Office of the Police and Crime Commissioner
STAFFORDSHIRE

Mental Health Review

Overview of statistical information & case scenario scoping

Commissioned by Matthew Ellis
Staffordshire Police and Crime Commissioner

Foreword

This report has been commissioned by Staffordshire's Police and Crime Commissioner Matthew Ellis. The report highlights how much time officers spend dealing with mental health issues and the significant impact this has on operational policing. The inspiration for the review came from a series of meetings the Commissioner held with frontline officers to discuss the issues that affected them most in their operational activities.

The Commissioner's report has already begun to drive national policy and the Home Secretary Theresa May has already cited the Staffordshire evidence and called for "full and effective mental health services and fully-staffed mental health centres," outlining an urgent plan of action with the Department of Health.

The report highlights that the police service tends to be the first port of call when people with mental health problems need assistance. The concern is for the welfare of individuals with mental health problems and the fact that the police service can't continue to be the primary place of safety when better, more equipped professionals and facilities are available elsewhere

Report Overview

The scope of this report is to start to identify some key statistical data relating to frontline impact and service delivery relating to mental health issues on the force. It identifies a range of case scenarios provided from frontline policing teams to identify examples of current blockages to service delivery and resource abstraction. Further scoping of the longer term resource implications on staff for partnership interventions for problem individuals does not form part of the review but if a true understanding of the cost of mental health is required further reviews of the case data provided by staff would be actionable to identify the costs of persistent and recurrent problem individuals where service intervention and partnership working has been fragmented.

Overview

- The Police are commonly a first point of contact in a mental health crisis. It also estimates that 15 percent of all incidents dealt with by The Metropolitan Police have some form of mental health element and recent efforts by the force to identify the reality of mental health impacts on our calls for service would indicate that to be mirrored or higher in Staffordshire..
- Mental Health Disorders is a common denominator in some long term ASB cases and there is national work ongoing to explore this link.
- Many of those identified as most vulnerable and most challenging problem solving scenarios have dual diagnosis of learning difficulties and mental health and/or substance misuse. Individuals can fall between agencies responsibilities.
- The Police are the agency of last resort for any crisis, it is perceived that the balance in the level of responsibility for long term support of those with mental health appears to have shifted, and that care in the community too often and inappropriately resorts to Police Interventions as the 24/7 service.
- The transition from children services to adults frequently see individuals fall out of the system, and into the Police to manage.

- Staffordshire Police focus on partnership working around a range of vulnerabilities, including mental health. It is recognised that closer working with partners, particularly community mental health teams, and early recognition of those experiencing mental health issues might avoid a crisis, but officers find it difficult to access support for the early interventions from specialist services.
- Historically the Police have played an important role in dealing with mental health related crisis, but there is an increasing demand to support greater numbers of people living independently within the community. It would appear that the services to support this have not grown at the same rate and emergency services such as the Police are filling the void.
- It is a growing concern that as the public purse shrinks, voluntary services struggle to meet the gap resulting from the withdrawal of discretionary services provided by the statutory sector- the police are increasingly picking up the widening gap in service provision.
- The Police or Community Safety Partnership often take the lead in convening Professionals meetings in relation to individuals with Mental health disorders (diagnosed/undiagnosed or those who have disengaged with mental health services/ refused to take medicines and are deemed to have capacity to make the decision not to engage.
- On occasions The CJS does not assist in these situations. The CPS guidance on prosecuting mentally disordered offenders quite rightly recognises that prosecution is not the most appropriate disposal. However where the individual is not effectively managed in the mental health system an individual is left to behave as they wish with impunity. The consequences of such individuals on the community and individuals has been so damaging it has resulted in community tensions, serious detrimental impact on key victims' mental and physical welfare.

