Institute for Public Safety Crime and Justice

Assessing the role, value and effectiveness of mental health triage: Operation Alloy

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Contents

Executive Summary

Aims and Objectives

The research aimed to:

1. Examine perspectives of Operation Alloy from involved staff, namely:
    a. Assigned police officers;
    b. Mental health staff; and
    c. Control room staff.
2. Assess operational performance and effectiveness in terms of:
    a. Reported incidents triaged in control room;
    b. Operational advice provided to frontline response officers;
    c. Deployment of Triage Response Vehicle.
3. Determine the positives and negatives in terms of:
    a. Partnership working;
    b. Decision-making;
        i. On-the-ground;
        ii. In the control room.

Method

To meet the aims and objectives, a mixed methods approach was taken. Semi-structured interviews were completed with 15 professionals involved in Operation Alloy (5 Force Control Room staff; 5 Police Officers; and 5 Mental Health staff) and analysis of police data records detailing recorded activities and incidents during 2 one-week time periods. Qualitative data were thematically analysed.

Findings & Recommendations

Value and Outcomes:

The findings demonstrate the operation was viewed positively, particularly by control room staff and mental health professionals. The operation was indicated to be worthwhile and valuable. Participants frequently emphasised the importance of the operation, in delivering a better quality service to people in need rather than simply freeing up resources. The combination of police and mental health professionals within the operation was viewed as being complementary, opening new disposals to enable positive incident outcomes. Whilst being an important feature of the operation, the reported value of the operation was not necessarily enabled through deployment, but through the sharing of information informing the professional judgements of both police and mental health staff. The operation resulted in people being dealt with using more appropriate care pathways, by conducting a holistic assessment of an individual's needs.

Behaviour and Practices:

A very positive benefit in terms of behaviours of staff involved in the operation was an articulated mutual respect for each other's professional judgement. Mental health staff felt that their contribution was valued and respected by the police; police felt consequently relieved and reassured by working with mental health professionals. It was suggested that consistent staffing enabled stronger relationships to be formed and having better outcomes for individuals in need. Police officers articulated respectfully how competent mental health staff were when communicating with individuals involved in incidents, striking a balance between empathy and assertiveness in resolving incidents. It was recognised how the approach adopted by police officers, informed by their identity and skills, was different to that of mental health professionals. The implicit messages and meanings of uniform and persona were found to be important. The florescent jackets and stab vests worn by police officer were viewed as both presenting a physical barrier and heightening anxiety within situations.

Management:

The aims and expectations of the operation were suggested to have evolved over time. While reducing s136 detentions was identified as being the original aim, other aims may be held by individuals and the respective organisations in relation to service quality, longer term resolution of incidents, and reduction of 'regular callers'. Broader guidelines and principles were suggested to be welcomed by all parties to guide practice during shifts on the operation. In particular, better communication about the operation to frontline officers would support how the operation is perceived and valued within IRTs. It was strongly indicated that more consistent staffing arrangements would be welcomed as it was recognised that staffing of the operation was irregular - from both police and mental health perspectives. The mechanisms to identify measurable impact were suggested to be inefficient and tiring. The extent to which the operation was able to demonstrate measurable impact based on its reporting procedures was limited, having implications for engaging response officers, and also informing perspectives within the wider organisations.

The following points identify key findings and recommendations.

1. The operation was suggested to have evolved over time, with individual staff holding different understandings of their operational expectations and perceived value.

> **R1. The operation has a refresh, with all objectives as well as the purpose/identity of the operation being explicitly communicated to all parties.**

2. Data recording for the purpose of adequately capturing the activities of the operation held by the police was found to be inaccurate, thus not allowing a comprehensive evidencing of actions, value or outcomes.

> **R2. Data recording procedures be reviewed and streamlined. As part of this, clear expectations and accountabilities for all parties in terms of documentation are formulated.**

3. Irregular staffing arrangements were suggested to contribute to inconsistencies identified during the completion of this project, being consequential to perceptions held by different individuals, and potentially resulting in inconsistent levels of service delivery to people in need.

> **R3. A dedicated and bespoke team is assigned regularly to the operation, with the respective composition of such a team being re-considered, and different roles potentially introduced (e.g. PCSOs, specials, paramedics etc.).**

4. The evidence shows inconsistencies between staff in terms of activities completed during shifts, and the thresholds or factors involved in deployment decision-making.

> **R4. The staff involved in the operation are afforded opportunities to share knowledge and good practice, enabling more consistent responses to, and resolution of, emergent incidents. Such learning opportunities should be monitored and appropriate amendments to governance and practice documentation made.**

5. The progress and achievements of the operation were found to have not been captured or meaningfully recognised.

> **R5. A quarterly partnership management meeting is held to review progress, in relation to agreed objectives (R1).**

> **R6. A communication strategy is developed to disseminate operational effectiveness both in terms of inward value (resource vs. outcome, frequency of s136 reduction/avoidance) and outward value (longer term resolution for the individual in need).**

> **R7. Appropriate succession planning is undertaken to ensure practices and management of operation is not held by any one individual, and is transferred when individuals move into different postings.**

1. Introduction

Operation Alloy is an initiative involving a partnership between police officers and mental health professionals to deliver street triage services direct to people experiencing mental health distress. The rationale for this is to ensure a timely response for better outcomes to service users, and enhance inter-agency working to ensure individuals were directed to the most appropriate services relative to their need. This reports provides a review of the operation which has been achieved through (i) a literature review, (ii) statistical analysis of police records and (iii) semi-structured interviews with control room staff, police officers, and mental health professionals.

This chapter sets out key observations drawn from a literature review, in order to contextualise the findings of this research with the current evidence base.

1.1 Current Context

Estimates vary as to the proportion of police time taken up by incidents related to mental health: between 2 percent to 20 - 40 percent (Independent Commission on Mental Health and Policing, 2013: 12). Whilst the proportion of time spent may differ across the county, there appears to be consistency in the nature of reported issues where public sector agencies seek to respond to and resolve mental health incidents. Notable gaps in provision have been highlighted to include:

- Limited access to services at night, with police becoming *de facto* first response to mental health issues. Notably, this has been recognised as a long-standing issue (see Fahy, 1989)
- Provision of 'places of safety' lacking across the country, with police cells being used to plug shortfall. If there is no significant reduction in use of police cells as place of safety, then HMIC may recommend that they be removed as a place of safety in the Mental Health Act 1983 (House of Commons, 2015: 11).
- Poor awareness of mental health conditions in policing, with staff lacking training, skills, and confidence to deal with such incidents (Adebowale, 2013: 7).
- Disproportionate use of police force and restraint to resolve incidents (Adebowale 2013: 7; House of Commons, 2015).

Whilst recent reviews have been critical of how the police resolve mental health incidents in this '*de facto*' position, it is recognised that surrounding provision of out-of-hours support for mental health is also poor. As Lord Adebowale's report states:

> *'Given that police officers and staff are often the gateway to appropriate care – whether of a criminal justice or healthcare nature – it is essential that people with mental ill health or learning disabilities are recognised and assisted by officers from the very first point of contact. The police, however, cannot and indeed are not expected to deal with vulnerable groups on their own'.*
> **Independent Commission on Mental Health and Policing, 2013: 6**

In light of this, the current Home Secretary, Theresa May, has affirmed a national roll-out of initiatives which seek to bring together the operational resources of police and mental health professionals, in order to improve outcomes for vulnerable people. One example of such a scheme has been the development of mental health 'Street Triage' schemes – as shall be discussed below.

