

# Policing and Mental Health

## Picking Up the Pieces

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## Foreword

### **The last resort, not the first port of call**

In our inspection, we found that the police approach to people with mental health problems is generally supportive, considerate and compassionate.

But we believe there is only so much the police can do to improve the overall picture. This is because, in our view, too many aspects of the broader mental health system are broken; the police are left to pick up the pieces. The fact that almost every police force now has its own mental health triage team indicates that there isn't nearly enough emphasis on early intervention and primary care to prevent the need for a crisis response.

This is letting down people with mental health problems, as well as placing an intolerable burden on police officers and staff. It is a national crisis which should not be allowed to continue; there needs to be a fundamental rethink and urgent action.

People with mental health problems need expert support. Those in crisis need to be cared for in a healthcare setting. They shouldn't be locked in a police cell or held for hours on end in the back of a police car for their own safety. This expert help needs to be available whenever people need it; mental health crises don't just happen during office hours.

All too often, the system is failing people when they most need help. This is not a problem that the police alone can solve. Other services need to stop relying on the 24/7 availability of the police.

We have grave concerns about whether the police should be involved in responding to mental health problems to the degree they are. Our inspection found that, in dealing with people with mental health problems, police officers and staff must do complex and high-risk work. They often don't have the skills they need to support people with mental health problems. And, too often, they find themselves responsible for the safety and welfare of people that other professionals would be better placed to deal with.

This means that already overstretched and all-too-often overwhelmed police officers can't always respond appropriately, and people in mental health crisis don't always get the help they need. All this can take a heavy emotional toll on officers and staff.

## **More emphasis on early intervention**

This isn't about blaming either the police or mental health practitioners.

We recognise the considerable work that all services and agencies have done to improve the response to those with mental health problems. But, in our view, the emphasis overall needs to be far more on early intervention and community care.

As HM Chief Inspector of Constabulary, Sir Thomas Winsor, said in his 2017 State of Policing report:

“There will always be situations where someone in crisis needs a rapid response from the emergency services. But too often, our public services are failing to work together to prevent the crisis in the first place ... Blue lights should not have to flash for someone to get the help they need in time.”

There are a few things the police could do better. They could give officers and staff better mental health training and have a clearer view of the level of demand from people with mental health problems. We have made some recommendations along these lines which could help improve their approach.

However, these can only go so far, and there needs to be a longer-term solution. When it comes to mental ill-health, the police should be the last resort, not the first port of call.



**Zoë Billingham**

**HM Inspector of Constabulary**

## About this report

“I had a bad relapse in May. I was left for so long where I didn’t get the support and guidance. I started carrying a knife around ‘cos the voices were telling me to harm people and myself. What I wanted was to get sectioned. I went and told my probation officer. She sat me down and contacted the community mental health team. I sat down in front of the doctor and psychiatrist and do you know what they said to me? ‘We can’t give you what you want, which is to get sectioned.’ So basically, I have to go out there and do something before the crisis team can section me. I’m there carrying a knife around looking to do something to someone, or myself, and I have to do it before I can get into hospital. This was a year ago. I was scared for people, I am a dangerous man.”

The police respond to people in mental health crisis every day. It is important for the police to recognise as early as possible that they may be responding to someone with mental health problems. That early understanding is crucial to assess the risk properly, and how urgent the response should be. In our 2017 inspection, we examined more closely how the police:

- respond to and provide care for people with mental health problems; and
- work with partner organisations to achieve the best outcomes.

We are in no way suggesting that the police don’t have a role in protecting those who are vulnerable because of their mental ill-health. This should be a priority for all forces. As Lord Adebawale, chair of the Independent Commission on Mental Health and Policing, stated in the [Commission’s 2013 report](#), mental health needs to be “seen as a part of the core business of policing”. But funding cuts have reduced community services, which means some needs are no longer being met. This unmet need means police forces are seeing unjustifiably higher demand for their services.

## What we assessed

To understand how effective forces are at protecting and helping those with mental health problems, we inspected how well they:

- identify people with mental health problems when they first contact the force;
- identify and record the number of cases involving people with mental health problems to provide the right support; and
- make sure expert help is available from other organisations, in particular health professionals.

## Methodology

In 2017, we inspected all 43 police forces in England and Wales and the British Transport Police on their effectiveness, as part of our PEEL (police effectiveness, efficiency and legitimacy) inspection programme.

One of the main areas we inspect in effectiveness is how well the police protect those who are vulnerable, and support victims. For the first time within this area, we inspected how effectively police respond to and support people with mental health problems:

- We reviewed crime files with vulnerable victims and suspects with mental health problems.
- We spoke with frontline officers, force control room staff, supervisors and police leaders.
- We held focus groups in each force with mental health experts, triage staff, ambulance, fire and rescue staff, NHS staff, clinical commissioning group staff and mental health practitioners.
- We commissioned a focus group of people with lived experience of mental ill-health to understand their experiences of contact with police.
- In the strategic briefings at the start of each inspection, senior force leaders explained how their force deals with people with mental health problems.
- For the first time ever, we were able to review all force management statements (FMSs), in which forces set out their current demand, future demand, capacity and capability in relation to mental health.

A mental health expert reference group was invaluable to us in challenging and shaping our methodology and inspection findings.

### **About the quotes in this report**

The quotes in this report are from people with lived experience of mental ill-health. We commissioned an agency to set up a focus group of volunteers, all of whom had lived experience of contact with police as a result of a mental health crisis.

We asked the volunteers to tell us about their experiences, positive and negative, of contact with police, as we felt it was important to represent the views and voices of people who have experienced mental health problems. The volunteers were frank and open about their experiences and were happy for us to use their experiences and quotes in our report. We are extremely grateful for their candour in talking about their experiences.

### **Future PEEL and mental health inspections**

We have now moved to an integrated inspection approach in our PEEL programme. We inspect each force once every year on how effective, efficient and legitimate it is. We will still examine mental health as an important part of this integrated inspection.

## Headline findings

### **We are concerned that the police are working beyond their duty**

We have significant concerns about whether the police should be involved in responding to mental health problems to the degree that they are. The police need to be clearer about the extent of this problem.

### **The Crisis Care Concordat is a step in the right direction, but there still needs to be a rethink**

All services and agencies have done considerable work to improve the response to those with mental health problems. A culmination of this collaboration is the [Crisis Care Concordat](#), in which 22 bodies committed to improving the service and experience of those people with mental ill-health.

However, people with mental health problems need expert support, and all too often this isn't available when people need it. The fact that people are calling the police to access health care is untenable, and the evidence later in our report shows that the demand for police to respond to mental health-related calls is increasing. We believe there needs to be a radical rethink to guarantee a timely expert response from health services.

### **Collaboration is helping the police provide a better response**

We were pleased to see the police working closely with other organisations to try to improve their joint understanding of mental health. These collaborations are working both at a strategic level to influence the direction of services and funding decisions, and at a more tactical level to solve specific problems.

### **The police need a clearer picture of mental health demand**

Overall, we found a general lack of understanding by forces of their mental health demand.

### **Leadership on mental health in police forces is generally strong**

We found strong leadership and governance on mental health across most forces.

## **Overall, the police are good at recognising when people are in crisis and responding to people at risk**

It is crucial that when people with mental health problems contact the police, the police can identify that they are vulnerable. Generally, forces do this well.

We also found that police officers have a good understanding of how to respond to those with mental health problems.

## **Forces are investing in mental health training, but it is inconsistent**

We were pleased to see forces investing in training to support their officers and staff to identify and respond to people with mental health problems. However, the quality of training, and the involvement from other services, is inconsistent.

## **Only a few forces are seeking the views of people with mental health problems**

We found that there is a missed opportunity to seek the views of people who have mental health problems. Only a few forces are doing this to improve the quality of training and develop and shape future services.

## **Prevention is far better than cure**

Mental health crisis is often preventable and avoidable. It is far cheaper for health agencies to intervene early than pay for specialist crisis treatment after harm and distress has already been caused.

For example, in their FMSs, 13 forces cited the pressure that responding to repeat callers places on an already busy command and control system.

The top five individual repeat callers to the Metropolitan Police Service (all of whom have mental health problems) called a combined total of 8,655 times in 2017. It cost the service £70,000 just to answer the calls. If services were in place to treat people earlier, the cost savings would be significant.

We made the same point in our 2016 State of Policing report:

“By the time depression or some other mental disorder has been allowed to advance to the point that someone is contemplating suicide, or engaging in very hazardous behaviour, many opportunities to intervene will have been missed by many organisations. When that intervention takes place on a motorway bridge or railway line, or when someone is holding a weapon in a state of high distress, the expense to all concerned is far higher than it should be. The principal sufferer is the person who is ill, especially when it is realised that his or her suffering could have been much less or even avoided altogether. Then there is the economic cost in terms of the expenditure of time and effort by the police and other public services, as well as the expense and trauma sustained by those adversely affected by the crisis at the time. The economic arguments for earlier intervention intensify the health and moral ones already in play.”

Prevention should ideally start in childhood. As we said in our 2017 State of Policing report:

“Early intervention must be given much higher priority. For example, there is so much that needs to be done to help troubled families; reduce parental conflict; support children’s emotional and cognitive learning; develop young people and divert them from offending; make the child protection system more effective; and treat mental illness and addictions ... The need for public-sector organisations to work together is particularly acute when it comes to children’s and adolescents’ mental health. ... if we do not act to support children early on, the problems that can develop are more complicated to address, not just for the NHS and the education system, but also for the police and the wider criminal justice system.”

# How the police help people with mental health problems

Mental ill-health is said to [affect one in four of us](#) at some point in our lives. It is a complex topic that cuts across every area of policing.

Some of the most vulnerable people in our society are those who experience mental ill-health, and they are at their most vulnerable when they are in crisis. Police can be called on to act in a criminal justice or healthcare capacity, or a combination of the two. This is complex, time-consuming work, which can put a considerable strain on individual officers.

The police respond to people with mental health problems in several different ways.

## Responding to emergency contact

A family member, friend or carer can make emergency contact via 999 about someone they know who is showing unusual behaviour. A member of the public may call if someone is ill in a public place or putting themselves or others in danger. Or the person in crisis may call for help themselves.

The Metropolitan Police Service receives a call about a mental health concern once every four minutes.<sup>1</sup> They send an officer to respond to a mental health-related call every 12 minutes. Officers responding to the call will spend time with the person to understand what they need. Analysis by the Welsh forces showed that on average this took about three hours. They may need more officers to help, and the person might end up being detained under section 136 of the Mental Health Act 1983 and taken to a [place of safety](#).

[Half the time](#), the police, and not the ambulance service, transport people to a place of safety. This can take a few hours, depending on the availability of health agencies and specialist hospital beds. Or it may result in a very long wait in accident and emergency for the person in crisis and the police officers accompanying them.

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<sup>1</sup> *Cost and Demand of Mental Health to the Metropolitan Police Service and the Public*, Metropolitan Police Service, 2018.