Local Issues identified as part of the review for frontline staff

The role of the Police is far beyond the recognition of signs, identification of concerns, directing and sign posting to appropriate services. The case studies identified in the report clearly show the boundaries of police responsibility in managing mental health within the community are blurred. There are a number of principles of mental health and issues that as a Police service we struggle to understand – particularly when as a result there are continuous demands for service –

1. The concept of capacity- which enables a person to chose to fail to engage with their CPN or mental health service, not take their medicine, but continue to put themselves at risk and cause other alarm and distress, which the Police whilst free from prosecution or accountability for their actions within the CJS.
2. The role of The CPN. There have been occasions when Neighbourhood officers have openly challenged the professional judgement of CPNs, which has done little to assist positive working relationships between individuals. There are wider issues of skills around negotiating and influencing.
3. There are some occasions when mental health workers have challenged The Police for not holding someone to account in the CJS whilst it is acknowledged that the CJS is not appropriate for resolving most cases where mental health is identified as the overriding concern and therefore prosecution is not in the public interest.
4. Agencies expectations that the Police can section people and that is a direct portal to the mental health systems and there are often no clear treatment pathways- (other than potentially access through detaining an individual for assessment but even this presents a number of exit routes and revolving doors.

5. Expectations from relatives, some agencies, including some CPNs and GPs that the Police can detain people for odd or bizarre behaviour, which is in their view puts them in need of care, custody and control or puts other people at risk. E.g. A senior member of a council demanded that the Police detained someone whose behaviour was odd, as he was refusing all agency support, and his oddities were upsetting residents' sensibilities. Another example is when elderly parents of RS came into the Police Station to ask The Police to arrest their son (who had not at that time committed any criminal offences or in need of section 136) so that he could be assessed and get mental health treatment. This illustrates the increasing reliance and expectation by agencies and the public on the Police service to act as the principle gateway to mental health and other social care and health services. A further example is the request of a mental health practitioner for the Police to secure a prosecution of an individual in order that the metal health team could then access a forensic mental health assessment for an individual who they identified as a risk.
6. The case studies often reflect frustrations with attempting to resolve issues that are not within the gift of the Police to resolve. There are however some positives:
7. Mental Health attend the partnership morning meetings on a local partnership hubs on some areas and this has been showed to improve local relationships and support early intervention strategies.
8. LSTs have been really helpful in facilitating access to mental health service for children and other family members as long as the families will engage (LST staff have managed to persuade some reluctant families).

Demand for Calls for Service

STORM (Result Code)

An initial scoping report in Jan 2013 identified a data set that reported :

- Mental Health Incidents (G41) – Jan-Dec 2012

For those incidents that indicated attendance (approx 600 incidents), the average attendance time is 1 hr 32 mins.

- Concern for Safety (Adult) - Mental Health (G42/A) – Jan-Dec 2012

For those incidents that indicated attendance (approx 14,183 incidents), the average attendance time is 51 minutes.

A review of this data will identify that on average at least 2 PC's are present at the incidents classifications above with the average cost to the Force based on 2 PCs attending, (midpoint including full costs) equates to £613,218.55.

- Missing Persons (G44s) where Incident Log details 'Mental Health' – Jan-Dec 2012

All reported incidents are recorded on the COMPACT System. COMPACT Data shows that out of the 4285 missing reports, 321 (7%) were highlighted in the 'found report' as having mental health issues.

- Form 12 – Police Sudden Death reports for unexplained / non accidental deaths– Jan-Dec 2012

Of the 654 Form 12s, there were 101 (15%) recorded to include mental health factors.

Additional data profiling

To verify the validity and accuracy of that data the force introduced a specific mental health tag to be added to all storm serials where control room or operational staff identify a mental health issue or connection with the call for police service.