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1.2 Street Triage Schemes

Street Triage schemes currently operate in a number of police forces across England and Wales.[1] The main rationale of such schemes appears to be to reduce the number of s136 detentions under the Mental Health Act, and ensure more appropriate outcomes for individuals. The delivery and organisation schemes varies across forces in England. Many are funded through 'local innovation' funds, whilst others by the Department of Health, Police and Crime Commissioners, Local Authorities, and Clinical Commissioning Groups (NHS, 2015: para. 24).

Little has been done to evaluate such schemes with due consideration for the potential influence variations in operating models may affect outcomes (House of Commons, 2015). That said, a key finding from published appraisals appears to be a reduction in the number of detentions under s136 Mental Health Act, albeit with variations across police forces. Through staff working together on scene, it is reported that such schemes have helped to build positive relationships between police and NHS staff, and break down barriers between participating agencies (House of Commons, 2015: 19). The collaborative approach has further been said to improve information sharing – sourced from both police and NHS records - ensuring frontline staff better contextualise incidents with information about an individual's previous contact with police, clinical histories, medications, and provision of current care plans (House of Commons, 2015: 19). As an example, one (internal) evaluation of street triage in Oxfordshire identified that 74% of those referred to the triage team were already known to mental health services; resultantly, mental health professionals were able to provide 'invaluable information' to officers on scene, in order to better inform officer risk assessments (Thames Valley Police, 2015: 7, 39).

NHS evidence submitted to the House of Commons also identifies provision of mental health staff on scene helps police officers to 'identify specific vulnerabilities'. This was said to cover a range of mental health conditions, but also for specific developmental disabilities: for example, certain diagnosable mental health conditions, such as autism, may be misinterpreted as aggressive by those who are not trained to diagnose such conditions (NHS England, 2015: para 19). NHS staff were further able to provide advice on appropriate interventions and diversionary services (NHS England, 2015).

Whilst little has been documented about client perspectives, initial findings are further positive. An independent evaluation in Essex conducted interviews with a cohort of street triage service users and their families. They found users to have overwhelmingly positive experiences, with more appropriate treatment outcomes, and lower use of restraint in resolving their cases (Scott, 2016).

The following two case studies provide details of alternative models adopted in different force areas. They illustrate similarities yet highlight developed distinctions to the model adopted in Northamptonshire.

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[1] Street Triage pilots are said to have been established in 25 out of 40 Police forces in England.

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Case Study: Thames Valley Police and Oxfordshire Health NHS Trust[2]

- Mental health street triage piloted 7 nights a week, between 18:00 – 02:00 hours.
- Scheme sought to bring together Mental Health Professionals (MHP) with TVP officers (triage team) to provide guidance and advice to assist police with decision making and risk management at such incidents
- Two models of deployment trialled:
    (i) MHP crewed with a police officers with ability to be deployed by the police control room;
    (ii) MHP unaccompanied and be deployed to incidents where police were already in attendance
- Funded for one year with £200,000.

Key Findings:

- Operational model 1 mostly favoured by staff involved, for it allowed better joint decision making from different information systems, and increased provision for shared learning between MHP and police officers (Thames Valley Police, 2015: 22).
- Deployments of the triage team to incidents dropped over the course of the pilot, from around 35% of incidents at the start to 20% during the concluding months (Thames Valley Police, 2015: 7); face to face triage therefore declined steadily over the 12 month period (Thames Valley Police, 2015: 26).
- Numbers of those detained under s136 reduced by nearly 40% (Thames Valley Police, 2015: 7). In fact, it was outlined that but for the street triage scheme being in place, officers would have used s136 powers on 66 occasions (Thames Valley Police, 2015: 7).[3]

Case Study: South London and Maudsley NHS Foundation Trust – from street triage to 24/7 support line.

- Mental health street triage was trialled with both face to face deployments of healthcare professionals alongside telephone support.
- Initial internal NHS evaluation found little evidence to support mainstream funding to continue street triage.
- Advice line was however found to have become 'embedded in police practice'.
- As such, new '24/7 support line' introduced in December 2015.
    - Operated by qualified and experienced mental health professionals.
    - Broader function than police support, with two numbers: (i) public number in care crisis leaflets, for those experiencing distress and concern about their own mental health; and (ii) an exclusive line to front-line NHS (A&E, London Ambulance Service) and Police.
    - Initial results highlight telephone line serves as a 'valid referral into services' and more appropriate disposals.

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[2] Information here is sourced from an internal evaluation. Whilst findings are illustrative of experiences similar to those identified in Northamptonshire, the methodologies through which such findings are drawn is not fully clear.
[3] This was identified by police officers who stated that but for the triage service they would have used s136 powers; again, the method through which this was discerned is not however clear.

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2. Aims and Objectives

This report aims to:

1. Examine perspectives of Operation Alloy from involved staff, namely:
    a. Assigned police officers;
    b. Mental health staff; and
    c. Control room staff.
2. Assess operational performance and effectiveness in terms of:
    a. Reported incidents triaged in control room;
    b. Operational advice provided to frontline response officers;
    c. Deployment of Triage Response Vehicle.
3. Determine the positives and negatives in terms of:
    a. Partnership working;
    b. Decision-making;
        i. On-the-ground;
        ii. In the control room.

3. Methods

This section provides an overview of method (3.1) and the approach to the analysis (3.2).

3.1 Method

To meet the aims and objectives, a mixed methods approach was taken. Semi-structured interviews were completed with 15 professionals involved in Operation Alloy (5 Force Control Room staff; 5 Police Officers; and 5 Mental Health staff) and analysis of police records detailing recorded activities and incidents during 2 one-week times periods. Interviews lasted around 30 minutes and were digitally recorded and transcribed to enable a rich, credible and dependable interpretation of the data. Ethical approval for the study was obtained from the School of Social Sciences Research Ethics Committee at the University of Northampton. Participants were provided information sheets and were required to sign an informed consent sheet.

3.2 Analysis

Qualitative data were thematically analysed involving six steps, based on Braun and Clarke's (2006) thematic framework: 'familiarisation' through reading and re-reading transcripts, 'code generation', 'theme identification', 'review' of themes and codes, 'labelling themes' and 'report writing'.

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4. Findings

This chapter is organised into 2 sections. First the results and analysis of statistical data are presented and second the findings from semi-structured interviews are detailed.

4.1 Statistical Data

Data presented in this section derives from two key data sources held by Northamptonshire police: (i) from Northamptonshire Police Control Room, and (ii) from mental health data held by Northamptonshire Police. For the sake of clarity, control room data is referred to as 'Police' in the graphs given below. Whilst both sources of data are held by Northamptonshire Police, the latter data set mirrors that which is compiled by mental health practitioners; in essence, this second data source therefore represents that which is held by Northamptonshire Healthcare NHS Trust.

Data were requested from two predetermined time points in order to better understand what is currently recorded, and to give a general indication of how the operation is resourced over a typical week.

Time points are referred to as 'T1' and 'T2', and are defined as follows:

- T1: Between 01/02/16 and 07/02/16 (7 days)
- T2: Between 07/03/16 and 13/03/16 (7days)

Mental health data shall also be considered of itself, given that a wider range of information is currently provided in this data source. From the outset, it is important to note that this section of the report does not offer a representative picture of the scope, scale, and nature of incidents involving Operational Alloy; rather, it serves to present a snapshot of what data are currently available and recorded.