## **Welfare checks and safe-and-well checks**

Another agency, social services or a GP may ask police to do a welfare check or safe-and-well check on someone. They ask for this when they can't contact the person, or they haven't seen them for a particular reason (for example, the person has failed to turn up for an appointment). Police look for the person, call for medical assessment if necessary, and report back to the agency who asked for the check.

These requests are common and involve a lot of investigation and understanding of risk. Often there are mental health concerns. Officers told us during fieldwork that these requests often come in when other services are ending their hours of service.

## **Supporting victims of crime**

A person with severe mental health problems is three times more likely to be a victim of crime.<sup>2</sup> This means they will need extra care and support throughout the investigative process. Research estimates that 30 to 60 percent of women with mental health problems suffer domestic abuse.<sup>3</sup>

## **Looking out for vulnerable people**

Neighbourhood officers will often spend time checking whether people living with mental health conditions are looking after themselves and their families. They also often identify modern slavery or 'county lines' organised crime cases, where vulnerable people with mental health problems have been exploited.

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<sup>2</sup> *At risk, yet dismissed: The criminal victimisation of people with mental health problems*, Mind, 2013, page 18.

<sup>3</sup> *Domestic violence and severe psychiatric disorders: Prevalence and interventions*, Psychological Medicine, Howard, L.M, Trevillion, K, Khalifeh, H, Woodall, A, Agnew-Davies, R, & Feder, G, 2009, 40(6), 881–893.

## **Attending mental health crisis incidents**

Police will be called to a person in crisis who is suicidal. There were [nearly 6,000 suicides in the UK in 2017](#). This means that 16 people take their own lives every day, and many more people attempt suicide.

Attending these incidents may involve road or bridge closures, and skilled negotiators to talk to the person in crisis and try to keep them safe. Between April 2016 and April 2017, police officers (from British Transport Police and local forces), working alongside rail staff and members of the public, [prevented 1,837 people](#) from taking or attempting to take their own lives on the rail network.

## **Looking for missing persons**

Police also respond to calls for missing persons where mental health problems are a factor – for example, if the missing person has dementia, or is in extreme distress.

## Summary of our main findings

### **We are concerned that the police are working beyond their duty**

We have significant concerns about whether police should be involved in responding to mental health problems to the degree that they are. The police need to be clearer about the extent of this problem.

Feedback from officers, partners<sup>4</sup>, service users and some limited data indicates that in some cases the police service is stepping in to fill shortfalls in health services. This may include:

- transporting someone to hospital because an ambulance isn't available;
- waiting with someone in hospital until a mental health place is found; or
- checking on someone where there is concern for their safety.

Often, as a 24/7 service, police are the only professionals available to respond because the person is in crisis 'out of hours'. Our detailed analysis shows that the peak time for calls to police for support with mental health-related incidents is between 3pm and 6pm Monday to Friday, towards the end of the working day.

In too many respects, police forces have an inadequate picture of the extent and nature of the demand they face from people with mental health problems. It is vital that the police service builds a clearer picture of what officers and staff are doing to deal with people with mental health problems. They can then develop a better understanding of the nature of this demand. We believe there needs to be a rapid investigation into this situation and, if necessary, proposals for fundamental change.

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<sup>4</sup> We refer to partners frequently in this report, to mean other agencies the police work with to respond to people with mental health problems. Partners we refer to in this report include: health trusts, GPs, local authorities, crisis care teams, triage teams, ambulance services, paramedics, clinical commissioning groups and police and crime commissioners. This list is not exhaustive, and police will often work with several partners across trusts and geographic boundaries with different funding streams and different local problems.

## **The public don't think it is the police's responsibility to look after people with mental health problems**

The amount of work the police do to help people with mental ill-health is currently out of step with public expectations. We commissioned a survey and interviewed 17,043 people in England to understand better the general public's perception of their local police force in this respect.

We found that:

- only two percent of those surveyed felt it was the police's responsibility to respond to mental health-related calls;
- 70 percent felt it was the main responsibility of the health services to deal with people with mental health problems;
- a further ten percent felt that the local authority or council were responsible; and
- the public saw terrorism, child sexual exploitation and violent crime as the most important crimes for the police to prioritise.

## **We found strong leadership on mental health in police forces**

It is of credit to the police service that we found strong leadership and governance on mental health across most forces.

All forces have a chief officer mental health lead. Their role is to make sure the force has the right systems and processes in place to help people with mental health problems when they come into contact with the police. They also help officers and staff if they are struggling and need support themselves. We saw senior leaders communicating with their officers and staff via internal blogs about the importance of protecting themselves, as well as protecting vulnerable people with mental health problems.

Some leaders hold drop-in meetings and join officers at changes of shifts. They explain how important it is to look after each other and recognise when colleagues may need help or support. This strong leadership is vital to support officers' mental health, improve their wellbeing and reduce stress.

Another resource that has been developed for all forces is the [Oscar Kilo website](#). It has been created and designed to host the [Blue Light Wellbeing Framework](#) and bring together those who are responsible for wellbeing. It is a place to disseminate learning and best practice from across the emergency services.

## **Partnerships are helping the police provide a better response**

It is vitally important that police work with partners to make sure the most vulnerable in our communities receive the help and support they need. Police shouldn't have to work alone to manage this demand.

We were pleased to see strong and well-established partnerships across the country. These partnerships are working both at a strategic level to influence the direction of services and funding decisions, and at a tactical level to solve specific problems. Those working with police forces told us how much they value these relationships. The leadership given by the police gives them confidence to exchange information within these partnerships.

The most widespread example of joint working is mental health triage or 'street triage', as it is known. It is operating in 42 out of 43 forces. Street triage includes a range of partnership work to help manage mental health demand and respond better to people in crisis.

The Department of Health funded nine pilot projects in 2013, following an initiative by Cleveland Police in 2012. Street triage is now an established practice in forces, with 42 out of 43 forces having some form of mental health triage. It aims to avoid the unnecessary use of section 136 of the Mental Health Act 1983 and offer other care options for those in crisis. Reducing unnecessary use of section 136 and not using custody as a place of safety are indicators of success for triage.

Street triage is a local model often dependent on local partner funding, and has taken several forms:

- dedicated vehicles staffed by police, nurses, approved mental health professionals (AMHPs) or paramedics responding to calls from people in crisis;
- control room-based nurses or mental health practitioners with access to medical records advising officers on the street; in some cases, they also answer calls from the public; and
- 24/7 helplines or peak-demand-time access to specialist mental health nurses.

We found that police officers believe these models are helpful and effective and do facilitate access to more appropriate care. However, there has been little recent and comprehensive evaluation of these approaches which considers long-term outcomes for vulnerable people. And there is a perception that triage is filling gaps that local health partners no longer can.

The original emphasis on evaluating the pilot sites was to test the reduction in the use of section 136. This achieved the reduction, but now different models have been developed. Forces are taking different approaches to try and provide a more effective response to people with mental health problems. The service would benefit from better understanding and evaluating these approaches.

## **The Crisis Care Concordat is a step in the right direction, but there still needs to be a rethink**

We recognise the considerable work all services and agencies have done to improve the approach to those with mental health problems. A culmination of this collaboration is the [Crisis Care Concordat](#), in which 22 bodies committed to improving the service to, and experience of, those people with mental ill-health. The Concordat is an excellent first step and an early evaluation indicates that it has made some improvements. The most significant is the reduction in the use of police cells as a place of safety. This is undoubtedly positive. We fully support the range of work the police service does for people who have mental health problems.

However, people with mental health problems need expert support, and all too often this isn't available when people need it. Those in crisis need to be cared for in a healthcare setting; they shouldn't be locked in a police cell or held for hours on end in the back of a police car for their own safety.

All too often, the system is failing people when they most need help. This is not a problem that the police alone can solve.

We believe there needs to be a radical rethink and urgent action to guarantee a timely response to people with mental health problems.

## **The police are good at recognising when people are in crisis**

It is crucial that when people with mental health problems come into contact with the police, the police can establish if they are vulnerable. Generally, forces do this well. We found that there are two main elements to this working effectively:

1. A clear, consistent and understood definition of mental ill-health. The College of Policing has developed one and some forces now reference this. Where forces had a clear and consistent definition, they were able to establish if someone was vulnerable due to their mental health more effectively. This has helped frontline staff, such as call handlers, establish vulnerability and provide a consistent approach. However, this national definition would benefit from being updated following feedback from our external reference group to bring it in line with current approaches to mental ill-health.

2. A good understanding of risk and applying the THRIVE risk assessment principles, or using the NDM (National Decision Model) to assess it. Enhanced mental health training for call handlers has helped to achieve this understanding. Access to a mental health professional can also support these risk assessments. We found that 21 forces now employ a nurse or mental health professional in the control room.

## **The police need a clearer picture of mental health demand**

Overall, we found a general lack of understanding by forces of the extent and nature of their mental health demand. It still isn't clear what percentage of all calls to police are mental health-related.

The full extent to which people with mental health problems place demands on the police isn't fully understood. We do know that last year there were 97,796 crimes and 431,060 incidents flagged in England and Wales as involving mental health concerns. This represents 2.4 percent of all recorded crimes and 2.8 percent of all recorded incidents in England and Wales. These figures seem exceptionally low and, in our view, link to forces' general lack of understanding of mental health demand.

The figures only include crimes and incidents that the police have identified and flagged as mental health-related. We asked all forces how many mental health-related incidents they recorded in the 12 months to June 2017. We found that not all forces use a mental health 'flag' or 'tag' to identify mental health-related calls, and they don't always apply it accurately. So we believe that these figures represent a significant under-recording of mental health-related crimes and incidents.

We have carried out detailed analysis on data from 23 forces. Although there are limitations with the data, it indicates that, for these forces, the actual demand is greater than the total number of incidents and crimes suggests. Our analysis of incidents flagged as indicating a mental health concern found that:

- more officers are sent to these incidents; and
- responding to these calls and dealing with the subsequent incidents takes longer.

Some forces are more advanced at understanding and measuring their demand in this area. They are digging deeply into their data to understand where the demand is greatest and where they need to focus their resources. Others are less clear. If data exists, it needs to be collected, analysed and exchanged with partners to understand where forces can make improvements.

Partner data is also very important to help build a local picture of the nature and scale of mental health demand. Forces need this to help them efficiently and effectively plan their services and approach.

## **The initial response to people at risk is good**

We found that police officers have a good understanding of how to respond to those with mental health problems. This relies on them understanding the range of behaviours associated with mental health. They can then reassure the person, gain their confidence and work out what is the right action to take in certain circumstances. The College of Policing has developed comprehensive [Authorised Professional Practice \(APP\)](#) in this area which draws together relevant information about policing and mental health in one place.

