would accept them:

*‘…I sat with him at the side of the road, trying to talk to him and keep him safe and calm whilst he’s in a cage. He then thought we were kidnapping him and trying to kill him. We were then told yep take him to suite 1, so we go, we just turn in and then they said we haven’t got anyone there you’ll have to take him to suite 2. Suite 1 said they’ve rung suite 2 and they’ll accept him. So, we’ve spun round gone there, which was another 40-minute trip, and when we get there there’s no one there. We buzzed the door, and a nurse lets us in. When we get inside the senior nurse comes down and says, “who’s let you in, you’re not allowed in here, get out”. Which they can’t do, can they? We’re now in a place of safety, we’ve taken him there and it had been agreed, but the nurse there said they haven’t been told and I said we had. They said they hadn’t got any staff, they said they’ve had to get people in on over time to man the suite so they could assess him. This nurse was shouting at us telling us to take him to custody. I said custody won’t agree that, so we won’t be taking him from there, he’s safe. We’re not going to take him back out of a hospital setting where invariably he’d end up in the end anyway, to put him back in a police van to travel all the way to the custody suite to be turned away from there as well….’* (PC 2, Hilltop)

Eventually, that situation was resolved when the officers took the return 40-minute journey with the detained man back to suite 1, where they had originally turned up 3 hours earlier. The assessment took place well over 12 hours after the man was originally detained and the man was subsequently admitted to a MH unit. The officer involved in this incident remarked he found it ‘*absolutely disgusting*’ and it would be hard not to echo his sentiments, given the likely effects that these kinds of circumstances would have on the individual in crisis. The instance provided above was not isolated, with such cases being observed over and over again during the fieldwork observation period.

* 1. Availability of inpatient beds: ‘*This is a problem everywhere, as simple as that’.*

Despite the evident commitment witnessed within all of the NHS sites in the study, to undertake the least restrictive practice and use the hospital as an absolute last resort, it was alluded to above that this issue is distinct from there actually being enough MH hospital beds or indeed nonhospital crisis house beds (the favoured option for many SUs) for those who do need them. The quote below is reflective of the tangible impact that the reconfigurations generated by austerity constraints were having not only on staff’s ‘good practice’, but also the potentially damning impact on SUs:

‘…*There’re just not enough beds, the pressures on the services are really high and I don’t think this reconfiguration has helped because people are slipping through the net, and by slipping through the net, they’ve reached crisis point without anyone being able to intervene. The other night there was a chap who had been detained in A&E for 16 hours in physical restraints and then had to be admitted into a ward, but to do that they had to change a seclusion room into a bedroom and admitted him into that. The wards are over [in terms of patient numbers] all the time now, they’re never not*…’ (MH Worker 1, Northfield)

The incident the worker described was not an isolated one, as there were many other occasions observed during fieldwork involving similar circumstances of people being detained in full restraints for long periods of time, often in obscure places. This was often the case when staff were informally admitting someone into the s.136 bed as alluded to above. When asked about it, staff jokingly told me to pretend ‘*you haven’t seen that’*, yet this became harder ‘not to see’ the more consistently it was observed. Health practitioners expressed their frustration at the challenges they faced in relation to securing an inpatient hospital bed for a person who needed it, as the quote below reflects:

*‘…I’m more surprised when there is a bed. I’ve been qualified 8 years and worked on the wards and in the community and only in the past 24 months or so has admitting people into 136 beds become a real norm…’* (MH worker 5, Northfield)

The practice of admitting a person into an unofficial holding bed, such as the s136 suite or seclusion rooms when in need of hospital admission had become a frequent practice. There is a case to be made, as a few workers stipulated, that ‘*if you create more beds, you fill more beds’*, as the era of institutionalisation showed. That said, inpatient availability is now so far removed from that period of mass incarceration, that it is difficult to justify further reductions in hospital provision without investment into the community crisis system. The admission criteria, or rather lack thereof, is a point which is returned in Chapter Six with regard to risk and decision-making processes.

In drawing to a close the first part of this chapter which has provided the context behind why PMHT was deemed a necessary addition to the crisis care landscape, it is hard to conclude anything other than there was simply no existing alternative to an emergency police response. The narratives from practitioners show how a series of austerity response measures had directly impacted their working practices and paints a bleak landscape for MH provision in England. The vast knowledge of both PCs and MH workers, some of whom had decades of experience in their profession, overwhelmingly supported prior research that highlighted the negative impact that a decade of austerity has had on an already historically, chronically underfunded area of NHS provision.

As depicted in Chapter Two, the devolved local CCC partnerships sought to implement the objectives of the national agreement at a local level. This had been done in the research sites through the bringing together of all relevant local services and organisations, in order to find a way to implement effective partnership working according to local needs. The CCC ‘local inspirations’ webpage showcases local responses to the national agreement, with PMHT being one such response identified in all research areas. The remainder of this chapter moves away from the narrative above that has demonstrated why PMHT was deemed necessary and moves towards the origins and implementation process of PMHT in each of the study sites. In considering the details of the implementation process below, a picture emerges of how the desire to work in partnership was viewed by each organisation as a way of enhancing their own ability to deliver services, easing the organisational and personal burdens felt in terms of demand, and the perception that they would ‘*get something positive out it’* for their respective organisation, the reality of which is considered further in the respective empirical chapters.

* 1. The origin of PMHT

The consistency of the organisation representation that was found to exist within PMHT partnerships through the multi-agency boards/groups at the middle management level and above (See Chapter Six), had been facilitated by the localised CCC action plans. These included the subsidiaries of the 27 national organisations that had signed the overarching governance structure of the national CCC in 2014 e.g., Northfield, Eastbrook and Hilltop NHS Trusts were the local subsidiaries of key national signatories such as NHS England, NHS Confederation, NHS providers, and NHS Clinical Commissioners. These local action plans were produced locally to translate the national concordat guidance into local practice (McPin Foundation, 2016), and the research has found that all sites had approached this through the establishment of varying multi-agency meetings that were found to exist.

By December 2014, eleven months after the national CCC was signed, local CCC partnership meetings had been established in all three sites. In addition to the police being key members of the CCC partnerships, the PCCs ‘Police and Crime Plans’ for both forces in this study, had since 2011 (when the Police Reform and Social Responsibility Act 2011 mandated their initial appointment), detailed MH as a strategic objective for their organisations. Northfield PMHT had run continuously, without reconfiguration since its initial inception in 2014. Recognising the importance of individual actors in the design and implementation of local partnerships is key to understanding how the partnerships emerged in each local area. The emergence of Northfield and Eastbrook PMHT followed the development of two similar schemes elsewhere in the country, but before the DHSC pilot had been announced and thus before ‘PMHT’ initiatives were widespread nationally.

Northfield’s AMHP Manager, Roy, was pivotal in setting up the scheme, referred to locally as ST. The decision to implement a PMHT initiative in this organisation was born out of the idea that agencies should work in partnership even before the local CCC plan had been agreed upon. He described the process of development as being ‘*literally written on the back of a fag packet’* during a conversation he’d had with a Sergeant from Northfield police during a s.136 encounter. At that time, he said there was ‘*a real buzz in the air between us and the police’* and how they [the NHS] *‘were getting some headway with some senior PCs’.* The reference to senior PCs was understood by Roy to be Sergeant and Inspector ranks, not senior management from the command team. Roy’s counterpart in the police, a Sergeant, who was the other pivotal individual in implementing the scheme has since retired and was not approached for participation in the study, although Roy talked about their shared enthusiasm and commitment to developing the partnership. This process was reflective of those in the other two sites, discussed below, where the onus on ‘*finding solutions’* was bought about locally through key individuals with a passion for ‘*making things happen’*.

Roy described the original vision for the scheme as *‘being quite a pragmatic one’* and that an officer and ‘*seasoned*’ nurse working together would be a dynamic way of working. Roy explained that a seasoned member of staff would be the equivalent of an experienced nurse, somebody who had ‘*been around the block a few times and wasn’t particularly grainy’*. When asked what Roy meant by ‘*grainy*’, he explained he meant someone with the confidence and ability to make decisions alone. The type of people he envisioned on the team were people who ‘*knew how to assess risk and not get too overwhelmed by demands’.* The ability to risk assess, manage demands and be able to work independently were therefore key considerations in the design of the partnership and the staff required to work within it. Roy’s vision for who would work on PMHT was reflected in practice some five years later, with the PMHT Manager explaining that he would not recruit newly qualified nurses:

*‘…everybody in the team is a band 6 nurse so that means that they have to be experienced at working with clients, so we would never expect a newly qualified nurse to put themselves in that position [crisis team or PMHT], and we don’t recruit newly qualified nurses to the team for that reason...’* (PMHT Manager, Northfield)

The Northfield scheme was first piloted using MH staff who volunteered for overtime, using ‘none recurring’ money. This meant Roy was able to use available funds from within the budget for out-of-hours provisions, to fund the extra hours for staff who wanted to volunteer to undertake the duty in addition to their existing roles. Roy described how ‘*it took off really quite well with people wanting to do it*’ and how ‘*it was seen as something exciting, something new*’, with Roy crediting the desire from staff to undertake PMHT duty as ‘*a change from their normal ground, you know, for use of a better word, from their work!’* The idea of a ‘new’ duty or role was therefore appealing to existing staff on the OHT.

Later, when PMHT formally began in Northfield, extra funding had been sought to pay for NHS staff overtime. In contrast, the PC role was never performed on an overtime basis, and the police therefore always ‘lost’ an officer and a vehicle from policing capability to PMHT duty (this was the same for Eastbrook). Given the impact of austerity on decreasing officer numbers in all forces at the time of the research, this suggests that both officers and middle management were invested in the partnership from the beginning, in spite of being an officer down on evening shifts when PMHT was also in operation.

The PCs who undertook frontline co-response PMHT duties were all of the ranks of ‘Police Constable’ and were attached to a police response team at a station within their district e.g., within Northfield there were four police stations that housed response teams and within Eastbrook, there were three. The assignment of the PC to a co-response PMHT duty was on a police district station rota system, whereby each police station would be responsible for providing an officer from the afternoon response team for the purpose of staffing the PMHT co-response and this varied on a weekly basis e.g., in Northfield this meant each station was responsible one week out of four, and in Eastbrook, this was one week out of three. Different stations had different ways of managing this process, in some stations, an officer was assigned or volunteered to do PMHT during the (on the day) afternoon police briefing, and in some stations, the Sergeant had already assigned an officer in advance and the officer thus knew they would be undertaking PMHT prior to attending for duty. The diverse nature of officers in any given response team by way of age, gender, years of service and experience was reflected in the officers who undertook PMHT duties. The least experienced officer encountered on a co-response duty had just left training school, and the most experienced officer was in the final month of service before retirement.

Many of the PCs who had volunteered for the duty (either during the day briefing or when the Sergeant was devising the officer rota) described personal motivations for doing so. Officers shared personal accounts of friends and family members they had lost to suicide, including in one case an officer on their own team and in another, an officer’s best friend from childhood. There were also accounts from officers about their own ongoing mental ill health, and that of others, which they felt made them ‘*better equipped’* to do the duty e.g., one officer explained how his brother had been in and out of inpatient facilities all of his adult life and because of that, he was extremely knowledgeable about MH and thought he would be a good addition to the team. Where officers had been assigned to the duty rather than proactively volunteered, there were also personal motivations, but of a broader pragmatic nature in terms of assisting the organisation to reduce their MH demand. The quote below reflects both types of motivations reported, that of a personal interest in mental ill-health and also the pragmatic perspective that undertaking the duty would help the police reduce MH demand.

‘…*All cops are interested in various things, some like traffic, some like burglary, but ever since I was a kid I’ve always been interested in psychiatry. We’ve all got this 2 ½ pound of porridge between our ears. What makes somebody Florence Nightingale and someone else Jack the Ripper? It’s that kind of thing that got me interested in it. Also, to try and help because MH is a massive, massive thing for the police and it takes up so much of our time. If this could help us and cut that time spent dealing with people, then I thought yes let’s go out there and do it. Somethings got to be done*…’ (PC1, Eastbrook)

For those officers who reported only pragmatic reasons for undertaking the duty, reference was also frequently made to the experience of SUs e.g., by referring to their perspective that they did not think it appropriate that a person in crisis received a police response only, and on that basis, they saw the value in them undertaking the duty. There was no reluctance expressed by officers on the basis of any perception that MH was not part of their role, to the contrary, every officer acknowledged and was accepting that it was a fundamental aspect. There was, however, reluctance about the extent to which it had become a core part of their role, and this reluctance was found to stem from a frustration that there was no alternative and thus on moral grounds, this ‘*was so, so, wrong in a supposedly functioning NHS and even society’*. The reluctance was thus not related to officer perceptions that mental ill-health was not ‘real’ police work, rather, that it was ‘*100% police work’* because there was no alternative in the community. Despite the frustrations reported around the underlying issues generating such demand, officers nonetheless expressed a widespread desire to contribute to PMHT initiatives on the pragmatic basis that there ‘*was a chance it might make things easier for us’*. The idea of PMHT initiatives was thus viewed positively by officers in the study, with the exception of those who had the experience of it not making this easier, returned to in the following chapters.

In Northfield, the PMHT health staff, which equates to two full-time members of staff have since been directly funded through the nursing budget, but officers remain seconded for the evening from their usual shift. Roy explained that providing the out-of-hours MH service requires twelve full-time members of staff and he now works on a model of fourteen, to ensure PMHT duty is staffed. Roy described how maintaining the budget to allow working on a model of fourteen had been challenging at times, and that he had needed to *‘keep battering the management, saying we need to provide this service’,* although he felt PMHT duty was now ‘*actually part of the establishment.’* In Northfield, PMHT had since remained a duty performed by those within the existing out-of-hours service and the Clinical Director of MH at the CCG echoed Roy’s account and support for its continuation:

*‘…It would be Roy and the team at Northfield on the ground demonstrating the benefits and what is the return on investment by analysing and feeding back data. Then within Northfield there’s a process to go through the Service Managers and then they would write a business case which goes to their Executive Management Group…we are not in the position, and we are very clear about this, like other parts of even our county, who have said they want to decommission it…’* [CCG, Northfield]

Despite the requirement for data, there had never been any detailed cost-benefit analysis on the scheme. Roy was, however, responsible for gathering how many incidents PMHT had dealt with, which had grown each year since its inception (Table 4.1). PMHT was initially piloted as a daytime not just night-time duty, but Roy explained how they could not operate 24/7 and the decision on operating times was a joint one with the police, based on what was considered peak demand for the MH services and on what worked well with the police shift system.

The introduction of PMHT in Eastbrook first occurred shortly after that in Northfield. During that time however, Northfield and Eastbrook, as part of the same police force, had a shared force MH lead and in Eastbrook, the officer in this role was credited as being part of the process of implementation for Eastbrook PMHT. In part, this may have been due to ensuring consistency across the force, with this MH lead trying to replicate the system designed and implemented by Roy and the Sergeant in Northfield.

Whilst observing in Northfield, staff referred to an Inspector from Eastbrook, called Andy, whom they credited with setting up a similar scheme there. My initial correspondence with Andy highlighted that he was unsure if PMHT was still in operation in Eastbrook, as he had not been involved since he had moved roles, but he was happy to talk about his role in setting up the scheme some four years before and what he knew of Eastbrook’s original PMHT scheme. Andy explained that the Chief Constable had given the force’s MH lead a paper from one of the two national founding partnerships, which detailed how one of those schemes had given an Approved MH Professional (AMHP) a police radio. The force’s MH lead delegated the responsibility for exploring the possibility of a similar partnership to Andy because, prior to joining the police, Andy had worked as a social worker. Andy explained:

*… ‘I got given the paper and was asked to see whether I thought we could do something similar, and so I did the lot. I looked at the original scheme, which had three [NHS] Trusts and was a cross border with a single vehicle, or two ideally with an AMHP deployable anywhere in the county. That would have been] impossible for us…*

This highlights again, the significance of the prominent individuals who became responsible for establishing the partnerships at the operational level and the localised nature of the design. Andy continued to explain that the use of s136 in Eastbrook was significantly higher than in Northfield and other surrounding areas, highlighting how reducing the use of s136 was a key consideration in this area. PMHT in Eastbrook and its surrounding neighbour Westlake ceased to operate in 2015 and there was no specific PMHT provision between the end of that partnership and the start of the new partnership that was operating at the time of the fieldwork. That is not to say, however, that there was no partnership working at all during this time. Jane, the ‘Out-of-hours’ and Hospital Liaisons Manager at Eastbrook NHS Trust, detailed how the ‘re-birth’ of Eastbrook PMHT in 2018 was a direct result of ongoing interactions with Northfield Police at the multi-agency meetings borne from the CCC, which included a monthly s136 meeting and a complex and serious case review meeting. She explained how the new scheme had come about from a conversation at one of these multi-agency meetings:

*‘…the Sergeant contacted me to say that every Christmas they try and look at getting an operation in place to look at the increased demand over Christmas and he named a couple of weeks when MH demand increases. He was looking at ways in which MH could get involved and support that. He said I don’t know what you think, maybe something like ST again, so that sort of started us thinking about it’…* (Out-of-hours Hospital Liaison Team Manager, Eastbrook)

In Eastbrook, the pilot was reliant on one-off and short-term funding, and the days of operation were dependent upon the police providing officers and a vehicle. The CCG had around that time, contacted Jane with an offer of some winter money to implement an initiative which would aim to reduce demand for mental services on A&E over Christmas. This provided the opportunity to operate a co-response model daily over the two weeks at Christmas. Over this time, Jane found it to be well received by both MH nursing staff and the police. Jane put forward a bid to the CCG for extending the funding and this enabled them to expand the scheme, with the idea that during this time Jane would be able to collect data to establish whether there was a business case for its continuation for an even longer period. During this short-term implementation of PMHT, the police specified Mondays and Thursdays would be the most beneficial days for its operation for them as they stated that whilst alcohol-related demand increased at the weekend, MH demand did not, and so the scheme has run for these two days since then.

Hilltop PMHT was originally implemented and funded as one of the thirteen DHSC PMHT pilot schemes in 2014 and had operated also as a co-response model. The pilot concluded in 2015 and the Hilltop PCC described how once the initial funding had ended, a series of strategic meetings occurred to discuss its future. Present at these meetings were the PCC, the NHS MH Commissioners from the CCG and Hilltop NHS Trust. The PCC described how during these meetings they wanted input from the wider concordat group for ongoing development talks, and so invited representatives from Hilltop Council as well. The PCC explained that the original model of PMHT was not cost-effective in Hilltop, as much advice was being given over the phone rather than on the street which meant they could not justify the loss of an officer and vehicle during every evening shift, when it was the health worker not officer giving the advice. No interviewees were certain of whether there had actually been any cost-benefit analysis done on the scheme after the pilot, although most said they were sure there would have been. The sentiment of value for money was echoed by Rachael, the PMHT Manager for Hilltop NHS Trust, who explained:

*…The initial pilot concluded that more advice was being given over the phone, so I think what they decided to do was pull everyone together, those in 111 who were only there over a weekend anyway and the people from triage to put it all together and it ended up being in the police control room at Hilltop Police HQ. From March 2017, I became full-time so in that period we lost a couple of nurses, purely because they weren’t having patient contact really at that time because of staffing levels and with them having no car it was a case of them being stuck in a control room here and they were just updating policing incidents really. I think there was then talk of Hilltop Ambulance Trust coming on board, but it took a good few months for that to happen, but from October 2018 that started a 6-month pilot. Hilltop Ambulance Trust were going to bring the vehicle, so we could offer face-to-face if we felt it necessary’…*

Hilltop Police recruited, Sally, a full-time civilian member of staff to become the lead for MH in the force at the start of 2018. The need and business case for recruiting a civilian member of staff to undertake this role on a full-time basis was put forth by an Inspector who had previously held MH within his management portfolio. The Inspector recognised that the role needed consistency as the high turnover in PCs undertaking the role meant that the force was unable to make meaningful progress in developing strong partnerships and meeting the forces strategic objectives in relation to managing MH demand.

Sally explained that in the decade prior to her recruitment, various Inspectors had undertaken the role of force lead for MH, but this had become problematic with the high turnover of staff who would move on after a couple of years due to changing teams, promotion, or retirement. This resembled the conversation with Andy from Eastbrook, who had been pivotal in the implementation of the partnership but four years later he was unaware if it was even still in operation. At the time of Sally’s recruitment, plans were well underway for trying to establish a new model of PMHT. The initial six-month pilot of the new MH triage ‘hub’, as it was commonly referred to, was funded jointly by NHS England as a Sustainability and Transformation Partnership (STP) and by the PCC. The contribution from Hilltop council was a staff member, but no additional funding from the council was sought. When Hilltop Ambulance Trust joined the partnership, it was agreed that the Hilltop PCC would fund their involvement for a further trial of six months, with the view to them jointly funding it afterwards if they continued with the partnership at the end of the pilot.

Despite Eastbrook’s scheme being the newest initiative running for the shortest time, it was Hilltop’s partnership which was still being developed and operating with much uncertainty, at the time of the research. The key difference and a plausible explanation for this, is that Hilltop were aiming to develop a fully commissioned service as opposed to a duty operating within an existing service, like that in Northfield and Eastbrook. The DHSC pilot schemes were funded for the pilot period as independent of existing services. The money was ringfenced and given only for the purposes of implementing and operating PMHT for a trial period. Without such money, it is unsurprising that establishing funding for innovative projects like PMHT was challenging in the economic climate, given that the public sector was in the midst of a decade-long period of austerity.

With regard to any future prospect of securing longer-term funding for PMHT, the likelihood of such was widely reported as being ‘*totally unknown’* and ‘*particularly problematic’* due to the *potential* benefits of PMHT not being quantifiable. In order to procure funding for PMHT, this was seen to depend on making a strong business case for it, which provided evidence of tangible and measurable outcomes. Though this was understood to be standard funding procedures, the prospect of there being any longevity to PMHT partnerships was questioned by nearly all interviewees in the study, regardless of role. As the quote below reflects, this was not only confined to local-level funding processes, with the Shadow Policing Minister also highlighting the problematic nature of producing a business case for something that is not easily quantified:

*‘... In policing, I wish there was some business cases and some more evidential assessment because we just seem to try things for the sake of trying them and things get piloted and things are either very successful and then they never happen again or they’re not very successful but we just keep on doing it because that’s the way we do things now, so there does need to be some more vigorous assessment and analysis of what works and that needs to be shared much better across police forces because it just feels like were reinventing the wheel over and over again which is why the assessment of the triage car scheme is really good and I’m really glad you’re doing that, but there’s so little of that in policing and it really is to all of our detriment...’* (Shadow Policing Minister)

This MP highlights an important issue about pilot schemes, in that with a partnership such as PMHT, some potential tangible long-term benefits can never be evaluated. It is only possible to assess where there is evidence already, for example, all SUs in this study spoke of their trauma arising from the response itself they had endured prior to PMHT, whether that be in a custody suite or hospital. It was possible for this research to speak to those people and report their experiences, but it is not possible to report in the same way about ‘prevented trauma’ for the future generations to come. At the time of the fieldwork, Roy remained the only founding partner still involved with the partnership out of all three sites.

* + 1. *Local identifiable aims and objectives of each partnership*

It was surprisingly difficult to locate anything formally written down about what each site sought to achieve by implementing a partnership arrangement, aside from more general aims and objectives set out in CCC action plans which focused on the broader aims of the CCC instead of the specific delivery of PMHT. In part, this may have been down to not having access to any potential recorded minutes from the meetings at the time sites were developing their PMHT partnerships. These were not publicly available and therefore I was reliant on the goodwill of relevant participants to share any earlier information that they still had floating around in their emails, which was scarce.

Eastbrook at the time of the fieldwork had a publicly available s136 policy but no separate formal policy document for their triage partnership. Hilltop Council had a joint formal policy with the NHS for the use of s136 and other aspects of the MHA, but these were only available to employees, as was the case in Northfield, again neither having separate policies or protocols relating directly to PMHT partnerships. The key variation between local s136 policies was that in Northfield the policy stated that although A&E is a legal place of safety, officers should not use it as such and instead make use of the s.136 suite. The end of 2017 saw the development of a county-wide MH Strategic Partnership Group, s.136 Policy Task & Finish Group which sought to streamline any prior local s136 policies in Northfield, Eastbrook and the surrounding areas within the county.

The purpose of the streamlining policy was to ensure agencies within a county-wide remit were not subject to individual practices, which were reportedly diverse. This document, in addition to the joint s.136 policy, set out the responsibilities of each agency, a s.136 risk assessment tool, a useful telephone numbers document, a s.136 outcome plan template, a s.136 monitoring form template, and dispute resolution numbers. In the event of any dispute arising, this document identified that the police contact would be the Duty Inspector 24/7 and for Health this would be the Duty AMHP Manager 24/7 in the individual district. In the absence of separate triage policies and processes, the identification of the aims and objectives of triage is reliant upon data gathered in interviews which are considered in the next chapter.

* 1. A day in the life of PMHT

Having set out the origins of PMHT partnerships in each of the sites, the purpose of this section is to introduce the reader to what a typical day in the life of PMHT looked like. Whilst the daily experiences of staff undertaking co-response PMHT duties were described as variable, there were common elements to their routines across both co-response sites. This descriptive section illustrates these, as well as highlighting any key local variations. On a typical day in Northfield and Eastbrook the MH workers would arrive at the PMHT operating base to start their shift shortly before the official start time to settle in, say hellos, and make a drink. At the start of a co-response shift, some MH workers rang the NHS switchboard to inform them that they were the designated PMHT worker for the evening, and most would then check emails and ascertain whether there were any jobs that were already awaiting a PMHT response. Co-location arrangements were not mandated for the co-response models and so if there was not a PC already in the building by this point, the MH worker would ring the police control room and find out which officer was undertaking PMHT duty that evening, and exchange direct telephone numbers. The officer had discretion as to whether they based themselves with the MH worker or remained at their station, however, contact was always made at the start of the shift. Due to the rota systems in both co-response model sites, it was unusual for the frontline PC to have ever met the worker assigned to PMHT duty prior to working together.

It was observed to be rare for there not to be staff available to undertake PMHT duty across all sites, although sometimes it took some time to locate the officer required for co-response models. For instance, on one occasion a team Sergeant had forgotten to assign a worker the day before and therefore no officer had agreed to report to the MH worker. More commonly, however, staff shortages occurred where there were unexpected resourcing issues on either side, such as sickness where cover had failed to be sought, or where officers had already been assigned elsewhere and notice to the MH team had been given in advance e.g., when there was a local football derby. The MH worker reporting for duty within the Hub in Hilltop would arrive in much the same way and follow the same administrative processes, although there was no handover to observe due to being in the police control room rather than a MH office setting. MH-related calls to the control room came in by:

1. A self-referral from the community, either from an individual in crisis or someone worried about them. This included someone known to the individual in crisis or a member of the public who was concerned about an unknown person they had encountered.
2. Practitioners (police, health, or others) concerned about an individual they have already had some form of contact with, for example, officers already on scene at an incident or hospital staff.
3. Officers who found a person in a public place in crisis and whom they believed needed immediate care or control under s.136.
4. Hilltop only: if a person self-referred to 111 rather than the police control room, the call to 111 would be diverted to the triage hub.

The first and second of these were found to be the most common referral routes to PMHT. There were no occasions during fieldwork when officers actually just came across a person in a public place in a crisis, during patrol. Where incidents involved a person in a public place, this was normally called into the control room by a member of the community, or the individual themselves. This was neatly summarised and specific examples were given by one Eastbrook officer:

*‘…It tends to be self-referral from someone in the community, they phone the police and say they’re going to kill themselves would be a typical job. Another one would be absconding from hospital if someone was waiting for bloods or to be seen who was felt to lack capacity, then the nurses would have to ring the police and report them as a missing person and I guess the third typical profile would be either alerted by a member of the public about someone acting strange by a bridge and they would come across it…’* (PC, Eastbrook)

The process of an incident actually reaching the radio of the officer undertaking PMHT duty, or the hub itself was dependent upon the initial access route. For self-referrals, the call handler in the police control room could forward directly to the PMHT co-response team or assign other officers to attend initially. For officers already in attendance at an incident, they could contact the control room and ask for the direct contact number of the triage officer, so they could be contacted directly by the officers on the scene. Similarly, in the hub, officers could ring through directly from the scene and any calls which came through the control room were flagged up as MH related and viewed by the hub. It would have been unlikely for the triage team to ever be the first response in a scenario three situation, as they did not operate as a patrol service. If a person was in crisis in a public place, and if a self-referral had not been made by the individual or a member of the public, it would have been patrolling officers or PCSOs most likely to encounter that kind of situation and call it in, although this was never encountered during the fieldwork. The standard process of a call reaching the PMHT officer’s radio from the control room was summarised by a Northfield officer:

*‘…if somebody reports something to the control centre, the control centre should identify it as being MH, especially if the word ‘suicide’ is mentioned, and they will say “right who’s on Street Triage duty?” and will pass it through to me. So, like I’ll just be sat here, and I’ll get a call on my radio saying right there’s a job, and I’ll then say [to the MH worker] ‘there’s a job for us’. The call handler takes the details and what’s been happening, what was the call about, and they’ll pass it all on to us…’* (PC, Northfield)

It was observed that in instances where suspected criminal activity was the primary reason for control room contact, PMHT were unlikely to be involved as staff indicated that first and foremost a criminal offence may have been committed and any MH element would be addressed by healthcare practitioners in custody. Given the low number of incidents that PMHT would attend, relative to the number of incidents that frontline officers would attend throughout the course of their shift, this highlights the crucial, yet difficult decisions officers faced about whether an individual whom they believed to have mental ill-health, entered the CJS or not.

* 1. Conclusion

The principal conclusion to be drawn from the findings reported throughout this chapter is synonymous with that of the coinciding 2018 HMIC inspection report titled ‘picking up the pieces’. The inspection process underpinning that report overlapped with the fieldwork period for this study, yet both independently came to a nearly identical conclusion. ‘Too many aspects of the broader MH system are broken; the police are left to pick up the pieces’ (HMICFRS, 2018:3). This chapter has, however, gone beyond that of the HMIC report in pinpointing austerity as increasing the reliance on the police to piece to pick up the pieces. The findings reported above have raised grave concerns about the adequacy of NHS crisis care provision. Instead of wariness around the value in what previously may have been perceived as ‘anecdotal’ evidence, the chapter has shown how the consistent view from those working on the frontline should be nothing less than cautionary. The reality versus the rhetoric of there being both a functioning and adequate 24/7 system of crisis care is illaudable; the reality has shown that outside of PMHT, there is simply no alternative to the police in providing an emergency response to MH crises in the community setting.

The research sites in this study have all, on the surface, ‘met the target’ of providing wraparound crisis care provision, an example of NPM principles in practice. Being able to applaud this achievement in the face of the demands faced by those working within the system and those in society seeking access to a system that cannot meet their needs, seems somewhat unacceptable, however. The findings would suggest many of the issues reported above go beyond a ‘broken system’, in that not only is the system broken, but it was never functioning to begin with. In particular, this is true for crisis care, which where it does exist, is wholly inadequate to meet the needs of the majority who need it e.g., whilst positive that there is a 24/7 SPA telephone number, this naturally can only function or serve a purpose if there is a subsequent crisis service there for people to access through contacting the number.

A further key conclusion of this chapter is the tangible impact that austerity has had on both MH and police organisations. These conclusions directly draw on the perspectives of those working within the services who have felt and experienced the damage of austerity. The nature of the findings has been able to provide a rich contextual layer to the ‘headline’ figures reported prior, and as per the title of the chapter, paint a portrait of the increasingly challenging times that have been faced by PCs and MH practitioners alike since 2010. The sheer paucity of out-of-hours provision for those experiencing a MH crisis, would be considered unthinkable in a discussion on physical ill-health.

This chapter also highlights a lack of parity with physical health care. Doing ‘*the best with what you can’* for a physical ailment such as a broken leg, for instance, would be deemed a national outrage. The equivalent of ‘the best you could’ for a broken leg when applying the same standards of MH provision in the response, might mean bandaging it until there was capacity for it to be x-rayed and treated over a year later. Yet for such a physical ailment there is an emergency service, one that is more capable of meeting the needs of a person with a broken leg. This may include quick access to appropriate medical care, which might include access to an x-ray and a plaster cast, overseen by a medical professional with expertise in broken legs. It’s likely this would take place in a hospital department with the facilities to treat it, with follow up appointments offered in the community until the leg had healed. The concept of the NHS currently being able to treat MH emergencies in the same way as the broken leg analogy, seems so far removed from the reality of existing provision, that this was reflected through the disillusionment shown by staff in the opening sections to this chapter.

The introduction of PMHT in all sites was a response to what practitioners from both police and health agencies considered an austerity-led breaking point in MH service provision, especially out-of-hours. Its emergence did not arise in two of the research sites from government monetary investment, and in Hilltop, where it did, local funding has been sought for its continuation post the 2013 PMHT trial. It arose due to the key individuals working in overstretched services, with the passion and commitment to enact their own change at the local level. The partnerships arose not just because of a move to ‘joined-up working’ or because the CCC told them to, but because of these certain individuals who saw intrinsic value in partnership working and a potential benefit to be gained from it for the wider good. PMHT thus emerged bottom up. One respondent used the term ‘*doing the wrong thing better’*, to describe the austerity-induced local reforms, including the creation of PMHT, though the problem of ‘*doing what we can with what we’ve got’* remains. Though this chapter is broadly foundational, the idea that PMHT is an attempt to ‘do the wrong thing righter’ will be returned to in the wider discussion that considers all of the empirical findings in Chapter Nine. At first glance, however, there is some indication that PMHT may be a somewhat expensive sticking plaster to cover the failed system of crisis care.

1. **CHAPTER SIX**

**The Organisational and Occupational Milieu of PMHT Partnerships**

* 1. Introduction

The methodology in Chapter Four and the empirical account in Chapter Five positioned PMHT partnerships within their police service area and highlighted the local PoS provision. It also introduced the frontline staff undertaking a PMHT duty and drew attention to key operational practices as part of a day in the life of PMHT. The reader will therefore now be familiar with the differing partnership models and arrangements in place at each site and have an overview of the key processes broadly undertaken on a typical shift by the teams. This chapter is presented in two parts, both reporting the key findings about the organisational and occupational milieu within which PMHT partnerships were found to be operating. Part One considers the organisational form and purpose that PMHT was found to take, serving the broader question of what can be understood about the purpose and delivery of PMHT partnerships. Part Two of this chapter builds upon Part I and reports on the occupational milieu of PMHT with consideration of several aspects of partner working relations, which were heavily impacted by stark variations in the practitioner approaches to risk management.

Part One considers the membership of PMHT partnerships, recognising their multi-dimensional nature and the issues that accompany it being as such. Secondly, it considers the purpose of PMHT from both an organisational perspective and that of the frontline practitioners working within it, highlighting the variances where they exist. Finally, it considers the relationship between what practitioners perceived the purpose of the partnership to be, and the consequential individual practitioner roles undertaken within the most common form of PMHT, co-response models. Collectively, these findings highlight how the informal ‘on the job’ education and training value for practitioners, arising from the operation of co-response model partnerships, are perhaps their greatest strength.

Part Two of this chapter speaks more specifically to the understanding of the specific nature of multi-agency working arrangements within PMHT partnerships. It identifies the problematic nature of contrasting cultures and ideologies, as well as the impact they had on policing practice and decision-making processes. It first considers the contrasting approaches to risk management, recognising that frontline practitioners were the vehicle for undertaking such on behalf of their employers. Secondly, it considers how the responsibility for risk was assumed by practitioners working within PMHT, in light of the dominant role of the health partner in decision-making processes which is shown to exist in Part One. Thirdly, it considers the impact of austerity on the inability to reconcile risk management approaches.

NHS MH under-resourcing, whilst undoubtedly the root of MH demand on policing, has also been found to contribute to clashes in organisational cultures, particularly in relation to risk, making the *prima facie* appearance of there being shared aims, an untenable reality. Part Two closes with three case studies that are provided to highlight how the issues presented throughout this chapter played out in practice with regard to the differences in perceptions of what constitutes a ‘mental disorder’; intoxication; and the issues associated with the s.136 consultation process and virtual models of PMHT.

**Part One: Organisational form and purpose of PMHT**

* 1. The membership of PMHT partnerships
     1. *PMHT as a multi-dimensional partnership*

The frontline partnerships existed within the context of larger organisational partnership arrangements and not as a single entity. It was part of multi-dimensional joint working arrangements across three levels. Table 6.1 demonstrates the multidimensional nature of PMHT and depicts five categories of partners, at the three levels of partnership. The first of these was at the organisational level, forming the headline act e.g., ‘*Northfield NHS and Northfield Police have teamed up*’. Within this level of the partnership, managers such as the Chief Constable and NHS Chief Executive were figureheads of their respective organisations but not actively involved in procuring the partnership itself or in its continued operation. The third level of the partnership was frontline operational, which included the frontline PCs and MH workers who came together to undertake a PMHT shift, i.e., either within the co-response or in a control room. The second level of the partnership was complex due to the large grey area of middle management partners created as a result of both the police and NHS being hierarchical agencies. This level of the partnership has been subdivided into three categories, considered against the police Basic Command Unit (BCU) structure. These are strategic, middle/territorial, and local managerial. This level included individuals from agencies that fell anywhere in between the front-line operational and organisational partners.