4.1.1 Comparison between Mental Health and Police Data

Key findings are presented as a comparison in order to highlight the disparities between the two sources. It has been suggested that control room data may not be fully accurate, owing to the different ways through which an incident record can be 'flagged' or 'updated' to reflect that it has been referred to Operation Alloy. Resultantly, incidents in which Operational Alloy has been involved may not always have been 'flagged', and so captured, in the control room data. The suggested assumption is therefore that mental health data may identify a greater number of incidents. Comparisons have, however, revealed that this is not the case: generally, there are fewer incidents identified in the mental health data in comparison to control room data – thus at odd with the explanations of disparities outlined above.

Figure 1: Number of incidents flagged as being relevant to Operational Alloy in weeks T1 and T2 in both Police and Mental Health data sources.
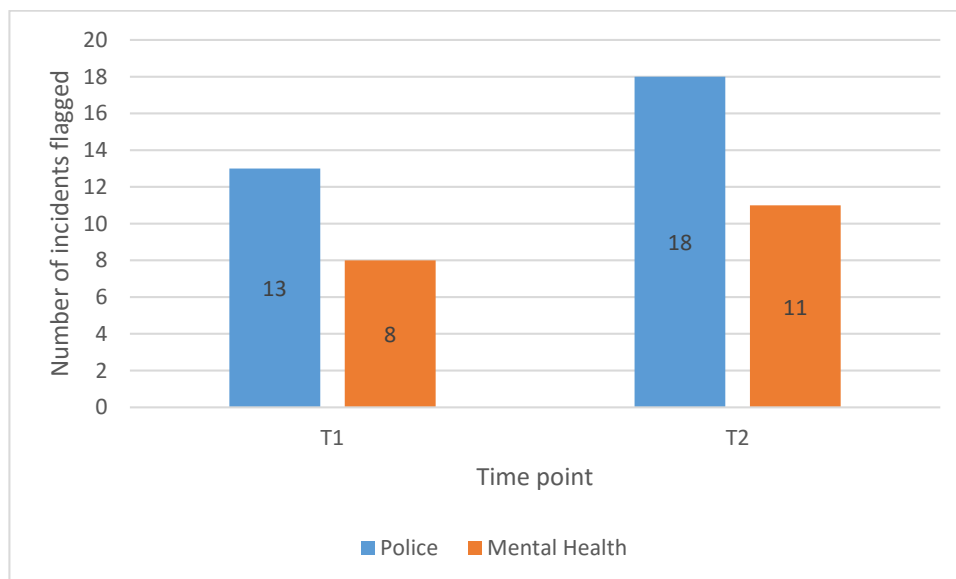

Figure 1 above highlights a consistent disparity between police data and mental health data. In both T1 and T2, police data identified more flagged incidents as being relevant to Operation Alloy in comparison to mental health records. Based on the records received, it was not possible to identify why such a disparity exists.

4.1.2 Mental Health Data

This section provides a snapshot of data held by Northamptonshire police which derives from records compiled by mental health staff. This data will be considered distinctly, owing to the fact that more comprehensive information was recorded.

Quick Reference Tables:

T1							
	01/02/16 Mon	02/02/16 Tue	03/02/16 Wed	04/02/16 Thu	05/02/16 Fri	06/02/16 Sat	07/02/16 Sun
No of incidents	0	0	0	2	2	3	1
Total time dealing with incidents (mins)	0	0	0	30	170	125	15
Staffed: Police?	✓	✓	✓	✓	✓	✓	✓
NHS?	✓	✗	✗	✓	✓	✓	✓
Car deployed?	N/A	N/A	N/A	✗	✓	✓	✗
s136 Detention?	N/A	N/A	N/A	✗	✗	✗	✗

In T1, Operation Alloy was not live on Tuesday 2nd and Wednesday 3rd February 2016. This was due to staffing issues, with no community psychiatric nurse (CPN) available for the shift. The table above shows that the vehicle was deployed on 2 of the days within T1; a little over 5 and a half hours was spent in time on dedicated incidents; and no s136 detentions were completed within the bounds of the operation.

	T2						
	07/03/16 Mon	08/03/16 Tue	09/03/16 Wed	10/03/16 Thu	11/03/16 Fri	12/03/16 Sat	13/03/16 Sun
No of incidents	0	3	2	3	3	0	0
Total time dealing with incidents (mins)	0	140	40	?	235	0	0
Staffed: Police?	?	✓	✓	✓	✓	?	?
NHS?	?	✓	✓	✓	✓	?	?
Car deployed?	N/A	✓	✕	✕	✓	N/A	N/A
s136 Detention?	N/A	✕	✕	✕	✕	N/A	N/A

In T2, no data were provided for Monday 7th, Saturday 12th and Sunday 13th March 2016; it is not possible to determine why this is the case without interrogation at source. The table above shows how the vehicle was deployed on 2 of the days within T2; a little under 7 hours was spent in time on dedicated incidents; and no s136 detentions were completed within the bounds of the operation.

The tables above highlights a range of inconsistencies in data recording. While many cells were left blank, other members of the mental health team completed the cells in accordance with instructions given. This therefore means it is difficult to conclude that blank cells mean 'NO', given that they are inconsistently completed.

This was pervasive in the following cases:

- Data flagging a repeat caller or 'Known to Mental Health services' was often left blank;
- 'Contact criteria' was inconsistently completed ('MH in public place' and 'MH at home' were often left blank);
- There does not appear to have been any s136 detentions in both T1 and T2. This was however inferred from cells being blank, rather than completed to say 'No';
- One incident was recorded without basic time and date information;
- In T1, no postcode information was recorded for 3 incidents.