As protecting people is a priority for police leaders, several forces have invested in more resources for their staff. This draws on the APP but makes it accessible to frontline officers. There are handbooks to help staff understand the range of vulnerabilities relating to mental ill-health. Some forces have devised apps that staff can access from handheld devices and tablets. Some of these apps have been designed with mental health professionals and include information about how to contact other organisations that can help (for example, national and local charities and services).

Feedback from partners was positive about the empathy officers show, and the time they spend dealing with and helping those suffering from mental ill-health. During a focus group as part of our inspection, we heard an example of how police had worked with health services to manage a vulnerable homeless repeat caller with mental health problems. She has now been housed and, after volunteering, has a job. She was very appreciative of the investment and support she received from the neighbourhood officers helping her in crisis.

## **Investigations where the victim had mental health problems are comprehensive**

Research indicates that people with severe mental health problems are more likely to be victims of crime than the general population.<sup>5</sup> They are more likely to suffer adverse effects (social, psychological and physical). They have concerns about whether they will be believed. They may have had contact with the police before as a victim, witness or offender.

Our inspection found that most investigations where the victim has mental health problems are carried out well. We examined 297 case investigation files. Four out of five of these were allocated to appropriately skilled investigators and were effectively investigated. Our inspection fieldwork supported this finding.

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<sup>5</sup> [At risk, yet dismissed: The criminal victimisation of people with mental health problems](#), Mind, 2013.

We also found the victims are typically well supported through this process. This is based both on our fieldwork and our review of crime files (84 percent of cases had good victim care).

## **Forces are investing in training, but the quality is inconsistent**

High-quality training is crucial. [Research](#) shows that officers may be concerned about responding to those with mental health problems. They may fear that they don't know how to help or that they might make the situation worse. They may also worry about things going wrong and potential legal reprisals, possible complaints about police action and about their own safety and the unpredictable nature of the situation. Training can help with all these things.

We were pleased to see forces investing in training to support their officers and staff to identify and respond to people with mental health problems. Twenty-one forces are using the [College of Policing APP](#) to make sure their training is consistent, accurate and up to date with any legislative changes.

The College of Policing devised a two-day training programme for forces to adapt to their needs. This was in response to requests from forces for guidance about mental health training. However, only a handful of forces have adapted and given this training. The biggest challenges for forces in scheduling training times are the competing demands of other important subjects and frequent changes in legislation.

The quality of training is inconsistent. Just over a third of forces have invested heavily in mental health training. This is in terms of time allocated in the training calendar and the breadth of different areas of mental health the training covers.

We also found some forces are relying too much on e-learning. E-learning can be helpful (for example, in understanding any changes in legislation), but forces should use it alongside face-to-face and interactive learning. Face-to-face, instructor-led training gives participants more focus. Complex topics can be explained and discussed with colleagues in a confidential environment.

## **Only a few forces are seeking the views of people with lived experience**

We found that there is a missed opportunity to seek the views of people who have mental health problems. Only a few forces are doing this to improve the quality of training and develop and shape future services.

## Recommendations

There are several ways the police service can make the current system more effective. These draw on current approaches and examples of excellent practice (many of which are set out later in this report).

### Recommendation 1

#### **The NPCC lead and College of Policing should agree a new national definition of mental ill-health for all forces to adopt**

We found forces using different definitions to describe mental health-related incidents. This makes it difficult for forces to identify people with mental health problems correctly, and to understand mental health-related demand. Many forces have adopted a consistent definition for vulnerability, which has helped them identify it and respond more appropriately.

A new national definition for mental ill-health would help all forces provide a consistent approach to people with mental health problems. It should be developed in consultation with officers across the country and replace the existing definition. It would also help them measure their demand and workload against a national standard.

#### **Recommendation**

By January 2019, the NPCC lead for mental health and the College of Policing should draft and agree a new national definition of mental ill-health. This should be included within the new national strategy on policing and mental health that they are developing together. All forces should then adopt this definition as soon as reasonably practicable.

## **Recommendation 2**

### **All forces should carry out a 'snapshot' exercise to assess their mental health-related demand**

All 43 police forces are committed to responding effectively and sensitively to people with mental health problems. The new national strategy on policing and mental health will be more effective if forces understand better the nature and scale of mental health demand in their area.

In this report, we refer to a 'snapshot' day that the Welsh forces carried out to develop their understanding of how much of their demand was mental health-related. A snapshot exercise like this is very useful and it would be beneficial for all forces to do the same.

We would then have a national picture of how much time and money forces are spending on their response to mental health demand. It is crucial that forces understand the full picture of demand and act where they can to reduce risk.

### **Recommendation**

By December 2019, forces should develop a better understanding of their mental health data, and the nature and scale of their demand. All forces should carry out a 24-hour snapshot exercise, using the new national definition of mental ill-health in Recommendation 1. This would help them see where their mental health demand is concentrated and identify any gaps in their data. The NPCC mental health lead should set out how the data was collected during the Welsh forces' snapshot exercise.

This exercise will help forces understand the strain on the service by assessing the combination of demand and workload. This will then help forces when establishing and reporting mental health demand in their force management statements (FMSs).

## **Recommendation 3**

### **All forces should evaluate their mental health triage services**

Mental health triage, or street triage, now operates in 42 of the 43 forces. Triage should be a service that acts as a gateway to further mental health care. There is still a perception that this is a service that is filling gaps that local health partners no longer can or will.

A more effective understanding of the service, and the environment it operates in, would show where the demand is coming from, and whether there are good enough outcomes and care options for patients. Patient feedback about individual experience of triage would help forces understand whether their partnership approach is working, and to shape future services.

### **Recommendation**

By August 2019, all forces should review their existing partnership mental health triage services to assess their effectiveness, and the environment they are operating in. This will help them make decisions about sustainable future services with partners to make sure mental health care needs are being met.

If forces find any deficiencies in their triage services, they should take steps to address them as soon as reasonably practicable.

The College of Policing has agreed to devise some practice guidelines to help forces benchmark their triage activity. We will inspect on progress in this area as part of our integrated PEEL assessments inspection framework.

## **Recommendation 4**

### **All forces should review their mental health training programmes**

The quality and quantity of mental health training varies considerably across forces. Several forces have developed multi-agency training that police officers and staff have found very useful. Forces need to make sure they are allowing enough time for quality training that allows officers to respond with a greater understanding of the complexity of mental health crises.

### **Recommendation**

By August 2019, all forces should review their mental health training programmes, using the College of Policing learning standards, to establish whether they are giving their officers the right tools to understand and respond to people with mental health problems.

If forces find any deficiencies in their training programmes, they should take steps to address them as soon as reasonably practicable.

Where forces invite outside organisations to train staff, they must make sure its content and quality are checked against College of Policing APP.

## **Recommendation 5**

### **The Crisis Care Concordat steering group should carry out a fundamental review and make proposals for change**

Although the first four recommendations are achievable, they won't solve the fundamental problem. There needs to be a comprehensive, long-term approach to identifying, assessing and supporting people with mental health problems.

#### **Recommendation**

By 30 September 2019, the Department of Health and Social Care (DHSC) and the Home Office should review the overall state response to people with mental ill-health. The scope of this work should include as a minimum:

- an assessment of the implementation of the Crisis Care Concordat;
- crisis response and whether people with mental health problems can access appropriate services;
- the role and responsibilities of police officers when meeting people with mental health problems; and
- whether there is sustainable and integrated support to prevent repeat contact.

The Crisis Care Concordat steering group should consider whether any changes are necessary, or should be considered, to legislation; structures; initial and ongoing training; and guidance and guidelines (for example, the APP and National Institute for Health and Care Excellence guidelines).

The Crisis Care Concordat steering group should report to the Ministers in DHSC and Home Office with relevant recommendations, to improve the whole system relating to mental health, for:

- the Department of Health and Social Care;
- the Home Office;
- the Ministry of Housing, Communities and Local Government;
- NHS England;
- the National Police Chiefs' Council;
- the Association of Police and Crime Commissioners;
- the College of Policing;
- Public Health England; and
- if necessary, other members of the Crisis Care Concordat steering group.

## Detailed findings

### Identifying people with mental health problems at first contact

#### Control room activities are improving

The first contact people have with the police is very often with a call handler when they ring 999 or 101. So it is very important for the police to recognise when a caller is vulnerable, or when the person calling is asking for help on behalf of someone who is vulnerable. They need to record incidents accurately so that they despatch the correct resource.

Control room staff are becoming more skilled at identifying and responding to vulnerability – specifically mental health problems – when callers first contact forces. During this inspection, we found most people working in force control rooms could identify a caller with mental health problems correctly. Many are using a recognised framework such as THRIVE or NDM to assess risk.

Using a specific definition for mental ill-health also helps call handlers with their risk assessment. We found that several have adopted the [College of Policing definition](#) of mental ill-health. A standardised definition helps to make sure callers with mental health problems receive a consistent supportive response whenever they contact the police.

Call handlers need to be able to record all the available information on the call log. They must then pass on as much information as possible to the responding officers, so they can help someone person in crisis quickly and effectively. Detailed information can alert officers that they might need to use de-escalation techniques (calming strategies to help someone in crisis). It also helps them identify any support already in place and arrange for further medical help if necessary.

#### **In action: call handling**

Many of the call-handling systems have in-built checklists or prompts to help call handlers identify mental health problems. **Cheshire Constabulary's** call handlers have access to 'evergreen logs' that contain data from triage crews (including nurses) and use them to help identify mental health concerns.

In **Cumbria Constabulary**, all control room staff have been trained in identifying mental health indicators at first point of contact. They use a 'keep me safe' checklist to help them understand their responsibilities.

**Sussex Police** treats as a priority all calls it identifies as involving mental health problems. Good processes for assessing risk help its control room staff make effective decisions. For example, as well as using THRIVE, call handlers use the acronyms VOWSIO (victim, offender, witness, scenes,

intelligence, other) when assessing risk and RARA (remove, avoid, reduce, accept) for the necessary action. This means the force can identify people with mental health problems and seek help from partner organisations more quickly.

### **Extra mental health support in the control room is invaluable**

Forces have identified that extra help from mental health professionals in the control room is one of the best ways to identify and enhance their initial response.

Twenty-one forces have partnerships in place to help people with mental health problems when they first contact the force. These involve AMHPs, psychiatric nurses or representatives from the mental health charity Mind working in police control rooms. Their expertise can be invaluable in identifying mental health problems and finding solutions for people in crisis. Immediate access to health records and data to find out patient history means forces can identify the right help more quickly.

#### **In action: call handling**

**Humberside Police** has a practitioner from the mental health charity Mind in the control room three evenings a week. The practitioner helps officers and staff identify vulnerabilities and manage risk when people with mental health problems call. They also review the calls that have come in to quality-assure the responses.

To enhance the quality of the initial response to people with mental health problems, **Kent Police** runs a telephone advice line from the control room on Sundays, Mondays and Tuesdays. This is staffed by a senior clinical support worker who has access to the electronic mental health patient record. A qualified mental health practitioner can attend incidents if necessary. This out-of-hours health information is vital and helps the police to make sure people experiencing mental health problems get the right support.