**Table 6.1: The levels, categories, and individual membership of PMHT partnerships**

Graphical user interface, text, application

Description automatically generated

Notes: PCC=Police and Crime Commissioner; GGC=Clinical Commissioning Group; MH=MH

The individuals situated within the organisational and frontline operational layers of the multi-dimensional partnership were much easier to identify by way of their roles and placement within the partnership. There was fluidity between members at this level of the partnership in terms of member attendance at multi-agency meetings and the various partnership boards in operation. As referenced in Chapter Five, for instance, a non-executive manager (AMHP lead) formed a strong working relationship with a frontline manager (Sergeant) to design and drive forward the implementation of the scheme in Northfield.

* + 1. *Member ambiguities at the middle managerial level*

There was a general sense of ambiguity about who was involved with PMHT at different levels of the partnership i.e., between frontline and middle managers, and between middle managers themselves. For example, frontline MH practitioners could identify their immediate line managers, but aside from the Chief Executive of the organisation, they could not name other individuals at the middle management level or identify who might be involved with the relevant partnership boards. Similarly, frontline officers were largely unaware of who the force police point of contact was for PMHT, or who managed the portfolio for MH at a strategic level.

Middle management interviewees showed uncertainty in the key details about the individuals they were in collaboration with. Members of varying partnership boards could not list the full membership of the partnership meetings they attended, or specify individual members’ job roles or titles, without referring to formal documentation. It was common for them to refer to their partners with descriptors rather than name and title, such as ‘*the lady from the police’* or ‘*the new AMHP bloke’*. Middle managers in all sites recognised that the membership of the partnership boards was ‘*not yet perfect*’ and that it had taken considerable time and effort to try and establish who the ‘*right people*’ were to partner with. One of the challenges was described as membership being a bit of a ‘*pick and mix’,* in that each meeting seemed to consist of new members.

* + 1. *Difficulties in establishing consistent memberships (middle management)*

The turnover of key staff was shown to disrupt previously established relationships and was associated with a loss of expertise and skills built up within a MH ‘specialism’. Managerial-level partner membership was thus dynamic and remained fluid due to the turnover, which hindered the embedding of the partnerships at the frontline level e.g., actions agreed upon at previous meetings weren’t completed by the next meeting, resulting in slow/delayed progress. In part, this was due to the often-short-term nature of managerial oversight of MH and staff moving roles in between partnership meetings e.g., officers undertaking a fixed-term secondment or assuming the portfolio for MH as part of their career development. Though meetings and partnership boards were held on a regular basis (monthly/quarterly), in practice this often meant a new staff member assuming the position of representation every two to four meetings.

Partners had also struggled to identify and achieve consistent representation of all relevant agencies/departments/teams which further hindered partnership progress e.g., establishing the perceived need for a new partner at one meeting, inviting them to attend at a subsequent meeting, then waiting for a further meeting for the required actions to be completed. For quarterly meetings, this delay in real terms meant almost a year for any necessary action to begin. This arose from the difficulty in establishing what decisions were meant to be taken at each board level and who the people were who actually had the power to direct and enact decisions at the broader level. Examples were given of member attendance on behalf of a team/department e.g., inpatient ward managers, but such attendees lacked the decision-making power for the organisation they sought to represent.

Where a member was unable to attend a meeting and assigned a replacement to ‘stand in’, such nominated individuals were often not in equivalent positions or did not possess the necessary decision-making capability knowledge, causing further delays. Through placing the emphasis on the representation of the organisation, rather than the most appropriate person, there was often ambiguity from meeting to meeting about who would turn up on behalf of the organisation. It had therefore not yet been established whether it was the individual person from an organisation or the organisations themselves that were members of a collaboration, or indeed both.

Progress in the process of embedding partnership work of this kind was slow, but even this limited progress was viewed positively by partners. The process of embedding partnership work at this level contrasts with that at the operational frontline level, where staff had readily embraced PMHT as an ‘*add-on’* to the existing out-of-hour provision. This could be seen in a practical sense, for instance, in Northfield by the staff rota whiteboard hanging on the wall of the MH out-of-hours office, which showed a column for the appointed PMHT staffing alongside that of the out-of-hours rota for the whole month.

* + 1. *A dynamic frontline partnership by design*

Within the co-response models at the operational level, frontline practitioners knew on each shift they would be working with a member of staff from the other respective police or MH organisation to create the evening’s partnership ‘team’. The membership of the frontline partnership was therefore dynamic by design. The rolling rota model of staffing made it very unlikely that the same frontline partnership team would ever work together more than once, though it was observed how a few officers had volunteered for the duty more than once in the absence of colleagues volunteering. This dynamic process of staffing the partnership meant there was ambiguity about who was in partnership on an individual level that day, every single shift. Often, the first time the team met was when an incident came in and the officer attended the operating base (if they attended the operating base during the shift at all).

This differed from Hilltop, which was less dynamic in membership due to the specific recruitment of designated staff employed within the hub. As Eastbrook and Hilltop had both previously trialled co-response models of working with specially recruited or designated practitioners to the team (like that of the hub), interviewees were able to compare their experience of this. Having designated PMHT staff was the favoured option by health workers as they ‘*knew the person was good’*. When probed, this meant they had been able to establish mutual trust with officers and both police and health practitioners reported how the frontline partnership felt like a team. This was reported as a sharp contrast to the rolling rota method of staffing the partnership, where practitioners did not have the same opportunity or desire to invest in creating strong working relations due to the short-term nature of the duty. Officers who had undertaken a six-month secondment to the previous designated staffed teams had enjoyed it, though both the officers and health practitioners all reported they would not wish to do it as a full-time permanent role. The reasons for this ranged from staff finding it ‘*de-skilling’*; ‘*not the job they trained for’*; ‘*lonely being the only officer/health worker’*; or the perception that it ‘*would get boring’* after a while. Despite the rolling rota model of staffing being at odds with existing knowledge about the importance of partners being able to develop trusting relationships (Huxham, 2013), a key benefit and ‘unintended purpose’ that emerged from those co-response models, was the informal ‘on the job’ training and education aspect it provided to the many PCs that undertook a single duty, discussed in 6.3.5.

* 1. The purpose of PMHT

Figure 6.2 depicts thirteen identified purposes of PMHT as perceived by the 53 practitioner interviewees. The purposes largely reflect those within the limited available literature, though that of improving working relations between agencies was notably absent in this study. The identified purposes have been broadly grouped into six key themes, namely, to reduce s.136 use; reduce MH demand on services (police and NHS); provide an emergency MH response; to manage risk; SU experience; and those considered ‘other’. Included within each of the broader purposes identified, are the narrower interpretations that varied not only between practitioners from partner agencies but also within agencies between the multidimensions of the partnership arrangements. The reader may note how within each broad category of purpose, the narrower interpretations appear similar and could be mistaken for unanimity. There were, however, subtle variations in language and interpretation, as discussed below, which significantly impeded the establishment of shared aims and commitments and the delivery of the meaningful outcomes that each partner sought to achieve through entering the partnership.

The variances depicted between agencies and within agencies at different layers of the partnership were not an unwavering indication that the general purposes of the PMHT partnerships were disputed. Rather, it highlighted key inconsistencies between agencies and the individuals within them, about the nature of the issues the partnership sought to address. The broader purpose of the partnerships directly related to the challenges faced by each organisation, which *prima facie* were shared, thus underpinning an assumption that the partnership could go some way to overcome such challenges for the benefit of all. In practice, however, these challenges were found to be underpinned by incompatible organisational assumptions and practice, and there was no evidence found that these issues were at the forefront of partner discussions, at any level. This section reports these findings and highlights how without establishing a shared commitment to the same issues in practice, the partnerships are unlikely to be effective at achieving the broader identified purposes.

**Table 6.2: Purposes of PMHT**

Graphical user interface, application, table

Description automatically generated

* + 1. *Understanding a reduction in the use of s.136 and the relationship to demand*

The organisations (reflected through managers and practitioners) had differing and incompatible, tacit assumptions about the ‘problem’ in the use of s.136, which they sought the partnership to solve. The destination, a reduction in the use of s.136, was shown through Table 6.2 to be the primary purpose of PMHT according to practitioners, but how to arrive at the destination differed depending upon whether you had the police or health map in front of you. Table 6.2 shows how frontline health workers and health management sought to reduce the ‘inappropriate’ use of s.136, whilst police managers sought to reduce the number of s.136 reductions and PCs simply sought to not use s.136 as much. The use of the word ‘inappropriate’ within the context of reducing the use of s.136 and thus demand on both agencies was key to this theme. Through a health lens, the concepts of ‘inappropriate’ and ‘unnecessary’ were inexplicitly linked. As the quote below demonstrates, reducing the inappropriate use of s.136 was understood widely in health to mean instances where a person wasn’t subsequently admitted to the hospital as an in-patient:

*‘…60% of people don’t get detained, so the police are bringing people who aren’t detainable. That’s not to say that they don’t have a MH problem it just means that they’re not detainable…’* (MH worker 2, Eastbrook)

As Chapter Five reported, extant provision was in most cases unable to meet the individual needs of people in crisis, staff were conducting resource-led assessments over needs-based assessments and the crisis provision for people without a diagnosed serious mental illness was limited. When considering the understanding of s.136 from a health perspective, the majority of s. 136 detentions undertaken by officers were therefore deemed to be inappropriate and unnecessary. There was a perceived overlap between the first two purposes in Table 6.2, as it was deemed that if s.136 use was reduced, then so too would overall demand on health agencies such as A&E and PoS provision. The health perspective was that as the available existing provision could be accessed via the SPA 24/7, this in turn would reduce the need for officers to physically take a person in crisis to a PoS, thereby reducing officer time spent on those incidents and demand on the health staff working within them. Health staff repeatedly reiterated their understanding of the issue to be the police using s.136 on people who were ‘*not detainable’*, although in practice this meant when a person in crisis would not meet the high threshold for either home treatment, third party support such as a crisis house, or as a last resort, subsequent continued detention.

The complexity of the issue stemmed from the incompatibility of available service provision with what the MHA 1983 stipulates for PCs. When inappropriate was taken to mean it was unnecessary or shouldn’t have happened, there were very few instances that it could be argued the PC’s decision to utilise s.136 was inappropriate. The wording of s.136 itself states ‘*If a person appears to a constable’* and ‘*the constable may, if he thinks it necessary’,* which is therefore reliant upon officer discretion and personal autonomy. As the quote below reflects, in the literal sense, if an officer felt the conditions of s.136 were met, then it was difficult for anyone but that officer (in hindsight), to define their decision to use s.136 as being as inappropriate:

*‘…I don’t think I’ve ever known an officer who would take out that section on somebody unless they genuinely believed it was for that person’s safety. That’s what PCs do, we come to protect life and if we think someone needs it, that’s what we’re going to do and we’re not going to take the risk on their life*…’ (PC, Hilltop)

Where an individual was displaying behaviour consistent with them telling the PC they had plans to end their life imminently, for example, officers thought it necessary in those instances to remove that person to a PoS to prevent harm occurring. Therefore, and as the quote below indicates, measuring the ‘correct’ use of s.136 by the number of people subsequently detained in hospital or gaining access to intensive home treatment, was met with discontent from officers:

*‘…They accuse the police a lot of inappropriately using that power because they define the success of 136 as a detention under the MHA once that person’s been assessed – and that’s just absolutely wrong. Getting sectioned is not the determination of success as whether 136 is appropriate or not…’* (PC 4, Eastbrook)

The messaging from CCG Commissioners was consistent with upholding published clinical values in that a person in crisis should receive the most appropriate response in the least restrictive environment with the most appropriate intervention, which rarely needs to be a hospital bed. When the Commissioner below was asked about alternative methods for accessing the crisis care pathway, they explained that rather than putting the focus on the term ‘inappropriate’, practitioners should instead be considering the ‘most appropriate’ response to a person in crisis:

*‘…language is important and can mean different things to different people, so the most appropriate response is what I’m meaning, so a reduction in inappropriate A&E presentation because it could be perfectly appropriate that you attend A&E, particularly if there’s an associated physical health concern which needs to be acutely resolved like poisoning or self-harm. So inappropriate attendance is the ability to be appropriately based into an acute pathway which may not mean to be admitted into bed-based provision…’* (MH Commissioner, Northfield CCG)

The ideals of the acute care pathway in the community expressed above raise once again the fundamental issue that the ‘most appropriate response’ does not exist for the overwhelming majority of cases. The above quote was also reflective of existing divides in knowledge around frontline practice at varying levels of the partnership. The entry route into crisis care according to that site’s own crisis care pathway was to contact the SPA, whose advice was that if a person felt they need to be seen they should self-present at A&E or call the police. In practical terms, the contradiction there was that every person who followed the organisation’s own crisis care pathway and attended A&E because they were in crisis and needed help would therefore be considered ‘inappropriate’ if they were not subsequently admitted as a result of that visit.

This highlighted how part of the ‘problem’ (i.e., the inappropriate use of s.136) the health partners sought to address and seek to benefit from working with the police, was within their own remit to address, not that of the police organisation. From a policing perspective, officers frequently failed to recognise that the aim of reducing s.136 was distinct from that of reducing MH demand more generally. Officer’s use of s.136 did not *need* to be reduced on the basis of it being used inappropriately by officers when the inappropriateness was considered through a police lens and not that of a health one. There was therefore no inclusive joint understanding of the whole ‘problem’ that sought to be addressed through working together, despite on the surface agencies wanting to reach the same destination of reducing the use of s.136 and the consequential demand on both agencies e.g., PoS provision.

* + 1. *Providing an emergency MH response (Northfield and Eastbrook)*

The second identified purpose, ‘providing an emergency crisis response’, was reported as a key purpose by frontline police and health practitioners only. In both co-response sites, PMHT had been designed at the middle management level of the partnership as one intended to operate as a secondary response only, after a first response by the police. Operational staff, however, did not see its purpose in these terms and so there was a divided understanding between frontline staff and those at the higher levels of the partnership. As the quote below reflects, frontline practitioners perceived the co-response model as an attempt to ‘*plug the gaping gap’* by providing an otherwise non-existent emergency crisis care response in the community, currently fulfilled by first responding PCs alone:

‘…*I think it’s reassuring for the MH staff we work with because otherwise, they’d be going on their own, well actually they wouldn’t be going out at all*…’ (PC 4, Northfield)

This understanding was also shared by SUs (see Chapter Seven), some of whom, for instance, were advised in crisis by the out-of-hours MH team to contact the police directly, as they had a designated MH team that would ‘*come out’*. Without the co-response duty, there was no alternative provision for the person to be seen by a MH professional in this way. In practice, this had resulted in the co-response vehicle sometimes responding to incidents as first responders, and not awaiting other responding PCs to attend first.

Frontline practitioners reported how this happened where there was consent from both members of the team, and that some practitioners chose only to attend once other officers were on the scene. It was reported that co-response first-responder circumstances generally arose when they were already in the vehicle when the initial call for officers came through the radio when police resources were over-stretched, and/or there was no one to attend to the incident immediately. Also impacting upon the decision was whether the individual was already known to either agency, which as reported in 6.4.1. was true for the majority of instances.

Officers recognised there was a heightened risk of attending an incident as first responders with a ‘*civilian*’ MH worker. Though they were confident in taking the risk themselves, as ‘*that’s what you sign up for’,* officers reported how they always needed to consider any potential risk of harm to the health worker. The decision to attend as first responders was influenced by the relationship between the frontline workers. As the quote below reflects, if this was good, then a first-attending co-response outcome was more probable:

*‘…the initial guidance from management was that we shouldn’t be dispatched on our own, they’d always have to be other officers there [first] because if it was criminal and that person needed arresting, I couldn’t do that because I’ve got a nurse in the car and I’ve got a duty of care to the nurse, so we always said there had to be other officers on scene. Once the nurse had got to know me and how I worked, probably 60% of the time they were quite happy for us to go to the jobs on our own. They sometimes knew the patient so would say ‘oh that’s John Smith he’s fine’ and I’d just tell control that we’ll go to that on our own…’* (PC 1, Eastbrook).

The lack of PMHT-specific policies meant there was nothing formally denoting whether frontline practitioners could/should do this. Some health practitioners reported that they believed the guidance had been changed to allow for them to attend as first responders where they deemed appropriate, even though this guidance may have only been communicated to them verbally. Whether practitioners subscribed to this fundamental purpose of PMHT impacted upon the exhaustiveness by which they could undertake the individual aspects of their role, outlined below. For example, health workers in these instances were observed to prioritise providing an urgent emergency response over the task of ascertaining background information about the person they were responding to. Difficulties were reported in the ability to perform this role when out of the office, due to MH records only being accessible via office-based computers (unlike officers who had access to their systems on phones). Had they not been responding in an emergency, they could have called colleagues in the office, instead.

In keeping with the perception that the co-response was for many an emergency MH response, blue lights were on occasions used during the journey to an incident. On one occasion, when a MH worker had returned to the office and was amused about nearly falling off their seat, the staff present were asked about the use and frequency of blue lights during a co-response. Their responses varied and whilst not reported to be frequent, all staff had experienced travelling to incidents on blue lights ‘*to get us there as quickly as we could’* or because ‘*it was an emergency’*. Though these kinds of explanations align with the understanding that providing a first response to MH emergencies was a key purpose of the co-response, others reported that sometimes officers would put the blue lights on in traffic simply to ‘*show off’.* In either case, their use was not perceived as necessary. The impact of police vehicles, uniforms and arrival on blue lights was shown to impact SU experiences (see Chapter Seven), though this was not a concern that was considered by practitioners in the research.

* + 1. *Managing Risk*

The fourth identified purpose shown in Table 6.2, was ‘helping the police manage risk’. This was identified by frontline MH workers when referring to the key purpose of PMHT, yet the concept of risk was discussed at a much wider level by all interviewees (i.e., those who did not view it as the primary purpose of PMHT) as a key component within the operation of PMHT. It was reported unanimously by all interviewees that the approaches taken to managing risk in MH incidents contrasted sharply between the police and health organisations. Such approaches were described as being ‘*polar opposites’* of one another that were ‘*fundamentally incompatible’*. The second half of this chapter reports in more detail on this divergence between a historically risk-averse approach (police) and the practice of taking ‘positive risk’ (MH) which were both shown to have manifested in practice within the operation of the partnerships.

Though frontline MH workers identified that ‘helping the police manage risk’ was a key purpose of the partnership, it is relevant to the next chapter to note here that frontline officers did not view the purpose of PMHT as such, nor was there widespread recognition that ‘help’ was needed in this regard at all. When frontline officers were probed about any role that PMHT had in their decision-making processes, there was some reference made to the ability of PMHT to negate their assumption of risk, though as shown later, such a belief was founded on misunderstandings.

* + 1. *‘Other’ identified purposes of PMHT.*

It can be seen from the sixth purpose in Table 6.2 labelled ‘other’, that some of the less frequent purposes of PMHT identified by frontline MH workers were wider than those identified by managers e.g., diverting people out of the CJS and preventing deaths in custody. Whilst loosely related to PMHT, these were notably absent not only from organisational managers but also from the literature reviewed in Chapter Three (perhaps because other police and health partnerships perform these functions e.g., L&D schemes). The identification of these ‘other’ purposes does, however, reinforce the sense of ambiguity surrounding the PMHT partnership and why it existed, for operational staff.

* + 1. *The unintended purpose of PMHT: informal ‘on the job’ education and training*

All officers in the study, regardless of their length of service, stated they had received either ‘*zero*’, or ‘*very little’* training on MH. Some officers stated that they thought they ‘*might have done an NCALT [police online learning package] on it back in the day, but whilst watching Coro [Coronation Street]*’. This sentiment was echoed across all sites.

Though not explicitly referenced in the context of understanding why they were undertaking a co-response shift, practitioners commonly reported that a fundamental benefit of undertaking a co-response duty was the informal ‘on the job’ education and training purpose it served. It was reported that even after undertaking a single co-response shift, officers felt they had gained a better understanding of the challenges faced by MH practitioners, and vice versa. Though perhaps an ‘unintended’ purpose of PMHT co-response models, it was shown to serve this purpose, nonetheless. Given the absence of adequate MH training for officers, many reported ‘*it [PMHT] was worth it*', just for that purpose alone. Whether this was cost-effective is another matter. Only a cost-benefit analysis could assess whether police investment in a co-response model is better than the cost of alternate training methods with equivalent training outcomes, such as the programme seen in traditional CIT models.

* 1. Practitioner roles undertaken by frontline partners in co-response models.

As frontline officers did not form part of the partnership in Hilltop, findings relating to their role are largely omitted from this section on individual practitioner roles.

**Table 6.3: Roles of individual practitioners working within a co-response PMHT team.**

|  |  |
| --- | --- |
| **Role of the PC** | **Role of the MH Worker** |
| Checking if a person was known to the police  Driving the MH worker to incidents  Providing Protection to MH worker | Checking if a person was known to MH services.  Deciding if the team should attend.  Providing telephone advice to first responding officers  Conducting MH screening assessments  Deciding the outcome of PMHT involvement  Liaising with other staff and services  Administrative/ recording the details of the contact |

* + 1. *Checking if a person was known to either agency.*

This aspect of frontline practitioner roles was the only element of PMHT practice that was shared. Establishing whether the individual in crisis was already known to services using basic demographic information (name, address, or date of birth) ascertained by the control room and passed to the officer on PMHT was the first step in the co-response triage process. This basic demographic information could be used by the MH worker to search their system for the person’s MH medical record. This system, as was the case in all sites, was different to other health recording systems in the same area, such as the one used by primary care or those used in hospital settings. The only record for an individual which could be accessed by the MH worker undertaking PMHT in each site was the one used by the MH professionals working in that particular NHS Trust and so would not provide information about any support they may have sought from other NHS providers, such as whether the person had been in contact with their GP regarding their MH.

PCs would search the police national computer (PNC) database, to ascertain if there was any record of the individual concerning previous police contact. Whilst PNC is not a MH record, other information from this system was often relevant to the circumstances surrounding the person that had come to the attention of the team. This included records of previous detentions under s.136 and other relevant circumstantial information, such as whether the person was a victim of domestic abuse or had a history of violence, whether children lived in the property (if the caller was calling from home), whether substance misuse was a relevant factor, along with many other social and environmental factors that could assist the team in gaining a clearer understanding of issues impacting on their MH. There were instances where an individual was unknown to the police, but it was more commonly the case that the PMHT team could ascertain some form of further information about a caller from at least one of the police or MH systems. Whilst cases where there was no record on either system were reported to exist, this was never observed during fieldwork and these instances were reported as ‘*very rare indeed’*.

Where co-location arrangements were not in place in Northfield and Eastbrook and the first call of the evening would arise, the officer would ring the MH worker directly on their mobile phone (having exchanged contact details at the start of the duty) and share this information. It was observed how when an incident came through via a PC not in the same location as the health worker, after providing basic demographic information, the officer would often state they were leaving the police station immediately and drive to the PMHT operating base. During the time it took for them to arrive, the MH worker would conduct their background search and the officer would conduct theirs upon arrival.

* + 1. *The fundamental role of the PC (transport)*

When frontline participants were asked about the role undertaken by PCs undertaking PMHT duty, the initial response from every frontline interviewee (police and health) was that transporting the MH worker to an incident was the fundamental role of the officer. As the quote below is indicative, the most common descriptor for this role was ‘*taxi’*:

‘…*we describe them as being our taxi drivers because they just get us there*…’ (MH worker 4, Northfield)

This was also the perspective of SUs, who equally viewed the key role of the officer as one of a ‘*taxi service for the health worker’*. Though frontline practitioner interviewees and SUs were unanimous about this, the presence of the officer within the team also served a more symbolic purpose of providing checks and balances on the actions or behaviour of the health worker (see Chapter Seven). PCs identified how there was no reason in law underpinning their role as part of the co-response team, and their practical value was limited to that of transport. The officer working within co-response had been assigned a police vehicle from the evening police shift and the MH worker would be driven to an incident as a passenger in this vehicle. The same vehicle would not then be used to transport a SU to a PoS, if necessary, as there were often other officers already on the scene who would perform this role.

When the PMHT vehicle attended in person, it was reported and observed that sometimes the officer would not exit the vehicle. If they did, they would often ‘s*tand back’* and/or return shortly after and wait in the car for the MH worker to finish undertaking their role. Officers often perceived that they had no role in attending to the person in need upon arrival, as they had fulfilled their enabling function of transporting the MH ‘specialist’ to the person who needed them. It cannot be said that this was ‘routine practice’, as there were instances observed during fieldwork where the officer and MH worker would both exit the vehicle and attend together, but the officer waiting in the vehicle was commonplace. Managers, however, seemed to be unaware that officers often did not exit the vehicle. For instance, they frequently referenced ‘*joint decision making’* and viewed the role of the co-response officer to be that of ‘*speeding things up’*, yet this was not observed to be so and remained within the ideals of effective partnership working.

* + 1. *Police protection (or reassurance of such) to the MH worker*

When practitioners were probed further about whether the PCs had any other role in the team, the second aspect identified was providing physical protection to the MH worker whilst attending in person. MH workers described them as ‘*default bodyguards if someone starts showing off*’. It was established that ‘*showing off’* meant becoming aggressive or using threatening verbal or body language. The quote below highlights how should a situation actually have required police involvement; the officer would be there to take control.

‘…*They put you at ease and they’re there for you. They’ll quite often say that “I will make sure that you are safe. If anything kicks off, you make sure you leave, and I will help the attending officers deal with it”. And you feel that, even with female PCs*…’ (Northfield, MH worker 6)

It was reported that MH practitioners rarely required the officer to actually undertake the role of physical protection, with practitioners all referring to the same example that had required police involvement over a year prior. It had not been observed to be necessary during fieldwork at any point and there was no evidence to support the notion that MH workers were dealing primarily with violent people and that they, therefore, needed constant police ‘protection’. MH workers in other areas of the same organisation did not have, or require, a police presence in order to fulfil their role. In addition, when co-responding as a secondary response, the presence of officers already on the scene removed this rationale, as if such protection were required, officers would already be present.

The roles undertaken by the co-response PC were, therefore, negligible in many instances, especially where PMHT was the secondary response. Instead, the weight of responsibility for the roles undertaken as part of the co-response rested heavily with the MH worker. This was owed to the fact that in essence, co-response was delivering a community in-person MH response to live incidents, in order to cover the absence of crisis care provision. As such, the police were ‘enablers’ of the shortfall in the provision, despite them having no tangible reason in law or practice to do so.

* + 1. *Role of the MH worker*

Once it had been established whether a person was known to either agency or the extent of any prior relationship, there were broadly three key subsequent courses of action, all of which were decided by the MH worker on PMHT. The first of these would be to attend the incident in person, which for Northfield and Eastbrook meant the officer and MH worker travelling in the police car to the place of the incident. In Hilltop, this meant the paramedic stationed in the hub would take their vehicle, either an ambulance or ambulance responder car, to provide a health-based response to the scene of an incident where officers were already present, with the MH worker remaining in the hub (aiding the officers at the scene). The second broad course of action, which was the most prevalent or ‘standard’ response in Hilltop due to the control room model in operation, was to provide information and advice to officers at the scene of an incident over the telephone, without either the paramedic or MH workers attending in person. The third and final course of action observed, was to abstain from any involvement and inform the requesting officers that the incident did not require a MH response and instead they should proceed with looking at criminal proceedings. By far the most frequent action observed to have been undertaken in all sites was providing advice and information to response officers over the phone (even where co-response models were in operation).

* + 1. *Deciding whether the team should attend an incident.*

The decision of whether the team should attend in person was based upon two key elements, one circumstantial and one practice based. The circumstantial element was the busyness of the shift. The practice element was undertaking a preliminary triaging function that established a) whether there was a crisis element to the call and b) the level of risk to the incident. It was observed that the practice element was not always undertaken if deemed unnecessary because the shift was quiet, as was more often the case. During observation, there were more shifts with no calls reaching the team, than there were with more than two. This reflected data held by Northfield and Eastbrook, which showed an average of two incidents a shift over the same period fieldwork was conducted. Both police and health practitioners reported that the ‘*quiet*’ shifts could become boring and monotonous. Whilst on such shifts, health practitioners were observed to assist their colleagues in the out-of-hours team (i.e., perform their primary role), while others would read magazines or occupy their time browsing the internet. Similarly, the officer assigned to the duty used the shift to ‘*catch up’* on their own caseload, or indeed find other ways to occupy their time like that of the health worker.

As well as providing an early insight into the risk assessment processes undertaken, the quote below reflects how on quiet shifts (and generally the first incident to come to the attention of the team), the decision to attend *any* incident was preferred to remaining in the office. Though staff reported shifts where they had experienced calls ‘*one after another’* and this presented a need to triage, these were not observed during fieldwork. Most commonly observed, were the shifts that could expect an average of two calls, and the decision whether these were to be attended in person was made by the health worker:

*‘…To put it bluntly, if it’s quiet and I’m bored I will see anything. I will just drop things to go and see people, anyone, and that’s fine. If I’m busy, I will start to triage things and I’ll go right you’re an intoxicated male that’s saying you’re suicidal and you’re a sober guy standing on a bridge I know exactly which I’m going to go to next. It depends on what’s going on really, I can’t put in words how I would prioritise, but I would look at what’s the highest risk and go to that first…’ (*MH worker 2, Northfield)

Where circumstances meant the preliminary triage function was necessary, health practitioners reported undertaking the process in the same way they did when triaging calls to the out-of-hour provision. The specific nature of this process is considered further through a series of case studies in the following section, though much like reported for officers, how ‘known’ a person was to MH services was pivotal to the process. The more comprehensive a person’s recorded history, the better able the MH worker was to make their assessment about the level of risk. Where an incident was referred to PMHT and a person was totally unknown to services (this was reported but never observed), or where there was very little recent information recorded, it was reported that the person would generally be considered the highest risk and the decision to attend in person would be likely. It was observed that the majority of contacts with the PMHT team came from individuals known to services already, such as people who were currently or had previously accessed MH services within the same NHS Trust e.g., inpatient and/or community services. In summary, there was no clearly defined remit for the types of incidents that necessitated an in-person response. First and foremost, incidents received an in-person co-response where there was the capacity to do so, and sometimes even when there was not necessarily a need, in law or practice.

* + 1. *Telephone encounters with first responding officers.*

Where the health worker deemed an in-person co-response unnecessary, or where there was not the capacity to attend in person due to the busyness of the shift, the health worker would often speak to the first responding officers on the phone in place of an in-person response. During the operating hours of the PMHT duties, first responding officers were also utilising the direct access they had to a health worker, via their police colleague, as a means to meet their legal requirement consult prior to using s.136 (MHA 1983 s.136 (1c)). This was a deviation from the specifically developed crisis care pathways that had been developed in each site for officers to be able to consult with a health professional prior to s.136 use (primarily the SPA line). The reasons for such are considered further in Part Two with regard to working relations and trust.

In practice, the nature of telephone encounters was the same regardless of whether the officer’s intention to contact PMHT was to request an in-person response or simply to consult. Instances were not observed but were reported to occur, where responding officers would ring to consult via PMHT and due to the available capacity of the team during the quiet shifts reported above, they received an in-person response they would not otherwise have had (or in some cases deemed necessary by responding officers). Telephone encounters were not without challenges with regard to risk management and the nature of the consultation itself. Such challenges resembled those reported in Hilltop in relation to virtual (phoneline and control room) models of PMHT and are thus considered in depth in Part Two.

* + 1. *Conducting in-person MH triage assessments*

This aspect of the health practitioner’s role was often conducted individually, in cases where the officer remained in the vehicle. Whether the PMHT officer attended in person with their health partner or not, the triaging decision centred on the perceived necessity for s.136. The triage assessments were described as ‘*screening for s.136*’ and involved the MH worker speaking with the person in crisis, to decide if or what further action they deemed was necessary at that point. This role remained that of a triage function, not a formal MHA assessment undertaken for the purpose of assessing whether a person needed admission to hospital. The MH workers considered this aspect of their role as ‘*engaging in conversation with the person’* and trying to ‘*formulate some sort of plan with them*’. The following quote reflected this process, though the figures given by the health worker may be inaccurate (Northfield did not hold this information):

‘…it’s *not to do a full assessment, but just sort of to see does this need to go any further at this particular point in time. It’s sifting and sorting, it’s basically working out when we’re called out, do we need to be doing anything else there and then, and that’s why we’ve been quite successful, to be honest. The figures I think are 65/67% of services users we went out to in the first year stayed exactly where they were*...’ (MH worker, Northfield)

PCs frequently showed that they did not fully understand this aspect of the MH worker’s role. Most did not realise there was a difference between the screening assessment undertaken by the PMHT worker and a formal assessment under the MHA undertaken by AMHPs. This issue was raised during a coroner’s court inquest, where the deceased person had contact with a PMHT team within 30 days before their death. The quote below from an officer at the CoP highlighted this issue was not confined to Northfield and Eastbrook:

*‘…The officers thought that following a conversation with ST on the telephone there had been a MHA assessment done and the conclusion from that was that he didn’t need 136’ing so ‘you’re safe to walk away’. When it came to the review of that phone call in coroners, where the officers had clearly understood this to be a formal assessment, the professionals when giving evidence had said no that was just a screening telephone call to establish whether or not there needed to be an assessment. It then gave rise to the coroners saying look you need to be really clear about what exactly these conversations are because if the police believe it’s a full assessment then that might mean the police take the view not to use 136, whereas if the police had known it was just a screening conversation about whether an assessment was needed, it makes it a very different type of encounter and maybe the officers would have thought about their decision making differently..’* (PC, seconded to The CoP)

Whilst a more cynical interpretation may be that officers did fully understand the difference but were attempting to relieve themselves of possible risk by stating they believed an assessment had been done by a professional, this was not observed to be the case in this study, and therefore, it is proposed that there is still work to be done in communicating the implications of this misunderstanding to officers, who may unknowingly be influenced by an inaccurate understanding of the role of their MH colleague in triaging rather than fully assessing a person in crisis.

* + 1. *Deciding the outcome of the screening assessment*

It was observed that there were many instances where PMHT attended in person when people were in their own homes and thus s.136 could not be used. In these instances, officers appreciated the value of PMHT attendance much more than in a public place, as their attendance was perceived as a tangible ‘*action*’ they could take in circumstances they otherwise reported feeling limited in. Though invariably there were also issues associated with this, such as after the PMHT attendance officers ‘*feeling uneasy’* at the prospect of leaving the home, the attendance of PMHT did reportedly assist with this in some cases.

Despite the decision to use s.136 being, by law, that of the PC alone, it was this aspect of PMHT where the boundaries became blurred. MH workers discussed the success of being able to ‘*convince*’ the responding officers that s.136 was not necessary (in the cases it could be used). Where co-response attended as first responders, the convincing also related to the PC working that PMHT duty. Though returned to later in the chapter, it was a common perception amongst both practitioners that the most appropriate person to be making the decision on s.136 was the MH worker, as reflected in the quote below:

*‘…the police while they’re very helpful and we have good arrangements with them, when it comes to a decision about MH the police quite rightly, they’re not qualified to do that and they shouldn’t be drawn into that…’* (MH worker 7, Northfield)

Much of this aspect of practice within PMHT centred around risk management, though the inability within the partnership to reconcile contrasting approaches between partners was problematic and forms the basis of part two. The case example below provides an introductory example of the frustration this caused within the working relations of partners.

*‘…PMHT went to a standard call-out at home, she’d been drinking and saying she was going to kill herself. This copper [on scene] who was dreadful decided he’d try and develop some kind of I suppose power or whatever by basically saying he’d found some weed at her house, not enough to deal or anything and said ‘I could arrest you for this’. It was the worst thing he could possibly do. She was absolutely furious about this, rightly so, the police had gone around to do a welfare check and he was threatening to arrest her. I thought this was very dodgy and not practically useful, we weren’t getting her on side, so I had a conversation with him, and he makes it very clear to me that he was making himself in charge of the situation. I’m not egotistical and insecure enough about myself that I need to do that, but he’s got a uniform on and obviously got issues and I don’t care [laughs]. So, I go and sit down and have a chat with her and get her on side, which was easy because she wanted to be onside, and talk about what she’d been saying and stuff and managing risk and it becomes very apparent to me she’s not going to harm herself. She makes it very clear she doesn’t want to go to her sisters because she doesn’t like her sister …I can appreciate that and so I go out and have a chat with this copper, say she’s absolutely fine and say we’ll follow up tomorrow and she doesn’t need to go to her sisters, she can stay here and you can write down in the paperwork that I say she can stay at home and devolve all responsibility to me and I’m comfortable and confident she will be safe. He goes yeah well I’m still concerned so I’m going to take her to A&E anyway. I thought to myself right you’re the police this is your responsibility, ultimately, you’re making this an easy decision for me. I mean I’d wasted 90 minutes. I was going to spend another 40 minutes writing this up, a really detailed report about clinical risk taking but he does not want me to take that clinical risk so that’s fine. I said to the officer I was with on triage with, nice kid, ‘right we’re off, he’s in charge, see you later!’ (*MH Worker 7- Northfield)

Where the MH worker deemed s.136 as an inappropriate action (which happened in most cases) and the officer either agreed or was acting on the misinformed view that the health worker’s expertise overruled their own judgment, the most frequent decision taken was the responding officers took the person home. Similar to the cases already in the home, officers often expressed unease during the transportation process due to ‘*being the last person to have eyes on that person’*. In many cases, however, officers reported that they were more likely to do what had been agreed with PMHT, during the duty. Though the alternatives were limited, they were reported to include voluntarily transporting the person to A&E as in the case above, or ‘enticing’ the person out of the house onto the public street, where they could legitimately use s.136.