This tag has been promoted across the force and since its utilisation rate has risen and then remained constant giving and indicator that on average between 40-60 calls for service a day relate to mental health. In January – Feb 2012 only 79 Storm records were identified in the first data report as having a link to mental health in the same period in 2013 there have been a total of 1030 Storm records tagged with mental health links. (this includes a conservative use of the tag before it was actively promoted in February so actual figures would now indicate a higher result)

As a direct comparison of current demand rates for the same 2 month period last year based on incident closure classification :

G41 Mental Health Incidents – No mental health tag

	Incidents	Attended Incidents	Average Attendance
1 Jan – 28 Feb 2013	107	78	1 hr 26 mins
1 Jan – 28 Feb 2012	167	111	1 hr 30 mins

G42/A Concern for Safety (Adult) – No mental health tag

	Incidents	Attended Incidents	Average Attendance
1 Jan – 28 Feb 2013	2742	2074	1 hr 01 mins
1 Jan – 28 Feb 2012	2799	2145	52 mins

This demonstrates the demand on the force remain constant despite a streamlined frontline officer and PCSO provision and that changes made to services through out the year by partners and providers to date have shown no impact on reducing police resource and demand requirements.

G44 Missing Persons DATA

STORM	G44 Missing Persons Incidents	G44 Missing Persons Incidents with Mental Health Tag
1 Jan – 28 Feb 2013	460	13
1 Jan – 28 Feb 2012	529	4

COMPACT	Missing Reports	Found Report – Mental Health Issues	%
1 Jan – 28 Feb 2013	480	30	6%
1 Jan – 28 Feb 2012	642	58	9%

This demonstrates there is a reduction of calls for service for missing persons which aligns directly to a change in recording and classification process in the force but also a recording issue between STORM missing reports and Compact and the true impact of mental health in relation to missing persons reports will be assisted as the consistent use of the mental health tag provides longer term data comparison to identify officer training needs on COMPACT.

Of the overall incidents related to mental health in this 2 month period 83.01% relate to concerns for safety (855 calls), 5.44% relate specifically as classified as mental health (56 Calls) and then small numbers of incidents across other crime and non crime incidents are recorded of less than 1.5% per category. This would indicate the use of the mental health tag is being applied correctly across incident types and the data is reliable.

Of those incident identified for concern for safety the following LPT breakdown has been abstracted:

CONCERN FOR SAFETY Incidents

LPT Long Description	Final Call Type Code	Incident Count	%
SOT Central LPT	G42/A	134	15.67%
Newcastle District LPT	G42/A	101	11.81%
Stafford Borough LPT	G42/A	97	11.35%
SOT North LPT	G42/A	91	10.64%
East Staffs LPT	G42/A	81	9.47%
Staffordshire Moorlands LPT	G42/A	81	9.47%
SOT South LPT	G42/A	79	9.24%
Cannock Chase LPT	G42/A	55	6.43%
Lichfield District LPT	G42/A	54	6.32%
Tamworth LPT	G42/A	42	4.91%
South Staffs LPT	G42/A	38	4.44%
Derbys	G42/A	1	0.12%
HQ South	G42/A	1	0.12%
		855	100.00%