**British Transport Police** has a dedicated suicide prevention and mental health (SPMH) team in each division, as well as a strategic hub at the force headquarters. These are joint health and policing teams that respond when people on the railway are in crisis or suicidal. They provide advice and support to control room staff, proactively review call logs and identify where there might need to be an intervention. Frontline officers and the force control room can contact SPMH nurses seven days a week.

**Cambridgeshire Constabulary** and **Essex Police** have integrated mental health teams in their force control rooms. This means nurses work alongside officers and staff to offer an enhanced service to protect those with mental health problems. Their medical training and expertise help with responding to calls. Because they can access patient medical records, they can quickly

establish what medication the person may need, the primary care contact, or the appropriate place they may need a referral to for further care.

This integrated model offers obvious benefits.

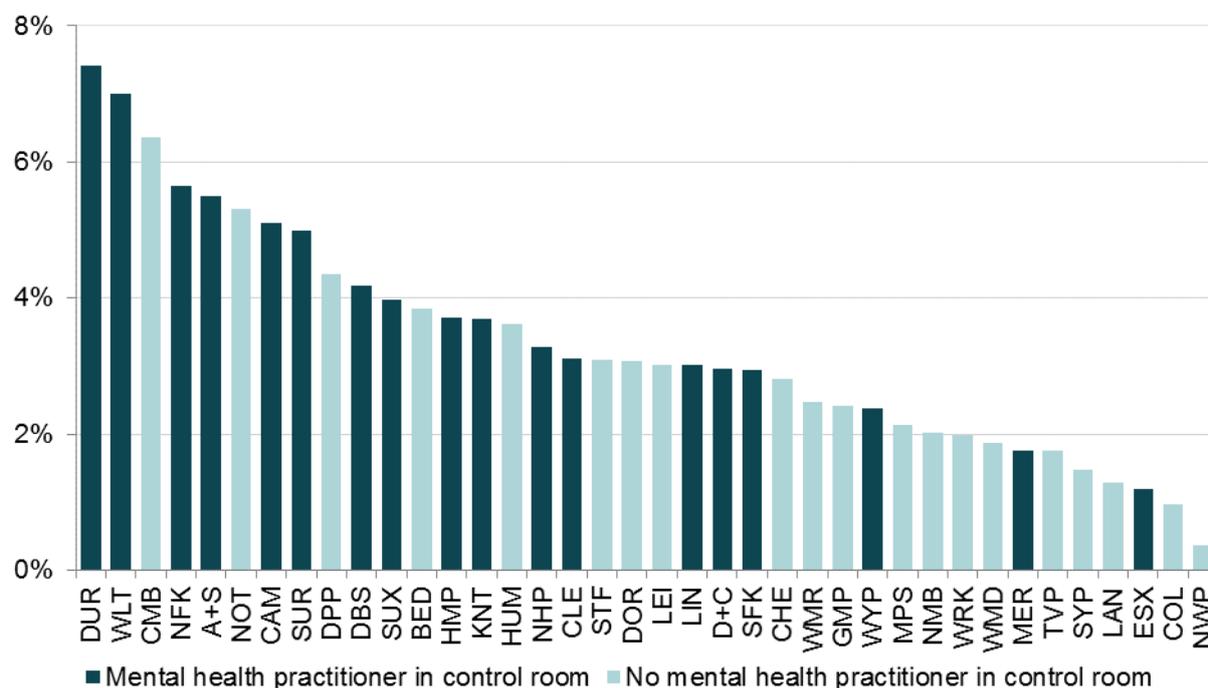
**Northamptonshire Police** runs Operation Alloy, a partnership with the local health trust to jointly support people with mental health needs. Mental health triage nurses, with access to police and NHS data, are in the control room between 7am and midnight. They help to identify incidents related to mental health and support the officers who are taking the calls. Operation Alloy staff make referrals, GP appointments and arrange mental health assessments with partner organisations. Call handlers in the force control room are extremely positive about Operation Alloy and say it is improving the quality of service to the public.

### **Flagging mental health incidents**

The graph below shows that forces with a mental health practitioner in the control room have a higher proportion of flagged mental health incidents. The call handler applies a flag to identify the type of call and indicate what extra support the person might need. Flags are also a useful way of helping forces identify and analyse demand. Most forces flag mental health incidents. But their command and control systems can't identify the different types of mental health incident that fall under this broad heading.

The higher proportion of incidents flagged indicates that extra specialist support at first point of contact could be helping forces identify people with mental health problems. It is difficult to confirm this, because the forces may have been good at flagging incidents before they employed an external specialist. But it indicates that forces with specialist support give more attention to flagging.

**Figure 1: Proportion of recorded incidents flagged or marked to identify mental health concerns in the 12 months to 30 June 2017**



**Source: HMICFRS Data collection 2017**

For the police forces in England and Wales, 2.8 percent of recorded incidents were flagged to identify mental health concerns. (Five forces couldn't give us any data on flagged mental health incidents: Gwent Police, Hertfordshire Constabulary, South Wales Police, Gloucestershire Constabulary and North Yorkshire Police.)

There was notable variation between forces. For example, Durham Constabulary flagged 7.4 percent of their calls as related to mental health. North Wales Police flagged only 0.4 percent of all calls. The command and control systems vary between forces; some have a bigger range of flags to determine the nature of the call. Some command and control systems can't flag mental health-related calls. All systems rely on a member of the workforce manually applying the flag. This is where a combination of good training and supervision of call handlers will help.

### Supervision

We found some evidence of good supervision of staff who have first contact with callers experiencing mental health problems. South Yorkshire Police's call centre supervisors carry out regular performance meetings with their police officers and staff. Supervisors listen to a selection of calls that call handlers have answered. They listen alongside the call handlers to check that their tone, response and advice are consistent. This helps to identify anyone who needs extra training, which will in turn improve performance.

It is important that supervision is proactive and regular. It should take place despite the pressure of call handler workloads. Answering 999 and 101 calls is an extremely demanding and stressful job. This robust approach to supervision means police officers and staff are supported and have regular meaningful contact with their supervisors.

## Providing the right response when the police arrive

“I told the officer I had mental health problems. He said, ‘Where’s your medication?’ When he saw it he said, ‘Ah, my sister suffers with that’. His approach towards me changed. He arranged for me to be assessed. I was taken to hospital. I wasn’t in handcuffs. He got me a cup of tea when we were waiting for the medical staff to assess me. He talked to me about his sister and how he had helped her. He told me about charities to get support. He understood the mental illness that I had.”

It is vital that people with mental health problems have complete confidence in the police when they come into contact with them. If the police are equipped with the skills and knowledge to help and understand someone in crisis, this will build trust and confidence. In general, officers we spoke to know how to support people with mental health problems and respond with compassion and empathy.

### Training for officers and staff

All forces have given officers and staff some training on mental health in the last 12 months. This was evident in the understanding and awareness officers and staff showed when we spoke to them during this inspection. However, the type of training, and the extent to which partners are involved in planning and providing it, varies between forces.

Several forces have developed handbooks, checklists or cards for officers to complement their training. This helps them understand the often-complex range of mental health problems and types of vulnerability they might encounter. Some of these have been designed with partner organisations. They include useful local information, local protocols and contact details for other organisations and charities. Several forces have introduced apps that officers can access on their portable devices while on patrol. This gives them instant access to help and advice.

Some forces have created extra training and awareness initiatives for officers and staff to help people with mental ill-health, including:

- care plans to support repeat callers;
- dementia awareness and the [Herbert Protocol](#);

- autism awareness; and
- awareness of learning difficulties.

Eighteen forces have invested heavily in mental health training, with a range of courses and time allocated to training throughout the year. It is of some concern that some forces rely heavily on online training and web-based training packages. Officers and staff can access these quickly and out of hours, but they would be more effective when supported by face-to-face training. There is more focus and opportunity for discussion and questions when training is face to face and in a group environment.

### **Joint training with partners**

The 18 forces we refer to above have developed joint training packages with partner organisations. This enables them to exchange ideas, knowledge and understanding about each other's roles and responsibilities.

When training is designed and provided by people who have personal experience of mental health problems, it helps make the training come alive for officers. It gives a different perspective on crisis. Joint training also helps officers build trust and nurture those partnership contacts that prove so vital in difficult crisis situations.

Officers we spoke to during our inspection said they feel that the partnership training they had received was more relevant and interesting. It has helped them understand mental health from a different perspective.

Twenty-three forces described their investment in training and their future plans in their FMSs.

### **In action: mental health training**

New probationary officers in **Nottinghamshire Police** now work for a day in a mental health setting. This can be on an in-patient ward, crew with the street triage team or community work with an AMHP. This gives them first-hand experience of the often-challenging nature of mental ill-health. They then have mental health training to reinforce their understanding.

**North Yorkshire Police** has developed a collaborative approach with the University of York and the College of Policing on policing and mental health: Connect Partnership. This resulted from an evaluation of existing training available for professionals who aren't involved with mental health. It showed that there wasn't a proven, effective training product that was suitable for the police service. Connect has given all officers and staff tailored multi-agency training. It is presented by mental health professionals from the local NHS Trust, based on College of Policing learning objectives. Evaluation and

feedback has shown that this training is effective, and it is going to be provided for all officers and staff.

**Northumbria Police**, its partner organisations and ‘experts by experience’<sup>6</sup> have devised a training package called Respond. This is a simulation training package that creates hypothetical scenarios for professionals involved in mental health crisis care to respond to. It increases collaboration and knowledge, with the aim of improving crisis care response. The scheme has been independently evaluated and the findings published.<sup>7</sup> This gives everyone involved with people in mental health crisis a better understanding of their roles and responsibilities. **North Wales Police** and **Cumbria Constabulary** have already announced their intention to adopt this training package.

### Lived experience is vital in improving response

“I have had a lot of support from police. My baby died in foster care. I went off the rails. The police saw me sitting on the pavement crying hysterically. The officer asked me what was wrong, and he put his coat around me. He put me in the back of the car and said, ‘I am taking you to hospital to get some support.’ He stayed with me and took me home and when I went into the treatment centre the police officer sent me a card that said, ‘Do well, this is your beginning’.”

Forces can only fully assess how well services are working for people in crisis through feedback, both positive and negative. Finding out how someone feels they have been treated, and if it resulted in a positive outcome for them, is instrumental in learning what works and will help forces improve.

We found that 11 forces incorporate service user and ‘lived experience’ feedback within their training programmes. In four forces<sup>8</sup>, some officers used their personal experience of mental health problems as part of training days.

We didn’t find many other examples where those with lived experience had been involved in consultation on and design of future services. All forces survey victims of crime and regularly seek feedback. But we didn’t find much consultation with mental health patients or victims to get feedback on how contact with police had

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<sup>6</sup> People who have personal experience of using or caring for someone who uses health, mental health and/or social care services.