In many cases, though, the health practitioner had ‘*formed a verbal plan’* with the individual in crisis. This plan was seen to consist of an intention to inform a person’s care coordinator (if they had one) of the incident by sending them an email or leaving them a message so that they could follow up during working hours. If the person was not already in contact with the MH services, they could choose to submit a referral on their behalf to the SPA or contact their GP. These were actions that officers alone would not have access to, nor did they report wanting access to. The key issue from this section is that of the de-facto s.136 decision-making process that the health workers undertaking PMHT were, on many occasions, trying to assume responsibility for.

* + 1. *Liaising with other MH practitioners*

It was reported above that, after a PMHT contact, the health practitioner would in many cases send electronic correspondence to a person’s care team if they had one. Where contact with members of the PMHT partnerships resulted in a s.136 detention, the health practitioner also liaised with health colleagues in other areas of the NHS e.g., those within the PoS to inform them that PCs would be arriving with a person in need of a bed.

* + 1. *Recording the contact*

PCs reported that they ‘*don’t go into much depth as regards to the write-ups that these [MH workers] guys* do’ but would record an entry in their pocket notebook.This was recognised by the MH workers who assumed responsibility for conducting more thorough documentation of each contact, as the quote below shows:

*‘…We fill paperwork in at this end where we’ve attended an incident. To be honest I don’t know what the police do. I imagine they will fill in something on their system, but I’ve not seen them do it…’* (MH Worker 4, Eastbrook)

Some MH workers specified that they set aside the last hour (sometimes two) of their shift to complete paperwork and thus they would be unlikely to attend an incident in person after this time. Accurate record-keeping was therefore viewed as a fundamental part of the job. In all sites, the contact with triaged SUs was recorded on the existing out-of-hours systems which allowed each person to be assigned a code for ST, which was searchable on the out-of-hours database. The motto echoed by many health practitioners was ‘*if it’s not written down then it didn’t happen*’, which was related to accountability mechanisms ‘*should things go wrong’*. The quote below reflects how MH workers viewed both the decision-making processes within PMHT, their role within it, and its importance as an accountability mechanism:

*‘…I guess one of the things about our role is very much aware that your documentation is kind of really, really, decent because ultimately you tend to be making a single-person decision…the decision-making lies heavily with you, the kind of decision itself and the actual action of that decision …and so you’ve got to be very, very, clear about your paperwork and justifying your rationale and any decisions you make...’* (MH worker 7, Northfield)

The concept of ‘*arse covering’* was highlighted by SUs (see Part Two) as a process in which they described staff being able to negate their personal responsibility of safety and care by ‘*dressing up’* an encounter to appear like all appropriate action had been undertaken and they had fulfilled their role accordingly. Both MH workers and PCs also used the term ‘*covering my arse*’ with regard to the formal documentation process and they recognised the importance of having a good ‘*paper trail*’ of events should they need to rely on it later for accountability purposes or to recall earlier contacts they had had with SUs. When describing this administrative role, MH workers did not report or indicate any recognition that thorough documentation may also improve future contact with SUs, the focus was very firmly on the personal benefits of good documentation and the benefits to colleagues who may access the record at a later date.

**Part Two:** **Partner working relations, risk, and culture.**

6.5. Contrasting approaches to risk management

The frontline practitioners in both organisations were the ‘vehicle’ for risk management in practice. This was reflective of not only the different regulatory frameworks within which they were operating but also the informal working practices and culture that were shown to exist alongside these. The risk-averse nature of officers when attending instances of mental ill-health was driven by the ‘*worst case scenario*’ and the repercussions of such occurring. The worst-case scenario for incidents of mental ill-health was a person suffering serious harm or death as a result of the officer’s action or inaction. Officers were concerned that if such an event were to happen, the worst-case scenario would involve being criticised by colleagues and the organisation; giving evidence in a coroners court; being viewed as incompetent; being subject to an IPCC investigation (now IOPC); losing their job; and having to live with ‘*what ifs’* had they taken a different course of action. All such reasoning centred upon being held personally accountable for their actions, leading to officers reporting a common belief that such outcomes would ‘*never be a risk worth taking’*. Officers were unanimous in explaining the need to try and eradicate those risks and their approach to doing so was methodical and remained a ‘*very conscious’* one.

The MH workers did not show the same level of recognition or place any emphasis on being held personally accountable for their actions. Contrary to officers when discussing risk management, MH workers talked more generally about the ‘*service(s)*’ within which they were one person ‘*trying their best’* to do their job within ‘*a not perfect’* organisation*’*. This was reflective of the issues around available service provision and the functional implications of under-resourcing and how this impacted frontline practice. The varying accountability mechanisms of each organisation were observed to have contributed to this divergence in risk cultures. An example of these differences in accountability was the requirement for police organisations to investigate any death that occurred in the 48 hours following police custody. Officers were fearful of such investigations reaching the IOPC, which could investigate and examine their personal actions, fuelling officer anxiety in relation to their decision-making processes. By contrast, there were no equivalent investigatory processes or thus concerns amongst MH workers. The divergence in organisational processes following serious harm or death was also readily accepted by health workers:

*‘…no matter what assessment we do as MH workers and what decision we come to, those officers feel that their name will be attached to any possible incident that happens subsequent to that. Because their disciplinary systems are much more stringent than ours. I’m not saying ours aren’t stringent, but as an NHS service our disciplinary services tend to take the human element into it at a higher account than the police do, and acknowledge that not all risk can be removed and acknowledge that some people will bring harm to themselves and other people…yet there’s an element of anxiety about what will happen to that officer, what punitive measure will take place, what consequence there’ll be for them if something happens to someone based on our assessment…’ (MH Worker 8, Northfield)*

One of the key points alluded to in the quote from the worker above was the punitive aspect associated with the initial investigation process itself after a death, which was not felt in the same way by health workers. A MH nurse, for instance, who had experienced the investigative process in the NHS following patient deaths, described how they remained at work with a ‘Serious Incident Review’ (SIR) taking place sometime after. At no point after the death did the worker feel they were subject to any perceived punitive action like a suspension from work or criticism from colleagues, again contrasting with the perceptions of officers in potentially the same situation. The focus of the SIR was described as a multiagency review of the circumstances prior to the person’s death involving any relevant organisations, not just that of the MH organisation. The worker was required to provide a detailed report of their involvement with the patient and a personal account of their recent contact.

The worker had felt supported by the organisation as he remained at work and was not ‘*demonised*’ in any way. He stated this is because he was confident in his ability as a nurse and felt he could logically explain every decision he took as these were in line with the organisation’s expectations of him. He recognised that if someone had acted in an ‘*unsafe way’* i.e., not in line with the organisational expectations when the investigation started*, ‘then yeah, they might be suspended’,* but he did not doubt that his actions would always be accepted as safe practice, a concept returned to below. He had the experience of being called to the coroner’s court and recognised it was unpleasant by stating ‘*coroners is horrible, there’s no way round it, it’s awful’*. Given officers are not professionally accredited MH workers, like their nursing and social work counterparts, (despite many having extensive experience in mental ill-health situations), many reported how they felt they were expected ‘*to make the same decisions’*, but without the same training and knowledge. Many spoke of being at a significant ‘*disadvantage*’ with respect to dealing with incidents of mental ill-health, feeling that they were being held accountable to the same level as their health counterparts, which was perceived as ‘*unfair*’.

Within health organisations, there was also both organisational and individual acceptance that death was an inherent aspect of the job. This contrasted with policing, in which death after contact was not viewed as an inherent part of the police role. For officers, they described their involvement when attending incidents of mental ill-health as being ‘*there to get that person somewhere safe*’ to prevent the worst-case scenario from occurring. This was often contextualised when discussing the breadth of their role and whilst MH ‘*jobs*’ were one notable element to it, such instances were accepted as no more likely to incur post-contact death than attending any other type of initial none-fatal incident e.g., a burglary or road traffic offence. As the quote below indicates, within health, there was in contrast an assumed expectation, that when working in a healthcare setting (physical or mental), death was sometimes inherent post-contact:

*‘…With the view of not sounding like a complete psychopath, if you work in crisis services then people will kill themselves. It’s the real raw and honest truth of it. The same as if you work in A&E, you’re eventually going to have to resuscitate someone who won’t come back. It’s an unfortunate and horrible part of the job but it’s something that happens when you work in these services…’* (MH Worker 7, Northfield)

The fundamental differences in risk management between the organisations, however, taking all of the above into consideration, were the working assumptions about what courses of action or inaction, constitute safe and effective practice. The following two sections report upon findings that relate to the divergence in understanding of safe and effective practices with regard to crisis care, focusing on risk and the impact that resource availability had on decision-making processes.

*6.5.1. Assuming the responsibility of risk*

Whilst the health worker broadly took ownership of the decision-making processes, the triage process itself had created a general sense of uncertainty about who was legally responsible for the person’s care ‘i.e., ‘*whose client is it, are they police or health?’*. This affected not only the operation of PMHT partnerships on a practical basis, in terms of the result being a s.136 detention or not, but also working relations between frontline partners and the effectiveness of the collaboration between the partner organisations more broadly. The extent to which practitioners perceived they were responsible for the risk involved (individually or jointly) during a PMHT encounter, impacted upon the extent to which they were willing to deviate from their ‘usual’ practice when attending to a person in crisis outside the partnership setting. The usual practice referred to their primary role outside of the partnership; for officers, this was the traditional types of tasks associated with response policing. This was particularly true for officers, who recognised that the use of s.136 was a discretionary power based upon the wording of the section, whereby they ‘may’ invoke it.

Overall, however, there was a reluctance of either partner to explicitly assume responsibility for the person in crisis, despite the dominant role undertaken by the health worker in decision-making processes more generally. The health worker in the quote below reflects the common understanding that it was the person at the scene who should make decisions about a person in a crisis, like the necessity for s.136. The triage process complicated this assumption when there was both an officer and MH worker on the scene:

*‘…[there’s] still a lack of clarity about whose responsibility a patient is and what individual responsibilities people have when they’re dealing with that patient, so, for example, paramedics or police phoning up or what have you and saying ‘we don’t know what to do with this person, shall we do this and shall we do that?’ and us saying ‘have they got a capacity?’ and them not understanding that it is whoever is on the ground at the time makes the decision, not everybody is comfortable with that…’* (MH Worker 5, Northfield)

Though both agencies were operating under the legislative framework of the MHA 1983, the sections within that which specifically regulated MH practice spun much wider than just s.136, the section at the crux of police involvement in PMHT. Officers and MH workers were also regulated nationally by the adherence to different regulatory frameworks, such as NICE guidelines and the Royal College of Nursing for health workers and APP from the CoP for officers. These were in addition to the local policies that had interpreted such national guidance to meet the needs of each respective organisation at a local level, whilst adhering to the national practice frameworks.

The wording of s.136 itself was based upon an officer making a sole decision about whether a person may need immediate care or control. In recognition of the emergence of partnership work, the 2017 amendment requiring officers to consult with a health professional prior to using s.136 was shown to be the core source of ambiguity within frontline practice and whether it was either a PC, MH practitioner, or both, who should assume the risks for the person in crisis. As the quote below reflects, the non-common-sensical predicament whereby officers held the legal responsibility for enacting s.136, despite ‘*trained MH experts’* being physically present within co-response models of triage, had led in some instances to misunderstanding in the assumption of responsibility for risk by practitioners from both agencies.

‘…*you could argue until you’re blue in the face about whether it’s a police responsibility or jointly mine, I’ve given them all the ammunition and equipment if you like for them to make that decision but ultimately it’s that person’s decision and not mine and I do feel sorry for them in that respect because he must be thinking wait a minute he’s the bloody nurse and he knows better than me but the law says I have to make that decision*...’ (MH worker 2, Northfield)

Particularly for newer in-service officers, who had known no alternative to either MH partnership work or the requirement to consult, when asked directly about legal liability for the decision to enact s.136, the most common response was ‘*I believe it’s the MH worker’.* This misinformed view was also strengthened by the officers through the dominant role that MH workers had come to undertake within the triage process itself. In such cases, the health workers were de facto making the decision on whether to use s.136, despite the legal responsibility resting with the officer. When these officers were informed that the decision to use s.136 remained theirs, there were elements of both surprise and frustration e.g., ‘*that’s silly/stupid/ridiculous when there are MH experts there’*. For officers with lengthier experience of the job, the perception of PMHT being a health resource was often reported as such due to the majority of PMHT incidents they attended having involved people in their own homes.

There was, however, no observable pre-meditated ‘buck passing’ in terms of the assumption of risk between frontline partners, rather a reluctance stemming from this described ambiguity as ‘*no one’s quite sure, it’s a tricky one*’. This was excluding instances involving alcohol intoxication (see case study 2), though even in those cases it was less about ‘buck passing’ on the basis of risk and more about ‘buck passing’ in terms of demand and available service provision. Practitioners frequently referred to PMHT as being a ‘*resource*’ for the benefit of their partner agency, with many indicating that it didn’t ‘*belong*’ to them. MH workers for instance, frequently described it as a police resource *‘entirely’* with several remarking how they did not think it benefited the MH Trust at all. This directly contrasts with the quote below, which reflects frontline officers who, conversely, viewed PMHT as a health resource:

*‘…The thing is it’s a health resource, isn’t it? I’ve come on before and we’ve left briefing and gone to sit with someone in their own home who’s wanting to kill himself, like literally, to the extent where he’s been and collected wood to make a guillotine, so that’s about health…’.* (PC 2, Eastbrook)

Practitioners from both agencies thus often viewed PMHT as a means to ‘help’ the other agency out with their standard practice, with neither agency reporting aspects within their own practice that may benefit from the partnership (other than the informal training and education). With this came an assumption that the people coming to the attention of PMHT ‘belonged’ to the other agency, which undermined who assumed responsibility for the risk they posed. This lack of joined-up practice within PMHT created tensions when neither party would ‘submit’ their practice to the other. The following section reports further upon these tensions, and the difficulties the partnerships faced in reconciling their contrasting approaches to risk management, in light of the regulatory frameworks governing each agency that was not designed with partnership working in mind.

*6.5.2. Understanding the inability to reconcile risk management approaches.*

There was an overarching inability to reconcile risk management approaches through the implementation and continued existence of PMHT partnerships, in and of themselves. These difficulties were related to the breadth of the MHA 1983 governing wider MH care practice, which goes beyond s.136. MH workers were by nature of their professional training, undertaking the role with a holistic understanding of whole service provision and wider legislative prerequisites. The MHA 1983 itself, for instance, has ten key parts (excluding schedules) and includes 149 different sections, s.136 being just one of these. The police focus within the PMHT partnership was observably siloed upon the use of s.136. Health workers did and could not, silo their focus in the same way due to the consideration they had to give to matters beyond the initial use of s.136. It was this divergence that underpinned much of the contrasting practice and culture already considered throughout this chapter, particularly around issues of necessity in the use of s.136 and its perceived appropriateness. It was observed in the study how MH worker practice had become increasingly determined by available resources, which had worsened during austerity. This was driving a culture of ‘positive’ approaches to risk management in crisis care, which contrasted so sharply with the risk-averse approach of frontline officers.

Positive risk-taking had become a mantra for MH staff who had frequent contact with people in crisis. It was cited consistently when explaining to the researcher why they had taken any particular course of (in)action. The observation note below highlights how this approach to risk management seemingly served as an accepted and justifiable way of negating personal responsibility for decisions made:

*‘… have just listened to the mother of a young woman distressed that her daughter had taken the third overdose in three weeks, crying and angry at staff saying she needed to be seen by a MH person and she has received no follow-up after her discharge from hospital and was still in crisis expressing plans to harm herself again. The worker told the mother that her daughter has the capacity to kill herself, and if that’s what she chooses to do then they can’t stop her. They told the mother the decision for her daughter to take her own life was hers to make, that people make unwise choices every day and there is nothing they can do from the other end of the phone. They advised if concerned to attend A&E again but that she’ll not receive a MHA assessment there so she’s wasting her time. If I hadn’t already witnessed this kind of conversation numerous times, I would be shocked at the lack of apparent compassion, maybe I have become immune to the shock factor I felt when I started the research. When I asked the worker about this conversation, they explained that they have to take positive risks every day as they don’t have the resources to see everyone who ‘claims’ to be suicidal. “If every suicidal person in Northfield got a service, we’d need another hundred hospitals”. They said the girl had become well known to them in recent weeks, ringing most days, but was ‘demanding’ a service that ‘we don’t do’ because they didn’t think she needed a MHA assessment and the best person to ‘manage’ her was her GP during working hours. They explained that they often get the brunt of abuse from people who think they don’t do anything, but this girl was experiencing extreme distress and not mental illness, and as she had the capacity, she could choose to do whatever she wanted, even take her own life. I can’t help but feel this is just horrendous…’* (Observation note, Northfield)

The ‘positive’ risk taken was deeming no immediate action was needed and advising the mother of the options available to her by way of attending A&E and contacting the GP. This was following the health worker’s risk assessment that the individual was perceived as unlikely to take her own life at that moment. In their risk assessment processes, MH workers widely reported how ‘*people exit their crisis as quickly as they enter it*’ and so the primary consideration they had was whether the person in crisis could ‘*survive*’ at that moment, usually until the next working day when GP services resumed. Their judgements about the risk for people in crisis had a low threshold and were deemed to be about immediate risk in terms of ‘*is this person going to be alive in an hour’s time?*’. In that case, the practitioner assumed that they would be, which was reflective of the standard practice observed and the inaction taken for the majority of the situations that came to their attention either through the SPA or PMHT.

The more comprehensive a person’s MH record, the more information the practitioner had to assist with their assessment and judgement about risk. In the vast majority of cases, people were ‘*known*’ to MH services and had a history of mental ill-health. Here it was observed to be commonplace for practitioners to use the person still living as the rationale for assuming they would not harm themselves imminently. Hence, health workers told the person in crisis (or their carer/family) ‘*you’ve been here before and you’re still alive, aren’t you?’*. This was unhelpful to the person in crisis but enabled staff to undertake their role within the available provision.

The practice of recording that ‘positive risks’ were taken was sometimes explicitly documented, though sometimes not. Where not, MH practitioners were observed to record their rationale for their (in)action e.g., ‘*client was advised they could attend A&E’* which was described as being a ‘*safety net*’ to justify the risks they as MH practitioners had assumed. Health workers spoke about being constrained by a ‘*risk barometer’* that impacted their practice and the decisions they could make about an individual in crisis. Given limited MH inpatient bed capacity, only the highest risk patients could be admitted, who did not always equate to being the ‘*most poorly’* or those who *‘needed that intervention the most’* or ‘*where it was most appropriate to provide inpatient care’* to a person. They, therefore, operated on a ‘*tightrope system’* which focused solely on risk management, over being able to provide an inpatient response appropriate to patient needs. This was attributed to local reductions in hospital beds. This had led to a situation whereby people who were deemed further down the ‘*risk barometer’* scale i.e., lower risk but who nonetheless were incredibly unwell and who would in an ‘i*deal world’* have benefited from inpatient hospital care or even intensive home treatment, no longer met the threshold for it. The threshold was described as being ‘*so, so, so much higher than it was even five years ago’*.

The impact of austerity was reported as having created a wave effect across existing community MH crisis care resources such as the most viable alternative to inpatient care, intensive home treatment. MH workers explained how in general hospital settings there comes a point where it is obvious someone requires hospital care and intervention, but in MH it’s a ‘*much greyer area, it’s all blurry’* and so it becomes about the amount of risk the practitioner is willing to take on a person. As the quote below reflects, MH practitioners were operating within a system that could not meet the needs of everyone that required it and because of this, they were undertaking their role in a less-than-ideal way of identifying the ‘*most risky’* cases rather than those who needed access to the limited provision ‘*the most’*. The quote also reflects how different levels of aforethought were required between the police and MH practitioners within PMHT (and beyond) when considering the use of s.136, which was directly linked to available resources:

*‘…Let’s say I know there is one hospital bed available, I’d love to be able to see a person I know is risky and be able to say they need hospital care and they’d be in that bed waiting for them, but I also know there’s then the potential that two minutes later I might get a job for someone who is even riskier than the first and I need them to go in as well, so what am I doing to do, tell the first person to get out of that bed?...’* (MH Worker 2, Eastbrook)

These views were limited to MH workers only, with officers unconcerned with resourcing issues beyond those that could inhibit their use of s.136 when required e.g., having an open PoS and sufficient MH staff available to meet them there. Officers reported vast discontentment with the risk management approach taken by MH workers, due to both physical and emotional implications for the person in crisis and the risks of harm that might arise. Officers described the approach of MH staff as ‘*fundamentally unsafe’* and ‘*lacking any ounce of care’*. The quote below followed an account involving a person experiencing psychosis, who had been detained under s.136 after officers had consulted with Hilltop PMHT hub. All designated s.136 provision within the police force area was closed due to insufficient staffing, with officers being told to wait at a suite while they ‘*found someone to attend’*. When an AMHP met them some 8 hours later, officers were advised to take the person to the train station and ‘*put him on a train’*, as it has been established the person was under a care team in their home city some four hours away and there was ‘no one’ to assess them in Hilltop. The officer described how ‘*ridiculous*’ such a suggestion was due to the danger the train network posed to that individual:

‘…*I just think he [AMHP] had a different agenda, more about money than the safety and the needs of the person and that is a scary thought. They were never going to treat him if it was down to that one AMHP, fortunately, it wasn’t. That was horrendous, it was disgusting. We look at the needs of the person and it’s rare the MH staff will do the same*…’ (PC 2, Hilltop)

Chapter Five provided an overview of the challenges facing frontline practitioners at the period declared ‘the end of austerity’. Though NHS under-resourcing was shown to heavily impact MH demand on the police role more broadly (HMICFRS, 2018; 2021), this section has shown how this was also reflected within PMHT partnerships through the inability to reconcile risk management approaches on the frontline. The siloed approach to s.136 use within police practice allowed officers to use their discretion in utilising the legislation in a way that they perceived was the safest practice, both for the person in crisis and also for themselves in terms of feeling confident in the level of risk they assumed. NHS MH under-resourcing, whilst undoubtedly the root of MH demand on policing, also contributed to clashes in organisational cultures, particularly in relation to risk, making the *prima facie* appearance of there being shared aims, an untenable reality. The following section contextualises the foregoing discussion with three illustrative case studies.

*Case study 1: Differences in perceptions of what constitutes a ‘mental disorder’.*

The conflicting approaches outlined above were shown to affect how practitioners interpreted ‘mental disorder’ (MHA 1983 (1)), which is fundamental to the use of s.136 and at the heart of the PMHT partnerships. It has been found how MH workers used the term ‘*un-detainable’* when referring to the ‘inappropriate’ use of s.136, and this was underpinned by the variance in risk management approaches and culture, fuelled within health by limited resourcing and available service provision. In practice, health workers’ interpretation of mental disorder and whether someone was experiencing a MH *‘crisis’*, was much narrower than that of PCs. Whether a person had a MH diagnosis at the time of the encounter was pivotal to the health practitioner’s risk assessment, as was the nature of that diagnosis, who diagnosed it, and how long ago.

When discussing their approaches to managing risk, MH practitioners distinguished between a serious mental illness (SMI) that was perceived as a ‘*real*’ mental ill-health issue, and the bulk of the encounters they had with people, which were described as ‘*mental distress’* albeit, sometimes ‘*extreme*’. People with SMI were considered to be those who had received a formal diagnosis of a ‘*psychotic disorder’* e.g., schizophrenia or bipolar. Their understanding of ‘*mental distress’* accounted for everything else, including formal diagnoses where psychosis was not a common symptom e.g., depression, anxiety, and personality disorders. The impact of under-resourcing was at the crux of this, as it was widely reported that when considering available crisis care capacity, ‘*realistically these days only those with SMI would ever get admitted or home treatment*’. In line with such limited availability of tangible crisis care, this was a constant consideration of the health workers within the partnership, which did not extend to the officers.

*Case study 2: Intoxication*

The second case study considers instances where alcohol intoxication was present or accompanied by a reported MH crisis, causing frustration and thus challenging working relations by the inability to reconcile risk management approaches at the frontline of the PMHT partnerships. Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of defining a mental disorder (MHA 1983 (3)), yet the presence of intoxication was a common feature within many of the cases reaching the partnership via police contact. Whether the person was alcohol/drug dependent, or whether they had consumed substances as a by-product of experiencing a crisis, was not the root of the issue. Alcohol intoxication divided practitioners even within the MH teams and was even more divisive within the partnerships. Illicit substances were less so due to the ability of MH staff to identify and differentiate quickly between the traits of a person experiencing a psychotic episode, versus a person under the influence of, for example, a psychoactive substance such as spice.[[3]](#footnote-3) Where they had identified there was no psychotic disorder, the person became categorised as either being in ‘mental distress’ if exhibiting accompanying signs of a crisis, or as having a substance use disorder that was seen, as shown below, as outside ‘*their remit’*.

For health workers, the complexity around alcohol intoxication stemmed from the variation in the effect of alcohol on a person’s functioning, the relationship of it to the person’s current crisis, and the intricacies contained within the Mental Capacity Act 2005 and The MHA 1983, which were misunderstood by health practitioners. Within the OHT, telling a person in crisis that they had the capacity to kill themselves should they so choose, was found to be ‘usual’ practice. Of specific concern was the issue of capacity:

*‘…ultimately you meet some people that are drunk and can maintain capacity and some people can lose capacity very quickly. It’s difficult to create a very specific picture of intoxication and how that affects capacity that then provides a cut-off point [for involvement] …’* (MH worker 7, Northfield)

Any admission at all from the person in crisis of alcohol consumption, whether appearing intoxicated or not, created an observable ‘*buck passing’* of the individual through a clear omission of providing any out-of-hours provision, including that of PMHT. Within PMHT, any incident where alcohol was a factor, or suspected of being a factor, meant the incident became wholly a job for the police and was passed back to the responding officers. This was an area where positive risk taking did not apply to MH practitioners, as described previously, as they had discretion i.e., professional judgment in cases where alcohol was accompanying a MH crisis (to any degree) to refuse their involvement altogether. This was described as a ‘*sticking point’* between officers and MH practitioners within the partnerships. Fuelled by a lacuna in specific available service provision for these people, the alternative was for officers to take the person to A&E. This suggests that the operation of PMHT partnerships was limited in achieving one of their fundamental aims, reducing wider MH demand on officers, given that many of the MH incidents coming to their attention involved varying degrees of alcohol intoxication and health staff were confident in referring such cases back to the officers on scene.

Within co-response models, police breathalysers were used in some instances to determine whether a person in crisis had consumed any alcohol, though several officers expressed concern about this with some describing how if they had a breathalyser with them (many did not) they refused their health partner access to it. The rationale for such included the ‘*message*’ it gave to the person in crisis, that being they are not believed and thus hindering trust, with some officers expressing how they ‘*fundamentally disagree with doing that’.* The second reason given was more pragmatic and related to the needs of the officer within the partnership and the perceived repercussions if the person blew above zero. If the person blew anything over zero, the person would be automatically refused entry into the s.136 suite and would be directed to A&E, despite people being ‘*evidently very unwell and needing support’* and remaining coherent, in spite of any alcohol they had consumed. As the quote below reflects, this was a source of tension between frontline partners, with officers believing that resourcing issues over common sense were to blame for the decisions taken:

*‘…They[health] use the excuse of drugs and alcohol a lot. For one, they were saying he had to go to custody because he’d been drinking, well he hadn’t, and I said to the AMHP he hadn’t and he didn’t believe me. So, he was put on a breathalyser where he blew zero. They were still then looking for excuses, trying to get me to take him into custody! The be-all and end-all for me were that this male had MH issues and he needed help and support and he wasn’t getting it and it looked like people were just trying to pass the buck when he was already in a place where we could get him the support. I don’t know if it’s down to funding cuts or whatever, but we weren’t fulfilling the needs of that gent*…’ (Police Constable 3, Hilltop)

In line with perceptions of what constitutes a mental disorder, MH practitioners widely reported how they were distinct from speciality drug and alcohol teams and therefore when discussing intoxication, it was often identified as ‘*not in our remit’.* In the absence of PMHT-specific policies, the health worker was defining the remit of the partnership based on their usual practice. Intoxication was thus another broad-brush screening tool for them to use to decipher the otherwise unmanaged demand they were tasked with responding to out-of-hours, as part of the PMHT duty. The only available PoS for these incidents was A&E, accompanied by the officer, thus shifting demand from out-of-hour MH crisis provision onto the police organisation and A&E department (managed by a different NHS Trust). The quote below was reflective of many of the calls observed within the OHT office but alludes to the often-multidimensional nature of a person’s vulnerability.

‘…*it is chicken and egg, and it is very difficult when we get patients, parents, girlfriends, wives whatever saying he’s off his head blah blah blah, he’s got MH problems, he needs help, you won’t help him, nobody will fucking help him. Well, no, that’s because he’s pissed all the time…we can’t take people away and section them because they’re pissed*…’ (MW worker 6, Northfield)

The ‘buck passing’ of demand to the other service was similarly perceived by health workers to be evident from their policing partners, also due to intoxication. Whilst officers widely reported their perception that intoxication was ‘*an excuse’* to manage ongoing demand in the places of safety by re-directing people to A&E which they knew was always staffed (albeit scantily), MH practitioners perceived how responding officers ‘*lied*’ to the MH worker on PMHT and ‘*downplayed*’ an individual’s level of intoxication so that they could ‘*avoid A&E’* and instead ‘*try to pass everyone off as MH to us*’ to reduce their own demand. Whilst there were complexities associated with any assessment of a person that had consumed even a small amount of alcohol, this was nonetheless a bone of contention between frontline partners within PMHT. There was an observable sense of scepticism if alcohol was mentioned at all in the initial call from responding officers to PMHT. The quote below was reflective of many instances observed where despite PMHT being in operation, responding officers remained restricted in how to deal with those exhibiting symptoms of a MH crisis where they had consumed alcohol. As the worker alludes to, the only available option in those instances was A&E, thus indicating PMHT schemes did little to alleviate the wider MH demand on either agency:

*‘…I’d probably do the same in their situation. I can totally appreciate how frustrated the police were. They were stuck somewhere outdoors in the middle of nowhere with a drunk person at 2 am in the morning, pissing it down with rain, and they want you to resolve that…so you have this group of people who are drunk enough to be at risk to themselves, but not psychiatric…’ (MH worker 2, Northfield)*

The issue was broader than that of PMHT alone and showed how influences from the breadth of each partner’s role in the course of their ‘usual practice’ strained working relations within the partnership itself. For instance, the MH practitioners working outside of specialised drug or alcohol teams, had a narrow approach to intoxication because engaging with intoxicated people was not part of their usual remit, making this an easy door to close. This contrasted sharply with the usual practice of officers, who encountered intoxication not only in instances of mental ill-health but across a range of other incidents that were part of their day-to-day work. For instance, whilst some incidents are alcohol specific, such as a person being found drunk and incapable or drunk driving, there are those that aren’t, such as public order policing at the weekend or the policing of football matches. All may have varying levels of intoxication associated, yet not all those people are expressing suicidal ideation along with it.

Unlike in MH, the police did not have a standard practice of refusing their attendance or action based upon whether intoxication is mentioned, quite the opposite. Given the pragmatic nature of officers, it is unsurprising that when faced with limited options to ‘solve’ an incident, including one where they believed there was an element of MH related to the situation, they would take the course of action that they perceived to be a) ‘*the most appropriate’* and b) the ‘*most logical’* to them. Whilst a lack of service provision for intoxicated people (either in MH crisis or otherwise ‘risky’) was of practical concern for officers, it was also outside of their remit when working in PMHT partnerships.

*Case study 3:* *The s.136 consultation process and virtual models of PMHT*

The third case study considers three aspects of practice that were shown to affect the police consultation process with a health professional prior to using s.136 (s.136 (1c)). All were underpinned by the same inability to reconcile risk management approaches, under-resourcing of NHS provision, and the consequent impact upon partner working relations as seen above.

Though the requirement to consult prior to s.136 use had only been law since 2017, every officer interviewed knew the criteria for it verbatim. Given that, at the time the fieldwork was undertaken, the amendments had only been in operation for six months, this was suggestive that the changes had been clearly communicated to forces, which had filtered down effectively to reach frontline officers. It was widely reported by health practitioners, however, that this knowledge did not transfer into practice, despite the de facto statutory footing that PMHT had been given through the amendment. As the quote below reflects, the experience of health practitioners was that often officers were continuing to use s.136 without prior consultation with a health professional.

*‘…our expectation is that the PC when they have somebody that’s in distress or potentially in need of a 136, contact us via SPA. So, they ring up, say it’s the police, we log how many come through and they’ll be put straight through to an AMHP, dependent upon who’s available. That’s the plan, does it happen? Absolutely not! Of the twenty-two 136s we had last month, only seven cases involved consultation first...’* (Eastbrook Clinical Lead for MH)

When asked for clarification, the manager confirmed that the figures provided only reflected the number of calls that actually resulted in consultation and not those where police had unsuccessfully attempted to do so. Within Eastbrook, for instance, the SPA was not yet manned by designated staff like the other two sites. This resulted in a crisis care pathway that had been developed for officers to access, not being consistently available due to staff undertaking other roles. Though PMHT was not specified within the crisis care pathways themselves, managers in all sites agreed that this was an acceptable use of the partnership, and frontline officers expressed a preference for contacting PMHT for this process during the hours of operation. As the quote below reflects, even where officers were aware of their designated crisis care pathway, they widely reported how the PMHT partnership route was a much easier way for them to access advice:

*‘…If I ask if there’s a triage officer on and you say no, it kind of throws a spanner in the works because you have to go through to the normal triage thing and there’s so many hoops, as opposed to that point of contact where they’re designated to deal with this for however many of hours, and that’s the majority of stuff that they’ll be dealing with, so you don’t have to jump through the hoops…’* (PC, Northfield)

The ‘hoops’ referred to above, are related to the availability of access to a health professional. In Northfield and Hilltop where they did in theory have access to a 24/7 staffed SPA telephone number, officers were still required to leave a message in the same way that SUs had to and wait for a call back (see Chapter Five). This contrasted with the co-response models where officers could contact their police colleagues instantaneously via their police radio and gain direct access to the health partner. The speed at which officers could access the consultation was not only important for officers owing to their culturally pragmatic nature, but also due to a conflicting legislative consideration for officers around their perceived need for a s.136 detention.

The original wording of s.136 (1) MHA 1983 had not been amended and thus required the officer to believe that a person was in ‘immediate’ need of care or control for s.136 to be used. By adding the requirement to consult prior to detaining someone who was in immediate need, it was perceived as an admission in itself that the original grounds for using s.136 were not met, because the officer had time to have a conversation about whether the grounds were sufficient, thereby removing any evidence they had of the immediacy required for legal use of the power. Although officers were aware that the legislation contained the caveat ‘where practicable’ (s.136 (1C), this caveat was perceived to remove any value in the amendment around consulting, as the requirement for immediacy followed by then only if practicable to do something, were viewed as inherent contradictions of one another. As the quote below reflects, officers’ key concern was about securing the immediate safety of the person in crisis, not resourcing issues.

*‘…I sort of question if you’re going to detain somebody that’s in MH crisis that’s in need of care and support at that specific point to safeguard that person or other people, there’s going to be very few circumstances where you would have the opportunity to phone and seek advice…’* (PC 3, Eastbrook)

Unlike officers being able to ‘de-arrest’ someone, they were unable to ‘de-136’ a person. Once the detention had been made, they had to be seen by a MH professional regardless of whether the information came to light which would affect an officer’s initial reasoning for it. This was a source of frustration for health workers, who perceived officers as ‘*acting blasé’* by not ‘*thinking about the repercussions for us’*, with health workers widely perceiving that the police could themselves reduce ‘*everyone’s*’ demand by placing more of an emphasis on the requirement to consult aspect of s.136 than they were perceived as currently doing. As the quote below reflects, the interpretation of the requirement for immediacy was disputed between officers and health practitioners:

‘…*I would argue that there’s only a handful of people that are literally hanging off a bridge. The rest are probably just distressed, and they could call it in…’* (MH Nurse 1, Eastbrook)

The reported lack of officers consulting prior to their use of s.136 was thus not necessarily synonymous with them not adhering to the amended law. Indeed, the predicament reported by officers supports what was observed during cases where officers hadn’t consulted first, in that they were, for the most part, *only* using s.136 when there was a perceived need for immediacy. Much like the interpretation of ‘mental disorder’, health workers were being driven by resource considerations beyond the initial use of s.136. Officers were forthcoming with their perception of ‘*what needed to happen to make this work’* with many indicating a necessity to remove the perceived contradiction. As the quote below reflects, a widely shared view was that the requirement to consult would be better placed after the grounds for the original s.136 had been met.