Maps illustrating car deployments across Northamptonshire

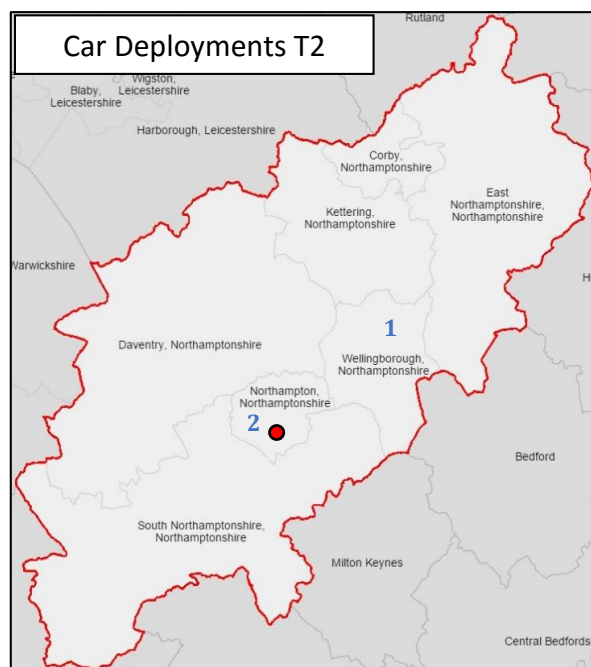🔴 Triage car base

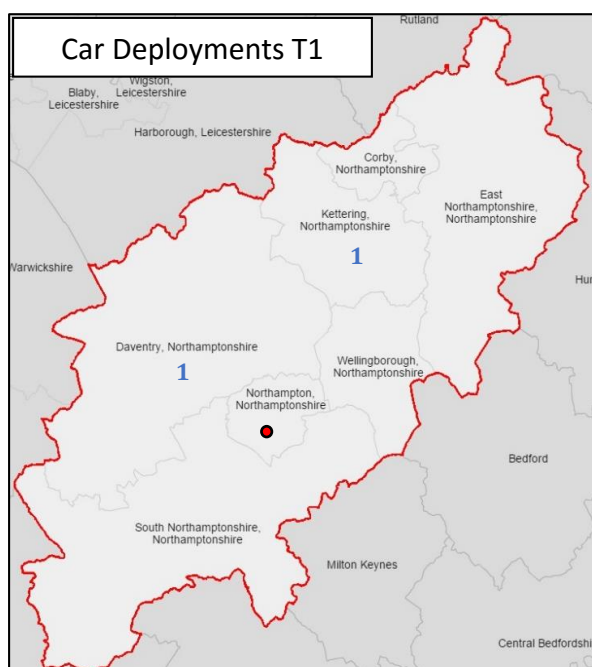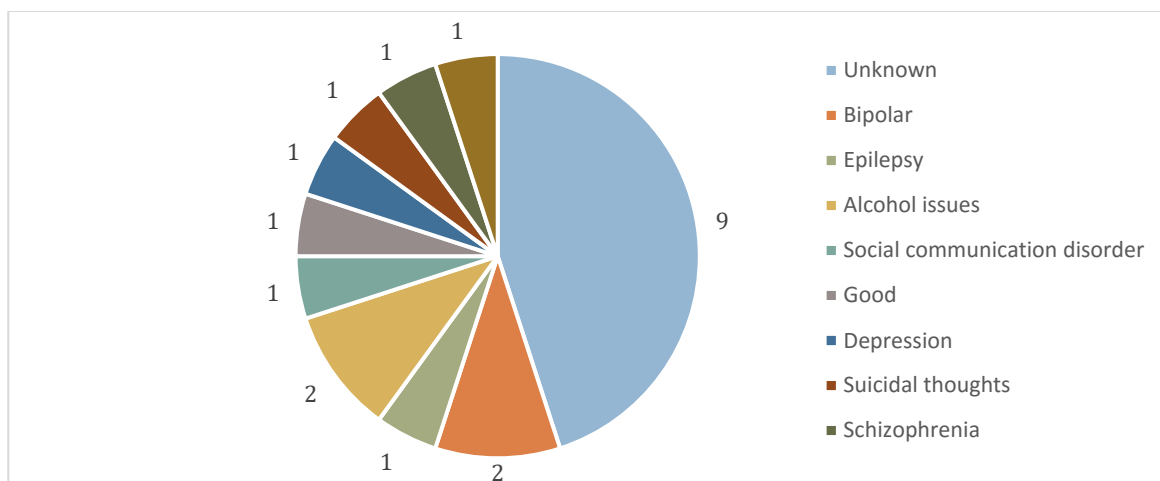**1** No of cars deployed to county area

Figure 2: General health / diagnoses of flagged Operation Alloy incidents across both T1 and T2.

For a large proportion of incidents general health diagnoses were unknown. It is difficult to determine if this is because individuals were not known to mental health services, and as such cells were left blank. Nevertheless, Figure 2 shows how, even from a two-week snapshot, the diversity of mental health conditions linked to the Operation.

Figure 3: Number of incidents flagged as Operational Alloy where tactical information had been shared across both T1 and T2.
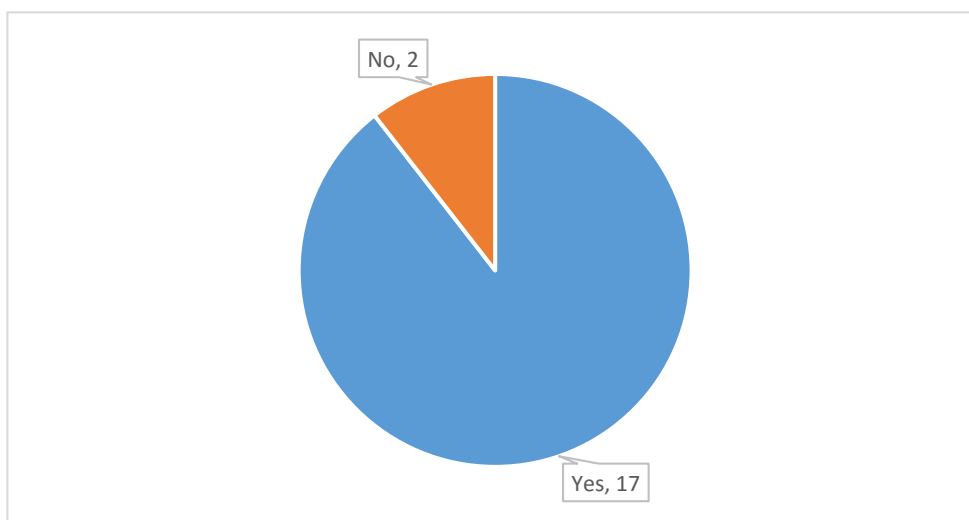
It is clear to see that in the majority of flagged incidents tactical information was shared. This shows how the sharing of information within the control room setting was more frequent than deployment, a point which is expanded upon in Section 4.2 where findings drawn from interviews with staff are presented. Moreover, the everyday language which is used to refer to the scheme ('the mental health car') overemphasises 'deployment' as the central aspect and purpose of the Operation, with more tactical exchanges of information being evident to inform the management of risk on the ground.

Figure 4: Number of referrals made by pathway across both T1 and T2.
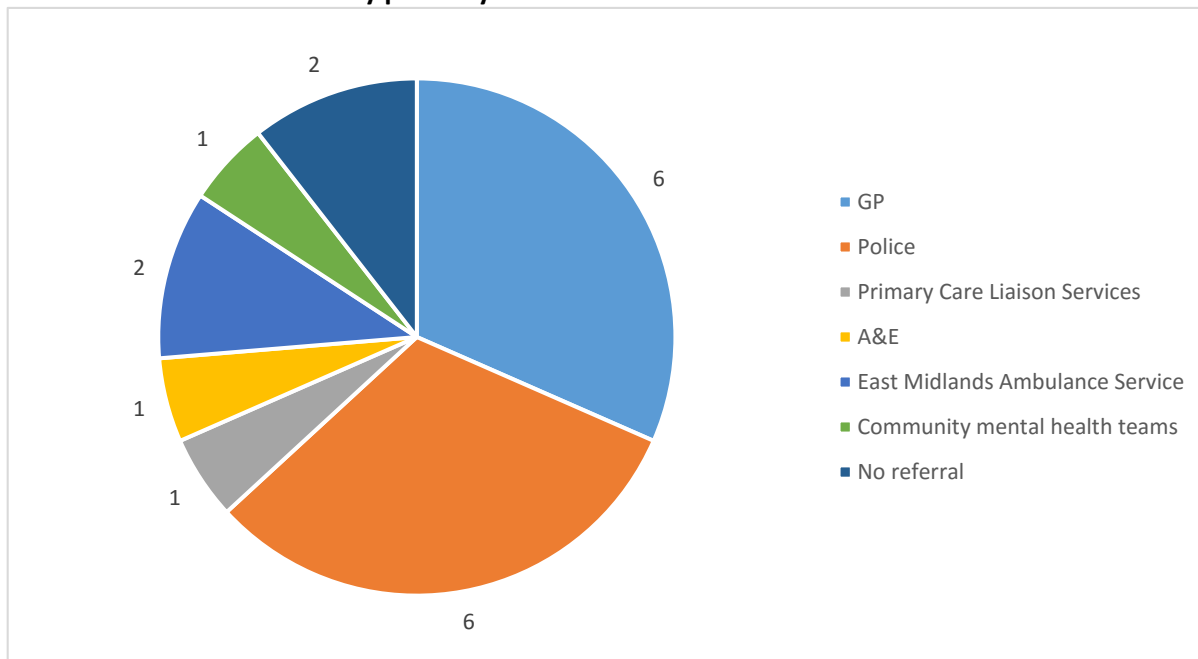
Across both T1 and T2, both general practitioner (GP) and police referrals are the most common outcomes identified. Incidents referred to the police appear to arise when CPN on shift provides information to officers on scene, and officers then continue to resolve the incident. A range of other disposals were also identified, including referrals to Primary Care Liaison Services and Community Mental Health Teams (a specialist mental health NHS service), and more immediate responses such as accident and emergency, and ambulance services. The data further demonstrate the added value of the Operation by enabling easier access to a wider range of disposals.