<sup>7</sup> The scheme was evaluated by Quintessent Ltd, an independent company, on behalf of the Academic Health Science Network.

<sup>8</sup> Hertfordshire Constabulary, City of London Police, Cambridgeshire Constabulary and West Yorkshire Police.

affected them. This is an area we will focus on in future inspections and is an area that forces are encouraged to review themselves.

The quality and quantity of forces' mental health training varies considerably. It is important that forces provide meaningful and useful training that will give officers a greater understanding of the complexity of mental health crisis. Forces need to be able to assess the effectiveness of this training.

“One time I was put in a van outside the house when the police attended. I said I needed my medication. An officer got my medication from the house. Not every officer recognises my vulnerability – it depends which officer it is and which police station it is.”

## **Crime: identifying numbers of cases and standards of investigation**

In the year to 30 June 2017, there were 97,796 crimes with a flag to identify mental health concerns in the 38 forces that could give us this data. This represents 2.4 percent of all recorded crime in England and Wales, which is an increase of 0.2 percent from 2016.

Five forces couldn't give us data on crime which had been flagged to identify victims who are vulnerable because of mental health problems. If a force doesn't know how many crimes of this type it is investigating, it will be difficult to calculate demand. It will also reduce the opportunity to identify any patterns or increases and plan the right levels of service. Forces must be sure they are identifying, safeguarding and protecting vulnerable victims of crime with mental health problems.

Before inspection fieldwork, we carried out a crime file review<sup>9</sup> in each force to assess the effectiveness of the approach to victims. The review assessed a total of 2,700 crime files. In 297 of the crime files, there was evidence that the victim showed signs of having mental health problems.

Despite the relatively small sample size, our findings were very positive: 94 percent of crimes were allocated to the correct team, and 81 percent (more than four in five) of crimes had all possible lines of enquiry followed up (better than the findings for all crime).

We found good victim care in 84 percent of the cases we reviewed, and a focus on identifying and bringing to justice those who had committed the offence in 82 percent of the files. Forces all understand they must develop their relationships with charities

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<sup>9</sup> We assessed 60 crime files in each force, apart from the Metropolitan Police Service, Greater Manchester Police, West Midlands Police and West Yorkshire Police, where we reviewed 90.

and partner organisations to help them safeguard vulnerable victims of crime. More than four out of five investigations had an effective investigation (again this is better than the findings for all crime).

<b>File review findings 2017</b>	<b>Number of cases</b>	<b>Percentage</b>
Number of cases reviewed with mental health concerns	297	-
<b>Crime allocation</b>		
Number of cases reviewed that were assigned to the most appropriate team	280	94%
<b>Investigative opportunities</b>		
Number of cases reviewed where all applicable investigative opportunities were taken	242	81%
<b>Overall judgments</b>		
Number of cases reviewed with an effective investigation	242	81%
Number of cases reviewed where supervision was effective or limited but appropriate	213	72%
Number of cases reviewed where there was a focus on identifying and bringing to justice those who have committed the offence	245	82%
Number of cases reviewed where there was good victim care	248	84%

## **Overall mental health demand**

Detailed national data on crime demand has been collected for many years. There has, however, been less focus on other aspects of policing demand, such as anti-social behaviour, domestic incidents, missing persons and traffic collisions. All forces record data on these incidents as part of their command and control systems, but few projects have aimed to combine data from different forces and analyse it to support local improvement.

Since 2016, we have been working with a pilot group of police forces to compile a database of all incidents reported to police control rooms, including information on how police respond to these incidents. We analyse and report this data through

interactive dashboards to help answer a wide range of questions, such as how demands vary, how different forces respond and what the effects of these responses are. As part of the data collection, we ask forces to highlight which incidents were flagged as being related to mental ill-health. The database is still being developed and the data refined, but we have included some general findings in this report.

### **Flagged mental health incidents**

We analysed data on flagged mental health-related incidents for 22 forces. Only one force in the pilot group didn't provide this data. Our analysis focused on incidents since 1 April 2016, excluding admin incidents (for example, messages – every message or request to police for assistance generates an incident number and a log) – a total of 12 million incidents.

Participation in this pilot exercise was voluntary and the data varies in quality and completeness. There was no formal data-sharing agreement in place with forces, so the analysis doesn't name individual forces.

### **Response data**

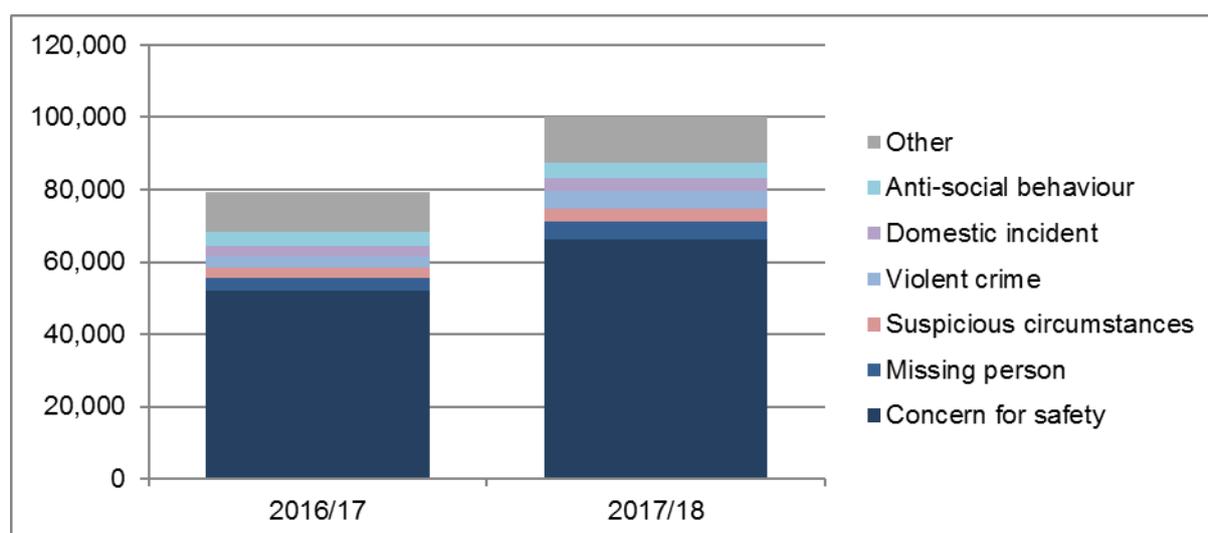
One of the headline findings from our analysis of data from participating forces is that responses to mental health-related incidents differ from responses to other incidents. Average response times (the time between when the incident was logged and when the first officer arrived) are slightly slower. On average more officers are sent and, crucially, more time is spent dealing with the incident.

This may be because officers often need to liaise with health or triage services. There might be a need for more officers to keep both the person in crisis and the wider public safe. For example, the response to crisis or suicide intervention often involves specially trained negotiators. Incidents can take a long time to resolve; they may need many officers to close roads or scenes and need ambulance and fire service support.

Of the 23 forces submitting data to us during the pilot exercise, 22 provided data on mental health flags. These findings relate to these forces alone:

- the overall proportion of incidents flagged 'mental health' was three percent;
- the total number of these incidents was 318,000;
- 66 percent of mental health-related incidents were related to a 'concern for safety' (compared with ten percent in incidents not flagged as mental health-related); and
- other agencies making calls to police account for around ten percent of mental health-flagged 'concerns for safety'.

**Figure 2: Proportion of recorded incidents showing an increase in concern for safety**



**Source: HMICFRS analysis of Command and Control data submitted by 14 pilot forces to the Response and Neighbourhood Policing Database**

Mental health-related incidents are more likely to be reported by 999 calls than non-mental health-related incidents (48 percent vs. 37 percent) and are much more likely to be graded for 'immediate response' (36 percent vs. 20 percent). This is encouraging, as it would seem to suggest that call handlers recognise risk and vulnerability, and are giving higher priority to mental health-related incidents.

### **Demand after 4pm**

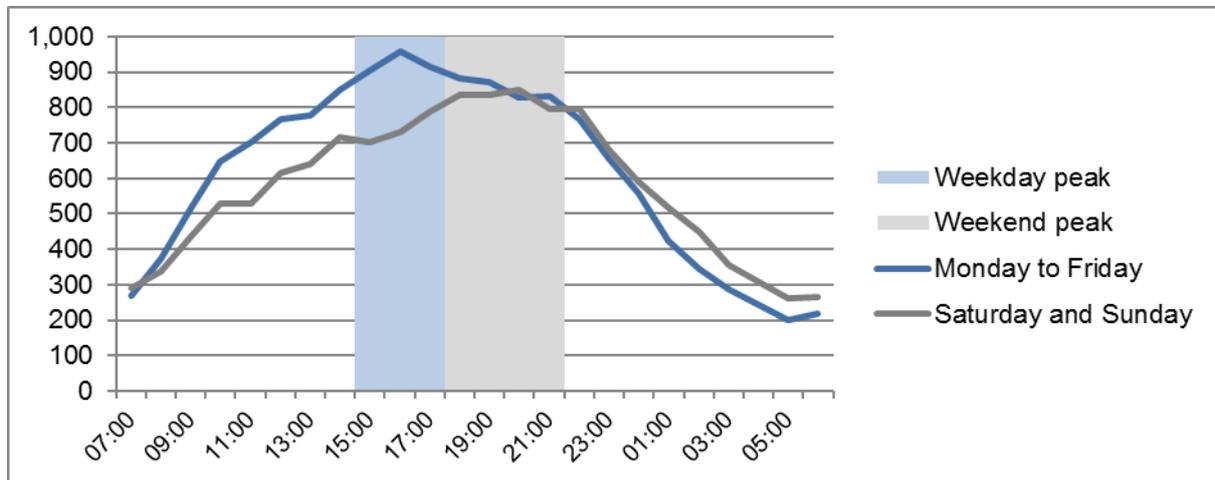
The peak time for calls to police for support with mental health-related incidents is 3pm to 6pm, Monday to Friday. This could be for a range of reasons, including people with mental health problems struggling to sleep, then waking late in the day and seeking help from services; or attempts by colleagues or families to resolve things during the day before ringing for help.

This also suggests that the concern for safety requests are coming at the end of the working day for other organisations, which are then transferring their risk to the police. GP surgeries, social care and community mental health teams tend to finish work at 5pm. Other agencies making calls to police account for around ten percent of mental health-related concerns for safety. These can involve welfare checks on people who haven't been seen for a while or who may have missed appointments. People who then can't access their primary care after 5pm will often ring the police.

There are also peaks in calls for service between 5pm and 10pm Saturday and Sunday. These times are typically when many services are closed but many people need mental health support, suggesting that there are gaps in mental health service provision. It may also be simpler for people to call the police than try and find a contact number for an out-of-hours service.