*‘…instead, they could add a subsection that says if you use the power, you should immediately then try to consult with an AMHP, doctor or whoever. Make the detention, then try the consultation. You could say for example, within 30 minutes or whatever of making the detention. If one of those registered professionals then gives you grounds in that consultation to feel that 136 is no longer necessary, you can de 136 and then proceed in whatever other way you think is more appropriate…’* (PC, CoP)

The immediacy that co-response models of PMHT often provided officers when seeking access to a health professional was viewed positively, overall. There was also a perception that the advice received from a health practitioner that had been specifically assigned to undertake a PMHT duty was ‘better’ than that they had experienced receiving from the SPA crisis pathway. When probed about what made it ‘better’, officers alluded to their experience of receiving ‘*useful information’* such as whether a person had any appointments coming up, whether they had a care plan, or whether they were receiving any current support. The quote below demonstrates the sometimes-limited options available to SPA workers when they were trying to undertake roles aside from answering the phone to officers.

*‘…It’s not a particularly well-commissioned service that health is providing. I think there’s a general reluctance for my officers to use it because the advice that officers get is pretty shocking, to be honest. I mean I’ve got cases where officers have simply been advised well just take them to A&E, well that’s no help to anybody, is it? I think there are some real challenges with that…’ (Supt, Northfield)*

Where consultation had been successful (either through PMHT or a designated crisis pathway), the final issue emerged, relating to the nature of the consultation itself and whether officers were bound by the advice given. Police practitioners showed uncertainty when asked whether they perceived the consultation to be a source of information, advice, or instruction from the health worker. This contrasted to health practitioners who spoke frequently about their frustration when they had ‘*instructed*’ an officer to take a course of action over the phone, primarily that s.136 detention was not necessary, but officers had done so anyway. The frustrations created through different approaches to risk management and practitioner approaches to s.136 use were thus exacerbated within virtual models of PMHT, where there was not a health professional on the scene. As the quote below indicates, officers unanimously reported that they did not always value the telephone advice provided to them from a health professional ‘*from a distance*’ or ‘*when they don’t have eyes on a person or situation’*, as they still remain responsible for the risk of that person:

*‘…Without knocking it, I’m not sure I would use it because ultimately, it’s my decision and yes the AMHP can advise but it’s me standing with that person and if I think they might die I’m taking them in regardless…’* (Eastbrook PC 2)

In practice, several cases were observed where a person in crisis had been detained under s.136 multiple times within a short period (48-72 hours). After the first attendances in the PoS, health practitioners deemed no further action was necessary and the individuals were tasked with making their way home. Upon leaving the PoS, the individuals made further attempts to harm themselves e.g., one individual lay in the middle of a busy road outside the general hospital, and another returned to the bridge they had originally been detained on. Officers attended each subsequent time and phoned the SPA line who ‘instructed’ officers to either take them home or leave them, as they had the capacity and were ‘just *causing a nuisance now’*. Upon each phone call to SPA, the communication between officers and health staff became more strained, with frustration evident from health workers who were sometimes observed to raise their voices. Officers expressed severe discontentment with the advice they had been given, all remarking how they would continue to use s.136 until they were assured ‘*an action plan’* of some kind had been made for follow-up, and they felt comfortable leaving. Such instances were observed to be far from rare, and in many cases left frontline officers feeling ‘*at a loss’* for what to do to help people when health agencies could do no more for them in crisis. In addition, frontline officers reported the negative implications felt when those from middle management in both organisations became involved:

*‘…You end up almost feeling like a pawn. You might have 136’d somebody and there are arguments going on between your CI screaming in your ear ‘why are you still at the 136 suites with this person, you need to be on the street you’re the only officer I’ve got armed with a taser, we’ve got these jobs coming in so get out of there!’ You’ve got the consultant at the 136 suites saying, ‘you can’t leave because they’re still been violent’, and I’m standing there thinking what do I do? Your policy says you should have enough staff to deal with this patient and they’ll say well I haven’t because two have phoned in sick. That’s not the police’s problem, that’s the NHS’s problem. The policy says unless they’re being violent then we’re leaving and they’re not being violent, so my CI is saying get out, but human nature is saying I can’t leave this person. I’m trying to help you, but I’ve now got two gaffers above me going head-to-head through me. So yeah, the policies are formalised, but they break down very very quickly on the ground, very quickly.* (PC 3, Hilltop)

There was an observable disconnect between what ‘should’ happen and what did happen in practice, with policies seemingly formulated based upon the ideals of having adequate out-of-hour resources, which did not translate into any tangible reality. In returning to the discussion around the differences in risk management, officers’ primary concern remained about the use of s.136 and they were not concerned with the limitations of service provision beyond that, in the same way, health practitioners were. As such, officers remained committed to their legal responsibilities and however frustrated with the repercussions of this they were, there was little they could do to negate the challenges, unless they were to collude with health colleagues in taking ‘positive’ risks, which they perceived to be a dangerous practice, and which were irreconcilable with their own duty of care to individuals who were experiencing distress.

* 1. Conclusion

There are early indications from the results presented throughout this chapter that the occupational and organisational milieu of partnership work in this area is fraught with complexities. Collectively, these findings have shown that multi-agency working arrangements within PMHT are underpinned by an abundance of incompatible tactic working assumptions and practices, particularly with regard to the ‘issues to be solved’ and the relationship of these with how partners approach and manage risk in attempting to solve them. These findings have also identified there was no acknowledgement or knowledge that such a position even existed i.e., there was no important dialogue ongoing about the different interpretations of the issues or problems that existed, resulting in a lack of collective intelligence about how best to address them. The research has thus identified that *prima facie*, the partnerships were operating with a sense of common purpose and shared aims, but these were unable to be supported, lest achieved, through practice in the operation and delivery of PMHT. It is proposed that this is an issue which may span further into the LEPH arena and is unlikely to be confined to PMHT ‘interventions’ alone. These findings need to be considered, therefore, at a wider level and through a lens of what their implications may be for other intervention-type partnerships that are known to be fast developing within E&W as the acceptance of LEPH grows.

This chapter highlights that such complexities have contributed to an inability to establish a genuine shared sense of commitment to the ongoing operation of PMHT partnerships, particularly those operating a co-response model. Fundamentally, each partner organisation has been found to be committed to slightly different versions of the same goals i.e., those identified and facilitated by the signing of the CCC at both national and local levels. More problematically, there were also different understandings of the purposes of PMHT *within* the organisations at the middle and operational levels. Despite the *prima facie* shared aims and purposes (the end game) evident at that level, this was underpinned by failures to fully understand the nature of the ‘problems’ to be addressed at a localised level, and what would be required for partners to reconcile their differing working practices to address this. Having fundamentally different understandings of the issues ‘to be solved’ inhibited the success of each partner agency ‘*getting something out of it’* and this was reflected in the role the partnerships were performing operationally and the manner in which they were doing so i.e., with a sharp contrast in risk management approaches.

This first part of this chapter has shown PMHT partnerships to be multi-dimensional by nature. There was ambiguity about partner membership evident across all levels of the partnership, due to the design of the frontline models and the challenges faced in establishing a consistent membership at the middle management level. At the managerial level of the partnerships, partners showed a shared enthusiasm for the perceived outcomes of working together, i.e., improving their respective services, and decreasing demand for all involved, but the inconsistent membership rendered progress slow. The lack of frontline representation at the middle management meetings was reflected through frontline practitioners being largely unaware of who was involved with PMHT at a more senior level or that a CCC even existed. There were varying degrees of commitment to the frontline duties involved in PMHT partnerships e.g., by officers in deciding if they needed to do more than merely transport the MH worker to an incident.

The strategic commitment to partnership work undertaken by the organisations in the CCC had also not filtered down to individuals at the operational level. Practitioner roles within PMHT partnerships were weighted towards MH workers, the most problematic of which were the de facto decisions taken with regard to s.136 use. There were also ambiguities about the purposes of PMHT partnerships, not only between organisations about why the duty was operating but also within the individual organisations, spanning across different levels of the partnership. This chapter shows that the operation of co-response models on the frontline had developed a purpose far beyond that for which they were seemingly intended. Within the context of providing an emergency service, officers had little need, either in law or in practice, to be present for the encounter, yet perceived this as the second primary function of PMHT in the absence of specific and clear PMHT policies, working guidance, or an overarching governance structure.

The absence of these also meant frontline practitioners were attempting to operate in the same manner they would in their day-to-day roles, leaving little room for compromise within the partnership setting. For example, partners held similar, but not identical, understandings of fundamental issues, and were approaching incidents with a siloed mentality. This was particularly prevalent with regard to defining what constituted a mental disorder; when intoxication was present in a crisis situation; and in the nature of the virtual consultations between police and police practitioners before the use of s.136. The result was often missed opportunities for all to benefit from the partnership and the unequal division of roles and responsibilities by frontline practitioners, particularly in their decision-making. Without resolving, or at least recognising these incompatibilities across all levels of the partnership, the tangible benefit to the police organisation, in particular, was inhibited.

1. **CHAPTER SEVEN**

**Perspectives from people with lived experience of PMHT**

* 1. Introduction

This chapter presents key findings from the SU postal questionnaire and interviews. The narrative presented throughout offers a sense of the cautious optimism felt by those with lived experience, about the prospect of an innovative addition to the existing crisis care landscape, in the form of receiving a co-response. This, however, had arisen out of the flames of a profound sense of injustice that was felt, relating to both the broader systemic failures of existing crisis care provision, along with peoples’ prior interactions with individual health practitioners working within it. The chapter opens with the findings that demonstrate how overall, perceptions of the co-response were generally positive, yet it also shows how such perceptions cannot be understood in a silo that relates only to the co-response experience itself. Much of this section includes references to crisis care more broadly, with a focus on how and why people came to the attention of PMHT. With this established, the remaining key themes are presented through two further sections, namely, perceptions around partnership working and perceptions around interpersonal relations with practitioners.

There is shown to be a fundamental want of receiving not only a dignified and compassionate response when in crisis, but also the ability to receive tangible and immediate MH crisis support from a MH professional - something that aside from the co-response was absent within the existent crisis care landscape. With the bar for such service provision set so low, the prospect of *any* novel addition, which was perceived as potentially being able to fill this void, underpinned such positivity. This was coupled with the perception that the primary aim of the co-response model was to ensure SUs accessed the support they needed, in contrast to the more strategic focus of reducing MH demand on agencies as identified by practitioners.

The chapter pulls together the range of expertise and contributions offered from both the survey and interview data, to provide a holistic understanding of the crisis care landscape, and the implications of such for the people who have received a PMHT co-response. The chapter concludes that, despite PMHT being viewed tentatively positive by those with lived experience, co-response models of PMHT served as a temporary ‘sticking plaster’ for existing crisis care provision (Wood et al, 2014), that remained consistently unable to meet the needs of the people who sought it. As the partnership arrangement in Northfield was locally known as ST, this was the terminology used for the survey.

* 1. Overall perceptions of crisis care and receiving a co-response from PMHT.
     1. *The primary purpose of PMHT*

There were four statements included in the survey which related to what respondents thought the purpose of ST was. These were based on the key aims and objectives identified in the literature. Respondents were asked whether they thought its main purpose was to better manage a person’s risk factors; prevent hospital admissions; ensure the SU receives access to help; and enable better data sharing between the police and MH workers. As shown in Table 7.1, there were 16 responses to all statements, apart from for the question about whether the main purpose of ST was to prevent hospital admissions, for which there were 13 responses.

Whilst there were varying levels of agreement with the ideas that the purpose of ST was so the team could better manage a person’s risk factors (86.7%) and enable data sharing (62.2%), the most common response, with 100% of respondents agreeing, was that the main purpose of the initiative was to ensure the SU received access to the help they need. The statement asking respondents whether the main purpose of ST was to avoid hospital admissions was the only one of the four statements about the purpose of ST that did not show much variation between agree and disagree (46.3/53.7%). Whilst one respondent commented that they would be detained more often without ST (they did not indicate if they viewed this as a good or bad thing), another commented on how they failed to see how it prevented hospital admissions.

The responses, overall, signified an optimistic outlook on ST, in that all thought it was for the benefit of patients to ensure they received access to the help they needed. That said, as the quote below indicates, there was some recognition that there had been no co-production with those with lived experience, in either the development or ongoing operation of the partnership. There were calls to ensure that the perspectives of SUs were included as standard, in future.

*‘…I think they really need to consider SU views and whether this is in their interests or not. It shouldn’t just be in the services best interests with the decisions that are being made...’* (SU1)

Chapter Six highlighted how frontline staff perceptions around the purpose of PMHT partnerships were much broader than the nationally identifiable objectives (in the absence of formal local protocols) e.g., to stop people from entering the CJS. Whilst SU respondents highlighted that they believed the aim of ST was to improve their experiences whilst in crisis, Chapter Six also showed that this was not a purpose identified by staff, signalling a variance in the understanding of the scheme’s purpose.

**Table 7.1: Number of respondents and % for the main purpose of ST**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement** | ***N***  **Total** | ***N***  **Agree** | **%** | ***N***  **Disagree** | **%** | ***N***  **Not sure** | **%** |
| I think the main purpose of Street Triage is to ensure the SU receives access to the help they need. | 16 | 16 | 100 | 0 | 0 | 0 | 0 |
| I think the main purpose of Street Triage is to better manage a person’s risk factors | 16 | 14 | 86.7 | 2 | 13.3 | 0 | 0 |
| I think the main purpose of Street Triage is so the police and health can share information about me. | 16 | 10 | 62.2 | 6 | 37.8 | 0 | 0 |
| I think the main purpose of Street Triage is to prevent hospital admissions. | 13 | 7 | 46.3 | 8 | 53.7 | 0 | 0 |

* + 1. *Situating the optimism of SUs: ‘anything is better than nothing’.*

The survey included statements which sought to gauge overarching perceptions of people’s experience of receiving a co-response to acute instances of mental ill-health. Respondents were asked whether they thought ST was a good idea (Table 8.2), 20 respondents answered, 100% of which agreed with the statement, indicating there was certainly support for such a partnership. The survey also asked whether respondents would be happy if they were to be seen by the ST team again if necessary and whether overall, they were satisfied with the way they were dealt with by ST. There were 17 respondents to the first statement about whether they would be happy if they were to be seen again, with 70.6% expressing agreement, indicative of a positive experience. The second statement about whether respondents were satisfied with the way they were dealt with had 18 responses and a 77.8% agreement rate, also indicative of a positive experience.

Interviews with SUs and the qualitative comments on the survey helped explain why these views were expressed. Across both sets of data, participants felt they had, *at least* once, during prior contact with MH services ‘*been failed’* by them when in crisis. Whilst the fact all respondents with lived experience of a co-response were already known to MH services and so this, in itself, was a notable finding in relation to the operation of PMHT and the demographic it served, this also meant people’s prior experience of ‘the alternative’ to receiving a co-response underpinned the largely positive perceptions about the idea of the partnership itself.

**Respondent 12:** *‘I have been sectioned nine times since the age of 19 (now 27). Every experience has been different. On balance, the police have done more than health have. The MH services have not met my needs either before, during or after, hence the cycle of sections keeps going’.*

As the quote above illustrates, many had been in a cycle of MH crises for some, if not all of their adult lives. The experience of participants accessing MH support when in crisis was vast and varied, including numerous police-only responses; attendance in an array of different places of safety (including police custody); periods of prolonged stays within MH inpatient facilities; access to third-party providers, such as crisis houses or cafes; and sometimes, in contrast, being unable to speak to any MH worker at all when in crisis. It was primarily these collective experiences that underpinned the perception that ST was a good idea. ST was seen to offer the prospect of ‘*change*’ to the existing landscape, by way of additional resources, rather than co-response being in and of itself a positive initiative.

Every interviewee believed an underfunded system of crisis care underpinned their difficulties in accessing adequate and appropriate support that could have met their needs when acutely unwell, on each occasion. As well as these difficulties often exacerbating the level of distress felt during times of crisis, the effects of the prior contact with crisis care provision also were prolonged into the future, something that was described as a ‘hidden’ harm of trying to access crisis care. The following sections reflect the wider difficulties with crisis care and thus contextualise some of the factors that led towards a person receiving a co-response through ST.

**Table 7.2: Number of respondents and % for items that assess general perceptions.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement** | ***N***  **Total** | ***N***  **Agree** | **%** | ***N***  **Disagree** | **%** | ***N***  **Not sure** | **%** |
| I think Street Triage is a good idea. | 20 | 20 | 100 | 0 | 0 | 0 | 0 |
| I would be happy if I were seen by the Street Triage team again, if necessary | 17 | 12 | 70.6 | 5 | 29.4 | 0 | 0 |
| Overall, I was satisfied with the way I was dealt with by the Street Triage Team | 18 | 14 | 77.8 | 4 | 22.2 | 0 | 0 |

* + 1. *The ‘hidden harms’ of an underfunded system of crisis care*

A key theme that emerged was around the infliction of what people described as ‘*hidden harms’* that were perceived as inevitable after contact, or attempted contact, with MH services. It was reported that a co-response also had the potential of hidden harms, though the innovative nature of the scheme meant the hidden harms were somewhat reduced. Chapter Five depicted practitioners’ decision-making as being resource-led over needs-led i.e., decisions based on available resources over meeting individual needs. This was felt harshly by those with lived experience, with some citing instances of friends they had lost to suicide due to staff ‘*getting it wrong’* in their decisions not to admit someone to a hospital due to high demand on inpatient provision, despite the belief that doing so may have prolonged the person’s life. As the following quote reflects, even when in crisis and expressing imminent intentions to end a life, people were acutely aware (or in the case below, explicitly told) that there was no available provision available that could meet their immediate needs to keep them safe.

*‘… Sometimes I’ve been told [when suicidal], literally, you’re the bottom of the list or there’s people that are ill-er than you, when requesting support …’ (SU1)*

People reported that resource-led decisions contributed to the sense of injustice felt towards the existing provision, as it fed into a feeling of ‘*hopelessness*’ or ‘*being beyond help’* when in crisis, and this feeling became heightened with every subsequent period of crisis. It was commonly described as an ‘*additional layer’* of emotional distress that people felt on top of the initial crisis, and this deepened the more it was experienced. For instance, it was commonly reported that upon ringing the MH team and ‘*reaching out for help’* as encouraged to do when suicidal, the ‘help’ was in fact not helpful in practice. On the contrary, it was described as ‘*harmful*’, given the impact that learning of the lack of available provision, for people experiencing suicidal ideation (especially in their own home), had on a person’s willingness to contact the service if in the same position again.

Interview respondents reported how telephone crisis support, described as ‘*standard provision you receive*’ centred on distraction techniques e.g., ‘*have a bath’* or ‘*make a cup of tea’*, with many participants expressing how such advice felt patronising when in such a state of distress. What was reported as missing, was an emergency MH response, with a MH practitioner able to attend to the person in the same way they would if they were experiencing a heart attack. This perceived lower offer of standard telephone provision, had in several cases, led to the person leaving their home with the intention of ending their life, only for the police to be called later. Such instances were reported to lead to people being categorised as ‘high-risk missing persons’, which then became a police ‘job’, rather than resulting in recognition that they were experiencing a MH crisis and needed immediate help to keep safe.

Experiences of attending A&E were also reportedly bleak, involving long waits in a ‘*distressing*’ environment, and a lack of any further care upon leaving the hospital. Long wait lists for follow-up care, an inability to access crisis care in the community e.g., home treatment, and the frustration of what was perceived to be ‘*playing with lives’* with regard to a lack of available inpatient beds, were all factors contributing to the perception that existing provision fell short of an adequate system of care. Those with experience in inpatient facilities described the environment as ‘*chaotic*’; ‘*about medication and risk management’*; and ‘*a lack of staff available to help you get better, or even just talk to you’*.

Fundamentally, people’s prior experience with MH services often affected a person’s decision as to whether to contact them again, in a crisis capacity or otherwise. In some cases, this directly led to police involvement as some people preferred to contact the police themselves instead of crisis care, or as described prior, the police became involved as a consequence of the unmanaged crisis. In some cases, this had the potential for some incidents to come to the attention of PMHT if the responding officers subsequently sought the support of PMHT during its operating hours. Beyond accessing crisis care, it was also reported how prior negative experiences with even one other team within the same organisation, had the potential to impact whether they chose to ‘*engage*’ (a word used by those with lived experience, lifted from practitioners who used it to describe non-cooperation with them) with the existing provision. The word ‘engage’ was on more than two occasions, used by SUs who placed metaphorical quotation marks around it (using hand gestures), signalling their contempt of the word when practitioners were said to have told them they were ‘*not engaging with services’*.

It would be disingenuous not to report that several people described grave instances of sexual, physical, and emotional abuse that they had experienced within MH inpatient facilities throughout their lifetimes, which go far beyond the described ‘hidden’ harms. Understandably, such experiences caused enduring trauma to people who were already experiencing mental ill-health. As the following quote reflects, these instances were not confined to such harm being inflicted by other inpatients, but also, disturbingly, to staff.

*‘…It [police] doesn’t bother me because I’m not a criminal and I’ve always had positive experiences with them, so they don’t frighten me. I’m more frightened of MH staff because of [what they did]. Part of what I’ve got now is PTSD, not only because of my childhood but also because of what happened to me on the psychiatric ward, and not just what happened to me, but what I saw happening to other patients from MH staff…’* (SU5)

Though such grave reported instances were thankfully much rarer than perceptions of the harmful impact of resource-scarce provision, or the prior negative interactions, many referred to the concept of secondary traumatisation that they felt had occurred as a result of prior interactions with MH services and the practitioners working within them. This is not only related to crisis care provision, but the harms also felt from an inability to access ongoing community support, which many perceived as being key to breaking the cycle of crises. Such prior experience and interactions also influenced the likelihood of people coming to the attention of PMHT, given that these people were more likely to come to the attention of the police than had they contacted crisis services directly.

* + 1. *Inability to access adequate support prior to the crisis.*

A total of 20 respondents responded to the statement asking if the ST team were the first workers that saw them when they were unwell (Table 7.3). Of those, 5 stated they were unsure. There was little variation, however, between those who stated ST were the first workers to see them when unwell (35%) and those who stated they were not (40%). This aligns with the findings in Chapter Six, about how secondary co-response models of PMHT were, in practice, sometimes operating as first responders to incidents of mental ill-health. This was also shown to underpin some perceptions that the co-response was capable of filling the emergency service provision void, as their experience was that it had done so in their experience i.e., they received an in-person MH response at the speed they would otherwise have received from an officer on their own.

The survey comment boxes allowed respondents to answer according to their own circumstances, with many interpreting this statement to be about the broader issue of people’s ability to access MH provision prior to reaching a point of crisis, which survey respondents indicated would negate the need for any crisis response altogether.

**Respondent 3:** *‘The staffing in MH is not consistent, hence a breakdown of support. When I leave hospital (after section) it is up to my mother’s care. Despite eight admissions there is little support at home. I have been passed from one worker to another and no one gets the context. I am always left to decline, and then it is up to emergency services to try and turn it around, by which point it is too late. The police then step in. What a waste of police resources’*

This comment reflects respondents’ inability to access sufficient community MH support prior to reaching the crisis point, and thus *why* they had received a police or co-response to the crisis, rather than emphasising whether they had received a primary or secondary PMHT co-response during the crisis itself. Though also about resources, this is distinct from the previous section, as the respondents’ focus was on community care provision, which many believed had they been able to access in a timely manner and on a consistent basis, would have prevented the need for a PMHT partnership response and would have stabilised their MH.

**Table 7.3: Table showing the number of respondents and % for ST as first responders.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement** | ***N*** | ***N***  **Yes** | **%** | ***N***  **No** | **%** | ***N***  **Not sure** | **%** |
| The Street Triage team were the first workers that saw me when I was unwell. | 20 | 7 | 35 | 8 | 40 | 5 | 25 |

* + 1. *Perceptions of the scenarios and/or circumstances leading to PMHT attendance*

The nature of the circumstances which people perceived as generating the co-response, broadly centred on suicidal ideation or unmanaged episodes of psychosis, both involving issues of personal and community safety. The following accounts are reflective of this, showing the largely unestablished remit of PMHT and how people came into contact with PMHT teams. Though it was perceived that there was an overall shortage of community provision that may have stabilised their enduring mental ill-health, the individuality of people’s circumstances meant there was a multitude of scenarios that generated a co-response.

One participant reported how during their MH crisis, a family member had contacted the SPA line to speak to the OHT. They were advised that, if they were unable to physically get to A&E to access medical support (as per the crisis care pathway), the quickest alternative was to contact the police, as the police now had a ‘*special MH team*’ (referring to co-response). This (mis)understanding of PMHT reflects the concerns and account provided by the CoP representative in Chapter Six, which highlighted concerns around PMHT being utilised in an emergency service capacity, even though this was not formally part of its remit.

Another respondent reported being approached by PCs whilst sitting on a park bench ‘*clearing his mind’* after having a ‘*bad day*’. Upon further questioning, the officers instructed him to stay with them in the park whilst they contacted PMHT, despite the person informing them he was aware of his long-standing MH challenges and stating he was not in crisis. Notwithstanding this explanation to the officers and the embarrassment he explained he would feel if they contacted PMHT (due to his own employment within the Trust), he described how the officers were insistent that he remained there and stood in front of the bench, preventing him from leaving.

*‘…I can understand and respect that they have their job to do, and they have to make sure you’re safe, but I also believe that part of that job is to listen and give you some space. I think they need to respect that as well. It doesn’t mean to say that they’ve got to leave but they could have just backed off and I could still have been in sight, but they didn’t need to be so intrusive…’* (SU4)

The account in that instance, fed into a perception that the co-response was a wholly unnecessary resource if officers were to use it in an overzealous way. Other examples of accessing multi-agency working in the context of PMHT, included them attending the train station following calls from British Transport Police and multi-story carparks within the city centre, where officers had requested the assistance of a MH worker. In these instances, the incidents were much more akin to MH crises, unlike the park example above.

One participant reported that PMHT attended her home as secondary response after she experienced hallucinations for the first time. She had phoned the police, seeking help from them to arrest her family for war crimes (due to the specific nature of the psychotic episode). It was reported that the responding officers provided a great sense of relief to this person, as did the secondary officer who attended as part of ST. This instance corresponded with observations that found many calls requesting PMHT assistance involved circumstances when officers were at people’s houses. The police in these instances would have been unable to invoke s.136 due to the person being in a private dwelling, and thus their attendance was unlikely to have been necessary.

* + 1. *Perceptions about the outcomes received after co-response encounters.*

There remains a lacuna in evidence about post-PMHT contact, though measuring this was a recommendation as part of the PMHT evaluative tool developed for the College of Policing post-fieldwork (Kane et al, 2021). The survey did, however, seek perceptions on whether respondents received an outcome they were happy with, whatever that may have been. It also asked whether people felt they had received adequate MH support after the co-response encounter.

As Table 7.4 shows, there was little variation between those who stated they were happy with an outcome, to those who were not. Table 7.4 shows that 52.9% of respondents agreed with the statement that they received an outcome they were happy with. The second statement however asked more specifically about whether respondents felt they received adequate MH support after their contact with ST, to which 68.7% stated they did not. Again, this is reflective of there being limited MH provision which was only awarded to the ‘*most unwell’* or ‘*most risky people that aren’t even the most unwell’*.

In the survey comments and interviews, participants described how, soon after the encounter with the PMHT staff, the team would quickly move on. Whilst this was perceived as being an understandable aspect of the nature of triaging, they also had a sense of ‘*dread*’ due to the knowledge that, even after receiving the immediate response, they were ‘*on their own again’* and they would not receive any further support or ‘*follow up’* from MH services. Whilst the co-response was positively perceived as something ‘*new*’ and ‘*unusual*’, it would not solve the shortfall in NHS provision. This section has highlighted an array of unresolved issues arising through the operation of co-response PMHT models, not least the extent to which the police continue to ‘pick up the pieces’ (HMRCFRS, 2018) of MH care in the community through responding to incidents in private dwellings, where they had no more legislative powers than a social worker or MH professional. With a perception that any innovative initiative that adds to the existing crisis landscape is ‘better’ than not, it becomes near impossible to consider it as a solution to the issues the partnership sought to improve.

**Table 7.4: Number of respondents and % for items that assess treatment outcomes.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement** | ***N***  **Total** | ***N***  **Agree** | **%** | ***N***  **Disagree** | **%** | ***N***  **Not sure** | **%** |
| After contact with the team, I received an outcome I was happy with | 17 | 9 | 52.9 | 8 | 47.1 | 0 | 0  0 |
| I received adequate MH support after my contact with the Street Triage team. | 16 | 5 | 31.3 | 11 | 68.7 | 0 | 0 |

* 1. Overall perceptions of partnership working
     1. *Two agencies are better than one!*

Table 7.5 shows that when respondents were asked whether they felt it was necessary for both the police and MH workers to be present in their case, 13 of the 18 respondents to the question (72.2%) agreed that it was. During the interviews, however, the reasons SUs gave for this, were unrelated to any particular policing needs. The key reason given was that had they not received a co-response, there would have been no in-person response at all. Participants recognised how having the officer working as part of the co-response team equated to them receiving an emergency in-person MH response, something which was otherwise unobtainable. The second reason was that their experience showed that having the police as partners, meant they were more likely to receive a compassionate response than if health attended alone. Finally, interlinked to this, there was a perception that the police could be trusted to provide checks and balances on the behaviour and interactions with the health worker, to avoid the perceived ‘*abuse*’, ‘*rudeness*’ or ‘*lack of compassion’* they had experienced during prior encounters with crisis care practitioners. None of these reasons, in law or practice, necessitated police attendance.

As aforementioned, prior crisis experiences (outside of the partnership encounter) meant many participants were able to use a comparative process to decipher specific aspects of their co-response encounter that they identified as being specific to the partnership itself. As a starting point, participants overwhelmingly reported that, during any prior experience with the police during a MH crisis, they had received a high level of compassion from PCs. Moreover, it was widely reported how people perceived there to have been a distinct lack of compassion from MH practitioners during prior encounters with them, not only when accessing the existing crisis care provision, but also from experience within both community and inpatient services, as Respondent 11 below explained.

**Respondent 11: ‘***The crisis team have traumatised me. Never again will I seek help, they do more harm than good. Police should be better trained, but even now, without it, they are caring and give a damn about what happens to you’.*

**Table 7.5: Number of respondents and % for items that assess team dynamics.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement** | ***N***  **Total** | ***N***  **Agree** | **%** | ***N***  **Disagree** | **%** | ***N***  **Not sure** | **%** |
| I feel it was necessary for the police and MH workers to be present in my case. | 18 | 13 | 72.2 | 5 | 27.8 | 0 | 0 |

* + 1. *It doesn’t matter who initially responds, so long as you can access the appropriate support.*

The survey asked respondents whether they minded who responded to their MH needs if they received the necessary support. Table 7.6 shows that the majority of survey respondents (77.7%) agreed, in that the agency that responded to their needs was less important than receiving the support people felt they needed. People sought compassion when at their most unwell, and there was a perception that they were more likely to receive this from PCs. The gateway to this support was less important than the support itself, though it was widely perceived that, for many, the support was unobtainable much, if not all, of the time.

**Table 7.6:** **Number of respondents and % for the item that asked about the response.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement** | ***N***  **Total** | ***N***  **Agree** | **%** | ***N***  **Disagree** | **%** | ***N***  **Not sure** | **%** |
| I did not mind who responded to my MH needs, so long as I received the support I felt I needed | 18 | 14 | 77.7 | 3 | 16.7 | 1 | 5.6 |

* + 1. *Perceptions of joint decision-making processes within the co-response*

Table 7.7 presents two statements that asked about perceptions of the decisions the PMHT team made about the outcome of the contact. The first asked respondents whether they agreed or disagreed that staff on the ST team made the right decision, even if they did not agree with the decision at the time. A total of 16 respondents replied, of which 10 (62.5%) agreed. The second statement from the survey sought perceptions about whether respondents felt at the time that ST could be trusted to make decisions that were right for them. Again, 16 responses were given, and 12 (75%) respondents agreed that they could. Although not a major variation, these results may indicate that, at the time of the encounter, respondents felt they trusted ST to make the right decisions for them, but slightly less so when considered in hindsight. The third statement in the survey about decision-making asked respondents whether the team clearly explained the reasons for their actions towards them. A total of 17 responses were recorded, and 14 (82.4%) agreed that the team did. During interviews, the key decision that had not been communicated was whether they have been detained under s136 or not. Several people did not know how many s.136 detentions were on their record, as often they were never told if the power had been invoked or not. Despite recognising it may not be appropriate for everyone in every circumstance to know this, the general consensus was that they would prefer to know this information, as it relates to transparency and trust.

The key decision that was perceived as being made during the co-response encounter, was whether the police should use s.136 or whether there was an alternative. Whilst this decision was perceived to have been informed by the health worker, there were cases reported where people had experienced the officer taking a different course of action. This was more common though in repeat instances, where the police had attended again within 4-72 hours after an initial co-response, and health workers (in the office) or responding officers, were reliant on the previous recent contact in their decision-making. Generally, it was reported that when both members of the co-response were present, the health worker coordinated the outcome, and the officers facilitated it.

*‘…I’m not 100% sure how many times I’ve come across street triage, I’m thinking probably like four or five times, and I think most of the decisions have been appropriate, whereas I have had inappropriate outcomes coming out of them not being there…’ (*SU9*)*

As the quote above indicates, it was felt by several participants that they had received better outcomes than if they had been taken to the s136 suite, the key one being direct admission into the local crisis house (operated by a third party). They believed this would have been the eventual outcome had the police taken them to the s136 suite, but by receiving a co-response, this was arranged without the long delays that would have arisen had they been taken to a place of safety first. The crisis house, which had six beds for the city, was the most favoured outcome and described as ‘*worth its weight in gold’* by several participants, though they also described getting a place there as like ‘*gold dust’*. The key message reported by SUs was the need for practitioners to treat each contact on its own merits when making decisions about a person.

**Table 7.7: Number of respondents and % for items that assess decision-making processes.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement** | ***N***  **Total** | ***N***  **Agree** | **%** | ***N***  **Disagree** | **%** | ***N***  **Not sure** | **%** |
| I feel the decisions staff made about me were the right ones, even if I didn’t think so at the time. | 16 | 10 | 62.5 | 6 | 37.5 | 0 | 0 |
| I felt the team could be trusted to make decisions that were right for me. | 16 | 12 | 75 | 3 | 18.8 | 1 | 6.3 |
| The team clearly explained the reasons for their actions towards me. | 17 | 9 | 82.4 | 7 | 11.7 | 1 | 5.9 |

* + 1. *The importance of practitioners recognising each contact on its own merit*

The importance placed upon the need for recognising the particular circumstances of each encounter was raised during interviews, especially from those with prior experiences of the police and MH services.

**Respondent 13:** *‘It is important for both police and MH workers to recognise that every incident is different. What I found to be useful on one occasion may not be on another’.*

What may have seemed the right decision on one occasion may not, therefore, be the right decision for that person thereafter. This was particularly pertinent to those who understood the way previous encounters were documented (see *8.3.6*), as there was a cynicism about whether what was ‘*on record as working’* aligned with the person’s perception of whether the previous course of action was a) effective at alleviating someone’s distress and b) compassionate. The ability to share information was recognised as something that *could* be helpful in assisting officers to make appropriate decisions outside the hours of when the co-response was in operation.

* + 1. *Perceptions of information sharing within the partnership*

The survey asked whether it was good that police and health agencies worked together so they could share information, and 75% indicated agreement. Although the majority of survey respondents agreed that professionals sharing information through PMHT was positive, those who disagreed indicated greater concern with *what* information was being shared (and the impact such information would have on treatment), than the process of information sharing itself. For example, the respondent quote below highlights issues they took with their patient record.

**Respondent:** *I attended A&E, but left, due to horrible, unprofessional staff who accused me of being violent based upon reading my notes. This has never been the case. I am a young professional who suffers with my MH from time to time. They lied (Liaison and Diversion). Street Triage were called by the police when they found me distressed in town. I would never trust a MH worker again. I don’t like the police that much either, but they are at least professional in MH situations.*

The acceptability of information sharing between agencies was further explored during the interviews and, fundamentally, the issue was mistrust. As shown in the survey data, rather than there being an issue about sharing information with professional partners per se, concerns centred on the accuracy of the information being shared and the perceived impact that inaccurate records may have on both the response received and future encounters.