Figure 5: Number of incidents where an assessment was conducted by a Community Psychiatric Nurse across both T1 and T2.
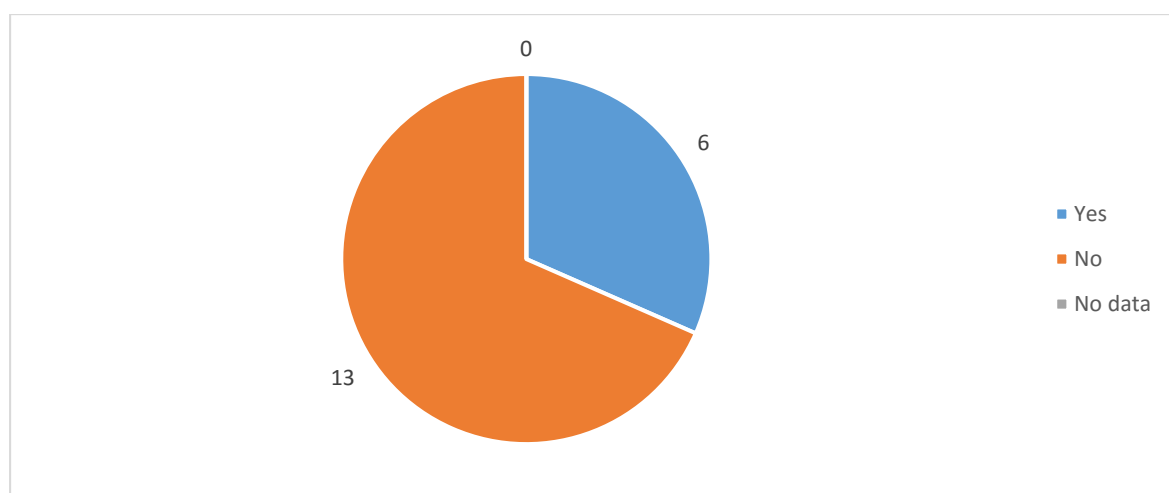

Figure 5 shows that there were 6 formal assessments completed (1 telephone) by a Community Psychiatric Nurse as part of the Operation. This meant, however, there were 13 incidents which were not formally assessed across T1 and T2. The data provided did not specify reasons as to why an assessment was not conducted.

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This section provides a snapshot of data held by Northamptonshire police which derives from records compiled by control room staff.

Figure 6: Number of incidents flagged as being relevant to Operation Alloy in T1 and T2 by incident type.
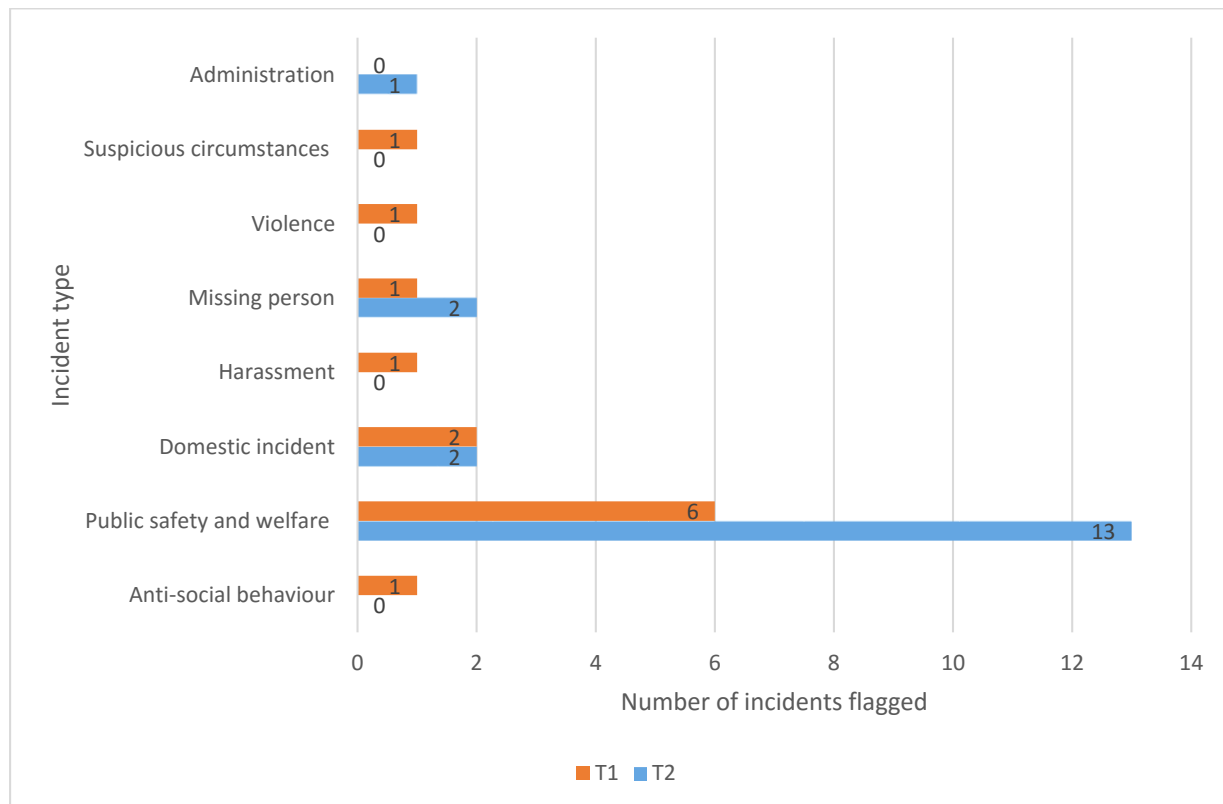

Figure 6 shows that the most frequently logged incident type was 'Public safety and welfare', though the category does not allow further breakdown of information as to the nature of incident. A key point to make here is that the frequency of incident does not necessarily translate to the time/resource investment in resolving respective incident types. For instance, the qualitative data presented in Section 4.2 highlighted an emphasis within the control room staff upon nuisance callers and missing persons, where it was suggested a high amount of resource was spent.

4.2 Qualitative Data

This section presents analysis and supporting evidence from the semi-structured interviews completed with 1. Control Room staff; 2. Police Officers and 3. Mental Health Professionals. Owing to the small number of individuals who took part in the project, references will be attributed to one of the respective groups, in accordance with good ethical practice.

The section will be organised into 3 overlapping sections: 1. Value and Outcomes; 2. Behaviours and Practices and 3. Management.

4.2.1 Value and Outcomes

Most staff reported that the operation was worthwhile and valuable, having a beneficial effect in terms of outcomes for people in need as well as organisational efficiency. The operation was viewed more positively by control room and mental health staff, with police officers interviewed having mixed opinions. The closer working arrangements enabled by the operation was viewed as reducing s136 disposals and reducing the cost and resource implications for police and health services.

> *"…it saves time, money, resource further down the line so for that little bit of pain in the frontline, you end up saving in a multitude of variants further down" (Control Room)*

> *"I think a lot of it is about partnership working, about actually working closely with the police. And also just having that extra resource there as a way of minimising, or trying to minimise the amount of people that end up on 136s either up in custody or, you know, down in the hospitals" (Mental Health)*

While mental health staff felt that the operation had reduced the frequency of s136 detentions, evidence of this reduction could not be explored in the data provided; this is however identified as a key performance measure in the Operation Alloy 'Terms of Reference'. Nevertheless, the 'original' aim of preventing the use of s136 was identified as being an important factor shaping the decision-making of nurses in terms of deployment.