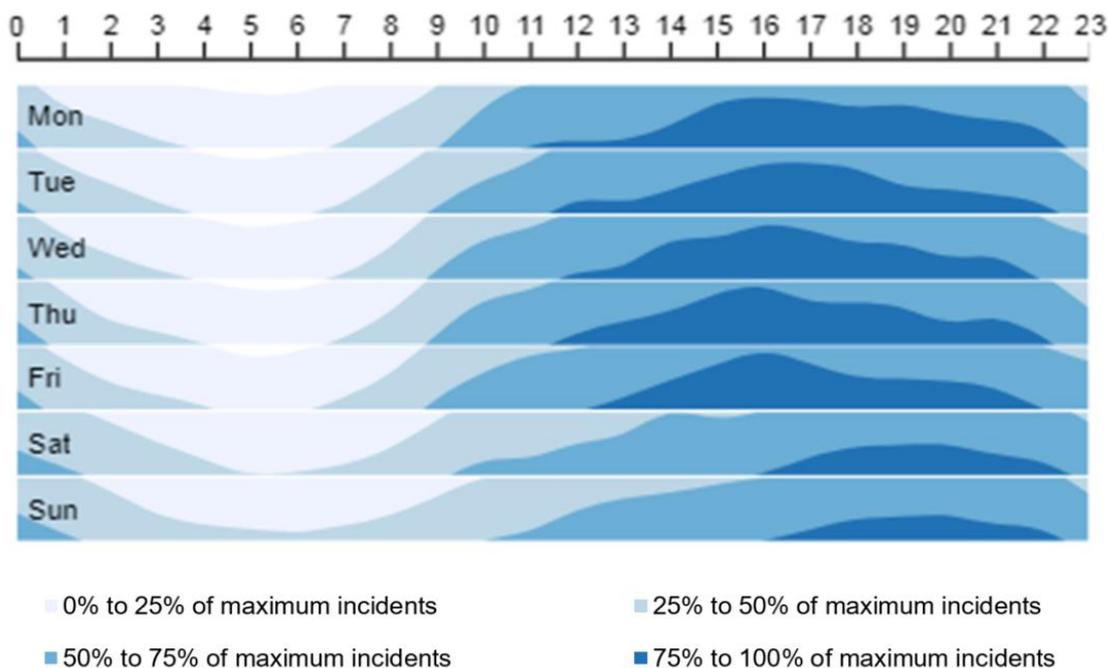
Figures 3 and 4 below show the hourly variation in mental health calls for police service across a week. Figure 3 shows this variation by weekday or weekend, whereas figure 4 shows it by day.

**Figure 3: Hourly mental health incident pattern (by weekday or weekend)**



Source: HMICFRS analysis of Command and Control data submitted by 22 pilot forces to the Response and Neighbourhood Policing Database

**Figure 4: Hourly mental health incident pattern (by day)**



Source: HMICFRS analysis of Command and Control data submitted by 22 pilot forces to the Response and Neighbourhood Policing Database

The data indicates that other organisations rely on the police to effectively ‘pick up the pieces’ after they have gone off duty. At the end of each working day, there appears to be a shift in responsibilities for mental health from partner organisations (who have the proper skills and expertise to deal with mental ill-health) onto

policing – simply because the police are a 24/7 organisation. It means that although the police will invariably do their best to respond, sufferers of mental ill-health are likely to receive a poorer service ‘out of hours’. We were told by someone with lived experience that, when they tried to contact a nurse through their GP surgery, they were told that there wasn’t a nurse on duty. However, they were told to call the police to access a nurse as there was one working on the triage car. Clearly, it is not acceptable for someone who needs medical care to have to call the police to speak to a nurse.

As we said in our 2016 State of Policing report:

“The inadequacy of mental health provision and the lack of parity with physical health provision in this country should disturb everyone. It should never be the case that someone who requires treatment, for any condition, should become the responsibility of the police simply because other agencies do not have the resources to act.”

A system needs to be put in place to make sure that the growing demand relating to mental ill-health is accommodated and appropriately responded to by the right professionals. Risk and responsibility should not be passed on to the police simply because policing is the service of last resort.

These peak times for mental health demand also overlap with a rise in demand for the police to respond to calls generated by the night-time economy. Weekend sporting and entertainment events stretch limited resources even further.

Thirteen forces noted in their FMS the demand their partners place on them. Dyfed-Powys Police recorded 4,060 incidents with a mental health tag in 2017. Further analysis of the 4,060 showed that 76 percent were related to public safety and welfare issues. Featured within the top ten callers for mental health incidents were local health board institutions, including those with mental health facilities. Understanding exactly where the demand for service is generated helps forces to present details to partners and find ways to solve problems.

### **Understanding demand**

Overall, we found that many forces don’t have a clear picture of their mental health demand. Many of the command and control systems aren’t sophisticated enough to flag data and identify patterns or repeat callers.

Identifying the nature and scale of demand that the police face in dealing with mental ill-health is difficult. Many types of incidents that police attend can be mental health-related in some way. The police respond to people who are in crisis or who present a danger to themselves or others. Neighbourhood police officers will also visit people in their communities who need mental health support: for example, elderly, vulnerable or homeless people, or people who are lonely and need to talk. This type of demand can come to the police to deal with in other ways, such as direct

calls to neighbourhood teams, visits to front counters and through referrals at partnership meetings.

In their FMSs, 31 forces referred to their current mental health-related demand and 22 referred to future demand. The FMSs showed that nearly all forces saw an increase in demand. The recording varied significantly, and ranged from an increase of just three percent per day to 40 percent over the year. One force in particular said that, over the last four years, they have seen demand in this area rise by 200 percent.

The reasons forces gave in their FMSs for the rise in demand were:

- a greater understanding of mental health by staff;
- better recording and flagging of mental health on incidents and crime reports;
- more public awareness of mental health conditions, leading to rises in those seeking diagnoses;
- cuts to mental health services;
- a lack of support services to cover large geographic areas, causing significant delays during the day;
- emergency duty teams (EDTs) not having enough resources to provide timely mental health support out of hours; and
- lack of beds for those in crisis.

### **In action: understanding demand**

**Humberside Police** has developed an innovative web-based mental health dashboard on the force intranet. The dashboard is easy to use and shows information on demand related to mental health. It includes numbers of incidents relating to self-harm, suicide and dementia. It also records locations, repeat caller information (with care plans) and the peak times that these took place. This enables the force to produce data which helps its operational planning and resource forecasting. The force knows its number of mental ill-health incidents has increased on average from 760 per month (April 2016 – March 2017) to 824 per month (April 2017 – March 2018). Most calls are related to suicide or self-harm.

**Avon and Somerset Constabulary** has developed a system called Qlik Sense, which can identify the numbers of calls received by type. The force can estimate proportions of demand that have a mental health factor based on how they are graded. The force has devised a mental health monitoring form to record a range of useful information on the specific actions taken at each incident. This will achieve an even more accurate measure of mental

health as a proportion of total demand. This relies on officers completing the forms, but a greater level of detail will help inform care plans and help the force to understand future demand.

To better understand the level of demand associated with mental health, **the four Welsh forces** carried out two national demand exercises in October 2017 and April 2018.

The October 2017 exercise found that out of 965 incidents reported to the force on that day, 118 (12 percent) were mental health-related. Officers spent on average 3¾ hours dealing with each mental health-related incident. Approximately 60 percent of people who contacted police were already known to mental health services.

The 2018 exercise identified that 112 out of 908 incidents were linked to mental health issues, which is just over 12 percent. Officers spent an average of three hours dealing with each incident. Again, the number of people who were the subject of police contact who were already known to mental health services was significant at 50 percent. The total cost of dealing with the 112 mental health incidents in April has been estimated as £7,161. Over a 12-month period, this would equate to £2,613,765 of police resource.

### **Hidden and repeat demand**

Police forces find it difficult to quantify hidden demand because it isn't easy to record. It may include officer time spent with people in crisis in hospital or transporting people to places of safety. It can be simply waiting with patients for beds to become available or responding to repeat callers with mental health problems. Often people call the police because they are lonely; they want to talk and can't get the help and support they urgently need.

Repeat or frequent callers can generate a disproportionately high level of demand. In their FMSs, 13 forces cited the pressure that responding to repeat callers places on an already busy command and control system. In the Metropolitan Police Service (MPS) there are roughly 13,000 calls from mental-health-specific premises (for example, hospitals and mental health suites) each year. Four thousand of these result in officers being sent to respond to an incident. This means that, in the MPS alone, this is a call every 40 minutes and a deployment every two hours to repeat callers from mental-health-specific premises.

The top five individual repeat callers to the MPS (all of whom have mental health problems) called a combined total of 8,655 times in 2017. It cost the service £70,000 just to answer the calls. The MPS is now working with mental health services to find a long-term solution to this problem.

## **In action: dealing with repeat demand**

**Kent Police** has developed a mental health team that is based in units throughout the force. Team members help to deal with mental health-related crime reports and manage repeat callers. Their analyst collates data on repeat callers and produces an analytical report, to help manage the problem. As a result, services are more focused and there is better support for people who may have fallen between services. It has also led to the prosecution of a small number of people involved in making nuisance calls.

Serenity Integrated Mentoring (SIM) is a cross-agency response to the needs of people with complex mental health problems in local communities. It was piloted in the **Isle of Wight** on a small group of people who were taking up a lot of police time. The police and local mental health teams identified the most persistent and challenging users of multiple services, and the partners then worked together to support these users and reduce repeat behaviours. SIM is now being adopted in many force areas as an effective approach to people with complex needs. It offers significant benefits to these people, their families and communities. It also reduces the use of section 136 of the Mental Health Act 1983 and the costs associated with repeat callers.

## **Competing demands**

Police forces face growing pressure to prevent and respond to emergencies that place huge demand on their resources. Large-scale incidents, such as terrorist attacks and the Grenfell Tower fire, place huge pressure on all police forces. This is in terms of the initial response, mutual aid and the subsequent investigation which can often last many months, even years. This, combined with the daily increase in demand, means that police resources are significantly stretched.

There has been a [22 percent increase](#) in knife-related offences, the biggest annual increase on record. Also, [as we reported in 2017](#), the number of domestic abuse crimes recorded by the police has increased by over 60 percent in less than three years. As a result, police resources are more stretched than ever.

To cope with these extra pressures, police forces have been gathering data to help them understand and map their demand. The benefits of this include:

- more accurate planning and better resourcing of times of peak demand;
- tailoring the response to the different types of demand;
- better protection for vulnerable people with mental health problems; and
- adapting and funding future services; and avoiding the need for a crisis response through preventative work.

These figures will also help forces to show where other organisations need to step in and support vulnerable people. For example, by calculating the cost of a few repeat callers, the police can show that there are people in the community who aren't being supported enough.

## **Making sure expert help is available from other organisations**

### **Strong partnership arrangements**

The 2014 Mental Health [Crisis Care Concordat](#) sets out how public services – including health, police and social care – will work together to respond to people with mental health problems. We were pleased to find that most forces already had long-standing partnership agreements and relationships with other services and organisations. As many services have absorbed funding cuts, it makes sense for them to work together. They can improve joint responses, share premises where necessary and exchange information to identify demand more accurately.