* + 1. *Perceptions of incident recording*

SUs expressed frustration about their inability to have any input into what the practitioners recorded about incidents they were involved in, and the disempowering effect this had on them. Unlike instances of physical ill-health where people can have access to their records, for MH, people have to rely on submitting Subject Access Requests (SAR) as per GDPR legislation or rely upon what the MH worker tells them.

It was observed that MH records were multifaceted and to an untrained eye looked relatively complex to navigate. For instance, instead of there being a singular ‘record’ document, practitioners were required to open up however many ‘tabs’ or ‘entries’ there had been made prior about a person, to access any individual communication or encounters on a singular basis. Entries include, for example, copies of correspondence sent and received, medical reports such as varying MHA assessments and psychiatric assessments, multi-agency care meeting minutes, an individual’s care plan if they had one, and also entries made by professionals after having contacts such as a telephone encounter or meeting. It was the last of these which was perceived as the most problematic to SUs, in terms of the way in which the crisis practitioners within PMHT and/or out-of-hours services recorded their contact with an individual in crisis and how this is related to trust and accountability.

Several participants referred to these kinds of entries as ‘*stories*’. It was found that such entries consisted of a description of the encounter, any action taken, and the reason for said action, written in a narrative type of format by the professional working within the team who had managed the call or contact. It was reported by several people who had requested access to either their own MH records or that of someone they cared for, that these entries were usually inconsistent with their own recollection of the encounters. The notion of feeling ‘powerless’ was alluded to in relation to this, supported by accounts that such entries could never be deleted, only amended to state that the person disagreed with the record and with little further explanation. One participant described how they believed this was going to affect their future care, because ‘*the same staff are still going to read you’ve disagreed with them, so straight away they’re going to think you’re difficult’*. Participants also believed that such disagreements would also serve as a warning to any future practitioners that their evidence and reasoning within future entries should be ‘*watertight*’, so no future questioning or possible complaints could be made:

*‘…I’ve had access to a friend’s notes, she died of mental illness. After she died, I cleared the house out I found her notes and I couldn’t read them all, I picked up the odd page and thought I never ever want to read my notes and what they’ve been saying about me behind my back. I don’t think anyone would be able to read those without causing some serious mental damage. It’s a back-covering exercise to save their arses when things go wrong…’* (SU5)

The quote is indicative of the emphasis practitioners placed on coherent documentation in relation to accountability reported in Chapter Six, and the need for there to be comprehensive documentation detailing actions and reasoning for every contact.

One of the key examples given where trust between the person and a practitioner/service had been eroded was in relation to communication and ‘*attempts to contact’* a person. One person described the profound impact of this on them at a time of feeling desperation, and how they ‘*were hanging* on’ for a phone call to be returned by health staff when they were in crisis. Despite ‘*purposely waiting’* for the call, they reported such calls were never returned and yet when they raised this with the next practitioner they had contact with, they had each been informed that a worker had tried to make contact and left a note in the record to state contact had been attempted. These instances place an emphasis and responsibility for care on to the SU, many of whom stated they had in their past been told they were ‘*not engaging with services’*, despite from their perspective, often never having had the opportunity to engage, notwithstanding proactive attempts to manage their crisis by reaching out for support when necessary.

This system of recording information also places a natural assumption of the practitioner being ‘right’ and ‘trustworthy’, as opposed to the SU who, in the event of conflicting accounts, felt they were treated as being untruthful or naturally less trustworthy. Several people had been through the NHS complaints procedure with regard to previous care received, yet were left with a sense of hopelessness, with one stating ‘*the only time anyone ever gets questioned is when you’re dead, well by then it’s too late*’.

When probed, such issues of documentation were as relevant to PMHT as they were to MH services. In part, this related to the way practitioners had used what was described as ‘*irrelevant*’ or ‘*made up’* information to aid the documentation relating to the determination of a person’s risk of harm. Respondents did not have experience accessing their records after co-response intervention so were uncertain if this applied to those instances, but suspected it was, due to prior experience with MH workers. One participant described how upon speaking with their care coordinator post-crisis (not involving a co-response), they were asked if they had enjoyed the trip to the seaside. When in crisis this participant had stated they were going to get a train to some cliffs and end their life, yet on their record it had been stated that the person was planning to the future and had a seaside holiday planned, indicating that there were no imminent plans to end their life. This was felt to be a gross misrepresentation of the circumstances, and one that was felt in the event of an inquest would be used to alleviate the responsibility of the person’s team. The lack of trust felt towards the MH services was therefore, by and large, due to the recording of the interactions overseen by a lack of accountability. This affected people’s perceptions of the service as being legitimate, hence concerns were raised about the impact of sharing such information with the police. It was perceived that a joint response increased the legitimacy of both agencies, as it was capable of providing the ‘*missing*’ level of accountability. Another issue relating to legitimacy was whether when in crisis people could identify and authenticate that the practitioners were whom they said they were.

* + 1. *Uniform to establish the authenticity of the practitioners.*

In Northfield, PCs wore full uniform and protective personal equipment (PPE) including their baton and incapacitant spray when co-responding to MH incidents. The survey data indicated that of the 13 total respondents, 8 (61.6%), thought PCs should wear uniforms on PMHT duty. This is complemented by the agreement that out of 15 total respondents to this question, 10 (66.7%,) indicated that the police uniform made it clear there were two types of staff on the team.

Those respondents who disagreed with the statement about officers wearing uniforms when attending to MH incidents, all left comments relating to the impact that police uniforms may have on a person in crisis, such as heightening emotions and causing fear. As well as raising this point in the interview, many commented on police uniforms being a ‘necessary evil’ as it was important to be able to establish the authenticity of the practitioners. Though some expressed how the presence of police uniforms could feed into their psychosis and the immediate distress of the crisis, there was a strong case for the continuation of police uniforms so that they could trust the practitioner was whom they said they were. As the respondent below refers, the lack of uniforms for MH workers meant they were unsure of their role.

**Respondent 20:** *I didn’t have a clue who was who at first. I didn’t know what their (MH staff) profession was which made me more scared…so I think all staff on the team should wear uniforms. It is imperative that SUs are aware of who is attending to them in a crisis.*

During interviews, participants reported, in many cases, the therapeutic effect they felt upon seeing the police uniform. For those who had previously had many encounters with the police during times of crisis, they reported how the feeling of being a criminal had been suppressed over time, as the police response had become normalised and an engrained aspect of their lives i.e., participants had widely adopted a ‘*that’s just part of life’* mentality. That said, the feeling of being a criminal had not always been so accepted, with many recognising how scary they found it the first few times. This is important in relation to the future of co-response PMHT, given people were often receiving a co-response where there was no tangible need for it. As such, it remains important for officers to consider how their presence may impact an individual in crisis, particularly with regard to whether they attend in full uniform or not.

Finally, on the issue of identifying who was involved in the interaction, as the below quote refers to, for some (especially in cases of psychosis), there is an element of recognition that some authority figures (if they are part of the episode), may feed into a person’s episode more than others.

‘…*the police that night did more for me than the MH team. I felt like the [MH] worker didn’t believe me. The policeman wrote me a list of what to do, that was on the Monday, and I was sectioned on the Saturday. The police were fantastic. It’s hard when you have a psychotic episode because you trust certain people and there’s no rationale behind it. That MH man, he gave me a number to ring but when your brains distorted and you only trust certain people, I didn’t trust him*…’ (SU4)

On this basis, people may naturally feel a greater element of trust in either practitioner with no seemingly rational reason. The perceptions underpinning the presence of police uniforms, however, varied when it came to the use of police transport.

**Table 7.8: Number of respondents and % for items that assess staff uniform.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement** | ***N***  **Total** | ***N***  **Agree** | **%** | ***N***  **Disagree** | **%** | ***N***  **Not sure** | **%** |
| Police uniform made it clear to me that there were two types of staff present when the Street Triage team arrived. | 15 | 10 | 66.7 | 5 | 33.3 | 0 | 0 |
| I think PCs on the Street Triage team should wear uniform when responding to MH incidents. | 13 | 8 | 61.6 | 5 | 38.4 | 0 | 0 |

* + 1. *Suitable transportation for people with mental ill-health*

It was readily identified that the co-response team operated in a marked police car. As per the views of practitioners (Chapter Six), all SU participants perceived the key ‘official’ role of the officer within the co-response team as being that of a driver to the MH worker. People also reported that the co-response vehicle was not, in their experience, used to transport them somewhere if such transport was necessary. Instead, the police first on the scene was regarded as responsible for transport, though some had also previously travelled via ambulance. Respondents were asked a series of statements regarding their perspectives on the forms of transport they regarded as being the most suitable to use when necessary to transport a person experiencing mental ill-health. Participants routinely accepted that ‘*no one size will fit all’* and similarly the survey respondent data echoed the need for ongoing respect of the particular scenario, based upon the individual’s background and needs.

Respondents were asked about varying forms of transport, including police cars, ambulances, and unmarked vehicles. Table 7.9 presents the most favourable response, that of an unmarked car being the most suitable form of transport (94.1%). This was compared to a police car (5.9%) or an ambulance (48.3%). There were split perceptions about the use of ambulances and of those who provided a response, 48.3% both agreed and disagreed in equal measures that an ambulance was the most suitable form of transport. Survey comments, like the one shown below, signified that they didn’t need a ‘medical’ response and they wouldn’t want to ‘*waste*’ the use of an ambulance.

**Respondent 19:** *‘A plain car would be better than a police car… and I don’t need to waste an ambulance either’.*

Interviewees similarly noted that paramedics were less suitable to respond to MH crises than the police were. In part, this was related to what they understood to be the ‘status quo’, in that the ‘*police have always dealt with it*’ and therefore, their perceptions surrounding transport were founded on the use of a police vehicle being a natural consequence of receiving a police response. This perception was therefore founded in their lived experiences, which has shown them that they were much more likely to receive a police response when in crisis than they would a health one. This is reflective of the data indicating that despite reforms to official guidance, police vehicles are still used in almost half of all cases.

It also relates to the notion of risk approaches detailed in Chapter Six, whereby officers face a double-edged sword in terms of balancing potential harms. For instance, whilst recognising that an ambulance may be a more suitable form of transport in terms of it being a recognised health response and reducing the likelihood of an unwell person feeling criminalised, first responding officers have to balance this with delays in getting the person to the most appropriate place of safety (if required). The feeling of ‘being a criminal’ reportedly occurred when the police responded in the first instance, and therefore it was perceived as ‘*the damage is already done’*. Many preferred to access the place of safety quicker by way of a police car than they would have, had they remained with responding officers until an ambulance vehicle arrived (reportedly usually some hours later). This was also the case in relation to the impact of PMHT attending as a secondary response in another police vehicle:

*‘…you’re already in a police car aren’t you so what’s another police car? What they going to do, make a car with MH written on side of it, everyone’s going to know then aren’t they, I’d rather be a criminal!’* (SU6)

As can be seen in this quote, the perspectives of those with lived experience who had received an initial police response highlight how the stigmatisation of being mentally unwell was perceived as ‘*worse*’ than being a criminal for those with enduring mental ill-health (who had experienced crises multiple times over their lifetimes). Seeking preferences from the person was described as the most realistic way of minimising further harm in the absence of a real-time MH specific emergency response, whilst acknowledging limited resource availability. It was reported that when in crisis, individual preferences regarding transport had not been sought from any participant, despite some acknowledging that even when acutely unwell, they would have valued officers doing this.

The survey respondents’ comments included in this section, also alluded to concerns relating to their perception that they were ‘*wasting*’ the use of an ambulance and as such, ambulances should be used for physical health emergencies only. During the interviews, this perception was further explored, and these views were founded not in a lack of acceptance that MH emergencies were health emergencies, but due to the perception that ambulances have the resources to prevent loss of life in physical-health emergencies. For this reason, there was a broad agreement in that the police were the only other service that could reasonably attend without compromising the life of someone else requiring an ambulance. As the comment below reflects, some people may value the use of the police vehicle to authenticate the police agency.

**Respondent 2:** *‘Sometimes, but not always, a police car can help the client feel safe, but only if the staff are good’.*

This, however, was generally made in consideration of others, rather than the personal preference of people interviewed. The personal experience was overwhelmingly that the feeling of being escorted anywhere in a police vehicle caused unnecessary embarrassment and fear, and unlike the presence of a police uniform, was an unnecessary evil. An unmarked car was by far perceived as being the most suitable form of transport, staffed by MH workers who would show them compassion. Many described such a potential vehicle as being like that of an on-call doctor, who could travel in a plain vehicle but with a mobile light. Despite the negative associations with travelling in a police vehicle, the role of the police in responding to instances of mental ill-health was not just recognised as inevitable, but also that it had come to be valued as a MH resource in its own right.

**Table 7.9: Number of respondents and percentages for items that asked about transportation.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement** | ***N***  **Total** | ***N***  **Agree** | **%** | ***N***  **Disagree** | **%** | ***N***  **Not sure** | **%** |
| An unmarked car is the most suitable form of transport in cases when it is necessary to transport a person experiencing mental ill- health. | 18 | 17 | 94.1 | 0 | 0 | 1 | 5.9 |
| A police car is the most suitable form of transport in cases when it is necessary to transport a person experiencing mental ill- health. | 18 | 2 | 5.9 | 16 | 94.1 | 0 | 0 |
| An ambulance car is the most suitable form of transport in cases when it is necessary to transport a person experiencing mental ill- health. | 18 | 9 | 48.3 | 9 | 48.3 | 0 | 0 |

* + 1. *The ‘unofficial’ role of the police within the partnership and beyond*

Table 7.10 shows how the majority of respondents indicated that PCs do have a role to play in MH crisis care; dealing with MH incidents should be part of their role; there was a sense of relief when they saw the PCs with the health worker; and they would not prefer a MH worker only response. During interviews, SUs expressed broadly similar views to practitioners, in that pragmatically there will always be a role for the police in responding to certain instances of mental ill-health. The police were, however, valued in their own right as an alternative to accessing specialised crisis care from the existing MH crisis care provision, due to the high level of compassion afforded to people.

‘…*If you had to give me staff from all agencies, I would want the police without a doubt. They have given me the best care I have ever received*...’ (SU5)

As this comment indicates, the high level of reported compassion shown by officers was demonstrated through a sense of belief from SUs that the officers genuinely cared about helping them, and this aided trust. It was reported how often the person in crisis felt they knew the system and processes better than the officers who attended to them. Though the officers would state words to the effect of ‘*we’re going to get you some help’* prior to using s136, and the person knowing that they would not meet the threshold for any NHS crisis care provision, they still valued the genuine efforts taken by the officers in those instances. Effective communication, body language, and a gentle tone were also paramount to this:

*‘…I was never not knowing what was coming or what was going to happen next and that was down to the officer. From the minute she spoke to me on the platform, all I could see were her feet, she was so kind in her voice, how she spoke to me, her body language, everything was thought out. She had her arm around me on the way back to the office, and the first thing she did was get water and tissues, like a friend really. She was very compassionate and validated what I was saying in terms of how let down I was by services…’* (SU7)

Chapter Three introduced the concept of ‘compassion fatigue’ and there is no doubt that this was felt by those with lived experience of MH crisis care provision. Whilst it may seem glaringly obvious that people, like the person above, would like a compassionate response when unwell, the fact that behavioural elements such as tone, body language and kindness were reportedly absent in health-only responses, suggests that such fundamentals require further exploration and reflection. The co-response was perceived as an innovative response, something new, and that bringing together practitioners from different agencies could bring with it a new culture of practitioner behaviour. To be able to maximise this, the final section in this chapter presents the findings on what factors were perceived as being the hallmark of creating positive interpersonal relationships between SUs and practitioners. These findings have implications not only for the future of a co-response but also for where agencies including health and the police, are providing singular responses to those experiencing a MH crisis.

**Table 7.10: Number of respondents and % for items that assess police involvement.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement** | ***N***  **Total** | ***N***  **Agree** | **%** | ***N***  **Disagree** | **%** | ***N***  **Not sure** | **%** |
| PCs should play no part in MH care. | 18 | 2 | 11.1 | 15 | 83.3 | 1 | 5.6 |
| Dealing with MH incidents should not be part of the police role. | 17 | 5 | 29.4 | 12 | 70.6 | 0 | 0 |
| I was relieved to see the police were there with a MH worker. | 13 | 9 | 69.3 | 4 | 30.7 | 0 | 0 |
| I would prefer only MH workers to respond to my crisis. | 14 | 5 | 35.7 | 9 | 64.3 | 0 | 0 |

* 1. Overall perceptions of interpersonal relationships between practitioners and SUs
     1. *Verbal interactions with practitioners*

The survey statements that asked about treatment by the police and health practitioners from the PMHT team, indicated that the interactions that occurred during the contact with PMHT were positive, overall. Table 8.11 shows 77.7% agreed that they were treated with dignity and respect by the PC on the ST team, and 86.7% agreed that they were treated with dignity and respect by the MH worker. The majority of respondents also felt the ST team in their experience treated them with kindness, humanity, politeness, respect and according to their individual needs. This paints a positive overall picture of the levels of dignity and respect felt by those who received a co-response, which was in some ways better than that received by MH workers alone as Respondent 9 explained, below.

**Respondent 9:** *At the time of my crisis, both the PCs and Street Triage team treated me with respect, they were friendly and helpful. I received better treatment from both the PCs and Street Triage team than I have ever done by the MH staff in the hospital. I would like to thank the PCs and Triage team for helping with my crisis on both occasions. They saved my life*

Interviews sought to further explore what the concepts identified in the survey looked like in practice. As alluded to elsewhere in the chapter, there were distressing accounts given of previous interactions with MH practitioners, and based upon these, the bar had been set low for the interactions with a co-response team.

**Table 7.11: Number of respondents and % for items that assess feelings interactions with staff.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement** | ***N***  **Total** | ***N***  **Agree** | **%** | ***N***  **Disagree** | **%** | ***N***  **Not sure** | **%** |
| I was treated with dignity and respect by the PC from the Street Triage team. | 18 | 14 | 77.7 | 3 | 16.7 | 1 | 5.6 |
| I was treated with dignity and respect by the MH worker from the Street Triage team. | 15 | 13 | 86.7 | 2 | 13.3 | 0 | 0 |
| I was treated with kindness by the Street Triage team. | 17 | 14 | 82.3 | 3 | 17.7 | 0 | 0 | |
| The Street Triage team treated me with humanity. | 16 | 14 | 87.5 | 2 | 12.5 | 0 | 0 | |
| Staff on the team treated me according to my individual needs. | 16 | 14 | 87.5 | 2 | 12.5 | 0 | 0 | |
| The Street Triage Team talked politely to me. | 16 | 14 | 87.5 | 2 | 12.5 | 0 | 0 | |

* + 1. *Kindness in action*

The kindness shown to people in crisis went beyond the officer’s verbally empathetic manner, but also on a practical level e.g., a SU described how the officers had returned to her garden to feed her rabbit and promised her they would make sure the rabbit got a cuddle. Interviewees spoke of the importance of being treated as ‘*an equal’*; ‘*a human being’*; and ‘*a person not a number’*. Such instances underpinned the perception that officers on the whole would show them compassion. To the contrary, there were numerous accounts given of interactions with MH practitioners that were at odds with such compassion, leading to a perception that MH practitioners did not care about them. Health workers were described as personally criticising a person’s situation e.g., ‘*you’re a mother/nurse/teacher and should know better [than being suicidal];* using derogatory language within earshot e.g., *‘they spoke about me like I was a dog’;* exerting unnecessary control over a person e.g., *‘all they kept saying was I’m a Band 7 nurse, I know better than you’;* and in the spirit of positive risk-taking, putting the onus on keeping a person safe back on the person e.g. ‘*If you want to kill yourself, I can’t stop you’.* The behaviour of the MH worker during the co-response encounter was reported as being ‘better’ than if they were alone.

The above is relevant to PMHT because it was shown to impact hugely upon people’s perceptions of the co-response model, with people expressing a belief that receiving a co-response would always be better than a singular one because a) a person would receive a more adequate initial response to their crisis (perceived to mean an emergency in-person response by a trained MH professional), and b) the response would be compassionate due to the presence of the PC. It was felt that the officer provided additional ‘checks and balances’ on the behaviour of the MH worker with regard to the interactions experienced during crisis care, as reported prior.

* + 1. *Keeping the encounter dignified: respecting privacy.*

The privacy of the encounter was the second key theme identified as part of receiving a dignified response, due to the recognition that a person’s behaviour during a crisis is often not consistent with their ‘normal’ behaviour. People reported often feeling embarrassed once the crisis had ended, especially when the police had attended their home address and/or instances where they were seen by the public. Table 7.12 shows how 81.3% of respondents felt that their privacy was respected during their encounters with PMHT. Where a lack of privacy arose, this was described as ‘*feeling like an animal in a zoo’*. This sense of a lack of privacy was particularly heightened when the police were involved, as described by Respondent 2, below.

***Respondent 2:*** *‘Uniforms draw attention to you and especially with a police presence you become aware that the public is looking at you and judging you, often as a criminal’.*

The visible presence of PMHT could therefore also lead to people ‘*feeling like a criminal’*. None of the SUs reported that they at any point believed they would be criminalised (i.e., arrested or would enter the CJS) during their encounters with the police alone or through a co-response, though the feeling that ‘*they had done something wrong’* was a natural part of their association and perceived stigma with police attendance. As discussed, prior, people expressed varying views around having a visible police presence in attendance (including police vehicles), which was identified as an aspect of the encounter that could be better managed to meet an individual’s needs. Despite it having been highlighted that some participants felt a sense of relief resulting from the police presence, this was balanced against the impact that the public seeing their encounter with the police would have on their feelings of ‘shame’ and ‘embarrassment’ when they were well again.

Interviewees also noted that often members of the public were seeking to help a person in crisis, rather than ‘*watching*’ them, and in some instances, this was reassuring. One person described how after they had left a GP appointment for seeking help in the midst of a MH crisis, they had curled up in a ball under a hedge out of sight whilst ‘*sobbing uncontrollably’*. They recalled how despite managing to ‘*keep safe’* overnight, the crisis team had informed them to attend their GP appointment the following day and this had been ‘*the only bit of hope keeping me going, to be honest, the thought I might actually get some help if I could just hold on [to life] another few hours*’.

Their GP reportedly stated that they were not ‘*qualified*’ to assist in matters of mental ill-health and recommended the person ring an ambulance or go to A&E. When the person became increasingly distressed during the appointment, as a result of this suggestion, the GP was said to respond by informing them that if they were not in a position to ring an ambulance then she would ring the police and asked the person to leave the surgery, so as not to upset other patients. Whilst there, a passer-by and her adult daughter approached. Despite the passer-by’s attempts to help, the GP did not leave the surgery or seek any other support for the person. When they returned, they informed the person that the doctors were ‘no help’ so they themselves called an ambulance and stated they were going to step away and wait just a few meters away, to make sure they were safe until the ambulance arrived. The person recalled how seeing there was someone who was ‘*so kind’* waiting from a distance, really helped in that crisis. A police car had arrived instead of an ambulance (due to available resources), and as, on this occasion, it was outside of PMHT hours, there was no triage involvement, and the officers took the person to A&E. This was considered by this person to be an example of how compassionate responses from the public could be:

‘*I wish I could thank them for what they did that day, just something so small, you know, that I know for a fact saved my life. I knew then that if I had got up without knowing they were there, I’d have just jumped in front of the next bus which probably wouldn’t have killed me but would have fucked my head proper’* (SU6)

Whilst elements within the harrowing account of this crisis (such as the GPs inaction) may raise disbelief, especially amongst the GP or MH professional community, these are the reality of a lack of adequate MH service provision which were echoed across numerous accounts given by the SUs in this study. They provide a compelling narrative highlighting how these instances are not ‘isolated’ or ‘regrettable’ examples of inadequate care but in fact *the* reality of crisis care for many, against which the prospect of PMHT provided welcome relief.

**Table 7.12: Number of respondents and % for items that assess feelings about privacy.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement** | ***N***  **Total** | ***N***  **Agree** | **%** | ***N***  **Disagree** | **%** | ***N***  **Not sure** | **%** |
| Staff in the Street Triage Team made sure my privacy was respected. | 16 | 13 | 81.3 | 3 | 18.7 | 0 | 0 |

* + 1. *Feeling safe and free from the risk of unnecessary force*

The use of force was observed as being rarely used when responding to MH crises, and the threat of force was not something that the SU interviewees recognised as ever having been a reality for them. More so than the realistic prospect that force could be used, people discussed the importance of feeling safe during an encounter. Fundamentally, this meant being safe, not only from the often-distressing thoughts they were experiencing around self-harm but also safe from both physical and emotional harm from practitioners. As Table 7.13 shows, 83.3% of respondents did feel safe whilst speaking to PMHT staff.

In the interviews, the concept of ‘retreating’ was discussed widely as an aspect of individual behaviour when in crisis, which included ‘*freezing*’, ‘*being unable to speak’,* becoming ‘*physically placid’* and ‘*assuming the foetal position’*. People described how they would be at their most vulnerable to physical harm when in crisis, but this was a consideration given only in hindsight.

*‘…I’m a bit abnormal when it comes to use of force…the minute someone puts their hand on me I go limp. I’ll literally like freeze, so for me it is a threat because I don’t like it, but I know it’s a last resort. It’s very hard to sit and talk calmly to someone who’s been holding you. Handcuffs and being restrained is usually because you’ve done something wrong…’* (SU1)

Whilst this comment highlights how the person believed they were ‘abnormal’ in that they were not vocal or violent, this research supports the account that this was a very common element of people’s crises. Accounts given were in the same vein, that of feeling relief and a sense of safety when they received an authority in-person response, police or otherwise. Interviewees spoke about how they could envision force being used in instances of violence or ‘very’ aggressive behaviour but felt this would always be used appropriately. In one of the two returned surveys whereby, all responses indicated a negative experience with PMHT, the respondent commented on previous use of force by officers (see the box below).

**Respondent 20:** *I have been tasered before and every time the police have used handcuffs.*

The circumstances surrounding the respondents’ experience remain unknown, but the use of force appears to relate to prior experience of the police and not the co-response. There was one notable case observed where force was used, and this was where the original call to the police related to a criminal matter that later required a secondary co-response. There had been reports of a man wielding a knife through his kitchen window at neighbours, though when officers arrived outside the window, they suspected he may be experiencing hallucinations and called for a secondary co-response. The MH worker knew the man from his previous role in an inpatient ward and went up to the window to speak to him. Whilst there was initially an element of conversation, the hallucinations were such that the man became distracted and stated he was now going to come out of the house and stab people. Once the man had left his house with a machete and stepped over the grass verge onto the public street, officers used force to disarm and restrain him.

Instances of this kind were rare but bought the issue of criminalisation and the notable interrelationships between LEPH to the forefront of the operation of PMHT. Much less rare was the feeling of desperation people reported as a key element of their crisis. It was this feeling that underpinned cooperation with authority, and the notion that in a person’s time of crisis, they would always cooperate with officers in the belief that they could be a gateway to *‘getting better’* again.

**Table 7.13: Number of respondents and % for item that asked about safety.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement** | ***N***  **Total** | ***N***  **Agree** | **%** | ***N***  **Disagree** | **%** | ***N***  **Not sure** | **%** |
| Whilst speaking with the Street Triage staff at the time, I felt safe | 12 | 10 | 83.3 | 2 | 16.7 | 0 | 0 |

* + 1. *‘**It’s not personal.’*

The final section within the theme of establishing positive interpersonal relationships highlights some common aspects that were perceived as challenges in establishing positive interpersonal relationships with practitioners. When speaking about interactions, the phrase ‘*it’s not personal’* was frequently used to describe crisis situations where people were ‘*not themselves’*, or rather not the version of themselves they are able to be when not in crisis. The importance of all practitioners recognising how the interactions they have with a person when in crisis are likely to be very different to interactions they may have otherwise, was paramount. All participants highlighted this as an important aspect of their encounter, describing how they felt their behaviour or ‘*how they present in crisis*’ might impact the treatment they receive from practitioners.

An array of personal characteristics were described by people reflecting on their own experiences, and these ranged from being mute and appearing unresponsive, seeming confused and ‘*not speaking sense’*, to being very vocal and/or expressing high levels of distress and frustration.

*‘…I’ve been quite distressed before when the police have come because I’ve been worried that they’re going to get hurt as well so this can really up my stress and I will literally be like “stay away from me don’t talk to me” and it’s not because I don’t like the police or whatever, it’s because I’m worried about their safety… but that’s really hard to explain when I’m in that situation so I’ll just be like “fuck off leave me alone”… but it’s not like I want them to leave me alone to go and do some damage or whatever, it’s because I’m scared for them…’* (SU8)

As the quote above represents, the ability to communicate when in high distress or experiencing an acute episode of mental ill-health is often compromised for people and there was a want for practitioners to routinely recognise this. Secondly, through interviews, a common theme arose of how during distress, people were further consumed with a feeling of ‘*what must this person think’* about me, and in particular, that practitioners have preconceptions about their character.

‘…*I think a lot of staff presume I drink and assume I’ve been in trouble with the police because I’m a bit rough aren’t I? They seem surprised when they find out I haven’t. I’m no angel but I’ve never committed a crime. When they check you out on the radio, I can see it in the nurse’s face that they’re surprised*…’ (SU3)

The above is indicative of how, despite being very unwell, people often remember ‘*not what you said, but how you made me feel*’ and compassion and kindness during such interactions can be fundamental to building trust and reassuring SUs that those responding to an incident are not there to judge their circumstances or character.

* 1. Conclusion

This chapter has depicted some of the key themes that emerged from the SU survey and interview data. These data show that prior interactions with the police and MH services not in partnership were a key factor influencing SU perceptions around PMHT initiatives, for both co-responder and indirect models (phone and control room). Whilst in itself, the fact that all SU participants in this study were already known to MH services was a notable element within the operation of PMHT, this did create difficulties in being able to decipher between the broader belief around a failed system of care, and the specific acceptability of PMHT as a novel partnership in its own right. Due to this, and how fundamental prior experiences were to perceptions around the operation of a co-response, it simply was not possible to separate the two. Consequently, the chapter has presented the related findings around the co-response model of PMHT in the context of the landscape within which it was perceived to exist.

The above indicates that the issue of MH demand is much wider than one that police partnerships of varying kinds are able to ‘solve’, and thus links back to the undefined remit and established aims of such partnerships from Chapter Six. Though certain aspects of the survey data indicated that people’s experience with the Northfield co-response partnership was generally well received, overall, this stemmed from a perception that, at the time of the research, there was a failed system of MH provision, both inpatient and community services (encompassing crisis care). When read in their entirety, only two returned surveys reported very negative experiences of receiving a co-response. As such, *prima facie*, the survey data alone may have allowed optimistic assertions to be made about the success of co-response PMHT in terms of meeting those objectives relating to the improvement of SU accessibility and experience. When contextualised, however, against a backdrop of prior negative experiences and the inadequacies of crisis care provision, co-response models of PMHT are no more than an expensive sticking plaster that goes only a small way towards reversing the damage of an inadequate and inaccessible MH care system.

Perceptions around the co-response largely stemmed from an undivided belief that *any* additional resourcing to the crisis care landscape (that did not detract from services elsewhere) was positive, regardless of what that looked like. By and large, this was because of how adversely MH services were regarded by those who had prior experience with them. In contrast, the police were generally held in high regard when responding to instances of mental ill-health in the community – for example, through the greater compassion that they showed towards those in crisis, their recognisability as a result of their uniforms - and this has led them to be seen as a viable alternative for support, rather than contacting crisis provision. In some ways, the police have become a victim of their own success when dealing with MH, as the findings in this chapter demonstrate they are valued in their own right and often a preferred response, even when the person is aware they are likely ineligible for the support officers try to seek for them. The chapter has highlighted that the want for police involvement is not due to a need in law or practice, rather the lesser of two evils.

1. **CHAPTER EIGHT**

**Considering the origins, purpose, implementation, and delivery of PMHT partnerships**

* 1. Introduction

The purpose of this research was to provide a rich, contextualised account of PMHT partnerships, undertaken with a critical lens, to plug a gap in the hitherto largely evaluative literature (Edmondson and Cummins, 2014; Reveruzzi and Pilling, 2016; Irvine et al, 2016). Its central objective was to explore what could be understood about the origins, purpose, implementation, and delivery of PMHT partnerships commonly referred to as ‘Street Triage’.In achieving this, the following research questions were developed:

* How did PMHT initiatives emerge locally, what considerations were given as to their purpose (s), and what were the key socio-political drivers underpinning their necessity?
* Has the implementation of PMHT altered the role of the police and its officers when responding to instances of mental ill-health in the community, particularly their use of s.136?
* What is the specific nature of multi-agency working arrangements within PMHT partnerships and to what extent have they become an accepted form of police practice?
* What are the perspectives of people with lived experience of PMHT about the purpose of this kind of partnership work and the value of it to the contemporary crisis care landscape?

The need to develop an independent and academically rigorous evidence base around the operation of PMHT was naturally a huge driver for the research. The research approach adopted, and methodology undertaken, have produced empirically informed findings that have encompassed both the anticipated and unintended consequences of PMHT partnerships (Merton, 1936). Specifically, an exploratory approach with a critical lens has allowed the researcher to move beyond prior research that has sought primarily to report upon whether PMHT partnerships have arrived at specified outcomes e.g., a quantifiable reduction in s.136 use. In taking this approach, a number of the key findings reported throughout Chapters Five to Seven, have raised important implications of this novel addition to the policing and MH landscape, and the nature of police partnerships therein. The purpose of this chapter is to delve deeper into these key findings by situating them within the extant literature and identifying what they mean for future practice and theory. This leads to a series of recommendations for policy and practice before closing with a discussion of the study limitations and recommendations for future research in the area.

As well as the literature on the role of the police in society, LEPH, and risk society, the chapter returns to the management-based theory of CA, and its themes-based framework, which was presented by incorporating police partnership work literature in Chapter Three (Huxham and Vangen, 2005; McCarthy, 2013; O’Neill and McCarthy, 2014). Though the framework identified the concept as singular themes, in practice, their application to partnership work can be cross-cutting, and it is known to be difficult to disentangle the overlay between them (Huxham and Vangen, 2005). This was found to be particularly true within the context of PMHT partnerships, with the analysis highlighting how, in many cases, multiple themes were pertinent to the research findings, which themselves formed part of a matrix.

The chapter is, therefore, not structured around the singular CA themes in the same way as they were introduced in Chapter Three. Rather, the chapter has sought to consider the research findings in relation to five overarching themes, structured around the central objective of the research and the narrower research questions that were established therein. Theme 1 considers the origin and implementation of PMHT, and Theme 2 its purpose, with a focus on its capability in reducing overall MH demand on partnering agencies. Theme 3 considers the role of the police in society post-PMHT implementation and the implications of such for wider police practice and theory. Theme 4 focuses on the operation and delivery of PMHT and the specific nature of multi-agency relations within, distinguishing the nature of LEPH partnerships from much of the extant police partnerships literature on CRDPs. The final section, Theme 5, considers the perceptions of SUs about its purpose and value to the policing and crisis care landscape, returning to the concept of compassionate care.

* 1. **Theme 1**: The origins and drivers (local and socio-political) behind the implementation of PMHT.

The first part of this discussion considers how the research findings reported in Chapter Five around the emergence and implementation processes of PMHT, can be understood with regard to the wider socio-political landscape depicted in Chapters Two and Three, including neoliberalism, the formalisation of police partnership work, the shift to joined up working, and the austerity induced need for partner agencies to ‘do more with less’ (Solar and Smith, 2022). The stark variations found between the adopted models, governance, and membership of the PMHT partnerships in operation, can be attributed to several subtle variables which are discussed here as being the ‘local drivers’ underpinning the implementation process of PMHT. At the most basic level, the notion of constabulary independence (Mawby and Wright, 2005; Yesufu, 2021) has meant that each of the 43 police organisations in E&W has operated in variable ways. As such, the implementation of PMHT can be viewed as the latest development in a longstanding trend of national inconsistency within police partnership work, given this was also seen after the introduction of the mandated police partnerships post-1998 (Hughes, 2005; Skinns, 2008).

It was a decade ago that police partnerships research first began to report how multi-agency working had generally become a positively perceived and institutionalised form of police practice. In addition to the formalisation of the practice through the CDA 1998, this shift had also been attributed to a cultural re-negotiation of trust, compromise, and ‘new’ pragmatism (McCarthy, 2013; O’Neill and McCarthy, 2014). While these variables certainly provided the infrastructure to facilitate the implementation and subsequent operation of PMHT, with mental ill-health being the novel aspect of the partnership arrangements (rather than the partnership work itself), they did not drive its implementation. The focus of this section is upon discussing what the drivers behind PMHT were, at both broader and local levels, though as the following discussion shows, these are heavily interlinked.