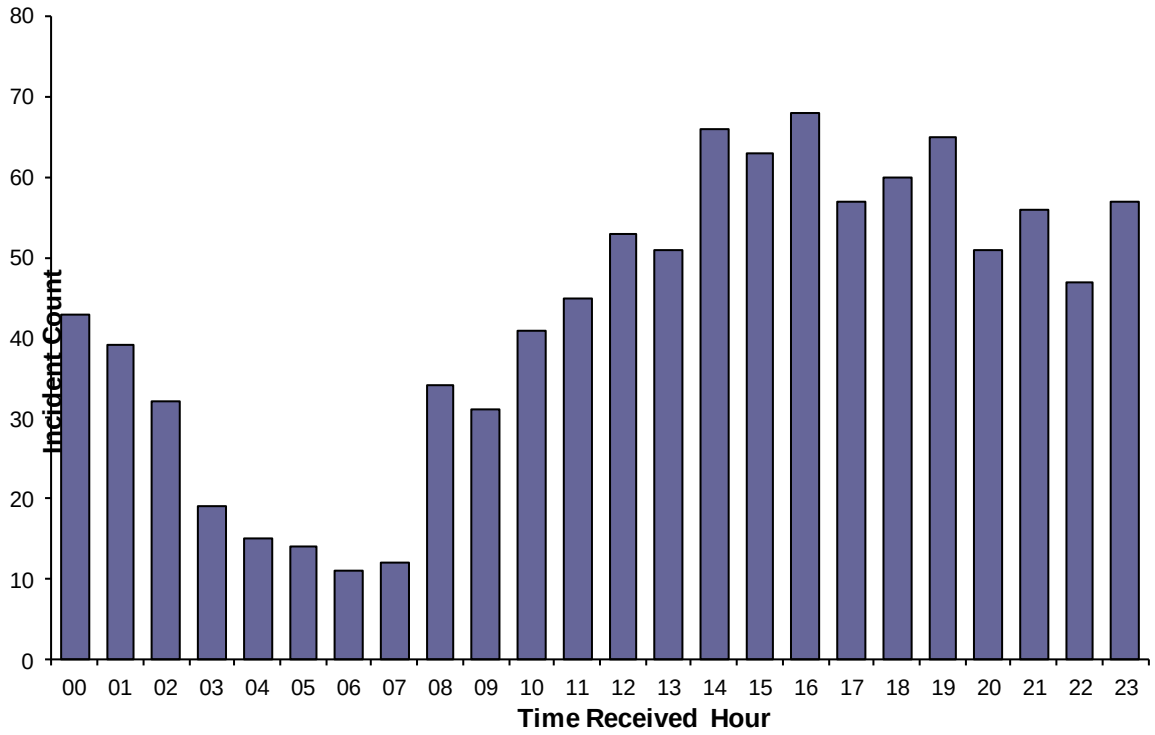
Of those incident identified for Mental Health the following LPT breakdown has been abstracted:

MENTAL HEALTH Incidents

LPT Long Description	Final Call Type Code	Incident Count	%
South Staffs LPT	G41	10	17.86%
SOT Central LPT	G41	7	12.50%
SOT South LPT	G41	6	10.71%
Cannock Chase LPT	G41	5	8.93%
East Staffs LPT	G41	5	8.93%
Newcastle District LPT	G41	5	8.93%
Stafford Borough LPT	G41	5	8.93%
Staffordshire Moorlands LPT	G41	4	7.14%
Lichfield District LPT	G41	3	5.36%
SOT North LPT	G41	3	5.36%
Tamworth LPT	G41	3	5.36%
		56	100.00%

Resource demand Implications for frontline Staffordshire Police

Incidents with Mental Health Tag Added Summary - By Hour of Day



Day Name Received	Sum Incident Count
FRIDAY	128
MONDAY	133
SATURDAY	146
SUNDAY	132
THURSDAY	196
TUESDAY	149
WEDNESDAY	146
Sum	**1030**

This data for calls for service increases the demand implications for each LPT and is of particular use in relation to the potential use of mental health practioner deployment with police staff to assist with calls for service in the most prevalent LPT areas.

Custody

Nos of Arrests where the Risk Assessment identifies there are Mental Health issues – (Jan-Dec 2012)

There were **5,504** arrests where the Risk Assessment identified the detainee suffered with mental health issues. Which equates to 19% of all arrests made (28,919 records)

There is a disproportionate spread of mental health being identified on the risk assessments between custody units with for example 57% in Jan 2013 records for NACF showing mental health as a risk factor with the other 43% being spread across both Watling and Burton custody..

Section 136 – Reason for arrest – (Jan-Dec 2012)

There were **169** Section 136 Arrests in 2012, ranging between 10-16 per month, the highest month being June at 23.

The total time spent by the 169 detainees in custody (from the point of authorisation) is approximately 61 days, 13 hours and 31 minutes. On average this equates to nearly 9 hours per detainee across the force.