During this inspection we held focus groups with some of the organisations that work with the police, including the NHS, mental health teams, local authorities and nurses who work with officers in triage schemes. Their feedback was positive. They enjoy good working relationships with the police and with each other, and feel confident about exchanging information at meetings. The Crisis Care Concordat meetings are hugely important – they help to build trust, which is needed to support people in crisis.

Partner organisations told us that continuing to work with the same group of people is very important. Partnership arrangements can be very complex – some forces negotiate with several ambulance services, various mental health trusts, up to four local authorities and several clinical commissioning groups – so it helps to have this continuity. These relationships are vital when forces need to have difficult conversations with partners about the pressure on already-stretched resources.

### **In action: partnership arrangements**

In **Cleveland**, the focus group noted that the police have helped reduce crime and drug use on the mental health ward. The force has improved how it handles information it receives from staff on the mental health ward. A lead nurse now regularly attends the reducing reoffending meeting. She was impressed that vulnerability is being recognised in prolific offenders and included in plans to reduce offending.

We saw many different examples of partnership working in forces that are tailored to address unique local problems, subject to local funding and commissioning.

In **North Yorkshire**, the partner organisations told us about their major incident response team. This team supports people in the community who have been affected by suicide. Officers and staff who have been involved in traumatic incidents can access and receive personal support from this team. The team also provides suicide prevention training to police community support officers.

## **Suicide prevention**

Eight forces described in their FMSs the work they and partners had done to identify suicide hotspots and develop suicide prevention packages. There were [nearly 6,000 suicides in the UK in 2017](#). This means 16 people take their own lives every day. Many more people attempt suicide. The police and health services are doing some innovative prevention work to understand and prevent suicide across the country.

### **In action: suicide prevention**

**Devon and Cornwall Police** established that many people who had died by suicide in the area in 2017 had a previously diagnosed mental health problem. The force is now working with Public Health England to develop its prevention work. It has also focused on young people as a target group and is working with the main universities in the area.

**City of London Police** is focusing on the effect of fraud on the mental health of victims. They have responded to over 170 calls from victims of fraud since October 2016, who have described themselves as feeling suicidal. These calls are dealt with by way of public protection notices, safeguarding referrals or signposting to specialist support services.

## **Mental health triage, or street triage**

The aim of understanding mental health demand isn't just to reduce it but also to respond to people in crisis in the most effective way. We found that one of the most widely used and popular approaches to providing enhanced support was mental health triage, or street triage.

### **What is street triage and where did it begin?**

Street triage is based on the model of police officers contacting a mental health professional – usually a nurse – to get information or advice about a person involved in an incident. The nurse might be with the officer to do a face-to-face assessment or might give advice by telephone.

Street triage began in Leicestershire Police and Cleveland Police in 2012 on a trial basis, for about a year. It tested a new kind of service in which health professionals worked closely with police officers in responding to people with mental health problems in public places. Both areas reported some early evidence of success.

In 2013 the Department of Health invested £2 million to examine the possibility of other areas using the same approach. It chose nine pilot areas – one factor was the number of people being taken to police custody under section 136 of the Mental Health Act 1983 – to take part in the scheme for 12 months, the first starting in Sussex Police in October 2013.

The forces were asked to come up with a model of triage that best suited their local circumstances. Some chose mental health professionals based in the control room; others wanted them to be mobile, in police vehicles or ambulances. In some cases, mental health nurses based in a hospital gave help and support over the phone.

The [results of the pilots](#) showed a reduced use of custody for section 136, and an increased use of health-based places of safety. The Department of Health made several recommendations, including better joint training. The study found control room or telephone-based support to be more cost-effective and suggested that triage should be available at all times, seven days a week.

In 2014, in our [Core Business](#) report, we recommended that:

“By 31 March 2015, those forces without a mental health triage programme should carry out analysis to assess whether adopting such a programme would be cost-effective and beneficial in their particular areas. Where the analysis indicates this would be positive, all forces should work with their local mental health trusts to introduce such a programme by 1 September 2015.”

At the time of our inspection in 2017, we found mental health triage operating in 40 out of 43 forces; since then, two more forces have adopted the scheme. The term ‘street triage’ now covers a range of activity to help frontline and community policing meet the needs of people in crisis – and in fact it usually happens on the phone, rather than in the street. It also includes multi-agency response vehicles, and mental health professionals located in force control rooms and in custodial settings.

As well as working with the health service on these arrangements, the police work with local government and voluntary organisations where appropriate. The aim is to make sure offenders, victims and witnesses experiencing mental health problems receive consistent and respectful treatment, including appropriate assessments and onward referrals. These joint approaches should lead to better and more appropriate use of police powers under the Mental Health Act 1983, including section 136.

### **In action: street triage**

**Merseyside Police** has a long-established triage service. The force knows from its own demand analysis that one in four calls for its service is related to mental health. Responding to these calls accounts for 20 percent of all the force’s police time.

In 2014, the force piloted a mental health triage car, staffed by specialist officers and psychiatric nurses to attend incidents identified as mental health-related. This has brought about a 40 percent reduction in patients detained under section 136 of the Mental Health Act 1983. The triage car has since become a permanent force resource and has attracted national attention for best practice.

The service has evolved over time, and the teams have developed action plans to help address repeat demand using a partnership problem-solving approach. The teams also have triage car action plans, giving them information about certain callers. The public protection unit is responsible for regularly reviewing the triage car action plans with the relevant mental health trust.

Street triage in **Sussex Police** has also expanded since the initial pilot project in 2013. A senior mental health nurse and a uniformed police officer in an unmarked car work late shifts Monday to Friday. They attend 999 and 101 calls. The triage nurse is also involved in partnership meetings relating to offender management. The triage service can refer people to other services without the need for further assessment. This prevents delays and makes sure people in crisis have easier access to mental health care services.

**Lincolnshire Police's** triage system is unique in that it has a fully equipped ambulance vehicle, staffed by a paramedic and a mental health nurse, which responds to both police and ambulance incidents. It operates between 4pm and 11pm seven days a week and was the first triage vehicle to get long-term funding. It is highly valued by all three services.

Since our initial inspection, 42 out of 43 forces now have some form of triage service. Hertfordshire Constabulary has noted in its FMS that its street triage scheme has reduced the demand on partners and has reduced the number of detentions under section 136 of the Mental Health Act 1983. However, it hasn't reduced the number of incidents involving people in mental health crisis, which continues to rise.

This might indicate that people aren't receiving the primary care or community-based mental health care that might prevent them from reaching crisis point in the first place. The ever-present threat of further cuts makes long-term succession planning of mental health services difficult for forces and partners. All the organisations involved want to provide the best quality of care, but they can't be confident that they have the resources to do so.

Twelve forces didn't use custody as a place of safety under section 136 in the 12 months before 30 June 2017, and a further 12 forces made very infrequent use of section 136. This indicates that those forces that don't use custody as a place of safety have good relationships with the local health providers and can access health-based places of safety or beds in hospitals.

## **Recent changes to the Mental Health Act 1983**

On 11 December 2017, amendments were made to the Mental Health Act 1983 in the Policing and Crime Act 2017. One of the main changes means that an officer can use section 136 in any public or private place (unless it is a “house, flat or room” where someone lives, or any non-communal “yard, garden, garage or outhouse” connected to such a place). This includes workplaces, railway lines, police custody and A&E departments. The police may also force entry to these places under section 136.

Another amendment is a requirement for the police to consult, if possible, with a doctor, nurse or an AMHP before using section 136 of the Mental Health Act 1983. This was introduced because section 136 is used less often when police can discuss possible alternative options with a health practitioner first. Triage has an important role to play in enabling the police to fulfil these requirements under the Act, but there must be care available to meet the needs of the person in crisis.

### **Assessing triage schemes**

During our inspection we found a lack of common or co-ordinated assessment of triage schemes. Forces often base their evaluations on incomplete data. Most haven't assessed the outcomes for patients, or continuing costs such as police officer and mental health professional time, vehicles, fuel and training.

As we say earlier in this report, we found that forces weren't using lived experience or patient feedback to evaluate their services, or to develop and add value to training. Our mental health reference group alerted us to some unintended consequences of triage, such as:

- Triage services are sometimes operating as the only crisis-care option for people experiencing mental health crisis. This means people are ringing police to access health care. It makes an already stressful situation more difficult for them and potentially makes them feel criminalised for being ill.
- Officers who aren't part of the triage service can be called on to deal with someone experiencing mental health problems. They may then call on the triage service for help, if they feel they have more expertise. They must then wait for triage, which can take an hour or more at busy times. It isn't always clear what powers they are using to detain the person while they wait for triage. This can be very distressing for the person being detained.
- There needs to be a protocol for how health nurses and officers exchange medical information. It can be very traumatic for people in crisis to find out that a police officer has access to their health records. Even if officers have the best intentions and need this information to get them urgent medical care, it is a sensitive area.

All forces need to make sure that the triage service they provide is effective. They should seek feedback from those with lived experience of contact or treatment by triage to help inform future service.

There is a perception on the part of some that triage is a service that is simply providing a 'sticking plaster' response – filling gaps that local health partners no longer have capacity to provide. If people reach the stage of needing crisis care, the system has already failed.

Triage should be complementary to, not a replacement for, other crisis services. People in crisis shouldn't be calling the police to access mental health care. It is essential that triage services are properly evaluated, to make sure this isn't the case, and to make sure that the right treatments are available for patients after crisis.

## **Leadership and communication**

### **Force policies on mental health**

All forces in England and Wales have a mental health chief officer lead who is responsible for performance, as well as an operational mental health lead, to help encourage and guide improvement in this area. There is a clear role for police leaders to make sure their forces develop a clearer understanding of their mental health-related demand.

The College of Policing published Authorised Professional Practice (APP) on mental health in 2016. This has helped forces to clarify their mental health policies and procedures and to formulate local protocols and procedures with partners. Twenty forces have a comprehensive local mental health policy that meets the requirements set out in the APP.

However, at the time of our inspection 11 forces didn't have any mental health policy. It is difficult to assess what guidance is available for operational officers and staff in those forces, or to establish whether they are aware of local procedures and health-based places of safety. Twelve forces have policies that either need to be updated or need more information about local procedures.

Local policies are important in making sure the police and partner organisations know what steps to take in crisis situations – for example, when there is no health-based place of safety for a child. Officers and staff need to know which senior police leader they should contact to escalate a critical issue. Policies mean that police and partner organisations can be held to account for their actions.

## **In action: mental health policies**

The **Metropolitan Police Service** has a particularly effective toolkit policy for officers and staff, which gives clear direction with flowcharts for each step that officers are likely to encounter in a mental health situation. The force has a central mental health team that provides training and information on legislative changes through a network of borough-based mental health liaison officers of all ranks and grades.