* + 1. *The impact of austerity on extant crisis care provision*

The overarching necessity, underpinning the introduction of the localised PMHT partnerships, was found to have emerged as a response to what practitioners, from both police and health agencies, considered to be a localised austerity-led breaking point in MH service provision, especially out-of-hours crisis care. Though prior commentary has theorised this to be the case at a broader level (Beresford, 2010; Cummins, 2018; Solar and Smith, 2020; 2022), the findings from this study have reported how austerity had tangibly impacted those working on the frontline, and why this became not only a broader socio-political driver in the move to joined-up working but the reason this had become the key driver at the localised level, i.e. the PMHT partnerships which emerged outside of the initial DHSC pilot schemes, leading to their widespread national operation.

The phrase ‘*attempting to* *do the wrong thing better/righter’* was often used to describe the austerity-induced local reforms, and more significantly, reflected largely the nature of the origins of PMHT partnerships. This research has found substantial differences in the rhetoric versus the reality of 24/7 wraparound crisis care provision, given all sites in the research had met the NHS target of providing such. The reality of a crisis system based upon a SPA telephone number meant this was where crisis care provision ended for the majority. The services that callers were signposted to (if they were signposted to) were fragmented and understaffed, with too few people filling multiple roles. This reflected the inadequate central investment in wider MH crisis care provision, a situation which was exacerbated by the reduced investment during the austerity decade (Cummins, 2018). The research found how MH Services had been unable to ‘*keep up’* with the rising demand for, not just crisis care, but wider community provision, which can often pre-empt the need for crisis care. As such, while more people were contacting the SPA phoneline, fewer people were ‘eligible’ for any care beyond this.

The impact of austerity on what was already scant crisis provision was found to mean people with mental ill-health were increasingly ‘*falling through the gaps’,* through the austerity-induced service reconfigurations, which had largely impacted preventative community provision e.g., the disbanding of outreach teams, the selling of local estate in favour of a central ‘base’ which reduced access to ‘local’ provision for many, and the loss of established practitioner-SU relationships. Despite the NHS crisis care provision itself having not been reconfigured, this increased demand on a service that was already unable to provide a real-time ‘emergency’ MH response in the community, led to this function being increasingly provided by the police, necessitating PMHT partnerships as a means of trying to do this ‘better’. The system is undoubtedly broken, and while mental health care has recently been depicted as ‘the next big, appalling, scandal in the health system’ (The Spectator, 2023), this research would indicate that this has been the case now for a considerable period. This research has contextualised what the outstripping of supply looked like in practice, driving forward the police need for a localised system of PMHT. It signals little doubt that the prior commentary which suggested crisis care was in crisis (McNicoll 2013; Beresford, 2013; O’Brien et al, 2018, Cummins, 2018), is a disappointing, yet precise assumption.

* + 1. *Austerity and the increased challenge for frontline PCs*

The extant crisis care service provision being unable to provide a real-time emergency MH response in the community was not perceived as having ever been part of their function or practitioner role, rather, it was the demand on the services they did provide that had been tangibly impacted e.g., people who would have been ‘eligible’ for home treatment provision before austerity, no longer met the threshold for it. It was seen how at a time when there had been a greater focus on reducing the use of police custody as a POS (e.g., CQC, 2013), designated health-based s.136 provision had become absorbed into general MH service provision, as it was not a ringfenced resource e.g., it was often found to be closed or unstaffed as staff had been ‘*drafted onto the wards’* to manage inpatient staff shortages.

As a result, officers were increasing the amount of time they spent with a person detained under s.136 trying to find the most appropriate place of safety for them. Often, this was if one could be found at all due to a lack of beds, a lack of staff, or both. The austerity-induced increase in demand itself was reflected heavily in frontline officer accounts of their role as response officers e.g., ‘*it is most of what we do’* and it was a rarity when they did not have a mental ill-health-related incident during every shift. This underpinned the perceived necessity for implementing PMHT e.g., middle, and strategic managers at multi-agency meetings held the belief that PMHT could ‘stop’ such delays and reduce the overall amount of time officers were spending on mental ill-health-related incidents (Chapter Six).

The police were therefore keen to work with health partners, to better manage the localised issues such as forces using neighbouring s.136 provision, but this research has shown such issues were not confined to one force. Across all sites, the *de facto* role of the police in responding to community crises was found to have grown with the constriction of NHS services and the (long overdue) removal of custody as a PoS. This challenge rested upon the fact that responding to mental ill-health has always been a core feature of police work (Bittner, 1967; Adebowale, 2013), yet officers were having to make discretionary decisions on how to do so in not only the absence of MH alternatives but in circumstances where there had been an erosion of what scant provision had previously been accessible to them.

Notwithstanding the developments, trends, and changing paradigms within the policing and MH sphere since the 13th century, this research has found that the fundamental challenges for officers on the frontline have remained virtually unchanged. As if written today, Bittner wrote almost sixty years ago how ‘the signs of mental illness, or a competent allegation of mental illness, are in themselves the proper business of the police and can lead to authorised intervention’ (1967:278). This research has found that beyond policy rhetoric, this was a sentiment felt sincerely by all those officers interviewed, who referred to the challenges they faced as feeling substantially ‘*worse /more significant’* now than they did before austerity.

Though the era of deinstitutionalisation pre-dated the MH practitioners working in the community settings at the time of the research, it has been found how this era still casts a long shadow, and that contemporary inadequacies in crisis care provision can only be understood in this light. The challenges for the police remain to exist against the backdrop of growth in the interface between police and health organisations since the 1960s, owing to deinstitutionalisation and the failure to implement an adequate system of community mental health care (Titmuss; 1968; Rose; 1979; Gruenberg and Archer; 1979; Busfield, 1986; Sullivan, 1998; Carpenter and Raj, 2012; Cummins, 2016). The fact that there has never been a functioning well-staffed mobile emergency community crisis service/team, which can respond to incidents in real-time, in the same way as the police, thereby reducing the need for police attendance altogether, reflects this. The origin of PMHT was thus borne out of the need for local partners to manage the ‘*fallout’* of the later austerity-induced local reconfiguration measures.

The second challenge for officers was the discretionary nature of how they dealt with instances of mental ill-health, in the absence of adequate crisis care alternatives. The ‘new’ provisions of the PACA 2017 went little way to evoke any objective features when officers were contemplating the use of s.136, with the discretionary position sustained. As Bittner stated, ‘the decision to invoke the law governing emergency apprehensions is not based on an appraisal of objective features of cases. Rather, the decision is determined largely by the absence of other alternatives (1967: 278). As outlined above, while the alternatives were already scant these had been decimated even further. Though the challenge for officers in making discretionary decisions about the need for s.136 has remained the same, officers’ decision-making around its use became the focus of increased scrutiny by both health and police managers. The perception that officers were detaining people ‘inappropriately’ was thus a key driver in the perceived need for a PMHT partnership, shown in Chapter Six as having become a key feature of the partnerships.

In addition, many of the practical challenges identified by Bittner (1967) that frontline officers faced in the 1960s, were found still to be relevant to the officers in the present research. For instance, he detailed: the discretionary methods used by the police to avoid taking someone with mental ill-health to the hospital; how for an incident to warrant police intervention the case must also have presented a serious police problem; how officers reckoned with the possibility of being turned down by MH services, thus leaving them with an aggravated problem on their hands; and how contacts with the hospital and the attitudes of MH practitioners were a source of endless frustration for them. All of these have been challenges that this research has found still to hold both before and during the operation of PMHT partnerships, signifying how the principal challenges for frontline officers have thus not changed much at all e.g., officers found to be turned away from s.136 suites leaving them very little alternative but to spend a whole shift waiting in A&E, instead. Though not new challenges, the exacerbation of these were localised police-led drivers for PMHT, with the assumption that the partnerships would ease the pressures.

As set out in the introductory sections of this thesis, there is a uniqueness about the period from which these findings were collected. They represent a critical point within the socio-historical landscape when the effects of austerity began to ‘bite’, but before the inevitable impacts of the coronavirus pandemic. Alas, though politics does not stand still, it would have been hard to imagine writing the following sentence at the time this research commenced. At the time of writing, it is a month into 2023, yet since 2020, the UK has experienced a global pandemic; three PMs; the Russian invasion of Ukraine; the fall out of what has been termed ‘Trussonomics’ which saw a drastic drop in the UK’s financial markets in response to PM Liz Truss’s and Chancellor Kwasi Kwarteng’s neoliberal-inspired ‘mini-budget’ proposals. Following such, UK inflation has risen to over 10%; and there is an ongoing national cost of living crisis. Though the edit of this chapter may be slower paced than any subsequent developments within the socio-political landscape, the UK currently looks set to embark upon a further period of austerity under Rishi Sunak’s premiership.

Given the findings reported throughout, which have strongly indicated what can only be described as catastrophic repercussions of austerity for staff and SUs alike, the impact on PHMTs and those who use their services seems likely to be severe. With a prediction that such a position would move to further undermine joined-up working, I would strongly urge the police to carefully consider the findings from this research before entering into further partnership work of this nature. It seems futile to push one public service off a cliff, to save one that has been there for some time, without consideration of the impact of this not only on SUs but also on the practitioners working within the system. Though austerity was the broader socio-political umbrella that drove forward the PMHT implementation agenda, under it at a localised level were diverse resource arrangements; the semi-formalisation of partnership work and the associated local governance; the actions of key individuals; as well as a cultural re-negotiation around perceptions of ‘real’ police work.

* + 1. *Local resource arrangements*

There was no central investment for the wider implementation of PMHT partnerships, beyond the initial twelve-month DHSC trial that began in 2013 (Reveruzzi and Pilling, 2016). Availability and access to the required resourcing were therefore found to be variable across sites, and this impacted upon how the partnerships were implemented e.g., their duration, the model, any monetary investment, and staffing/vehicle allocation. This, coupled with the localised management of services, reflective of the neoliberal principle of decentralisation and the further rolling back of state involvement in such processes, has resulted in not only the fragmented nature of the extant crisis care provision beyond the SPA, but also the localised implementation process of PMHT itself, which was also found to be fragmented, uneven, and lacking consistency in all aspects, from the form and model it took to the purpose they purportedly sought to serve.

When looking at the now widespread operation of PMHT, it is proposed that the schemes such as Hilltop, which were included in the DHSC trial of PMHT, were given a free ‘practice run’ in their implementation, that had enabled them to assess what the evaluation showed about its operation and how they might adapt or vary their model based upon what they learned from the initial trial (Reveruzzi and Pilling, 2016) e.g. though Hilltop continued to operate PMHT, it had shifted from a co-response to the virtual ‘hub’ as they perceived it to be more a more affordable model once the initial funding had ended. This shift to a virtual model of PMHT based upon affordability occurred even before many of those localised PMHT schemes outside of the trial had begun their own PMHT implementation process.

This reflects how a) the localised forces outside of the trial were entering into a resource-intense partnership without any such knowledge of affordability, b) the imitation of the co-response model found within the DHSC pilots was perceived as the ‘*gold standard’* in operating models, that forces felt they should aspire to implement, and c) even forces with more annual expenditure per head such than others, such as Hilltop, were unable to justify the costly resource-intensive model of providing a co-response. The research thus highlights how within the division of wider localised schemes, such as Northfield and Eastbrook, there was no attempt to ‘wait and see’ how the initial nine schemes in the national evaluation faired against their aims and objectives, which, as the evaluation showed when published in 2016, were variable, to begin with (Reveruzzi and Pilling, 2016). The speed and manner upon which PMHT schemes started to emerge up and down the country reflected this; in that, it was before the publication of the DHSC evaluation that over 30 other police force areas were in either the planning stage of PMHT or had already implemented a model, the majority of which were co-response (Reveruzzi and Pilling, 2016).

The required austerity savings required by each police organisation, affected forces to varying extents due to the variance in central government contributions that each received e.g., budget cuts varied between 10-25% (HMIC, 2013:28). This was in addition to variances in annual force expenditure per head of the population, which ranged from £150 to £250 (HMIC, 2013: 36). Northfield and Eastbrook were required to make an additional 3% savings than Hilltop, as well as attracting a higher central funding contribution, which meant Northfield and Eastbrook had likely felt the impact of austerity more heavily than Hilltop. It is proposed that this was one driver behind Hilltop’s ability to recruit additional designated staff into their PMHT arrangement after the DHSC trial, compared to Northfield and Eastbrook who allocated a staff member and vehicle from within the existing provision.

Though Eastbrook was on the ‘second version’ of their co-response PMHT arrangement, Chapter Five found the ability to re-start the scheme came from a short-term NHS grant which paid for health staff overtime, with Eastbrook still contributing to the initiative through providing an officer and a vehicle from the existing resource provision. From a policing perspective, the earlier co-response in Eastbrook had concluded due to internal data on the number of force-wide s.136 detentions, that had shown Eastbrook was not the target area within the force, as the s.136 rate was much lower than in Northfield and the other districts within the same police force area. The re-start of the co-response model in Eastbrook, resulted after a turnover in middle management staff, and it was with this renewed support for implementing a PMHT scheme in Eastbrook, that meant officers were once again assigned to undertake a PMHT duty. The importance of key individual actors in the implementation process of PMHT is returned to below.

* + 1. *Partnership (in) formality, and the national governance framework*

The ‘status’ of PMHT partnerships differs from the forms of other police partnership work, to which this chapter refers. PMHT partnerships have neither a formal statutory footing, like those partnerships mandated under the CDA 1998, and which have been a key focus of prior police partnership research (Hunter, 1999; Bailey and Williams, 2001; Skinns, 2005; 2008; O ‘Neill, 2014; O’Neil and McCarthy, 2012; McCarthy, 2011, 2012; Mawby and Worrall, 2011), nor do they exist solidly as ‘informal’ partnerships, like those that were the focus of police partnerships research before this (Sampson et al. 1988; Pearson, 1992; Crawford, 1994, 1997; Walters 1996). It was the signing of the national CCC that provided, for the first time, a national governance framework for partnerships in this area, including PMHT (though this was notably without a legal basis).

This research has shown how there were (limited) informal local multi-agency police-health partnership groups in place before the signing of the CCC, but that there were pre-existing individual inter-agency relationships, and it was in this context that the PMHT partnerships had initially emerged. The findings have indicated that it was the signing of the local CCC action plans that sharply accelerated an enhanced investment in joined-up working at a local level from all partners. Despite this broader shift, however, this research has also shown that a multi-agency hierarchy or overarching local governance system relating specifically to PMHT was not found to exist. The ability of strong leadership to provide strategic direction has been noted as a major factor in driving forward improvements in police partnership work (Crawford and L’Hoiry, 2017), but as Chapter Five reported, the absence of such overarching governance, and the absorption of PMHT oversight into wider subsequent multi-agency arrangements, were shown to undermine the frontline operation of PMHT.

The national CCC, though providing a national framework concerning the future direction of policing and MH policy, was itself largely based upon the need for innovative thinking and ‘solutions’ to austerity restraints. The indication of ‘promising signs’ (HO/DHSC, 2014:4) from the early PMHT schemes, leading to the promotion of PMHT partnerships as found within the national CCC, was also notably without an evidence base at its inception. Reflective of the enhancement of the neoliberal ideology and an emphasis on individualism since 2010, coupled with the pre-occupation with NPM across policing and health which has continued since it became prevalent in 1997, it is perhaps unsurprising that the CCC national governance framework omitted wider performance indicators, such as those that sought to address whether SU experience was indeed improved. Instead, the guidance largely focused upon the principle need for efficiency across public services, and this is returned to in the second part of this chapter concerning the purpose they were purportedly serving.

* + 1. *Local governance* *and the importance of key individual actors*

Outside of the DHSC pilot (2013), this research has shown how PMHT schemes had often emerged bottom up, with their implementation driven forward by a few key individuals working in over-stretched services, with the desire to enact local change. Their emergence was ad hoc and reliant upon the hard work of those key individuals to define the model and purpose of PMHT and bring it to fruition by managing the staff and resource allocation for it. With regard to the CA theme of risk and the initial taking of risk that is necessary to initiate a new collaboration (Huxham and Vangen, 2005), the research has found that it was the perceived risk of not implementing a PMHT partnership, that prompted a response akin to a knee jerk reaction, given the speed and informality in how they were found to have emerged.

This was also found to hold with strategic level partners, as without the support at the highest individual level of local governance i.e., the PCC and/or the highest-ranking officer with the MH portfolio (if not the Chief Constable, then Chief Superintendent), local schemes would have been unlikely to ‘*get the go ahead’*. This can be seen in those few police force areas nationally that have never operated a PMHT initiative, instead choosing to focus on alternative endeavours. Even where the police were found to be primarily or wholly funding PMHT schemes e.g., Hilltop, they would not have been able to do so without the individual PCCs’ honest (though unevidenced) belief, that PMHT was ‘the silver bullet’ to solving the issue of MH demand on their organisation. Even where the police held all the purse strings, this was shown to have little to no bearing on the extent of their strategic oversight of its ongoing operation, which was found to be that of a subservient partner at all levels e.g., the PCC in Northfield/Eastbrook was largely unaware of what the schemes did, or that they were in operation at the time of the interview.

In consideration of funding having been identified as a key point of power within the CA framework (Huxham and Vangen, 2005), it was the individual beliefs of those individuals at the strategic level of PMHT, that have resulted in the police funding initiatives that have shown no evidence of cost-benefit returns to the police organisation. The consequences of such were reported with regard to the local governance, or rather a lack thereof, in Chapter Six, e.g., no partner agency at the middle management level or above claiming responsibility or ownership for it, and consequently, the issues regarding lack of established purpose that were also found to exist at the frontline. This leads one to conclude that, within the context of PMHT, while it may appear health partners carried more power (in practice), the power to exit and the power to withdraw funding (Huxham and Vangen, 2005) often remained with the police, but that this had largely remained an untapped point of power given the lack of oversight and knowledge of PMHT.

The localised implementation of the wider schemes also reflected the decentralised manner in which the original nine partnerships funded by the DHSC had been required to take. These DHSC schemes were asked to establish an operating model that was appropriate and relevant for their local circumstances, with each area being asked to consider s136 data, geographical area covered, available resources and other local service issues in their choice of appropriate operating mode (Reveruzzi and Pilling, 2016: 15). Much like the requirement to consult that was legislated by the PACA 2017, the CCC contained no guidance on how to implement the schemes. There was also no requirement for evidence-based practice, and though there was no evidence on PMHT, specifically, there was on related aspects of practice that could have been drawn upon, such as the value of patient and public involvement in mental health service development (e.g., Gibson et al, 2013; Jennings et al, 2018; Capabianco et al, 2023).

Consequently, a fragmented and variable system of PMHT has emerged, with a broad range of initiatives that in many cases do not resemble each other at all e.g., the co-response model (Northfield) and the MH ‘hub’ (Hilltop). Given that the now-established CRDPs have never achieved national consistency (Hughes, 2005; Skinns, 2008), it casts doubt upon whether this is achievable for PMHT partnerships, given both their short-term/unsecured nature of funding and that many of the broad issues relating to its implementation are the same as those that partnerships with greater longevity have been unable to address. An enduring national inconsistency in PMHT partnership arrangements means the practice is likely to remain one of variable ‘quality’, affected by the availability of resources, its governance, and the decisions of key individual actors. As the recommendations for policy and practice show (8.7), this is something forces need to consider in the localised review of their schemes.

* + 1. *MH as ‘real’ police work*

If it were possible to draw out an element that has changed since 1967, it is how the frontline response officers were found to understand their role and the nature of the tasks they undertake, with a perception that responding to mental ill health was ‘real’ police work i.e., generating the want to undertake a PMHT duty. Contrary to much of the other extant police culture literature, which portrayed officers favouring their role as crime fighters to peacekeepers, and perceiving their social function to be that of crimes poorer relative (Banton, 1964; Skolnick, 1966; Westley, 1970; Cain, 1973; Punch, 1979; Holdaway, 1983; Loftus, 2009, 2010; Cockcroft; 2015), PMHT did not concern crime and was found not to be perceived in any way as a supporting function to crime work, nor was it perceived to be peripheral or a nuisance (Manning 1977; Ericson 1982,1993; Reiner 1992). The findings from this research are suggestive that there has been a broader and more systematic cultural shift surrounding frontline officer perceptions of what constitutes ‘proper’ police work, about both partnership work and responding to mental ill-health incidents. It is this shift, that was found to have formed the final variable underpinning the implementation of PMHT partnerships.

Though it is recognised that there are other variables at play e.g., coinciding trends in society such as the heightened awareness and acceptance of mental ill-health more broadly (Yanos et al, 2015; Grey et al, 2020) and those trends within contemporary policing itself e.g., a shift towards LEPH, it is proposed that the rise in austerity induced mental ill-health demand on the police organisation was a variable that contributed heavily to this more systematic cultural shift. This was reflected through the finding of not only a willingness of the police to enter into PMHT partnerships but also genuine enthusiasm from frontline officers to work in partnership with health colleagues. Officers were found to emphasise the importance of this aspect of their role e.g., noting that it was ‘so important to get right’. Officers described mental ill-health being akin to a ‘hot potato’ that everyone was concerned with, and this was perceived by them to be a positive thing.

It was a large feature of their work that officers were found to consider to be of equal value to crime-related matters, suggestive that the rise in austerity-induced demand and the prevalence of MH-related tasks had exponentially altered the overall nature of their duties and the ’balance’ between crime and social matters. Anderson and Buris (2017) proposed that one of the difficulties within LEPH has been the inadequate characterisation and legitimisation of the role of the police in the protection or promotion of public health, given most law enforcement agencies have not constructed their identity in this way (Anderson and Buris, 2017). This finding suggests the contrary, that though the police in E&W may not have historically constructed their identity in this way, there was a broader acceptance of those principles underpinning LEPH (fuelled by austerity and the need to do more with less), which had led to a definite perception that as police officers working within the police organisation, they were a fundamental part of the crisis care landscape.

In considering Chan’s (1997) theory of cultural change, the field had thus changed from what it was when the interface was substantial, to what it was when the interface had become maxed out. Adaptations to the habitus had accompanied this, e.g., the CCC and the PACA 2017, and it was the relationship between the two that I propose that underpinned the shift in perceptions about mental ill-health being considered ‘real’ police work. It must be recognised, however, that differentiations in culture between not only police organisations, but between the departments and teams within them (Westley, 1970; Chan, 1997; 2011; Bacon, 2014), mean that this cultural shift may be limited to frontline response policing. Officers in other areas of policing, such as tactical and firearms policing, for example, are unlikely to have undergone the same cultural shift, given they have been largely unaffected by both the habitus and the field of frontline response policing matters and are likely to have been protected from the rise in demand and the changing nature of frontline response policing.

* 1. **Theme 2**: Revisiting the aims and purpose of PMHT partnerships.

The second theme within this chapter considers the aims and purpose of PMHT schemes as they were found to be, in respect of those that were identified in Chapter Three. The research has identified that there was no common wisdom (Huxham and Vangen, 2005) within PMHT partnerships, as in, there was no broader understanding of the aims and purpose of the partnerships, the nature of the ‘issue’ to be solved e.g., the variance in the understanding of ‘inappropriate’ s.136 detentions, or the returns on such aims from any investment they gave. Partners did not fully understand each other’s positions well enough to have meaningful dialogue about the different interpretations of the problem and to exercise their collective intelligence about how best to seek to resolve it (Huxham and Vangen, 2005). For instance, rather than the police recognising that officers were not ‘overusing’ s.136 at all, and its continued increase was following the national rising trend (which could be attributed to broader socio-political impacts), they had become preoccupied with the assumption that this rise was ‘bad’ i.e., unmanageable for operational policing.

Consequently, the police in recent years have become gripped on reducing it to previous levels. This appeared favourably to health partners, who in trying to reduce their demand were also keen for officers to reduce its use e.g., they wanted fewer officers bringing people detained under s.136 through their doors, so they could better manage their own scant provision by not assessing people who were not ‘ill enough’ for either subsequent inpatient or home treatment care. This contributed to how each partner organisation was committed to slightly different versions of the same goals, and more problematic than this, were the variances in the understanding of purpose within the organisations themselves at the middle and operational levels. This was underpinned by the failure to establish common wisdom at the higher strategic levels, despite the *prima facie* shared aims and purposes (the end game) evident at that level from those broad objectives that each partner agreed to by signing local CCC action plans. The absence of a broader understanding that reducing demand was largely beyond police control, coupled with an overreliance on s.136 data as a measure of the challenges happening on the frontline (see *9.3.1*), has shown the creation of PMHT partnership work has gone little to no way to recognise or acknowledge these issues.

It was noted in Chapter Five that there were difficulties in locating any formal documentation e.g., a term of reference or multi-agency meeting minutes, which explicitly contained any common aim or purpose underpinning the PMHT partnerships, nor were there standard operating procedures or similar that included reference to specific PMHT schemes. Following the introduction of the requirement to consult with a health professional (s136 (1C) MHA 1983), Chapter Six noted that partners were actively working to establish official crisis care pathway policies, but PMHT schemes had not been explicitly included within those related documents when they emerged (including the s.136 pathways). It is proposed that these kinds of ad hoc changes in policy delivery, which were rapidly prompted by the move to joined-up working, were difficult to make within the existing polycentric institutional and political arrangements, mirroring what Solar and Smith (2022) have previously theorised. It was not that partners were unwilling to include PMHT in formal policies and procedures, or that they were unaware of the position around the ongoing informality of PMHT, rather, the sheer pace that it arose which meant the nature of its implementation process was ‘act first, write policy later’.

The purported shared aims of PMHT partnerships were not re-evaluated at any point once the schemes were in operation and there was no ongoing dialogue about what may have been helping/hindering the attainment of the CCC aims. In terms of any commitment that partners were found to be making to achieve this sense of common wisdom, it is proposed that partner agencies believed they had already achieved it through the signing of the local CCC action plans. A shared feeling of solidarity was evident, through the belief that the partners had established their common goals, and there was a sense of being part of the same team (Murphy, 2005) e.g., seen through the positive interpersonal relationships found within multi-agency meetings. As the research has found, despite *prima facie* there being common aims, these were underpinned by fundamental differences in working practices that were unlikely to be resolved through PMHT (Chapter Six). The destination was thus shared, but the means of getting to it, as previous research has shown, deviated from this (Huxham and Vangen, 2005). This research has found this to be particularly true for the capability of PMHT partnerships to reduce s.136 use and overall MH demand on all agencies, which is considered in depth below (*8.3.1*).

Without this vital ongoing dialogue, it is even more unlikely that the partners within PMHT will attain the common wisdom required to tangibly achieve CA i.e., achieve those aims of the CCC because this wisdom is broader than simply setting out (or in this case inheriting) a series of aims (Huxham and Vangen, 2005). Though this research has shown that there was a commitment to the broader aims of the CCC, whilst the police actively continue to seek to plug the gap in MH crisis care provision as part of their involvement in PMHT partnerships, NHS partners have less cause to become invested in the attainment of common wisdom. Once this absence of common wisdom is recognised and accepted by the police middle management and strategic partners within PMHT partnerships (the potential of which may be aided by this research), the basis for their continuation is likely to be called into question.

As first detailed in Chapter Two, after the fieldwork for the study was completed, a joint thematic inspection of the criminal justice journey for individuals with MH needs and disorders (HMICFRS, 2021), reported that where they found actual deployable triage vehicles or MH ambulances, these were commonly under review, were being withdrawn or had recently been withdrawn. This signals a promising sign that forces are now starting to think about the purpose and implications of their PMHT arrangements, and these research findings would support this shift in practice.

* + 1. *The capability of PMHT in reducing overall MH demand*

Whilst the aims relating to SU’s experience during the crisis were often publicly framed as the ‘primary’ aim of PMHT, positioned above multi-agency relationships and the resource-related aims of PMHT, this research has found that resource considerations were dominant in the discourse around PMHT implementation processes. The primary consideration of all partners was to reduce s.136 use, and from a policing angle, this also equated to the amount of time officers spent dealing with mental ill-health-related incidents and reducing the delays associated with such (see Table 6.2, Chapter Six). Though ‘quality’ is a difficult concept to define and measure in a public services context (Bevan and Hood, 2006), the research has found that the use of s.136 data as a measure of quality within PMHT, tells us very little about its effectiveness or who it was effective for.

The number of s.136 detentions nationally has continued to increase in E&W, from 23,859 detentions in 2016–2017 to 25,143 in 2017–2018. The latest figures again highlight how for the year ending March 2022, there were 36,594 s.136 detentions. This was an 8% increase compared with the previous year (excluding Dyfed-Powys who were unable to provide data in the year ending March 2021), and a 7% increase compared to the year before the pandemic (Home Office, 2022). The rise in s.136 detentions has thus continued despite PMHT operating during this time, which should raise questions for those considering the purpose of their schemes and what they are seeking to achieve. If the discourse around s.136 reduction being the most effective measure of success for PMHT continues, then the continued rise in s.136 detentions alone refute the assumption that PMHT is an effective strategy for managing this.

The common discourse that was found within PMHT, was that if s.136 data could be shown to have reduced from the previous localised figures, then this was a) a good thing and b) meant progress had been made concerning the overall aims of PMHT. In respect of the first of these, that a reduction in s.136 use is a good thing, there was no greater understanding or exploration by agencies, of who this was good for, and the wider implications of this. Through the findings of this research, I propose that the system of governance by s.136 targets and/or measures is inherently flawed due to its ‘synecdoche’ (Bevan and Hood, 2006), with this measurable aspect of PMHT having become interpreted as a measure of the whole system i.e., whether the issue of there being a maxed-out policing and mental ill-health interface had been ‘solved’ or at least was perceived as being ‘solvable’ by PMHT’. This was not, however, unexpected, given not only was this the most obvious measure to the police organisations themselves (Keown, 2016), but it is that which is primarily collated and used by the government for wider resource allocation e.g., the HMIC ‘*Value for Money’* reports.

Despite the theory that targets will always be subject to ‘gaming’ and unintended consequences and behaviours (Bevan and Hood, 2006), the police, like many other public services (Keown, 2016) were not considering these within the ongoing operation of PMHT. Due to the lack of deeper common wisdom having been established, but with the existence of purportedly shared aims through the CCC, little consideration had been given to the different ways in which success could be measured in a PMHT context between organisations. This lack of consideration is known to inadvertently drive unhelpful organisational interventions (Dijk et al, 2019), and these were found within PMHT. This research has produced several indicators of such unintended consequences and behaviours arising as a result of PMHT, a key one being how it may be inadvertently increasing the overall use of police resources spent dealing with MH incidents when s.136 has effectively been ‘ruled out’ by health partners on PMHT.

For instance, if a decision was made by PMHT that s.136 was not necessary and so not invoked, this did nothing to tangibly solve the crisis e.g., the police feeling ‘stuck’ in cases where a person in crisis had recently been detained under s.136 and came to the attention of the police again, a short while after, but with health professional unwilling to see them again. The informal use of PMHT to meet the requirement to consult during decisions about s136 detentions had become another unintended consequence of the schemes, and in consideration of resource reduction, one that remains a costly alternative to the one formally devised for 24/7 access via the SPA. The operation of PMHT in all sites, but particularly the virtual model in Hilltop, was also shown to be complicating many operational matters for officers on the ground, in particular with regard to finding a PoS. As a result of such, lengthier s.136 detentions were reported in Chapter Five, many described as being in the back of police vehicles and many of which included force (e.g., long periods of restraint in handcuffs) that would otherwise not have been necessary, had a POS been found almost immediately.

As this section concludes, the implementation of PMHT has had implications for practice that are much wider than a success/failure measure could show based upon s.136 data alone, though in any case, national s.136 data itself showed an increase in detentions (local data not available). Rather than PMHT partnerships having been found to be operating in a way conducive to reducing overall MH demand for all partnering organisations, the only obvious ‘winner’, if there were such a thing in this context, was the health partners, who gained resources and an agency to share their demand e.g., the ‘additional’ funding generated to bolster staffing an out-of-hours provision to operate PMHT (Northfield and Eastbrook), or indeed being able to provide this ‘extra’ health staffing entirely through the police budget itself (Hilltop). The notions of success and effective outcomes were shown to be very much variable, depending on where in the partnership process you sit. This research has highlighted the importance of the police organisation considering the issues set out above and taking a more holistic approach in consideration of the ongoing operation or engagement with PMHT arrangements.

* 1. **Theme 3:** The role of the police in society post-PMHT

While the focus of this section may be considered an extension of the unintended consequences of PMHT outlined above (and in many respects, it is), it is also undoubtedly one of particular significance for both police practice and theory. Since the introduction of PMHT, not only has police involvement in crisis care been formalised through their involvement in such partnership arrangements, but it has undergone an expansion, fuelled by the widespread perception found that the police are now the solitary gateway for people to access in-person emergency crisis care in the community setting. The research has uncovered these perceptions exist not only across the health services and by the service users interviewed but also within frontline operational policing by the officers undertaking PMHT duties. While the role of the police in mental ill-health has long been ‘informally’ established (e.g., Banton, 1964; Bittner,1967; Muir, 1977; Ericson, 1982; Thomas, 1988; Newburn, 2008; Loader, 2022) the introduction of PMHT has had consequences beyond a mere formalisation and/or recognition of the role officers take (and have always taken) in MH crisis instances, for which the formation of LEPH is founded upon. The formal recognition of the police role in MH crisis care through the introduction of PMHT partnerships has served to re-position their role from ‘incidental’ or ‘de facto’ MH workers in the absence of an alternative, to this formalised and solitary gateway to care for those experiencing a crisis in the community.

The clearest finding of this from the research can be seen through the people in crisis ringing the NHS-provided SPA for support, only to be re-directed to ringing 999, as the police were perceived as having a ‘specialised MH team’ i.e., the co-response models of PMHT, that people could only access via the police control rooms. Echoing earlier concerns raised in evidence to the HASC in 2018, these research findings support anecdotal reports that were starting to emerge from 2016, about the increasing reliance that PMHT was inadvertently placing on the police. The second key finding that further supports this position, was the perceptions of purpose given by the frontline practitioners themselves, in that the aim of the co-response was to provide an emergency community MH response (Table 6.2). Prior to the co-response duty, there was no alternative provision for the person to be seen by a MH professional in this way i.e., in person, within an ‘emergency’ police response time, and in the environment in which the crisis occurred, including at home.

In practice, this had resulted in the co-response vehicle increasingly attending MH incidents as first responders, despite the duty being designed and implemented to function as a secondary response at the middle management level of the partnership. The gradual shift from secondary to first responders could be theorized using the notion of mission creep (Corbett, 1998; Crawford et al, 2005; Rice, 2019; Skinns, 2011). Similarities can be drawn with the ‘creeping mission’ of the co-response vehicles, which was found to have become akin to a traditional first police response, but with the added delivery of a MH worker to the scene. Unlike previous research that adopted this theorization, however, as there is no viable health alternative to a police emergency MH response, the concept is limited to understanding how the purpose of PMHT has moved beyond that for which it was originally intended, and towards something that is so desperately needed, but does not exist i.e., the formation of a MH based emergency response.

The circumstances around when PMHT was being used as a first response indicated, however, there was no suggestion it was ‘more than the police could handle’ like prior research had shown to be a negative consequence of the creeping mission (Murphy, 2005). The reason for such in the case of crisis incidents is that in the absence of PMHT, the person would have received a police-only response anyway. This further solidifies how the role that the police have historically taken in MH crises, is moving to a position whereby through PMHT, the perception of them as a formal gateway to emergency MH care is gradually being put into practice with the enablement of co-response PMHT models. From a LEPH standpoint, the introduction of specific interventions such as PMHT was to formalise the public agent role of the police in society. These findings have shown; however, the implications of this targeted intervention have been that once an understanding of the police role as public health agents widely exists, any subsequent assumptions made or perceptions inferred from this have been left free to flare, in a way that was more limited prior to PMHT.

This becomes problematic for several reasons, though not least for the future implications of any formal assumption of responsibility (and the extent of which) that the police are undertaking in delivering a targeted MH service in the absence of an NHS alternative. As Manning (1978) pointed out, the mandate of the police is fraught with difficulties, many of them self-created, and this research has provided early indications that the adoption of specific LEPH interventions such as PMHT may be an area where the police are unwittingly creating such difficulties. The long-term impacts of such are yet to be seen and it is only through the development of an emergent evidence base that the repercussions of such will emerge. It would be encouraging to see police organisations revisit their PMHT provision (as they are due to do in line with the CoP guidance) at a time when they are not still grappling with the prospect of making a future fiscal saving of 20%.

Whilst it may be questioned whether there is anything wrong with this ‘newfound’ position as the official gateway to healthcare, given this does signal the police have fully acknowledged their role as public health agents within the LEPH arena, the debate must be situated within the context of the other findings from the study. The key ones relating to this issue include the perceived need for police involvement in the crisis incidents at all; the impact of this expanded role on those in crisis; and the uneven benefits to be gained by the health partners i.e., MH Trusts being able to position the operation of PMHT as an ‘add-on’ to bolster the extant limited out-of-hours provision.