- 15 Section 136 cases were managed by Watling custody. Average custody stay 11 and ½ hours per case
- 11 Section 136 cases were managed by Burton custody. Average custody stay 14 and ¾ hours per case
- 143 Section 136 cases were managed by NACF. Average custody stay 8 ½ hours per case

<u>Doctors/Medical Services Fees</u>

The cost of medical services for all detainees and victims (including mental health issues) in 2011/12 was £1,008,654.
The forecast total cost for all detainees and victims (including mental health issues) in 2012/13 is £1,117,000

During the recent force procurement process on provision of medical services for detainees. It calculated that approximately 26**%** of doctors time is spent on Mental Health calls for service equating to a cost of £290,420.

Reason	No of records	2011 2012 as % of calls
Fit to detain / Interview	1106	9.34
MH Act/ Issues	1051	8.88
Self Harm/ Depression	967	8.17
Total	3,124	26.39%
	Total records for force 11,836	

Primecare Medical Services have provided a quick summary of their attendance to Custody for mental health issues since the start of their contract as they have now primacy for custody provision. This will

continue to be monitored and contractual information relating to actual time spent in custody relating to mental health and s136 assessments and delays due to alcohol in stating assessment has been requested as part of the future update reports.

(Primecare Medical Services Data) 1st Jan 2013 to 1st March 2013

Force custody Blocks	Type	Jan- Feb	Feb-March
All	Self Harmer	26	26
All	Mental Health	17	71
All	Suicidal	9	5
	Total	**52**	**103**

The link between mental health and alcohol / substance abuse has been assessed based on information provided by people on completing a risk assessment in custody during their booking in procedure. This breakdown is included on the next page.

43% of custody suspects identifying a mental health risk factor also present as being under the influence of a substance on arrival in custody and 20% of the total state they have an alcohol dependency and 30% a drug dependency.

People in custody claiming to have mental health issues (during 2012) who are also under the influence of, or dependant on substances.

Risk Assessment Questions - 2012

Forcewide

	Total	Influence of Substances	%	Alcohol Dependency	%	Drug Dependency	%	Solvent Dependency	%	Other Substance Dependency	%
JAN	434	198	45.62%	76	17.51%	124	28.57%	0	0.00%	16	3.69%
FEB	410	182	44.39%	83	20.24%	131	31.95%	1	0.24%	12	2.93%
MAR	463	194	41.90%	101	21.81%	141	30.45%	2	0.43%	18	3.89%
APR	440	191	43.41%	88	20.00%	129	29.32%	1	0.23%	11	2.50%
MAY	451	172	38.14%	80	17.74%	122	27.05%	1	0.22%	10	2.22%
JUNE	480	208	43.33%	96	20.00%	149	31.04%	2	0.42%	10	2.08%
JULY	506	202	39.92%	106	20.95%	148	29.25%	1	0.20%	16	3.16%
AUG	531	217	40.87%	108	20.34%	167	31.45%	3	0.56%	9	1.69%
SEPT	398	168	42.21%	78	19.60%	118	29.65%	0	0.00%	9	2.26%
OCT	478	224	46.86%	106	22.18%	157	32.85%	0	0.00%	15	3.14%
NOV	440	198	45.00%	92	20.91%	126	28.64%	2	0.45%	13	2.95%
DEC	432	209	48.38%	80	18.52%	109	25.23%	1	0.23%	7	1.62%
	5463	**2363**	**43.25%**	**1094**	**20.03%**	**1621**	**29.67%**	**14**	**0.26%**	**146**	**2.67%**

Calls for service Impact on Force from mental health units

- **Impact on resources that one mental health unit is having on a Local Policing Team in Staffordshire. Over the last 6 months alone there have been 44 calls for service regarding incidents at the location (94 in 12 months).**

In the last 6 months 23 concerns for safety calls have been made requesting support for voluntary patients who have walked out of the premises threatening or at risk of self harm and 8 missing persons reported.

- **Impact on resources. Over the last 6 months there have been 106 calls for service to the unit and 255 calls in the last 12 months.**

In the last 6 months 33 concerns for safety calls have been made requesting support for voluntary patients who have walked out of the premises threatening or at risk of self harm and 12 missing persons reported, one of who was found deceased as detailed below as a case study.