The **College of Policing** has also invested in a mental health subject matter expert. This is a seconded officer, who runs quarterly meetings, helps with legislation changes and has designed a two-day mental health training package that forces can tailor to meet their own needs.

## **An archive of good practice**

Strategic partnerships are central to making mental health policies accessible and agreeing partnership responsibilities. We found innovation, creativity and excellent examples of partnership in action throughout forces in England and Wales. Some forces had visited others to seek advice and ideas, but this wasn't a widespread practice. An archive of good practice would be valuable, helping forces to exchange ideas, solve problems and access information easily.

## **Mental health for officers and staff**

One of the positive, perhaps unintended, outcomes of the police working closely with mental health professionals is that stress and wellbeing are discussed more openly, not just in terms of looking after the public but also looking after each other.

The chief officer lead for internal police wellbeing has introduced a website, [Oscar Kilo](#), which hosts the [Blue Light Wellbeing Framework](#). This holds a library of evidence-based resources and guidance to help forces develop and provide support for emergency services staff. The benefits of this are that it is easy to access and best practice information is kept up to date. Many forces have now signed up to the framework.

We were pleased to see an emphasis on the wellbeing of officers, maintaining good mental health and protecting the workforce from stress. Most forces recognise how police work can negatively affect mental health, and make a positive investment in keeping the workforce healthy. As we highlighted in our [2017 police effectiveness report](#), in some forces individual officers are still managing a high number of investigations. So, it is vitally important that forces invest in officer and staff wellbeing. Some have made supporting and protecting their workforce a high priority.

**In action: looking after officers and staff**

The engagement and insight department in **Cheshire Constabulary** devises regular communications packages on: looking after your mental health, wellbeing, men's health and talking about mental health.

**Essex Police** runs a 'Feel well, live well' course for all its officers and staff, focusing on how to deal with stress and personal mental health.

**Leicestershire Police** supports a range of initiatives to promote wellbeing, including wellness recovery action plans that support people's in-depth conversations with their line managers about their physical and mental health needs.

## Definitions and interpretations

In this report, the following words, phrases and expressions in the left-hand column have the meanings assigned to them in the right-hand column. Sometimes, the definition will be followed by a fuller explanation of the matter in question, with references to sources and other material which may help the reader.

approved mental health professional (AMHP)	person who is authorised, to make certain legal decisions and applications under the Mental Health Act 1983
Authorised Professional Practice (APP)	official source of policing professional practice, developed and approved by the College of Policing, which police officers and staff are expected to follow while performing their duties
chief officer	in police forces outside London: assistant chief constable, deputy chief constable and chief constable; in the Metropolitan Police Service: commander, deputy assistant commissioner, assistant commissioner, deputy commissioner and commissioner; in City of London Police: commander, assistant commissioner and commissioner; includes a member of staff who holds equivalent status to an officer of these ranks
clinical commissioning groups (CCGs)	groups which plan and organise NHS services for their local area

Code of Practice for Victims of Crime (Victims' Code)	statutory code of practice issued by the Secretary of State for Justice under section 32 of the Domestic Violence, Crime and Victims Act 2004; the code establishes minimum standards on the rights, support and protection of victims of crime; its stated objective is to ensure the criminal justice system puts victims first, making the system more responsive to them and easier for them to navigate; it also aims to ensure that victims of crime are treated well and receive appropriate support to help them cope and recover, and to protect them from becoming victims again; the code specifies the services which must be provided to victims of crime in England and Wales, and sets a minimum for the standard of those services; higher entitlements are set for victims of the most serious crime, persistently targeted victims and vulnerable or intimidated victims; the public sector bodies which are obliged to provide services to victims of crime are specified in the code, and include police forces and police and crime commissioners; the Victims' Commissioner has a statutory duty to keep the code under regular review; the code is at: <a href="http://www.cps.gov.uk/legal/assets/uploads/files/OD_000049.pdf">www.cps.gov.uk/legal/assets/uploads/files/OD_000049.pdf</a>
College of Policing	professional body for policing in England and Wales which provides the police with the skills and knowledge necessary to prevent crime, protect the public, and secure public trust
command and control system	police call centre which answers emergency calls, and which continuously monitors, updates and reviews them
community mental health team (CMHT)	secondary care service for people who need more mental health support than a primary care service, such as a GP, can provide
concern for safety	request for police to help when a person, healthcare agency or partner organisation is worried about someone's welfare
county lines	practice of individuals or gangs using vulnerable children and adults to transport and sell Class A drugs, primarily from urban areas into market or coastal towns or rural areas to establish new drug markets or take over existing ones; they also use children to transport and hide weapons and to secure dwellings of vulnerable people in the area, so that they can use them as a base from which to sell drugs

demand	in the context of this report, the amount of service that the public and other organisations require of the police; the police carry out a wide range of interventions in response to this demand including preventing disorder in towns and city centres, protecting vulnerable people and property, responding to crises, stopping crime and anti-social behaviour as it happens, and apprehending and bringing offenders to justice
force management statement (FMS)	annual statement, published by each force and certified by the chief constable, containing in respect of the following four years: (a) projections of demand on the force, including crime and non-crime demand, latent and patent; (b) an assessment of the state of the force's people and assets to be used to meet that demand (their condition, capacity, capability, performance, serviceability and security of supply); (c) the steps the force intends to take to improve the efficiency and economy with which the force will maintain and develop its workforce and other assets, and discharge its obligations to the public; and (d) the financial resources which the force expects to have to meet demand
Herbert Protocol	national scheme encouraging carers, family and friends of vulnerable people to fill in a form recording the individual's personal details; if the vulnerable person goes missing, the form can be given to the police and reduce the time taken gathering this information
incident report	report of an event that requires police attention; it may become a crime record depending on the balance of probability that an offence has occurred, but must be logged on the force's incident-recording system even if it doesn't turn out to be a crime
lived experience	knowledge and understanding someone gains when they have lived through something
mental health practitioners	people in specifically mental health-related positions, such as psychiatrists, nurses or psychologists
modern slavery	crime encompassing slavery, servitude, forced labour and human trafficking

mutual aid	provision of police officers or other assistance by one police force to another for the purpose of meeting any special demand; can be provided on the application of the chief officer of the force requiring assistance or at the direction of the Home Secretary; the provisions governing the provision of aid are contained in section 24, Police Act 1996
National Decision Model (NDM)	risk assessment framework, or decision-making process, adopted as a single national decision model for police in authorised professional practice, which has six elements to help police officers and staff make effective policing decisions
National Police Chiefs' Council (NPCC)	body which replaced the Association of Chief Police Officers on 1 April 2015; it brings together operationally independent and locally accountable chief constables and their chief officer teams to help the police service coordinate operations (including operational responses to threats such as terrorism, organised crime and national emergencies), reform, improve and provide value for money; its primary decision-making forum is the Chief Constables' Council; it is underpinned by a collaboration agreement between chief constables, police and crime commissioners and non-Home Office force equivalents under section 22A, Police Act 1996
night-time economy	business taking place at night, such as pubs and clubs, cinemas and theatres, cafés and restaurants, and the sale and consumption of alcohol
NPCC lead	senior police officer responsible for maintaining and developing NPCC standards and guidance for all police forces in a particular area of policing
partner agencies	public sector entities, such as those concerned with health, education, social services and the management of offenders, which from time to time work with the police to attain their common or complementary objectives
place of safety	residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1948; a hospital as defined by the Mental Health Act; a police station; an independent hospital or care home for mentally disordered persons; or any other suitable place the occupier of which is willing temporarily to receive the patient (defined in section 135(6) of the Mental Health Act 1983)

police and crime commissioner (PCC)	elected entity for a police area, established under section 1, Police Reform and Social Responsibility Act 2011, responsible for securing the maintenance of the police force for that area and securing that the police force is efficient and effective; holds the relevant chief constable to account for the policing of the area; establishes the budget and police and crime plan for the police force; appoints and may, after due process, remove the chief constable from office
risk assessment	estimating and regularly reviewing the risk posed by a perpetrator to others
risk management	managing the responses adopted to minimise risks that have been identified
section 136 of the Mental Health Act 1983	one of the powers the police use to detain someone in need of immediate care, to take them to a place of safety where medical staff can assess them; reducing unnecessary use of this power and not using custody as a place of safety are indicators of success for triage
street triage	scheme where mental health nurses accompany officers to incidents where police believe people need immediate mental health support, aiming to make sure people get the medical attention they need as quickly as possible; this can also take the form of advice and support to police from control room-based mental health practitioners
THRIVE	structured assessment based on the victim's levels of threat, harm, risk and vulnerability, to help staff determine the appropriate response to a call
Victim Support	an independent charity supporting victims and witnesses of crime committed in England and Wales; it was set up almost 40 years ago and has grown to become the oldest and largest victims' organisation in the world; Victim Support offers assistance to more than a million victims of crime each year and works closely with the police and other institutions and entities in the criminal justice system
vulnerability	condition of a person who needs special care, support or protection because of age, disability or risk of abuse or neglect

vulnerable victim    victim eligible for extra support under the Code of Practice for Victims of Crime, defined as someone who was under the age of 18 at the time of the offence, whose quality of evidence is likely to be affected because of a mental disorder or other “significant impairment of intelligence and social functioning”, or who has a physical disability or physical disorder

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## **Annex A: About the data**

The information presented in this report comes from a range of sources. These include data published by the Home Office and Office for National Statistics, inspection fieldwork and data we collected directly from all 43 geographic police forces in England and Wales.

Where we collected data directly from police forces, we took reasonable steps to agree the design of the data collection with forces and other relevant interested parties (such as the Home Office). We gave forces several opportunities to check and validate the data they gave us, to ensure the accuracy of our evidence. For example, we checked the data that forces submitted, and queried with forces where it was notably different from other forces or was internally inconsistent.

### **Data in the report**

British Transport Police was outside the scope of inspection. Aggregated totals for England and Wales don't include British Transport Police data, so numbers will differ from those published by the Home Office.

### **Population**

For all uses of population as a denominator in our calculations, unless we say otherwise, we use Office for National Statistics (ONS) mid-2016 population estimates. This was the most recent data available at the time of the inspection.

For City of London Police, we include both resident and transient population in our calculations. This is to account for the unique nature and demographics of this force's responsibility.

### **Review of crime files**

We reviewed 60 police case files (90 files in the four largest forces) across crime types for:

- rape (including attempts);
- theft from the person;
- harassment;
- stalking;
- common assault;
- wounding or grievous bodily harm; and

- actual bodily harm.

Our file review was designed to give us a broad overview of:

- forces' identification of vulnerability;
- the effectiveness of their investigations; and
- how forces treat victims.

We selected files randomly from crimes recorded between 1 January 2017 and 31 March 2017. We assessed these files against several criteria. We supplemented our file review assessments with other evidence we gathered, as the small sample size meant file review evidence alone wasn't a robust enough basis for assessing individual force performance.