> *"We know that the comparable timeframe between 2014, six till midnight and 2013, six till midnight, we reduced 136s by 41%." (Mental Health)*

> *"It's been very effective at picking people up who aren't known to services, and making sure that they get followed through, and they get the right help" (Mental Health)*

> *"I think you're basing a lot of it on the judgement of the police officers that are there and how they're sort of viewing the situation. And if they're sort of getting to that point where it's like, "Yeah, we think this person needs to come in and we're gonna put them on a 136, then yeah, that would be a good time (to deploy)…" (Mental Health)*

Participants frequently emphasised the importance of the operation delivering a better quality service to people in need rather than simply freeing up resources. This was said to have been better achieved through providing a speedier response to mental health need, positioning professionals with right skills, at the right times, in the right places. The combination of police and mental health professionals within the operation was viewed as being complementary and as opening a wider range of disposals to enable positive incident outcomes.

> *"I think the ultimate aim is the outcomes I think we get are for the individual, 'cause it's not about the policing saving money ultimately or the NHS saving money, it's about having an outcome for that individual, they've called because they want help."* (Control Room)

> *"And for me that's what Op. Alloy is about, giving them the service they need there and then"* (Control Room)

"I think the… the police and mental health nurse, they do work completely differently. But I actually think that they work quite well together. They inform each other quite nicely. Especially if you're out on situations, so you can only get so far mental health wise, and you're like, 'Right OK, I've tried this, tried this, tried this'. And you can actually have that discussion with the officer and then… so that's what I mean, it's a very joint venture, really" (Mental Health)

The operation allowed quick access to a wide range of information, with mental health staff being able to access and share information from NHS systems (e.g. System 1). The provision of non-incident specific information provided to the police on mental health conditions by mental health staff was also identified as being valuable, and was seen as informing the related dynamics of risk (e.g. the meanings and implications of specific mental disorders within the context of an incident). The facilitation of a wider range of disposals to emergent incidents was a critical and extremely positive benefit of the operation.

"…the initial aim is to try and reduce the amount of Section 136s that are used unnecessarily. Because obviously the police don't always feel that they've got any other option. It's about opening up the pathways and the communication and liaison between various services in support of each other, really, for the best of the client to ensure that pathway is timely and consistent" (Mental Health)

It was felt that individuals in need responded more positively to mental health professionals on-the-ground, with their communication skills being critical to positive resolution of specific incidents.

"The majority of them is just talking to them. Getting them through that crisis of emotional stress at that time and giving the tools to keep going, type of thing, until the next day and see your GP and stuff like that. So the majority of it is actually dealt with just by talking and doing like face-to-face therapy type stuff, brief intervention, really" (Mental Health)

The value of Operation Alloy was perceived differently by control room staff in comparison to mental health staff. For control room staff, the mental health car was often valued as a deployable resource, with an articulated link between deployment and resolution of an incident.

"…I'd like to see a bit more, I don't know, resolution involved. 'Cause it's fine giving advice, I must admit I'd like to see them out more, deploy more" (Control Room)

"For me, an effective response from the team would be an intervention that saw that being managed to the extent that actually it stopped that repeat demand into our force control room" (Control Room)

However, for mental health staff, the true value of Operation Alloy was somewhat more varied. Some staff commented how they would deploy to 'see what they could do'; others saw their value being more beneficial in the control room, where they have access to patient records and are able to provide advice to officers on scene.

"I have gone out to some cases where I thought, 'Actually, it's not really that relevant, but actually I can see that you're struggling with this, so I'll come and help you.' And do it as a joint thing." (Mental Health)

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'I've got access to all my mental health systems. I've got access to the GP records. I've got access to the Crisis team, inpatient beds, Acute Liaison service at the General. I've got access to the out of hours GP service if I think they might need some meds to hold them overnight with a view to them being seen by someone else tomorrow. I can refer them through to the Community Mental Health teams, the outpatients departments. I can do all of that before I even consider Mental Health Act assessment.' (Mental Health)

Whilst being an important feature of the operation, the reported value of the operation was not necessarily enabled through deployment, but through the sharing of information and professional judgements of both police and mental health staff. The operation resulted in people being dealt with using more appropriate care pathways, by conducting a more holistic assessment of an individual's needs. As part of this, mental health professionals described how their judgement differed from police officers, especially in terms of familiarity and knowledge of mental health conditions. This was identified to be key when officers, by not understanding specific conditions, assessed an individual to be a higher risk in comparison to a lower risk mental health staff assessment. As such, a by-product of the operation was a sharing of knowledge about mental health to individual officers. Officer's respective level of engagement and interest did however appear to affect this.

"…it's about explaining (to Police Officers working on Operation Alloy), "Well, there's a reason why that person behaves in that way. Let's look at the history. Let's look at how they form their views of themselves and their place in the world." (Mental Health)

"I think there's sometimes some frustrations I can see with some particular difficult individuals, which isn't… they don't really suffer from a true mental illness, as such, like your psychosis, schizophrenia type things, but more of a personality disorder, because they're more difficult to manage. So sometimes some people may present as though they're hallucinating and shouting and talking, and stuff like that, which obviously police on the floor will say, "Oh no, they're really unwell." And then once we review it, it's actually they're not... So sometimes it can be a bit frustrating trying to get the right pathway for them, for those individuals, 'cause sometimes they need to be looked at more of the police route rather than a mental health route. But again, it's down to the case" (Mental Health)

Nevertheless, the analysis suggested that the demand on the control room due to 'regular callers' and 'missing persons' was a continual cause of frustration, with the operation failing to resolve repeat cases. Whilst mental health staff did report on-going work with individuals encountered through the operation (demonstrating a willingness to develop a longer-term relationship with service users) this was done beyond the bounds of the operation. There is therefore perhaps an unreasonable expectation of the capacity of the operation to resolve these types of incidents fully; this could instead be the focus of a distinctive and separate partnership between police and health care services.

"We've got regular callers, so we've got regular people who go missing who go to bridges over the M1 and things like that and threaten to jump off and climb over the barrier and various other things, so we've got people who go outside and threaten to do things so they're not contained in an environment. I think that happens probably, we could probably say a couple of times a week…" (Control Room)

"I do feel sorry for the police, it is a difficult situation… 'Cause you will always have the same people who call in to say the same things, yeah. Yeah, and sometimes the person's only been assessed in A&E an hour ago, but the same situation is replaying because the person hasn't gained the admission to hospital that they feel that they need, obviously. But sometimes it's about arranging, you know, professionals' meetings and getting a robust risk assessment and plan in place so that there's a set plan for when this situation does occur…" (Mental Health)

"So I came across (description of individual with a condition associated to Post Traumatic Stress Disorder) and I managed to do some work with [them] (involving specialist technique). So [they] became part of my ongoing caseload. So it is a good way of finding and targeting people, and trying to get them the right help" (Mental Health)

4.2.2 Behaviours and Practices

This section focuses on the behaviours and practices of professionals identified in the analysis both in terms of benefits and dis-benefits of the operation. A key benefit recognised in the analysis for officers was an increased confidence to respond to mental health needs within emergent incidents - stated to be an increasing feature of service demand. This was enabled particularly through the easy access of advice and information from mental health professionals. While this provision of information might be seen as a 'nice-to-have' resource, it was indeed recognised to be potentially the difference between life and death within certain incidents.