Within the research sites, there was no indication, at the time of the research, that the SPA lines were to be disbanded. Evidence given to the HASC (2018) committee, however, included reports from wider schemes, in which the extant limited out-of-hours provision had been disbanded in favour of operating PMHT on a full-time basis. Despite this leaving some areas with no fully funded NHS crisis care provision out-of-hours at all, the existence of PMHT allowed them to report that they had met the ‘target’ of operating a 24/7 system of crisis care. There is thus a real danger that a continued expansion of the police role has the potential to replace an out-of-hours MH crisis system that has already been decimated over the last decade, and the final words of this thesis offer further significant cause for caution about this.

In returning to the extant debate around the role of the police in society and the rapid acceleration within policing of there being a need to consider complex social issues such as the policing of mental ill-health through a LEPH framework, it is vital to reflect upon this. These findings suggest that specific interventions, such as PMHT, have the potential to undermine the concept of LEPH as a whole when they are not well thought through. The preceding section has already identified that the lack of common wisdom found within PMHT partnerships would hinder its ability to attain CA i.e., being able to meet the aims of the CCC. Dijks and Crofts (2017) talked about there being a re-definitional process taking place regarding the remit of LEPH, though they did not explicitly place it or explain it within the wider social context in terms of the effects of austerity policies on those most vulnerable. The findings here pose little doubt that its rapid expansion and acceptance within the E&W policing sphere was a direct consequence of the socio-political climate within which PMHT emerged as a knee-jerk reaction to austerity, as considered in Theme 1.

To be clear about my position, the need for a combined approach to LEPH remains essential and there should be continued efforts to establish broad partnerships between agencies that take account of the unique role that each provides society and the relationship between them. Two of the fundamental bases of LEPH thus hold particularly true i.e., that there should be societal concern about the issues each agency raises and there should be strong cooperation between LEPH agencies in approaching such issues (Punch and James, 2017). Partner agencies should be cautious, however, when considering more specific or targeted interventions such as PMHT, because as these findings suggest, without thorough aforethought, they have the potential to undermine the value that a broader combined approach to LEPH could bring to society and to the people LEPH agencies serve. It remains possible to recognise, for instance, the valued role of the police as public health agents more broadly, while still calling into question the extent to which they *should* be responding to people with mental ill-health owing to the absence of a health-based alternative.

My position thus lies somewhere in between that of Millie and Herrington (2014a), but it is arguably easy to position myself here with a decade’s worth of hindsight and with the knowledge of these new research findings. Commentators around at the time austerity commenced were not so fortunate. The implementation of PMHT as a means for the police to be able to do what they always have done more efficiently has detracted from the wider debate that was at the forefront of Millie’s position in the early 2010s (2012; 2013; 2014a; 2014b). Though it may be argued that the time for a reconsideration of the role of the police has now passed with the rapid acceleration in the acceptance of LEPH, there is still value to be had in reengaging with Millie’s proposals as new evidence on combined initiatives continues to emerge. If anything can be learnt from the era of deinstitutionalisation, it’s that doing more with less has long-lasting repercussions.

Given E&W is once again in the midst of economic restraint, experiencing a record rate of inflation and an ongoing cost of living crisis, the impact of such on all areas of society is likely to, once again, be huge. While we may be moving towards what may be another re-definitional period for policing and health services, LEPH requires a reassessment. The aspirations of the approach are unquestionably admirable, and as a theory in and of itself, it makes total sense. It is hard not to take issue, however, with what is at present (due to its infancy) a broadly generalised framework that has not been tested enough against the ‘pockets’ of activity within the LEPH arena i.e., those which have already become special interest groups within GLEPHA, including policing and mental ill-health. As the first study of its kind in E&W, these findings would dispute, for instance, that there should be more law enforcement involvement in delivering frontline mental health crisis care (Bartkowiak-Theron and Asquith, 2017). While there is a place for law enforcement in recognising mental health as a complex societal issue that they encounter in a similar way to health colleagues, I propose its place is not as the primary service provider.

Millie (2012; 2013) suggested that should the police have passed on responsibilities during austerity, then others may not have been able to fill the gaps immediately, but he proposed over time the result would be a narrower, more focused police service. While I am not calling for a more focused police service, given it is imperative that there remains a broader focus on the fundamental values underpinning the LEPH agenda, such as greater cooperation between agencies, I am calling for what was found to be the want of people who access MH services in Chapter Seven. That is a fully functioning MH-based alternative to the police in responding to mental health crises in real-time, in the community.

There may be cautious optimism ahead, in that the mission set out in the NHS Five year forward review (2016) showed signs of developing in January 2023 with the announcement of government investment to procure up to 100 new MH ambulances that would take specialist staff to deliver support on the scene to a person in crisis or transfer someone to the most appropriate place for care. This was in addition to developing projects that would centre on supporting MH provision through providing crisis cafes, crisis houses and other similar safe spaces, all of which were perceived favourably and preferable to hospital care when unwell. The tide may very well be turning, and it is vital that a combined approach to LEPH is pivotal in these ongoing developments, with all agencies remaining concerned about how such initiatives can benefit not only the involved organisations but more fundamentally, those who find themselves in a position of crisis. While remaining only cautious optimism at this point, the announcement has signalled that the creation of such initiatives may reengage the debate about the roles that each partner agency is currently fulfilling, and the findings from this research suggest this can only be a good thing for the future of policing mental ill-health.

In the current climate, however, it is hard to conclude anything other than how PMHT, though particularly co-response models have become a ‘sticking plaster’ for the chronic underfunding of MH services and the absence of an alternative *emergency* MH service. Though in this analogy it was conceded that while plasters are temporary, they are nonetheless helpful (Wood et al, 2014), the findings from this research indicate that PMHT as an intervention is not helpful to either the police organisation or to SUs on a longer-term basis. Whilst the police actively seek to ‘plug the gap’ in the absence of an alternative emergency mental health community response, it is unlikely that NHS partners would actively object due to the resource benefits to be gained by the health organisation from these arrangements.

* 1. **Theme 4**: The nature of police partnership work in the operation and delivery of PMHT.

The requirement for officers to consult with a health professional before using s.136, as introduced by the PACA 2017, did not give PMHT an explicit statutory footing. It did, however, mandate communication between practitioners within LEPH, though not how this was to be done, leaving this up to individual PCs to work out on a case-by-case basis. Like the CCC, this also reflected the neoliberal principle of individualism and the reduced role of the state, which Chapter Two discussed as having become the prevalent government ideology from the 1970s (Cummins, 2018). This position was found, however, to have created somewhat of a ‘grey area’ concerning PMHT e.g., despite not being recognised as a ‘formal’ practice, officers were utilising PMHT during operational hours on an informal basis, for this consultation, via their police colleagues.

This research has highlighted that PMHT was operating in a middle ground, not statutory, not informal, but somewhere in between the two. PMHT sits within the emergent LEPH field, an area that reflects how the nature of police partnership work is continuing to shift far beyond that of a crime reduction sphere, but where empirical evidence of combined interventions such as PMHT, is limited (Dees and Anderson, 2003; Bartkowiak-Theron and Asquith, 2017 Enang et al., 2019; Shepherd & Sumner, 2017; Murray et al, 2021). This has been a key consideration when interpreting the research findings in the context of the extant police partnerships literature, and where the findings contrast to those from the largely crime-related literature, these differences are highlighted and discussed.

Crawford and L’Hoiry (2017) found that many of the difficulties highlighted in the early scholarship of police partnerships had remained stubbornly persistent, and this research has too found a disconcerting number of issues that resemble those from the early days of the CDRP, yet the long-term impact of these issues and the absence of a formal statutory footing is still to be seen. The purpose of this section is therefore to consider some of the key issues that were found to be present within the operation of PMHT partnerships in greater depth, and what can be understood about them in relation to the CA themes and the nature of partnership work within the LEPH arena.

* + 1. *An (un)stable membership and the multi-dimensional nature of PMHT*

The consistency of the organisation representation that was found to exist within PMHT partnerships through the multi-agency boards/groups at the middle management level and above, had been facilitated for by the localised CCC action plans (*9.2.3*). In many respects, reflective of the semi-formalised position of PMHT partnerships, there was no legal obligation for localised partners to embark upon partnership work at that stage (PMHT or more widely), yet as the implementation process showed, there was a strong commitment at the localised organisational level to do so, driven forward locally by key individual actors (*9.2.2*). There were no issues found, for example, with organisational engagement i.e., there was a consistent representation of organisational agency found at the multi-agency meetings in which PMHT had become absorbed, in the absence of a specific PMHT governance structure overseeing its operation. An element of trust between agencies was found, in so much as that each was committed, and believed other partners to be as committed, to the *prima facie* shared aims of the CCC. This aligns with prior work which noted how in establishing and maintaining trust, the consistency of agency representation is essential for allowing time for understanding each agency’s motives and goals behind their engagement in partnership work (Berry et al, 2011; McCarthy and O’Neill, 2015).

As such, it appears concerning that Mind’s role as Concordat Secretariat came to an end in 2016, signally that this overarching governance framework was time limited i.e., the action needed for the wider commitment to improving crisis care was to be overseen and managed on a short-term basis only. The wider ‘informal’ commitment made through the CCC had thus officially ended before the introduction of the PACA 2017 which ‘formalised’ communication between the agencies, leaving little doubt that there was never a long-term Government commitment to tangibly improving the extant crisis care provision through giving it the time and investment it needed, which this research identified, was perceived by those working within the system to be not only necessary but essential. Furthermore, despite announcing there was to be a 10-year cross-government Mental Health & Wellbeing Plan in April 2022, by January 2023 this had been scrapped, with charities such as Re-think and Mind publicly expressing their disappointment (Re-think, 2023).

Despite the CCC evaluation stating that the DHSC/HO/NHS England organisations would continue to enable the CCC to play a central role in improving the outcomes of people who experience a mental health crisis, support the national signatories and local groups respectively to update their actions and implement their plans (McPin Foundation, 2016), this research would indicate that the wider shift to joined up working has ended before it has even begun. The findings have identified the challenges within PMHT, and wider agency relationships were not even close to being resolved at the time that the CCC appears to have become somewhat redundant as an overarching governance framework. This leaves the future of LEPH police partnership working at a broader level (i.e., not confined to PMHT, specifically) in this area questionable, to say the least. The research found scepticism from practitioners about the actual prospect of any ‘*real change’* occurring as a result of ‘*another policy document or similar’*, and the ceasing of the Concordat Secretariat and actionable ongoing commitment to change, suggests their perceptions may be well-founded.

Despite the CCC evaluation recognising a need to maintain momentum (McPin, 2016), this research has shown that this momentum rests so much on that of key individuals (*9.2.2*), that without them, there is no certainty that any tangible commitment to establishing meaningful partnership work will continue. This has implications for PMHT, in that it was already found to have no specific overarching governance in place, and there is thus a higher potential for this to be watered down even further, which if the practice continues is likely to exacerbate many of the issues this research has highlighted e.g., all those hindering the prospect of achieving CA. The research has identified there was still much work to do before PMHT could be considered a solidly worthwhile initiative with equal benefit to all partners (particularly the police) and without any wider commitment to ‘make this happen’, it is proposed that this is therefore, unlikely to happen.

Pivotal to the emergent nature of LEPH partnerships, this research found that beyond the representation of agency at meetings, was the importance of consistency in this individual representation e.g., managers were unable to list the membership of the groups or identify partners’ title/role within it, there was a failure to establish a consistent or core membership of individuals, and this was routed in a high staff turnover. The main challenge for PMHT partnerships was identified to be getting the right people around the table, at the right time, and then keeping them long enough for actions to occur and partnership progress to be made. Aside from the key ‘founding’ individuals identified in Chapter Five, who entered into the partnerships together as individuals in an informal, ad hoc way, to bring the organisations into partnership, the findings showed that individual partners did not view their relationship with other members on an individual basis. They, instead, perceived their role as a representative of an agency. Without a broader commitment to the representation of agency within LEPH partnerships, there is unlikely to be an individual commitment. This is vital given the membership of a collaboration influences what the partners can achieve (Huxham and Vangen, 2005), and without the ongoing broader momentum of the CCC, there is less inclination for individuals to secure consistency at the middle management level and above.

The turnover of key staff of particular teams or localities, for instance, was shown already to severely disrupt interpersonal relationships that had built up over time (Huxham and Vangen, 2005). This ‘churn’ of personnel has previously been highlighted also as problematic for police partnerships in terms of the loss of human capital through expertise and skills that are built up in specialisms (Crawford and L’Hoiry, 2017). The research found that particularly for police personnel, staff had ‘*just got their head around MH*’ and then moved on to other endeavours. This was an issue that partners were aware of, and there was evidence of some active attempts to achieve greater consistency in some of the research sites e.g., Hilltop recruiting a permanent civilian force MH lead. This was a positive development, given that relationships between individual participants in collaborations are fundamental to getting things done (Huxham and Vangen, 2005), and is suggestive that at the time of research, there remained momentum to achieving effective partnerships.

Thus far, this section has considered the themes of membership and trust at the middle management level of PMHT partnerships, and as such, the considerations relate to the ‘semi-formal’ overarching governance framework for PMHT, without which, effective partnership within the confines of policing and mental health is challenged. At the frontline, however, many of the issues outlined above were at odds with how frontline models of PMHT in practice had been designed. By design, the rolling rota system of routinely assigning different officers to each PMHT duty, inhibited the potential benefits to be gained from co-location, for example, along with the design of the short-term (8-10 hour) nature of the duty. Where co-location arrangements were possible e.g., co-response models operating from NHS/police premises, staff were not always co-located, with officers opting to remain at their station ‘*unless a job came in*’. There was also a lack of integration from health workers with the police staff in control room models, owing to the positioning of health staff out of the main control room. It is proposed, however, that co-location would have made little impact on the level of trust between frontline partners in such a short-term context anyway, in the absence of consistency of representation i.e., the same two practitioners working on the team.

* + 1. *The police as a subservient partner*

The research has found that the traditional dominance of the police within partnership work (Sampson et al. 1988; Crawford, 1997; Skinns 2008), has been hugely challenged within PMHT arrangements, across all levels of the partnership. This section proposes how this may likely be the case for other police partnership initiatives that have come to operate within the wider LEPH arena. On the frontline, the CA themes of power, ownership, and leadership (Huxham and Vangen, 2005) were shown to heavily intertwine due to the overtly dominant role taken by the health partner (Chapter Six), particularly where co-response models of PMHT attended as first responders and thus the frontline partnership was confined to two people i.e., one officer with one MH worker. There is a case to be made that such frontline dominance was only possible due to the nature of PMHT often being a ‘two-person show’ with the dominant decision-making of the health worker resting upon them holding ‘the power’ to tangibly resolve the situation e.g., whether to attend in the first place; whether to ‘rule out’ s.136 use; or whether to plan for ongoing care.

While prior conceptualisations of the police favouring the pragmatism that partnership work often affords them (O’Neil and McCarthy, 2012), could have contributed to the subservient nature of the police at the frontline e.g., when they were found to wait in the car and ‘let the MH worker deal with it’, that was, of course, only true until they did not deem the situation ‘resolved’ i.e., the PMHT worker leaving the scene with the police feeling what little action they could have previously taken in the way of s.136, was no longer available to them. Even where PMHT attended as secondary responders, and PCs were already on scene i.e., sometimes one MH practitioner and up to Seven PCs (the most observed before PMHTs arrival) the subservient nature of the police rarely faulted. In these cases, with numbers aside, the MH practitioners were found to swiftly enact their power in the same way as a two-person team, by assuming ownership of the situation e.g., asking the police to step away whilst they spoke to the person in crisis (though not concerning relevant risks and legal culpability) and making decisions as to the outcome of their attendance, thereby demonstrating leadership within the duty itself. Within virtual models of PMHT, and the telephone encounters that were found to operate alongside co-response duties, the ownership was also seen through the perception that MH practitioners were ‘telling PCs on the scene what to do’ and the frustrations that were reported in Chapter Six when officers did not do as they had been ‘*requested/told’* by the MH worker during the consultation.

It becomes apparent how seemingly irrelevant the ‘expert by policing experience’ knowledge had become at all levels of the partnership, even in cases where there were Seven sources of it and many years of collective experience of dealing with MH, when there was a MH professional involved. This reflects a sharp contrast from prior police partnerships research, which found it was the police who were to have taken or assumed ownership of the partnership at that frontline operational level. In crime partnerships where the roles had been identified as not being clearly defined, the ownership of the partnerships was found to become a contentious issue which created uncertainties among participants about their roles and responsibilities and the division of labour (Skinns, 2008). This is perhaps one of the more transferable aspects of prior CRDP research, therefore, about how a lack of formal protocols and procedures surrounding PMHT, coupled with the lack of operational oversight, had too led to uncertainties over personal responsibilities and the division of labour, though against the police rather than in favour of them. The uncertainty in roles at the operational level was another evident point of power (Huxham and Vangen, 2005), or rather a loss of power for the police.

It was at the middle management level, however, that was shown to deviate even further than what the prior police partnerships literature relating to crime has shown. Even where the police were the primary or whole funder of PMHT e.g., in Hilltop, the police were found to be a more subservient partner e.g., middle management multi-agency meetings chaired by NHS personnel, and attending officers appearing to accept what was being said within the meetings at ‘face value’, often going unchallenged. This domination and/or assumption of owner or leadership has previously been linked to pragmatism (O’Neil and McCarthy, 2014), and whilst there were certainly aspects of ‘the new’ pragmatism observed e.g., frustration where actions from previous meetings had not been completed, this research suggests the ‘traditional’ position of police partners within middle management multi-agency partnerships is challenged within a LEPH partnership context.

It is proposed that such fundamental deviations from what has previously been established about the nature of police involvement in multi-agency partnership work, are owing to the perceptively ‘MH-owned’ concept of MH crisis care. This subservient position of the police varied from the prior police partnerships research which was largely concerned with the perceptively ‘police-owned’ concept of crime reduction. Whereas crime reduction partnerships were said to serve more of a purpose for the police than they did other partners, with other partners perceived to be assisting the police to meet their organisational goals, this cannot be said to be true for the issue of MH demand, which spans much wider than any singular organisation. Within police partnerships that have a crime focus, it has been said to be in the interests of the police to take ownership of the partnership agenda, irrespective of overruling other partner members, yet this research found no evidence of a desire to overrule health partners at that level.

Whereas the police have traditionally been organised in terms of risk communications to and from other institutions (Ericson and Haggerty, 1997), this has not been considered in a partnership such as PMHT that falls within the LEPH arena. Despite both policing and health being traditionally considered risk professions, it was the health organisation that was the occupational group that could claim a higher level of abstract knowledge concerning how to address particular risks and a unique ability to provide expert services of risk management (Ericson and Haggerty, 1997). Those particular risks and access to knowledge were, of course, mental ill-health, for which it was found that despite the extensive ‘expert by experience’ knowledge of officers, this counted far less than the training and qualifications received by MH practitioners. There was thus a very clear uneven division of expert knowledge perceived within the system of professions involved within PMHT (Beck, 1992; Gale, 2016), yet it is proposed that the extensive expert experience knowledge that the police possess in responding to incidents of mental ill-health was often wrongly discounted altogether.

This was seen to be founded on the same basis as what Sands et al (2012) had noted, in that mental ill-health is only one aspect of the police role, whereas MH clinicians working in emergency crisis assessment teams or MH triage roles are routinely required to make rapid and accurate risk assessments as part of their core function. As such, officers were found to perceive this as being ‘*their expertise, not ours’*, reportedly feeling out of their depth in that they had to perform the same role but without the same training and knowledge as their health partners, as reported in Chapter Six. While this is factually correct concerning formal training and qualifications received, the expert experience and knowledge that officers possessed from the sheer number of incidents they attend on the frontline, was deemed inferior to that of qualifications.

The distinctive nature of the imbalance in roles within PMHT did not consider the fact that without the partnership in operation, it is only the police who hold the capability to attend to people in crisis, in a way the OOT crisis care practitioners cannot. The police are also routinely required to make rapid and accurate risk assessments as part of their core function, whether that be mental ill-health related or otherwise. At the crux of this issue, it is proposed that the issues discussed thus far rest upon the key finding that police attendance was found in most cases to be wholly unnecessary i.e., many of the clientele were already known to MH services, and more instances occurred in private dwellings than they did on the street or in public places, thus falling outside the police legislature remit of s.136.

Aside from transport being identified as the primary purpose of PMHT for co-response models, which it is proposed is an unjustifiably expensive resource, the secondary role was that of protector. The role of the officer undertaking PMHT as a protector, is also somewhat dormant considering that other PCs were already at the scene in areas operating a co-response model. By virtue of the additional officer attending as part of a co-response, there is one more officer there than there would have been without the co-response and therefore more resources were allocated to incidents than there were before the implementation of PMHT. For instance, the attending officer on scene would be more than a sufficient resource in protecting the health worker should this ever be necessary, despite this contradicting what is already known about the nature of mental ill-health incidents, whereby the majority of incidents do not carry any increased risk of violence. People with mental ill health are at a higher risk of being a victim of crime than the general population and are more likely to be a victim of crime than they are a perpetrator of the crime (Pettitt et al, 2013). Hence, it is probable that whatever the future relationship between policing and MH is, there will always be a future.

For this reason, while the further promotion of a LEPH approach to complex societal issues and a continued increased recognition of the notion of ‘vulnerability’ within policing is favourable (Bartkowiak-Theron and Asquith, 2017; Punch and James, 2017; Dijk and Crofts, 2017), specific interventions such as PMHT, which have sought to bring together those in police and health practice through touch points, i.e., a person in crisis, will only be an effective strategy if there is recognition of the extent to which policing and public health share common ground (Murray et al, 2021). This research has highlighted through the police being found to be a subservient partner in such arrangements, that the common ground they shared had been overridden entirely in favour of health being perceived as the expert knowledge brokers.

* + 1. *The importance of maintaining differences in risk management approaches*

The findings related to risk have strongly supported prior research which showed that MH and police agencies were wholly independent of each other when they were identifying and managing risk when responding to people with mental ill-health (Ericson and Haggerty, 1997; Dodd, 2016; Thomas and Forrester Jones, 2019). The terminology used in describing their approaches, mirrors almost verbatim what a prior local PMHT evaluation had reported about challenges within the delivery of PMHT e.g., ‘positive risk taking’ and ‘risk averse’ (Irvine et al, 2014:8.1). Despite the frontline practitioners in both organisations acting as the ‘vehicle’ for risk management in the delivery of PMHT, the variances reflected what was found to be not only the different regulatory frameworks within which they were operating but also the informal working practices and culture that was shown to exist alongside these (Chapter Six).

Concerning the regulatory frameworks, risk-taking was seen by officers as an individualised and potentially punitive matter, if they misjudged the risks involved in an incident (Beck, 1992; Ericson and Haggerty, 1997) e.g., their reference to organisation accountability structures such as the IPCC (now IOPC), the fear of judgment from within the organisation and colleagues, as well as that of losing their job. All of these factors they identified would support what Heaton (2010) discussed about the potential negative consequences that taking risks might have upon reputation, and this contributes to the risk-averse culture within policing which was reflected through their decision-making about s.136 use. While there was no evidence that officers were being ‘overzealous’ in their use of s.136, especially given it was the primary tool afforded to them in cases of mental ill-health, the ‘worst case’ scenario for officers not using it has been found to go beyond the risk of the possibility of an adverse event, outcome or behaviour arising from the unwanted actions of the SU alone, notably risk of harm to self, others, or both. This contrasts with the health partners, whereby self-harm, suicide, or violence were perceived as the only risks (as per Dixon, 2001, 2015 and Ahmed et al, 2021), with none of the wider negative reputational consequences reported.

While the research findings have highlighted how risk, therefore, remains a key cultural influence within police practice when responding to potentially vulnerable people (Manning 1977; Ericson 1982,1993; Reiner, 1986; 1992; 2000; 2010; Heaton, 2010; Bowling, 2019), fuelled by their regulatory frameworks, it is proposed that this differs to MH practice which has become reliant upon the notion of positive risk taking as a core feature in the role of a crisis care practitioner itself. Taking positive risks was found not just to be perceptively necessary, but essential, by MH practitioners, for the SPA phone lines to operate i.e., taking ‘positive risks’ was a fundamental and expected practice that was required to manage the scant provision available to them. This was seen, for instance, through health workers reportedly having to work within ‘*the system we’ve got’* and through the recognition that if everyone who ‘*needed*’ more intensive care received it, the city would be able to fill the existing provision ten times over. It is proposed that it was this cultural/practice distinction between the individual nature of the roles each partner took respectively, that led to the variance in working assumptions about what courses of action or inaction, constituted safe and effective practice.

It is these variations that also underpin why PCs did not approach MH incidents in the same way as MH staff, and in light of the findings from this research, it is proposed, nor should they be expected to be. The police’s subservient role, in which they had to sometimes defer to the expert knowledge of MH staff, disadvantaged them in these decisions, including ones where, by law, they should have been the main decision-maker. It is proposed that these ongoing incompatibilities in the working assumptions regarding risk management were impacted by the absence of common wisdom and the broader understanding of the partnerships described in 9.3. While partners at all levels of the partnership were aware of the different approaches to risk and were focusing upon this being an ‘issue’ to be solved through PMHT, there was no higher level of common wisdom that was required by partners to understand these deeper issues underpinning the different and in the case of PMHT, contrasting approaches to risk (Huxham and Vangen, 2005). NHS resources, for instance, such as whether there is an available bed for a person who would need it, were not to be the frontline PCs’ primary concern and again, it is proposed that nor should it be.

Despite this, however, PMHT had created a ‘grey area’ about the assumption of risk, seen through an observable reluctance from either partner to explicitly assume responsibility for the person in crisis, despite the dominant role undertaken by the health worker in decision-making processes more generally. Given the implications of such issues are likely to affect not just collaborative interventions such as PMHT, but those within the wider LEPH arena, the following discussion provides an original contribution to the knowledge of how MH practitioners were using positive risk-taking within this context, leading to the conclusion that the attainment of common wisdom must be established at the outset of any future combined LEPH interventions.

The taking of ‘positive’ risk within the practice of MH crisis practitioners was founded primarily on their knowledge gained from being an experienced practitioner e.g., all of these practitioners were at least a ‘*Band Six, usually a Band Seven*’, meaning they were well above graduate level practitioners. The findings showed MH practitioners drew upon their prior experience of assessing those who were in crisis and the likelihood that the person would harm themselves. There was no evidence found of any standardised approach to risk management within PMHT, and the process of positive risk-taking can be thus categorised as an unstructured clinical judgement (Doyle and Dolan, 2002), whereby staff were making judgments based on their clinical experience, opinion, intuition or ‘gut feeling’ (Sands et al, 2012). Reflecting upon this position, considering the theory of ‘Risk work’ (Gale et al, 2016) has been a useful conceptualisation for understanding the issues that the variance in risk approaches caused for the operation and delivery of PMHT. The first two aspects of this, the transference of probabilistic risk and the minimisation of risks in practice are considered in relation to these research findings, with the third aspect, caring in the context of risk discussed in the subsequent section due to its seeming incompatibility with the first two aspects.

The research findings have shown how MH practitioners were undertaking their role in the knowledge that however ‘ill’ a person was e.g., often receiving the knowledge the person in crisis expressed intent to end their own life, the likelihood was that the person would not go on to cause harm to either themselves or someone else. This was based upon their knowledge of probabilistic risk based on population-level data i.e., the knowledge that most of the people who ring the SPA line or come to the attention of the police do not go on to lose their life. This probabilistic risk was found to be translated by practitioners to individual cases, which could be converted into auditable data for organisational use e.g., Chapter Six showed how death was perceived as an inherent part of working in MH crisis care. As reflected in the perspective widely found to be shared by MH staff, ‘*you can’t save everyone, some people will die’*. The auditable data would have demonstrated, for instance, that the proportion of suicides to the proportion of calls to the crisis team or PMHT was low. Based on this information, the staff knew that the likelihood of someone going on to harm themselves or others was also probabilistically low, so this can be understood as a translatable risk (Gale et al, 2016).

The research has found how MH practitioners often could not specify how they assessed risk, only that often their gut feeling about a case was ‘usually right’, and whilst they continued to be ‘usually right’, they perceived they were undertaking their role with safety. This supports what prior research has shown about how MH practitioners assess risk, based upon ‘tacit knowledge’ (Wood et al., 2003, Scamell & Stewart, 2014, MacLeod & Stadnyk, 2015); ‘broad, practical experiences’ (Williams, Alderson et al. 2002); ‘intuition’ (Warner & Gabe, 2004), and ‘intuitive expertise, and embodied knowledge’ (Godin, 2004), which further reflects the unstructured clinical judgments that the practitioners were making within the context of not only PMHT but their wider role in out-of-hours crisis care provision.

The second component of risk work, minimising risks in practice (Gale et al, 2016), could be understood within the context of PMHT through the nature of the conversations and the advice and (in) action given to those in crisis e.g., the questions ‘*have you had a bath?’ ‘Have you had a cup of tea?’ ‘Have you tried listening to music?’* in response to a person in crisis expressing suicidal ideation and/or extreme distress. While such questions or responses to someone expressing suicidal ideation were perceived as ‘futile’ action by those at the receiving end of such a response, the practice of asking such questions was reflective of the practice of the ‘minimising risk’ kind of activities, understood as the encouragement or support to change the behaviour of the person in crisis (Gale et al, 2016).

The tangible impact of this approach to risk management, however, is principally serving as an accepted and justifiable way of negating personal risk for decisions made, owing to inadequate resourcing that would have enabled practitioners to take an alternative course of action e.g., in the many situations where practitioners recognised someone may have needed a more extensive response to their crisis, but there were not the resources to provide as such. The most obvious example of this from the research, was when practitioners sometimes felt that someone needed to be admitted to the hospital but could not allow this in case someone ‘riskier’ came along. While acknowledging the damning impact of austerity on the capability to provide an adequate service to many people who need it (*9.2.1*), it is proposed that there should be careful consideration about how much the police are expected to culturally ‘absorb’ with regard to finding a shared approach to risk management within collaborative interventions such as PMHT.

Thomas (1986) spoke of ‘the dangers of collusion and merger’ which resulted ‘not in good collaboration but in a form of incorporation of one service into the other’. The idea of officers relinquishing their discretion to MH workers in cases where s.136 is at stake, fundamentally undermines the existence of s.136 in the legislation itself. It has been established that no explicit assumptions were made about the implementation of co-response models being to formally fulfil the only NHS in-person community crisis response, let alone that officers should take the advice from MH workers with no questions asked, as the research found frontline MH workers were expecting of their police partners for the partnership ‘to work’. The realities of such occurring lean towards the presence of a merging of agencies, rather than effective collaboration. For this to be regulated, the law would need reforming to reflect that s136 has, in practice, become a joint decision and not that solely of the PC. Without reform, this merging is concerning not least because of the prospect that the individual qualities that each agency can bring to the partnership would be lost.

* 1. **Theme Five:** Situating SU perspectives of PMHT within those of the wider policing and MH landscape.

It was noted prior (*8.3*) how improving the experience of SUs when in crisis has been presented nationally as a primary aim of PMHT, positioned above the other objectives of such interventions. This research has presented evidence contrary to this being the case in practice, which supports what Solar and Smith (2022) have purported in that the decentralisation agenda within the context of the CCC, was developed as a means for managing reduced resources and not as a mechanism for local level accountability and democracy.

It is proposed that the dominant discourse around how to do more with less, was reflected through the lack of local accountability and democracy found in relation to any efforts to establish the impacts of schemes on the people they serve e.g., SU perspectives were found not to have been considered when partners deliberated the implementation of PMHT and the effectiveness of the partnerships therein. There was also a continued notable omission of any SU participation, co-production, or inclusion in local evaluations (where they existed), or ongoing operation of PMHT through an invitation to any of the multi-agency boards, meetings, or groups post-implementation. This research presents a clear opportunity for PMHT managers to reconsider their position on this. The absence of any co-production with SUs does not equate to mean that those involved with the implementation and operation of PMHT do not care about this. There is indeed a case to be made that an improved SU experience could be perceived to be a natural consequence of managing the resource-related demands, though the pitfall to this has been the lack of any consequent investment to establish whether this was so. Without such, the ongoing positioning of the SU experience being at the heart of PMHT can only be described as at best, idealistic, or at worst, disingenuous.

The satisfactory experiences detailed in Chapter Seven were found not to reflect the purpose of PMHT itself, but rather served as a reflection of several other things. Though perceptions of PMHT were generally well received, this was not based upon the personal encounter of PMHT, but rather, the broader systematic failures of existing crisis care provision, along with peoples’ prior interactions with individual health practitioners working within it. The aspirations about the *potential* benefits that people could foresee were thus distinct from whether those benefits were experienced first-hand, which this research can conclude was not routinely the case e.g., a less stressful experience; prompt and efficient access to the crisis care pathway; or receiving a perceptively ‘better’ outcome through their PMHT encounter. It has been possible to determine that PMHT was perceived positively, primarily because it bridged a gap between a perceived lack of compassion and providing the *hope* of a tangible outcome to their crisis, which was seen as unattainable based on the extant NHS provision alone. The purpose of this section is therefore to consider these aspects with the crisis care and policing literature, and what this signifies about the ongoing operation of PMHT for which improved SU experiences may likely continue to be framed as its core purpose.

The optimism of the potential benefits to be had from PMHT can be understood in the context of earlier research that had highlighted the negative experiences of accessing crisis care provision (MIND, 2007; The Sainsbury Centre for MH, 2008; Clarke et al, 2009; CQC, 2015). Though the police were the ‘vehicle’ for delivering a MH specialist in real-time to the person in crisis, the outcome of such encounters was found often to end with the co-response itself. The reason for such is that it is only possible to ‘triage’ people to further services, where services exist and are capable of meeting demand. The constriction of community services such as home treatment, and the reliance on third-party sectors such as the ‘crisis house’ charity that was perceived so favourably by SUs, were found often to be ‘full’. The outcome of PMHT contact was therefore regularly found to be the same had someone not had face-to-face contact with a MH professional through PMHT or had the officer not consulted virtually.

Though this research has identified that the difficulties and negativity associated with accessing crisis care support held true, the level of optimism surrounding the police presence signals a substantial deviation from what prior research has reported about SU satisfaction with police encounters when in MH crisis (Jones and Mason, 2002; Bloom and Farragher, 2010; Riley, 2011; Mind, 2013). It was particularly startling, for instance, that despite all the negative connotations described and felt deeply around the implications of receiving a police response e.g., the ‘rigmarole’ of blue lights, police uniforms/vehicles, privacy, and the underlying potential for use of force, people often were found to still prefer an in-person police attendance over ringing the SPA (that they knew would connect them to a MH professional). Though this does not negate the less-than-ideal experiences that people described when recounting singular police responses to prior crises, nor does it outright reject the prior literature that reported the implications of such e.g., it being a custodial rather than therapeutic experience, and one that fuels a feeling of criminalisation (Jones and Mason, 2002; Riley, 2011), it does signify the damning state of MH crisis care provision.

The research has shown that in 2023, there are people with enduring mental ill-health needs that would favour a police response to a crisis over a specialist MH-based one. This rested upon the need for compassion in such circumstances, which they felt was more likely to be received from the PCs in their role as ‘custodians of coercive state power’ (Bloom and Farragher, 2010) than they did from those working in MH specialist services where compassion is widely recognised as ‘being core’ to quality health care (DHSC, 2012; Cleary et al., 2015; NHS England, 2018). This was notwithstanding the awareness that SUs showed about the limited-service provision beyond PMHT e.g., even when they knew despite officers’ assurances they would ‘*get some help’*, such help simply did not exist for them.

Two theories are proposed for such stark variances in the levels of compassion perceptively felt between PCs and MH practitioners. The first is that MH practitioners were undoubtedly experiencing compassion fatigue (Salyers et al., 2015, 2017; Turgoose & Maddox, 2017 Marshman et al, 2022), and this was negatively affecting the manner and tone upon which they interacted with people in crisis on an almost daily basis e.g., coming across as rude and abrupt to SUs and/or their carers. Though by no means an excuse for what was found to be often ‘panorama worthy’ i.e., cruel, or condescending treatment towards those in crisis, this theory does explain it.

The second relates to risk, and the third part to Gale et al’s (2016) theory of risk work, namely caring in the context of risk. It has been noted that caring in the context of risk can be difficult to reconcile with the other two aspects of risk work, translating and minimising risks as discussed in 9.3.3, above. When MH practice requires the translation of risk upwards, as it was shown to be in this research e.g., managers collating s.136 data for organisational use to (in part) measure the effectiveness of PMHT, or reviewing patient records for quality assurance purposes, this led to the SUs ability to trust the practitioner being severely threatened, something prior research predicted could occur (Brown & Calnan, 2013). This was notably seen concerning perceptions around information sharing with the police e.g., a widespread perception that MH practitioners lie when recording a contact, necessary to ‘downplay’ the extent of the positive risk they have taken and ‘*cover their arses’*. The variances in assumptions of risk have been well documented throughout this thesis, yet it is difficult to contribute any meaningful solutions to the debate that do not require a total cultural renegotiation of crisis care and substantial investment and reform.