- **Impact on resources. Over the last 6 months there have been 180 calls for service to the unit and 416 calls in the last 12 months.**

In the last 6 months 74 concerns for safety calls have been made requesting support for voluntary patients who have walked out of the premises threatening or at risk of self harm and 28 missing persons reported.

The following patterns or examples exist for the units :

1) Calls/text messages made by section 3 patients to police complaining about their treatment / advice re the tests being carried out / injections administered, asking to be removed from the hospital as they are being held against their will etc and ringing 999 wanting to go home.
2) High risk MISPERs walking out of location as not a secure unit and suicidal patients there on informal - i.e Ms T - Frequent MISPER with recent suicide attempt including setting herself alight and suicide pact with daughter, voluntary patient then reported as a High risk MISPER with expensive police resource required having walked out of location . Several calls of this type from unit relating to same individual over a few week period.
3) A person sectioned from custody following mental health assessment in custody is transferred to a mental health unit and walks out within 40 min of arrival. Located in local pub following extensive enquiries as a high risk MISPER.

It is not able to extract the exact implications for resourcing of the management of concern for safety / missing persons reports from such units based on the current reports available but included is an overview case scenario of the type of resource implication involved. Such missing persons enquiries regularly involve extensive deployment of police staff and the use of dog support and Ariel support from the police helicopter in addition to support from the control room and intelligence departments and technical enquiries such as mobile phone tracking, costing extensive amounts of money.

The above calls for service do not include those made for similar issues for the various A&E units or ambulance service which service the Force area.

Case Scenario Missing person (MISPER) voluntary patient from a mental health unit.

1. A report was received of a person acting suspiciously in a rear garden. The police attended and spoke to the person and returned them to their home address. Although slightly confused the person appeared capable of taking care of themselves.

2. A call was received from another address of a person acting suspiciously on the driveway of the address. That same day the police located a person and detained under section 136 Mental Health Act 1983. The person was conveyed to a mental health unit as a place of safety where they accepted responsibility

3. A call was received from a mental health unit reporting a person having been admitted as an informal patient, had climbed over a fence and left the hospital. The report was dealt with as a missing person.

4. A report was received of a sudden death, a naked body having been found and the body was later identified as the missing person above.

5. The following enquiries have been undertaken to ascertain if individual or organisational failings contributed in any way to the death of a missing person.

    a. The missing person report, indicates a series of enquiries undertaken and then ongoing with an appointment of at least one PC to the active enquiry 24/7 until the body of the missing person was found

        i. Checks at the missing person's home address

        ii. Checks with neighbours

        iii. Area checks on the roadways adjacent to the mental health unit

        iv. Attempts made to call mobile phone

        v. Checks with mother of missing person

        vi. Checks with friends and ex-boyfriends of missing person

        vii. Checks with ex-husband of missing person

        viii. Checks with local hospital

        ix. Checks of public houses frequented by missing person

        x. Facebook checks

    b. The enquiries indicate the MISPER had wandered into a flooded marshy area. In this area the MISPER would have become wet and very cold. The night time temperature would have been between -1 to 3 degrees. Having become wet the MISPER would have quickly suffered the effects of exposure leading to hypothermia, severe hyperthermia and then death.

        The MISPER was found naked; it is likely that the following phenomenon took place in cases of severe hypothermia referred to as 'paradoxical undressing' whereby individuals remove their clothing as if burning up, when in fact they are freezing to death.

It is likely the MISPER wondered into the wet marsh area direct from the mental health unit.

c. The phone call from the unit to the police control room has been listened to and assessed. The following information is disclosed:

   i. The MISPER was reported missing by Staff Nurse from the Unit. The Staff Nurse stated the MISPER had been brought in earlier as a 136 MHA case, but had been admitted as an informal patient. The MISPER had then 'gone over the fence' and needed to be reported missing.

   ii. Through conversation with the police call taker, it was stated that the person was being reported missing in order that a 'welfare check' was undertaken. As the person was not under a Mental Health Act section, so could not automatically be detained.