"I think definitely it's (Operation Alloy) effective, 'cause mental health is a massive issue for us, because we get limited training on it. So we're, you know, sort of… sometimes certainly in situations with a lot of people with different personality disorders, bipolar, and having an understanding of how to deal with those people, I think it's quite massive, and that's where this really helps" (Police Officer)

"So if someone says they're going to kill themselves, you haven't got that luxury of half an hour to start making phone calls…" (Control Room)

A very positive benefit in terms of behaviours of staff involved in the operation was an articulated mutual respect for each other's professional judgement. Mental health staff felt that their contribution was valued and respected by the police; police felt consequently relieved and reassured by working with mental health professionals. It was felt that consistent staffing enabled stronger relationships to be formed and having better outcomes for individuals in need.

"…obviously you strengthen it more if you work with the same people, because their knowledge gets stronger. And there are some officers that are just really, really eager and to learn more about mental health… And most officers are brilliant, you know, they've got really good communication skills and they do care" (Mental Health)

Whilst police officers expressed a respect for the judgements of mental health staff, there was confusion (and sometimes tensions) in relation to the decision-making processes of deployment. This was heightened when resources were scarce on the ground, and control room staff saw the car/team as a deployable resource. From the perspective of police staff, this was interpreted as an issue of 'willingness'; from the mental health perspective, this was an individualistic decision based upon their self-perceived value to the county and to the specific incident. That said, there are difficulties in reconciling the threshold at which a deployment should be made in relation to the overarching aims of the scheme; this was inconsistently reported by mental health

staff. It is recommended that the value and purpose of deployment be clarified and agreed upon by all parties involved, in order to minimise potential risk to staff and the public.

> *"I wouldn't be comfortable coming in and directing a health professional to deploy to a job, put it like that, as it sits at the minute. Because there's not enough information about what we can and can't tell them to do, so yes, that would be helpful, if we got some sort of deployment strategy in place" (Control Room)*

> *"For example, when I said earlier about this, trying to get you to go out as a frontline, to go out and see somebody that hasn't been seen… that will often come from the Inspector within the control room… So you're having to sort of almost, you know, have a disagreement with them about that's not appropriate to do that. And they don't… because they have their own agenda, sometimes you get that clash there" (Mental Health)*

> *"…in the end it's actually felt like I've just been obstinate, but I haven't because there's a reason behind it, and it's not appropriate just to go out and cold call somebody. You know, there's been incidences within the team where nurses have been put at risk because it hasn't been risk assessed" (Mental Health)*

Police officers articulated respectfully how competent mental health staff were when communicating with individuals involved in incidents, striking a balance between empathy and assertiveness in resolving incidents. It was recognised how the approach adopted by police officers, informed by their identity and skills, was different to that of mental health professionals. One officer in particular was struck by how competent the mental health nurse was in speaking, listening and formulating a plan to deal with an individual in need. This was felt to lead to a better level of service and higher likelihood of positive outcomes for the respective individual. Related to discussion presented in the previous sub-section, however, there were inconsistencies that must be acknowledged between mental health professional in terms of deployment, as well as readiness to speak to an individual over the telephone.

> *"The one good thing I'd say about Op. Alloy is if we have had some sort of incident where we don't need to go out to them, the nurse have had a chat with them on the phone, they've sort of calmed them down and they do like a referral to their own sort of GP or whatever it is that they go and see sort of on a regular basis" (Control Room)*

> *"… just watching [nurse] in action, [nurse] was very good, [nurse] knew exactly how to talk to the [patient]. 'Cause sometimes we can be a little bit… we have our police hat on, so sometimes we can be a little bit different, the approach. [Nurse] knew exactly how to talk to [patient], where to signpost [patient], how to sort of, you know, show [patient] that [nurse] was gonna do something. 'Cause sometimes when we turn up, you know, we don't know where to sort of send them. But [nurse] knew exactly what to do, how to say it, what [patient's] issues were." (Police Officer)*

An important and related issue to this point were lines of accountability and responsibility to such decision-making. For instance, it is critical to consider who holds responsibility for the shared decision to withdraw officers from the scene of an incident (i.e. taking no further action) involving for example suicidal thoughts if the individual then went on to commit suicide. This is especially important as this dilemma directly relates to the gap in police powers between s135 and s136, an unplanned detention of an individual to a place of safety. A more equitable division of responsibilities should be considered, in order to stay true to the ethos of partnership working.

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"And I know it differs from person to person, but I just feel like I'm a bit out of my depth with mental health. I just… I'd rather leave it to the professional that knows what they're doing and has got the time to head over to the Well-in Centre or A&E, or whatever." (Police Officer)

"I mean, yeah, sometimes I'll speak to the person on the phone and then advise the officers that they're free to go. But obviously then we're carrying a lot of risk ourselves" (Mental Health)

The final point related to behaviours and practices were the implicit messages and meanings of uniform and persona. It was recognised that mental health staff were interpreted less confrontationally in comparison to police officers by people in need. The florescent jackets and stab vests worn by police officer were viewed as both presenting a physical barrier and heightening anxiety within situations. While this was downplayed by participants, it did nonetheless have implications for the ease of completing assessments.

"I don't know, 'cause I think sometimes this (Stab Vest) is a barrier to people, 'cause they hate this uniform, they hate what it stands for. I mean, maybe… I don't know, I think a stab vest, again, would… if they turned up wearing that, it might send a message to the person… I don't think there's anything they could have, 'cause I think it would just form some sort of barrier" (Police Officer)

"Yeah, sometimes it can be quite difficult when you've got… when you go out with a police officer, and they're kind of sort of sat with you, and you're trying to do an assessment. That can be quite difficult. But to be honest, a few times the police officers just tend to fade into the background and they don't sort of speak and they don't… they just let you get on with it" (Mental Health)

4.2.3 Management

The aims and expectations of the operation were suggested to have changed over time. This was particularly evident in respect to the frequency of deployment, which was understood to have decreased over time, reflecting the experiences of other schemes identified in the literature. While reducing s136 detentions was identified as being the original aim, other objectives may be held by individuals and the respective organisations in relation to service quality, longer term resolution and reduction of 'regular callers'. These inconsistencies in terms of expectations (re. practices and deployment) and purpose for individuals involved in the operation may contribute to the identified inconsistencies between staff in terms of their practice and behaviours. This consequentially led to a growing tension and frustration held by a minority of individuals.

"So I've asked someone (mental health professional) before to say, oh could you just give them a phone call just to, you know, have a chat with them over the phone? And [they] said no. But I know they can do it because all the other ones do it. But I can't say, well everyone else does it and you're not… My understanding was that they could just do it. [They] told me that they couldn't, so I don't know. Whether the other ones are doing it wrong and they're not allowed to and they're just making phone calls or whether [they've] just not been told that [they] can or, I don't know" (Control Room)

"I have gone out to some cases where I thought, "Actually, it's not really that relevant, but actually I can see that you're struggling with this, so I'll come and help you." And do it as a joint thing" (Mental Health)

Broader guidelines and principles were suggested to be welcomed by all parties to guide practice during shifts on the operation. It was felt this would help to deliver a greater degree of continuity between shifts and staff,

and therefore provide a more equitable experience for the partnership between the police and mental health. Moreover, such an agreement would help to reconfigure the reputation (and the implicit expectations) of the operation, better reflecting the realities of how and why the operation works.