It was noted when setting out this theory (Chapter Three), that what counts as a risk is dependent on social, political, and ethical constructions (Thomas, 2015; Gale et al, 2016). When the broader socio-political landscape is as this research has found it to be, there is little scope for MH practitioners to alter their way of working without the extant system ‘*crumbling*’, though they could (and should) address the issue of compassion fatigue and its associated issues. While risk minimisation has been said to potentially challenge practitioners' commitments to enhance patient choice or control (Hall et al., 2012), these findings suggest it was not the practitioner’s commitment that was at issue. The challenges that the practitioners were found to be facing during encounters with people in crisis were often beyond their control. However unhelpful the risk minimisation strategies deployed were found to be to a person in crisis e.g., ‘*have a bath/cup of tea/walk/listen to some music’,* practitioners recognised that this was what was often all they had in their tool belt. Exacerbated by the austerity-induced service constrictions, the limited number of inpatient beds reserved for the ‘*most* risky’ coupled with the increased pressures on home treatment alternatives, meant MH practitioners had nothing to enhance patients’ choice or control with, except inform them they could ring the police or attend A&E in person.

Within policing, the concept of compassion has previously been associated with ‘soft’ policing tasks (McCarthy, 2013). Though it has been advocated that emotional intelligence is a developable skill within policing (Millar and Buttler, 2019), the compassionate police behaviours observed in this study were not taught or ‘developable’. When considering the sharp contrast to the practices of MH practitioners, no amount of police training or otherwise will instil compassion in a practitioner who operates without it. The so-called ‘soft skills’ are what I would argue to be the hardest skills to have in any challenging public-facing role, especially one involving what Bittner referred to as ‘the dirty work’ of society (1967). Where such skills were shown to exist in the current research, they were invaluable to the receiving party e.g., the PC who cleaned a person’s rabbit out and offered assurances it would be cared for, should the person have been admitted to the hospital.

Within the LEPH sphere, it has been recognised that despite the relationship between police and health organisations and the function they serve in society, police work is not the same as public health work (Anderson and Burris, 2017). This research has highlighted that this difference should not be underestimated, given even what are considered to be traditional fundamental values, such as that of compassion within healthcare, is open to challenge and thus should never be assumed.

* 1. Recommendations for policy and practice

Based upon this discussion, the key decision faced by the police is the extent to which they are willing to continue with the practice of PMHT or withdraw from it and refocus their attention on more efficient alternatives and let the health service do the same. In November 2021, a joint thematic inspection of the CJS reported that where they found deployable triage vehicles or MH ambulances, these were commonly under review, were being withdrawn, or had recently been withdrawn. The findings from the current research would suggest this is a positive step forward, with a clear need to focus on removing the burden on the police, rather than continuing to provide a ‘sticking’ a plaster over it in the form of PMHT. If, as this research suggests, the benefits to be gained from PMHT are largely felt by health partners, then this may also call into question the appropriateness of sole police-funded arrangements for PMHT in the future. Though, of course, that is a decision to be taken at the strategic partnership level, I would advise against the police wholly or primarily funding PMHT partnerships whilst they serve to plug a gap in NHS provision i.e., through PMHT fulfilling the purpose of an emergency MH response.

In 2016, the NHS Five year forward review ‘next steps’ document outlined its revised mission and included several tangible forms of triage for those in crisis. By 2023/24, for instance, it stated that NHS 111 will be the single, universal point of access for people experiencing a MH crisis. There will also be an increase in alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute MH pathways. It described how they would introduce MH transport vehicles, introduce MH nurses in ambulance control rooms and build MH competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a MH crisis. Finally, it stated how MH liaison services will be available in all acute hospital A&E departments and 70% will be at ‘core 24’ standards in 2023/24, expanding to 100% thereafter (2016:73). The findings from the study would support the need for all of the above, as these appear to be ‘real’ alternatives to the police role, whether formal or otherwise. At the time of writing, however, despite progress on the above aims being unknown, achieving all the above still feels somewhat idealistic, yet an ideal worth striving for, nonetheless. The following recommendations for policy and practice are thus based upon the premise that PMHT continues to operate as it was found to be operating at the time of the fieldwork.

1. PMHT managers should avoid the temptation to continue to examine the effectiveness of their partnership initiatives on singular measures, particularly s136 data.

2. There should be meaningful co-production with MH SUs in all aspects of the continued operation of any PMHT partnerships. This may include, but is not limited to, SU representation on every multi-agency board/group and at related meetings, as standard. Partnerships may: seek the recruitment of an expert by experience advisor; liaise with any existing local SU networks; engage with SU engagement strategies common in other areas of healthcare; and adopt best practice guidance with regard to SU involvement and effective co-production.

3. Partners should ensure that every multi-agency board/group has an agreed set of terms of reference (or similar) document in place. It should include a defined purpose, as well as collaboratively agreed aims and a pre-determination of the expected duration of operation, based on the funds that are available at the time the terms of reference are agreed upon. These should be periodically reviewed to ensure the operation of the partnership remains conducive to its established purpose.

4. There should be a targeted effort to establish a core and consistent membership of PMHT strategic partnership boards, recognising the detriment that high membership turnover has on the development, delivery, and oversight of meaningful partnership work. Partnerships may introduce a shared ‘minimum term’ agreement of general member attendance, lasting a specified duration e.g., 12 months. Whilst it is recognised that such propositions would require a wider commitment from partner organisations, such measures will support the timely progress of agreed objectives, by assisting the ability of the partnership to achieve their common purpose and nurturing trusting relationships between partner agencies.

5. All operational PMHT partnerships should have co-produced defined standard operating procedures (or similar) in place. Partners should avoid a reliance on wider or related documents e.g. s136 pathway policies, where they do not explicitly include detailed reference to the operation of the PMHT partnership itself. Where related documents are already in place, it may be appropriate to amend them to include the specific standard operating procedures for all PMHT partnerships.

6. Where multiple PMHT initiatives exist within a police force area, forces may need to consider how existing models of PMHT could be adapted to better meet the statutory requirement for PCs to consult with a health professional when contemplating the use of s.136 (as set out in the Police and Crime Act 2017), thereby reinforcing a tangible benefit of PMHT to the police organisation.

7. The evidence suggests that where multiple models of PMHT exist in one force area, forces should move away from co-response-based models that include a PC (on a designated or rolling rota basis), due to the specific set of issues these models raise. Instead, they should work towards a 24/7 accessible telephone system of PMHT operated by health partners, with support from the police and other partner organisation, where needed, meaning the continuation of partnership work between organisational partners remains crucial.

8. For the effective continuation of PMHT schemes, greater communication is needed for practitioners around the use of s136, particularly when police and health practitioners work together in PMHT partnerships. In practice, this means officers should fully exercise their legal obligations under the MHA 1983 legislation. To do this, all staff should be clear that the decision to use s136 rests with the officer, and officers should understand the key differences between a triage assessment through PMHT schemes and a full MHA assessment. This could be facilitated through continued joint training initiatives with health colleagues, which were received positively by all practitioners.

9. As co-response models were viewed as an effective form of ‘on the job’ training, where these exist, a cost-benefit analysis could be done by the police to assess whether their investment in that type of training outweighs the cost of alternative methods with potentially equivalent outcomes.

10. Frontline police practitioners would benefit from carrying with them the information they need to contact a health professional when considering the use of s136 i.e., a business card-shaped resource containing the primary SPA telephone number and ‘backup numbers’ so they can access a MH professional promptly. Officers need *direct* access to a SPA telephone number, as any facility which requires them to leave a voice message causes unnecessary delays in consulting.

11. Where co-response models continue to exist, there should be encouragement and facilitation of co-location working arrangements, where appropriate, to help build trusting relationships e.g., shared workspaces and a visible presence for all relevant partner agencies. This may mean it is necessary to ensure that officers and health staff are physically in the same space and building, as trust is more likely to be established through face-to-face contact.

12. Within the NHS MH out-of-hour teams, cultural change is needed, with a focus on SU wellbeing and providing compassionate care. This may involve enhanced training of experienced staff within these teams, who often also worked on PMHT schemes. Bringing in lived experience perspectives from SUs is paramount to this for both health and PCs to gain a better understanding of how their practice impacts SU perceptions of fairness, dignity, and humanity.

* 1. Limitations and recommendations for further research.

Research is rarely without limitations, and this research is no different. The methodological limitations of this research relate primarily to the SU survey. As a result, though there was never an intention to generalise the findings from these data, the research should be interpreted accordingly, with these limitations in mind. During an interview with the PMHT Manager some months after the questionnaire had been sent to participants, an issue came to light which indicated that the number of eligible participants would have been significantly lower than the 347 who were contacted. The Manager described how even when a decision is made *not* to go out and see the person at the scene, this is still recorded on their systems as a Street Triage incident. For these occurrences, incidents were documented as Street Triage interventions without the person ever knowing they were the subject of such a process. Of the 347 questionnaires sent out, it is unknown how many participants were seen or spoken face to face or spoken to on the phone, directly by the PMHT ‘Street Triage’ team.

When this issue was raised with Northfield’s Information Manager to differentiate between those with direct experience of the scheme and those without, it became apparent that it would not be possible to differentiate between the two based on their current patient recording systems. This is likely to be the cause of two returned questionnaires stating they were never seen by such a team. As they were designed to ask about direct contact with the team only (either in person or on the phone), it is unknown how many of the 347 people had no direct experience and therefore did not feel in a position to complete the questionnaire. This created difficulties in establishing exactly how many people would have been eligible at all and, therefore, it has not been possible to state an accurate response rate.

Even had the survey elicited a 100% response rate, the responses relate only to one site and one model of PMHT, the co-response in Northfield. Though used primarily as a recruitment tool in the current study, if in future, the survey was to be replicated on a larger scale, it should be conducted across more than one site and for the other models of PMHT. In doing so, it would be possible to undertake advanced statistical analysis, beyond that which was possible here due to the small sample size. This would be particularly useful for gaining an enhanced understanding of the perceived strengths and shortcomings of each model of PMHT from those with lived experience of mental ill-health.

The primary recommendation for future research, however, is the need to build upon what has been initiated by the current study, and for more research that includes the perspectives of those with lived experience of PMHT more extensively. This would benefit from a standalone piece of research, and I cannot stress enough, the importance of listening and learning from the ‘real’ experts on police involvement in crises. This research was conducted within the resource and time constraints of a PhD programme, and thus without the financial investment that larger scale projects may attract. All available funds attached to this project were allocated to the survey postage costs, but it would have undoubtedly enhanced the study if the potential recruitment pool could have been widened and there was greater SU participation. Future research should be co-produced with SUs at the heart of it, from proposal through to completion and dissemination and those involved should be appropriately compensated for their involvement.

Finally, it is also recognised that due to delays caused by the Covid-19 pandemic, some time has passed since the completion of the fieldwork. Taking the delays into account, as well as some of the more recent crises noted above, including a likely return to the austerity agenda of 2010-2020, future research is therefore required to re-visit the operation of PMHT arrangements in the post-covid era, also taking account of these other socio-political developments.

**9. CHAPTER NINE**

**Conclusion**

In bringing the thesis to a close, the purpose of this chapter is to provide a succinct overview of the research findings and the original contributions to knowledge that they have provided. While it was never the intention of this study to decide whether the implementation and operation of PMHT partnerships are a ‘good’ or a ‘bad’ thing, the findings have unquestionably cast doubt upon whether PMHT is the silver bullet that many assumed it could be in ‘solving’ longstanding matters associated with the policing of mental ill-health and in offering an effective way of doing more with less. The research has shown this to be only somewhat true for health partners, though the same does not hold for the police. It has been recognised that other modern forms of police partnership work rarely exist without challenges (Crawford and Cunningham 2015), and so from the outset of this exploratory research it was never supposed that PMHT would be operating without any issues at all.

That said, the key findings, such as those related to the impact of the chronic underfunding of mental health services and the incompatible, tacit assumptions about the problem of MH demand and ways of working to ‘solve’ this, go beyond being without issue. When considered against the CA framework, the findings raise a number of distinctive matters hindering the attainment of CA and thus effective partnership working arrangements. Upon reflection upon these, it is maintained that while the implementation of PMHT may symbolise a positive step forward in the advancement of the LEPH agenda, as an initiative in and of itself, the continued existence of PMHT serves principally as a ‘sticking plaster’, to cover the gaping hole in alternate emergency MH crisis care provision, and this should prompt cause for caution with regard to the purpose it fulfils and it’s future. It is imperative that caution is exercised regarding the extent to which the police are fast becoming a primary and formalised gateway to healthcare for those in desperate need of help. Whilst it is positive that forces are continuing to explore ways not only to meet the legislative requirements within the MHA 1983 but to better meet the needs of the people they serve, it is important to continually review these practices against the best available evidence, as it emerges.

* 1. Thesis overview

Chapter One defined PMHT and introduced the key concepts, issues and themes underpinning the thesis. Chapters Two and Three provided a critical review of the existing literature that depicted the policing and MH interface over time (Chapter Two), and the development and nature of police partnership work more broadly (Chapter Three). Chapter Four considered the research methodology used to address the overarching research questions. The study adopted a qualitative-led MMR design and was conducted across three research sites with varying demographics and models of PMHT in operation. In addition to a SU postal survey, 214 hours of observation were conducted, which included ‘ride-a-longs’ with co-response vehicles, attendance at multi-agency meetings and time spent in MH out-of-hour offices, and a police control room. Semi-structured interviews *(n=64)* were conducted with frontline police and MH practitioners, people with lived experience of PMHT (including carers), control room staff, and those with varying levels of seniority and management responsibilities for policing and MH partnerships, including key stakeholders.

Chapters Five to Seven presented the empirical findings from the study.By drawing upon extensive fieldwork and relevant literature, this thesis has offered a theoretically, historically, and empirically informed insight into the operation of PMHT partnerships and the working practices of those involved in delivering the schemes, both individually, and in partnership. Within these chapters, the analytical themes that emerged from the analysis, along with those previously identified from the CA, risk and LEPH frameworks (Huxham and Vangen, 2005; Gale et al, 2016) were primarily supported through reference to the primary data gathered during fieldwork. Chapter Five opened the empirical chapters and further contributed to an already extensive evidence base about the historic failure to adequately implement community care and the consequences of this for the relationship between policing and MH today. It considered the damning impact of austerity on frontline policing and MH services and positioned PMHT as a way of doing more with less, detailing the specifics of how PMHT was implemented at a localised level.

Chapter Six explored the occupational and operational milieu in which PMHT, and the practitioners working within it, were found to be operating. The first half of this chapter focused on the organisational form and purpose of PMHT, and the second on partner working relations with reference to risk, and culture. The nature of multi-agency working within PMHT was underpinned by an abundance of incompatible tactic working assumptions and practices, particularly with regard to the ‘issues to be solved’ and the relationship of these with how partners approach and manage risk in attempting to solve them. NHS MH under-resourcing, whilst undoubtedly the root of MH demand on policing, also contributed to clashes in organisational cultures, particularly in relation to risk, making the *prima facie* appearance of there being shared aims, an untenable reality.

The final empirical chapter, Chapter Seven, reported the findings from SU’s perspectives of PMHT partnerships, which were broadly positive, but only given the paucity of the existing MH crisis care and thus was not based upon the PMHT encounter alone. There was shown to be a fundamental want of receiving not only a dignified and compassionate response when in crisis, but also the ability to receive tangible and immediate MH crisis support from a MH professional - something that aside from the co-response was absent within the existent crisis care landscape.

* 1. Revisiting the research questions

This research has provided an understanding of the origins, implementation, purpose, and delivery of PMHT partnership arrangements in E&W. The origins of PMHT can be understood as a response to austerity, in the context of neoliberalism, which has been conceived in this thesis as a policy framework, an ideology, and a mode of governance. The era of deinstitutionalisation was also found to still cast a long shadow on community mental health provision and had driven the soaring growth in the policing and mental health interface through the PMHT partnerships examined in this research. Austerity forced public sector organisations, including the police and NHS, to ‘do more with less’, which furthered the shift towards polycentric governance and joined up working, driven by this enhanced form of neoliberalism. The CCC was introduced as the national framework and form of governance over police and mental health policy, yet in line with the wider decentralised approach prescribed by the government, this was reliant upon local partners to execute it, encouraging them to agree on their priorities and processes as to how people in crisis should be responded to, and by whom. PMHT had emerged as an innovative response, for the first time formalising a role that the police were already undertaking in the community crisis care setting. This research has shown, however, that many of the issues that PMHT sought to better manage, such as a reduction in s.136 use, remain unlikely to be attainable due to continued chronic underfunding of available MH provision e.g., available MH beds; place of safety provision; out of hour or emergency MH resources; and long wait lists. More specifically, the research has shown the following about the four central research questions:

***How did PMHT initiatives emerge locally, what considerations were given as to their purpose (s), and what were the key socio-political drivers underpinning their necessity?***

Localised PMHT schemes were found to have emerged ‘bottom up’. The research found their perceived necessity was in response to what both police and health agencies considered to be an austerity-led breaking point in local MH service provision, especially out-of-hours crisis care. The stark variations found between the adopted models, governance, and membership of the PMHT partnerships in operation, can be attributed to several subtle variables which have been discussed in the thesis as the ‘local drivers’ underpinning the implementation process of PMHT. Under the broader socio-political umbrella of neoliberalism and austerity, the local drivers behind PMHT included the increased challenge for officers on the frontline in accessing place of safety provision; access to locally available resourcing for the schemes; the transference of the national CCC to localised CCC action plans, which semi-formalised PMHT; local governance structures; key individual actors; and a broader more systematic cultural shift in the nature of mental ill-health constituting ‘real’ police work.

With regard to their purpose, while consideration had been given to the broader aims of the CCC, little regard had been given to these in the implementation of PMHT itself. The research found that there was no shared understanding about the aims and purpose of the partnerships, the nature of the ‘issues’ to be solved e.g., the variance in the understanding of ‘inappropriate’ s.136 detentions, or the returns on such aims from any investment they gave. Partners did not fully understand each other’s positions well enough to have meaningful dialogue about the different interpretations of the problem and to exercise their collective intelligence about how best to seek to resolve it. All partner organisations were preoccupied with reducing s.136, but each partner organisation was committed to slightly different versions of the same goal. Rather than PMHT partnerships operating in ways conducive to reducing overall MH demand for all partner organisations, they appeared to be inadvertently having the opposite effect e.g., the use of PMHT as a means to consult instead of the localised crisis care pathways; the fact the attendance of the PMHT officer was unnecessary when serving as a secondary response; and the heightened delays and the complication that virtual models of PMHT were found to be causing for frontline officers.

***What is the specific nature of multi-agency working arrangements within PMHT partnerships and to what extent have they become an accepted form of police practice?***

This research has highlighted that PMHT was operating in a semi-formalised manner, not statutory, not informal, but somewhere in between the two. Owing to constabulary independence, PMHT can be viewed as the latest development in a longstanding trend of national inconsistency within police partnership work. Multi-agency working arrangements were also found to have an abundance of incompatible working assumptions and practices. For example, partners held similar, but not identical, understandings of fundamental issues i.e., what constituted an inappropriate or unnecessary use of s.136 and what the partnership sought to achieve. This was resulting in missed opportunities for all to benefit from the partnership as well as an unequal division of roles and responsibilities by frontline practitioners rendering the police officer role almost redundant. The traditional dominance of the police within partnership work was found to be challenged within PMHT, in fact, the police often deferred to their health partners in their decision-making, including those which were legally speaking theirs to make such as about whether to detain someone under s136. It is proposed this may be the case in other forms of targeted LEPH interventions where the police are not perceived as the custodians of health-based issues such as mental health care. Without resolving, or at least recognising these incompatibilities and blurred boundaries across all levels of the partnership, this inhibited the benefits to the police.

Within the partnership, the extent to which officers perceived they were responsible for the risk involved (individual or joint) during a PMHT encounter, impacted upon the extent to which they were willing to deviate from their ‘usual’ practice when attending to a person in crisis. Partnership working in the LEPH domain, including PMHT partnerships, is fraught with complexities. This suggests that such partnerships are far from being common wisdom or institutionalised within the police organisation, as has been found to be the case in community policing and crime prevention settings. Institutionalisation and organisational acceptance are not being held back by the principle of partnership working per se, but rather by the type of partnership, its lack of statutory footing, and uncertainties about its longevity and its ability to ‘see its course’. While we may be moving towards what may be another re-definitional period for policing and health services, targeted interventions in the LEPH domain require a reassessment as evidence such as this emerges.

***Has the implementation of PMHT altered the role of the police and its officers when responding to instances of mental ill-health in the community, particularly their use of s.136?***

The research has found that rather than PMHT partnerships reducing MH demand on the police, the formal recognition of the police role in MH crisis care through the introduction of PMHT, has served to re-position their role from ‘incidental’ or ‘de facto’ MH workers in the absence of an alternative to a formalised and solitary gateway to care for those experiencing a crisis in the community. The co-response model of PMHT, in particular, served a purpose far beyond that for which it was originally intended, and towards something that is so desperately needed, but does not exist i.e., a MH emergency community response team.

Outside of the partnership setting, the research has highlighted that co-response PMHT has had little to no impact on officers’ decisions on whether to use s.136 despite it serving as a useful training and education method. This is owing to the stark differences in risk management culture and procedures between police and health organisations, which were underpinned by different systems of accountability mechanisms e.g., individual versus organisational accountability, with officers fearful of repercussions such as scrutiny of their actions through IPOC investigations and mental workers not fearing the same reputational damage. Virtual models of PMHT could, however, have the potential for officers to receive useful information to aid their decision making such as receiving information that a person has an appointment the following day. Though s.136 was generally well understood by officers, involvement in PMHT schemes (including telephone models) appeared to exacerbate uncertainties that had arisen from the recent amendments to the MHA 1983, particularly around the requirement to consult and whether they still held the legal responsibility for the decision to use s136, with many indicating they believed that the health professional they were working with/consulted with had the ‘final say’ and legal responsibility for the person in crisis.

***What are the perspectives of people with lived experience of PMHT about the purpose of this kind of partnership work and the value of it to the contemporary crisis care landscape?***

People with lived experience of PMHT viewed its primary purpose to be for the benefit of patients to ensure they received access to the help they needed when in crisis. Though perceptions of PMHT were generally positive, this was not necessarily based upon their personal encounter of PMHT itself, but rather, the broader systematic failures of existing crisis care provision, along with peoples’ prior negative interactions with individual health practitioners working within it. The aspirations about the *potential* benefits that people could foresee were thus distinct from whether those benefits were experienced first-hand, which this research found was not routinely the case e.g., a less stressful experience; prompt and efficient access to the crisis care pathway; or receiving a perceptively ‘better’ outcome through their PMHT encounter. The research found a fundamental want of receiving not only a dignified and compassionate response when in crisis but as well the ability to receive tangible and immediate MH crisis support from a MH professional - something that aside from the co-response was absent within the crisis care landscape, at the time of the research. With the bar for such service provision set so low, the prospect of *any* novel addition, which was perceived as potentially being able to fill this void, underpinned such positivity.

* 1. Original contributions to knowledge

This thesis had made several key original contributions to knowledge which add to both practice and theory. The adopted methodology has yielded unique findings by deviating from the scant and almost entirely evaluative extant research on PMHT partnerships. This research has not been conducted in collaboration with any of the participating police organisations for the purpose of locally evaluating their individual initiative, meaning it has been possible to produce this research as the first wholly independent study of its kind in E&W.

This study has not sought to report upon numerical outcome measures, conduct any costs-benefits analysis, or attempt to measure the success of PMHT based on how much schemes claim to have generated a reduction MH demand. Instead, it provides a new offering in our understanding of the specific mechanisms behind PMHT. This is underpinned by how those within the system itself have perceived the impact of both the austerity measures and the introduction of PMHT on their working practices and/or experience. It is also the first study that has included the perception of SUs and considered not only their overall experience of being seen by a co-response team, but also how they perceive its value in the broader crisis care landscape.

Theoretically, this thesis has contributed to extant debates about the future of LEPH, the role of the police in society, police culture, and the nature of police partnership work within the LEPH arena. The variances in risk management between the police and health agencies have not been considered through a theoretical lens before, nor has police partnership work been considered through the application of CA theory. Another further original contribution has been the application of risk theory to MH crisis care practice both within the context of PMHT and at a broader crisis care level. It is hoped, therefore, that this thesis will be viewed as the starting point for further discussion, rather than an endpoint in and of itself.

* 1. Final Words

If adopted, the findings and recommendations detailed in this thesis could present police forces and NHS services nationally with opportunities to make realistic and valuable changes, not only to partnership working but to the wider policing and MH services and the people they serve.

*‘…To those that said I never could or would… I did...’-* (Rivka Smith 2023 - PhD candidate, mum, sister, daughter, auntie, friend, mental health service user)

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**APPENDICES**

**Appendix 1: Ethics Approvals**

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**Appendix 2: Project Information Sheets**

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**Appendix 3: Project Consent Form**

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**Appendix 4: Service User postal survey**

**\*Edited to preserve anonymity\***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ‘The Street Triage Project’ Survey  Below is a list of statements. Please read each statement and tick the box to show the extent to which you agree or disagree with the statement in relation to the time you were seen by the Street Triage Team (Police Officer and Mental Health Worker). There is an additional comments box at the end of each section if you wish to add anything else.  Please also feel free to add any further information on a separate piece of paper and return it with the survey in the pre-paid envelope provided. | | | | | |
| The following statements relate to access to the Street Triage team | Strongly Agree | Agree | Disagree | Strongly Disagree | Not Sure |
| This is the first time anyone has asked about my experience or opinion of the Street Triage team/service |  |  |  |  |  |
| The Street Triage team were the first workers that saw me when I was unwell |  |  |  |  |  |
| I was/would be happy to wait to be seen by the Street Triage team |  |  |  |  |  |
| I felt/would feel like I was being detained against my will whilst waiting for the Street Triage team to arrive |  |  |  |  |  |
| I did/do not mind who responds to my mental health needs, so long as I receive the support I felt I needed |  |  |  |  |  |
| Additional Comments: | | | | | |
| The following statements relate to the delivery of the Northfield Street Triage team | Strongly Agree | Agree | Disagree | Strongly Disagree | Not Sure |
| I think Street Triage is a good idea |  |  |  |  |  |
| An unmarked car is the most suitable form of transport in cases when it is necessary to transport a person experiencing mental ill- health |  |  |  |  |  |
| A police car is the most suitable form of transport when it is necessary to transport a person experiencing mental ill-health |  |  |  |  |  |
| An ambulance is the most suitable form of transport in cases when it is necessary to transport a person experiencing a mental ill-health |  |  |  |  |  |
| A police car should never be used to transport a person experiencing mental health issues |  |  |  |  |  |
| Police uniform made it clear to me that there were two types of staff present when the Street Triage team arrived |  |  |  |  |  |
| I think the main purpose of Street Triage is to ensure the service user receives access to the help they need |  |  |  |  |  |
| I think the main purpose of Street Triage is for staff to better manage a person’s risk factors |  |  |  |  |  |
| I think the main purpose of Street Triage is to prevent hospital admissions |  |  |  |  |  |
| I think the idea of Street Triage is pointless |  |  |  |  |  |
| I think the main purpose of Street Triage is so that the police and mental health team can share information about me |  |  |  |  |  |
| I think police officers on the Street Triage team should wear uniform when responding to mental health incidents |  |  |  |  |  |
| Additional Comments:     |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | The following statements relate to the police and mental health professionals working together as part of the Street Triage team | Strongly Agree | Agree | Disagree | Strongly Disagree | Not Sure | | I feel it was necessary for the police and mental health workers to be present in my case |  |  |  |  |  | | The police and mental health workers took an equal role in my care |  |  |  |  |  | | It was clear to me that the police and mental health worker were working together |  |  |  |  |  | | It is clear to me who did what in the Street Triage team |  |  |  |  |  | | I felt that the police officer was in charge of the Street Triage team |  |  |  |  |  | | The police will always be in charge of a Street Triage team because they have more power |  |  |  |  |  | | It was good that police and mental health workers worked together in a Street Triage team so they could share information |  |  |  |  |  | | The mental health worker spoke to me more than the police officer |  |  |  |  |  | | I felt that the mental health worker took control of the situation during my encounter with the Street Triage team |  |  |  |  |  | | Additional Comments: | | | | | | | The following statements relate to your personal experience of being seen by the  Northfield Street Triage Team | Strongly Agree | Agree | Disagree | Strongly Disagree | Not Sure | | I was treated with dignity and respect by the mental health worker |  |  |  |  |  | | After contact with the Street Triage team, I received an outcome I was happy with |  |  |  |  |  | | I feel the decisions staff made about me were the right ones, even if I didn’t agree with them at the time |  |  |  |  |  | | I feel the Street Triage team dealt with my situation the best they could |  |  |  |  |  | | Staff in the Street Triage team tried to make sure my privacy was respected |  |  |  |  |  | | Overall, I was satisfied with the way I was dealt with by the Street Triage team |  |  |  |  |  | | I received adequate mental health support after my initial contact with the Street Triage team |  |  |  |  |  | | The team did as much as they could to reassure me and to make me feel safe |  |  |  |  |  | | I was treated with kindness by the Street Triage team |  |  |  |  |  | | The Street Triage team treated me with humanity |  |  |  |  |  | | Staff on the team treated me according to my individual needs |  |  |  |  |  | | The Street Triage team talked politely to me |  |  |  |  |  | | The team clearly explained the reasons for their actions towards me |  |  |  |  |  | | I felt the team could be trusted to make decisions that were right for me |  |  |  |  |  | | The team acted in ways that are consistent with my own ideas about what is right and wrong |  |  |  |  |  | | The Street Triage team listened to my concerns |  |  |  |  |  | | I feel that control and restraint procedures would always be used appropriately by staff in the Street Triage team |  |  |  |  |  | | The presence of the police made me feel like a criminal |  |  |  |  |  | | Whilst speaking with staff at the time, I felt ashamed |  |  |  |  |  | | I would prefer only mental health workers to respond to a mental health crisis |  |  |  |  |  | | Whilst speaking with Street Triage staff at the time, I felt embarrassed |  |  |  |  |  | | Whilst speaking with Street Triage staff at the time, I felt safe |  |  |  |  |  | | I was relieved to see the police were there with a mental health worker/s |  |  |  |  |  | | I felt more scared than I would have done because the police were there |  |  |  |  |  | | I feel the police officer viewed me as a 'decent' person |  |  |  |  |  | | Staff spoke respectfully about me to one another |  |  |  |  |  | | I feel the mental health worker/s viewed me as a ‘decent’ person |  |  |  |  |  | | I feel that the police officer saw their role in my care as important |  |  |  |  |  | | The police officer seemed to genuinely care about what happened to me |  |  |  |  |  | | All staff cared about were my ‘risk factors’, rather than the person I really am |  |  |  |  |  | | I feel a different outcome would have happened had I only been seen by the police and not the Street Triage team |  |  |  |  |  | | I feel a different outcome would have happened had I only been seen by a mental health worker and not the Street Triage team |  |  |  |  |  | | The police were more concerned about my ‘risk factors’ than my health |  |  |  |  |  | | The mental health worker/s were more concerned about my ‘risk factors’ than my health |  |  |  |  |  | | Additional Comments: |  |  |  |  |  | | The following statements relate to how you feel about the police being involved in mental health care and the future of Street Triage schemes | Strongly Agree | Agree | Disagree | Strongly Disagree | Not Sure | | Police officers should play no part in mental health care |  |  |  |  |  | | I would prefer only police officers to respond to a mental health crisis |  |  |  |  |  | | Police officers are more sensitive than mental health workers when talking to a person experiencing mental health difficulties |  |  |  |  |  | | I felt the police officer on the Street Triage team understood my needs |  |  |  |  |  | | I was treated with dignity and respect by the police officer from the Street Triage team |  |  |  |  |  | | Dealing with mental health incidents should not be part of the police role |  |  |  |  |  | | I would be happy if I was seen by a Street Triage team again, if necessary |  |  |  |  |  | | Although the idea of Street Triage is good, it doesn’t work in practice |  |  |  |  |  | | Additional Comments: |  |  |  |  |  | | | | | | |

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**Appendix 5: Interview Schedules**

**RESEARCH QUESTIONS**

* How did PMHT initiatives emerge locally, what considerations were given as to their purpose (s), and what were the key socio-political drivers underpinning their necessity?
* Has the implementation of PMHT altered the role of the police and its officers when responding to instances of mental ill-health in the community, particularly their use of s.136?
* What is the specific nature of multi-agency working arrangements within PMHT partnerships and to what extent have they become an accepted form of police practice?
* What are the perspectives of people with lived experience of PMHT about the purpose of this kind of partnership work and the value of it to the contemporary crisis care landscape?

**(The probes for these questions will be developed when the survey data has been analysed)**

**INTRODUCTION**

A. (Establish Rapport – If new to researcher) [shake hands if appropriate] My name is Rivka and I am a PhD researcher based at the University of Sheffield.

B. (Purpose – If interview prearranged by researcher) Just to remind you about the research, I am conducting this research as part of my PhD which I’m doing at the University of Sheffield. I’m undertaking some research which looks at Street Triage schemes.

C. (Confidentiality and timeline) The interview should take around an hour and is completely voluntary, so if you want to stop at any point or if there are any questions you don’t want to answer then that’s fine – just let me know. The interview is informal and although I have an interview guide in front of me, that’s purely for my benefit, so think of it as a conversation. All your responses will be confidential and participating schemes won’t be identified in any reports or any form of publication which may arise from this research in the future. Are you happy for me to record the interview? And, before we start, do you have any questions about the research project?

(Transition: So, it would be really helpful for me if we could start with you telling me a little bit about yourself if that’s ok?)

**PRACTICALITIES OF DELIVERING STREET TRIAGE**

* Can you try and recall how you came to be seen by the Street Triage scheme?

(who phoned? How long wait? New to services? Feelings?)

* What do you remember happening from when the ST team arrived?

(uniform, process, transportation, radio? questions asked?)

* What happened after you were seen by the Street Triage team?

(outcome? feelings about this? Supported?)

**ROLE AND PURPOSE OF STREET TRIAGE**

* What do you think the purpose of Street Triage schemes are?

(necessary? what role did they play in your care? Good/bad?)

**PARTNERSHIP WORKING**

* What is your understanding of who is involved in a ST team?

(obvious who was there? Who took control? Who did what?)

**ROLE OF THE POLICE**

* What do you think the role of the police is?

(opinion on role involvement in MH)

**FUTURE OF STREET TRIAGE SCHEMES**

* If you had a magic wand, what do you think the perfect response to a mental health crisis look like?

**Interview Structure: Practitioners**

**RESEARCH QUESTIONS**

* How did PMHT initiatives emerge locally, what considerations were given as to their purpose (s), and what were the key socio-political drivers underpinning their necessity?
* Has the implementation of PMHT altered the role of the police and its officers when responding to instances of mental ill-health in the community, particularly their use of s.136?
* What is the specific nature of multi-agency working arrangements within PMHT partnerships and to what extent have they become an accepted form of police practice?
* What are the perspectives of people with lived experience of PMHT about the purpose of this kind of partnership work and the value of it to the contemporary crisis care landscape?

**(The probes for these questions will be developed when the survey data has been analysed)**

**INTRODUCTION**

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C. (Confidentiality and timeline) The interview should take around an hour and is completely voluntary, so if you want to stop at any point or if there are any questions you don’t want to answer then that’s fine – just let me know. The interview is informal and although I have an interview guide in front of me, that’s purely for my benefit, so think of it as a conversation. All your responses will be confidential and participating schemes won’t be identified in any reports or any form of publication which may arise from this research in the future. Are you happy for me to record the interview? And, before we start, do you have any questions about the research project?

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(necessary? what role did they play in your care? Good/bad?)

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(obvious who was there? Who took control? Who did what?)

**ROLE OF THE POLICE**

* What do you think the role of the police is?

(opinion on role involvement in MH)

**FUTURE OF STREET TRIAGE SCHEMES**

* If you had a magic wand, what do you think the perfect response to a mental health crisis look like?

**Appendix 6: Coding Framework**

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**Appendix 7: SU network adverts**

Timeline

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1. The PEEL inspection programme is an assessment of the effectiveness, efficiency and legitimacy of police forces in England and Wales (HMICFRS, 2018) [↑](#footnote-ref-1)
2. The NDM is suitable for all decisions and should be used by everyone in policing. It can be applied to spontaneous incidents or planned operations; by an individual or team of people; to both operational and non-operational situations. Decision makers can use the NDM to structure a rationale of what they did during an incident and why (CoP, 2023) [↑](#footnote-ref-2)
3. Spice is a brand name for a herbal mixture containing one or more of a group of drugs called synthetic cannabinoids [↑](#footnote-ref-3)