   iii. Description of clothing and personal details given by the Staff Nurse they indicated that the person had taken overdoses in the past but on these occasions had contacted the police.

   iv. Staff Nurse stated the person had given no indications of intent to self harm. The person had approached her in the garden area and stated "go away I don't trust you." The person had then climbed over the fence.

   v. Contact numbers were given for next of kin. A mobile phone number was given for the person, but the Staff Nurse stated the person was not believed to have a mobile phone on them.

   vi. The Staff Nurse stated that the person having gone over the fence, would still be within the hospital grounds, the area was where building work was taking place, close to the dual carriageway. A direction of travel for the person thereafter was not known.

   vii. The incident number was passed to the Staff Nurse. If was agreed that attempts would be made to locate the person and thereafter officers would assess if a 136 was applicable or attempt to return her as an informal patient.

6. Enquiries undertaken indicate this death was a tragic case of misadventure by a person suffering from mental illness. The person's behaviour prior to hospital admission indicated the person was confused.

7. The initial report of being a missing person was not assessed as high risk. There were no indications intended to self harm and no indications the person would be in danger by wondering into a flooded marshy area.

8. The outcome of the investigation concerning police action is that on the facts as they were known at the time, there were no individual officer or organisational failings which contributed to the unfortunate death.

There are a large volume of such reports that consume large amounts of police time and resources once the person leaves a mental health unit where they are voluntary patients and sectioned under the mental health act. This example whilst demonstrating the extreme consequence of such an incident is as just as likely to happen again with current policies and supervision / access issues to such sites.

Whilst the police fully appreciate that some patients are at the unit on a Voluntary basis and are free to leave at any time. However with some simple design and engineering modifications to the site at the mental health unit for example so the yard is made fully enclosed and therefore totally secure, preventing any Escape/Exit and that **EVERYONE** who wants to leave has to go through one door which has Camera Coverage and if Voluntary they sign out at that point or before with a member of staff it would assist in identifying an immediate risk to the individual and enable mental health practioners to intervene immediately to support that person to prevent harm to them.

Further work relating to the design and layout of mental health units could support a reduction in calls for service for those voluntary and sectioned patients leaving the units. Local partnerships are in place in the key LPT's to try and improve liaison between the identified 136 units but these would benefit from strategic guidance and support to prioritise key areas of action around identified threats and risks.

There is evidence of numerous working practises across the force and inconsistencies between the application of the agreed S136 policy and resources and partnership engagement to assist in the management of mental health issues in the community.

The recommendations recently agreed between the force and mental health services align directly to the issues identified, including:

- Set up of a Police & Mental Health Strategic group
- Review of S136 Policy
- Review of GP and EDS service provision re 135 calls for service.
- Review of ambulance attendance requirements and service level agreements for Section 135 / 136 calls for service.
- Review of alternative place of safety options for assessment needs.
- Handover practises and acceptance process at 136 units
- Practioners guide for each service for frontline staff that align in overall strategic arrangements for delivery of a cohesive service provision.
- A multi agency awareness event of mental health service changes and plans
- Supervision of custody detainee arrangements
- Joint training options for multi agency attendance and partnership working
- Mobile community support options for support from MH practioners to frontline policing staff
- Information sharing practises

Problems with Mental Health and Emotional Well Being are prevalent amongst adult and young offenders. Indeed, it is one of the top risk factors leading to the highest rates of re-offending. There is a striking similarity between profiles of suicide in Staffordshire , potential contributing factors towards suicide and a profile of offenders most likely to re-offend in Staffordshire (A Strategic Assessment of Offending Behaviour). As regards the latter, offenders most likely to re-offend are aged 18-25 years, have at least 10 previous convictions, have needs in relation to drugs, finance, employment, accommodation and lifestyle, have multiple needs (specifically seven or more 'crime' pathway needs), and are living in the most deprived areas of Staffordshire. This serves only to encourage further commissioning of work to analyse the links between the CJS and high risk suicide groups, and to improve services as part of the newly agreed Strategic group.