> *"There needs to be more coordination and kind of organisation, I suppose, of the role and what it should be. We need to all know that we're responding in the same way, really. 'Cause it's not fair if I say, "Yes, I'll go to that job", but somebody else says, "No, I'm not doing that job." 'Cause then we've lost that consistency. So I think maybe we need clearer guidelines about… Imagine that's easy to say, 'cause it is a judgement call, and everything's so different"* (Mental Health)

> *"…I've rarely seen them go out, which I was surprised about. I thought there would be a lot more driving round actually face-to-face stuff going on with people, just to maybe stop more phone calls coming into us or whatever, but there's a lot of sort of computer work goes on in here and you see them all tapping away and having conversations"* (Control Room)

In particular, better communication about the operation to frontline officers would support how the operation is perceived and valued within IRTs, with current briefing information not being fully read and interpreted by some. Indeed, some response officers felt that they are letting their IRT down (e.g. exposing their colleagues to a greater degree of risk) when deployed to Operation Alloy, rather than adding wider, systemic value. This has consequential implications for staff assigned to the operation in terms of motivation and self-perceived value.

> *"But I guess it's just one of those things, we're dragging Response staff away from doing Response. There's not enough staff anyway to be on Response, let alone pulling them off to do a mental health triage car. It's not for the want of the officers, 'cause it's quite nice to do something a bit different, but just Northants Police, we haven't got the officers on the frontline…"* (Police Officer)

A key issue affecting the operational performance of the operation were the staffing arrangements. It was strongly indicated that more consistent staffing arrangements would be welcomed as it was recognised that staffing of the operation was irregular, from both police and mental health perspectives, affecting continuity. For police, it was felt that officers pulled from their IRT to the operation were not backfilled, thus taking their team below minimum cover. From the mental health perspective, it was indicated that, more recently, 'bank staff' were increasingly assigned to the operation.

> *"…on the Friday, you find out these officers are going on Op Alloy you think, "Well, hang on, we're covering the town centre. There's mass public disorder. Violence, drunks. You can't reason with people. But yet they're taking our staff off us." I personally resented that, because I thought, "Well, hang on, that's not fair on us. Can these resources come from somewhere else?"* (Police Officer)

> *"It can be hit and miss… But I know there are a good number of nights where we've had a notification come through to say you don't have a mental health professional tonight or the cop's gone sick, so literally the mental health professional will just sit here on her own and if she needs to liaise with one of the guys out there for any police intel, but in terms of then its effectiveness as a unit to be able to respond if it chooses to do so is immediately eradicated."* (Control Room)

The inconsistent arrangements to staff the operation, alongside the poor articulation of expectations in the form of briefings, has resulted in a reduced utilisation of time. This was expressed by police officers in

particular in not know what to do or how to add value within the control room during quiet periods. Equally this was the case during incidents when an assessment was being completed.

> *"If I didn't have [CPD] work to do, 'cause I'd no crimes at the time, I would have just sat on the Daily Mail for the entire evening… Because I wasn't told to do anything else. It wasn't even a case of like, "What can I do?" Because I was under the idea of, they'll tell you if there's a job, there's nothing else for you to do" (Police Officer)*

> *"I felt a bit like when she was dealing with it, and the family were there, and they were kind of thing… and they said to me, "Well, why are you here for?" And I said, "Well, basically I'm the driver and the minder."" (Police Officer)*

It was stated that the operation historically had a more regular pool of individuals who worked on the shift. On the one hand, the operation would benefit from having closer relationships being formed within the team with the potential to lead to more efficient practice, while on the other hand, the added benefit for staff in terms of increased knowledge between the organisations would be more isolated to a core set of individuals.

> *"…when this system was first set up, there was lots and lots of nurses who expressed an interest, and there was lots of people sat round that table initially. But as people realise it's maybe not always as exciting as what you think, or it's more tiring than what you expect, then the numbers dwindle, so there's only quite a small handful of us left" (Mental Health)*

> *"I think it'd be helpful if there was… Because they understand, and then they'll understand what's expected of them. They'll have a genuine interest in mental health and in making the car successful. And you get to know them, so you'd have a better working relationship with them as opposed to somebody… you can have an officer with you and then you may never see them again. And they don't really know. They come on, they don't know what's expected of them. They don't know what the real purpose of it is, you know. They've just kind of heard from other people. You know, I've had officers come in with sort of just paperwork, past paperwork that that's what they're planning on doing, is just sitting and doing their paperwork all evening" (Mental Health)*

The mechanisms to identify measurable impact were suggested to be inefficient and tiring, explaining gaps in the data presented in Section 4.1. The current arrangements also meant that mental health nurses were required to provide data twice, which was viewed negatively.

> *"…well that's just a paper form. But that's basically just copying down the name, the incident number, the date of birth, and everything that's already on the system. So I think it'd be more better use of time if we just left a… emailed the admin lady, for instance, or the team leader, to say, "I saw this person last night."… Just seems a bit of a round the houses…" (Mental Health)*

The inaccuracies in documenting the activities of the operation possibly contributes to the lack of communication from the operation about its impact and value. The extent to which the operation was able to demonstrate measurable impact based on its reporting procedures was limited, having implications for engaging response officers, and also informing perspectives within the wider organisations.

> *"Don't really get briefed as such. There's been quite a lot of changes. Obviously there was a custody lead nurse, but now the role is being covered by two members of staff. We used to have meetings when it was first set up. I think it was every month… but the custody staff would be there because obviously it was part of their role to cover that. But they seem to have petered off really because I think lack of resources, lack of people" (Mental Health)*

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5. Discussion and Recommendations

The findings demonstrate how the operation was viewed positively, particularly by control room staff and mental health professionals. The operation was indicated to be worthwhile and valuable, especially at facilitating a wider range of disposals for individuals in need, and responded to by the police. There were, however, a range of problematic issues which, if addressed, would allow the operation to improve in terms of efficiency, effectiveness and reputation.

The following points identify key findings and recommendations to address each point made.

1. The operation was suggested to have evolved over time, with individual staff holding different understandings of their operational expectations and perceived value.

> **R1. The operation has a refresh, with all objectives as well as the purpose/identity of the operation being explicitly communicated to all parties.**

2. The data recording for the purpose of adequately capturing the activities of the operation held by the police was found to be inaccurate, thus not allowing a comprehensive evidencing of actions, value or outcomes.

> **R2. The data recording procedures are reviewed and streamlined. As part of this, clear expectations and accountabilities for all parties in terms of documentation are formulated.**

3. The irregular staffing arrangements were suggested to contribute to inconsistencies identified during the completion of this project, being consequential to perceptions held by different individuals, and potentially resulting in inconsistent levels of service delivery to people in need.

> **R3. A dedicated and bespoke team is assigned regularly to the operation, with the respective composition of such a team being re-considered, and different roles potentially introduced (e.g. PCSOs, specials, paramedics etc.).**

4. The evidence shows inconsistencies between staff in terms of activities completed during shifts, and the thresholds or factors involved in deployment decision-making.

> **R4. The staff involved in the operation are afforded opportunities to share learning and good practice, enabling more consistent responses to, and resolution of, emergent incidents. Such learning opportunities should be monitored and appropriate amendments to governance and practice documentation made.**

5. The progress and achievements of the operation were found to not be captured or meaningfully recognised.

> **R5. A quarterly partnership management meeting is held to review progress, in relation to agreed objectives (R1).**

> **R6. A communication strategy is developed to disseminate operational effectiveness both in terms of inward value (resource vs. outcome, frequency of s136 reduction/avoidance) and outward value (longer term resolution for the individual in need).**

> **R7. Appropriate succession planning is undertaken to ensure practices and management of operation is not held by any one individual, and is transferred when individuals move into different postings.**

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