

TIME 2 LISTEN

Report 2018



**Northamptonshire Police and Crime
Commission**

Foreword



As Police and Crime Commissioner, everything I do is with the aim of making Northamptonshire safer. A fundamental reason for PCCs to exist is to hear the voices of those we serve. It is vital that we understand the experiences of those who have been touched by the criminal justice system, whether they have been victims, offenders or indeed have been caught in the system as a result of their mental ill health, ADHD or Autism.

Mental Health affects us all. We all experience periods of greater or lesser Mental Health. When people hit crisis they often turn to the emergency services for support and often the police are the first people on the scene, charged with making decisions to keep the individual and wider community safe. We must not underestimate the challenging situations that the police and other first responders find themselves in. But equally it is our duty to ask whether there are changes in behaviours, processes or interventions that can improve both the health of the individuals we serve, as well as reduce their impact on the criminal justice system and therefore wider society.

Time 2 Listen has been focussed on hearing the experience of individuals who have experienced the Criminal Justice System, whether they are those who have designed the system, the members of the public who have been through it, or those who work on the frontline in it. There is a wealth of experience that my team have captured that cuts across responsibilities of the police, wider Criminal Justice System and health and social care agencies. Those agencies will consider the recommendations in this report and there is commitment across partners to seek to address the findings of Time 2 Listen to improve the systems for everyone.

I believe it is my responsibility as Police and Crime Commissioner to seek to ensure that agencies improve services for everyone. I am determined to do all I can to work with my fellow leaders across the county to better serve us all.

A handwritten signature in black ink, appearing to read 'Stephen Mold'. The signature is fluid and cursive, with a long horizontal stroke at the end.

Stephen Mold,
Police and Crime Commissioner

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Appendices, including details about the engagement events attended, the demographics of those we spoke to and references are available at www.northantspcc.org.uk/Time2Listen

All the artwork used in this report was submitted by young people in the county as part of our Time 2 Listen competition. To view our shortlisted entries, please see the Time 2 Listen section on the OPCC website.



Executive Summary

Nationally one in four people experience a Mental Ill Health in any given year and many will come into contact with the police either as victims of crime, witnesses, offenders or when detained under Section 136 of the Mental Health Act. People with Mental Ill Health are more likely to be victims of crime than others, and up to 90% of prisoners and two fifths of those on community sentences have Mental Ill Health.

It has been identified nationally that up to 40% of demand on the police is Mental Health related. However the issue of Mental Health impacts not only on policing services but is a much broader public service and societal issue.

There have been several examples in the national media which specifically point to poor service delivery by the Criminal Justice System to these with mental illness and similarly with those with Attention Deficit Hyper Activity Disorder (ADHD) or Autism.

There was a lack of awareness in Northamptonshire of victim's and offender's experiences of the service provided by the police, and the wider Criminal Justice System and the support agencies around it. Perceptions from professionals as to the effectiveness of partnership work around the Mental Health criminal justice pathway had also not been captured before. Therefore Northamptonshire Police and Crime Commission launched Time 2 Listen.

Time 2 Listen aimed to:

- Consult with people who have a Mental Illness, ADHD or Autism and their carers about their experience of the Criminal Justice System and support services that work alongside it.
- Capture experiences of those professionals and support agencies, to understand the Mental Health pathway and service provision.
- Capture experiences of those who work in frontline roles, and how effectively organisations work together.

It was important to ensure people with Mental Illness, ADHD or Autism were engaged through a range of methods so that the consultation was as accessible as possible, and reached both young people and adults, victims and offenders. Overall 1274 people were engaged through; 46 one to one interviews, an online survey, support groups and events with service users and carers. In addition a competition was run with young people to respond through creative methods such as art and poetry. Social media was used to promote the consultation and reached over 300,000 people across

Executive Summary

Northamptonshire. Frontline professionals feedback their views through focus groups, workshops, interviews and via a survey, in total 262 responded.

Findings and Recommendations:

Consistency of approach

There is a lack of a consistent approach to working with people with mental illness, ADHD or Autism. This report has demonstrated that there are some really good front-line staff who tailor their behaviour and approach to best meet people's needs however this is not consistent. The majority of the feedback in relation to this was in regards to the police (this may be because the majority experiences people spoke to us involved the police more than any other agency) but several examples were given in other criminal justice and health settings;

1. Service users should be at the heart of all services and should expect a consistency of service.
2. There needs to be a significant culture change within the police and the wider criminal justice, health and those within social services, to achieve services that are compassionate, non-judgemental and treats people as individuals.
3. Organisations should work together to tackle issues and have joint measures of success based on the experience of service users so that joint responsibility is taken.
4. To ensure officers do not feel that they are carrying risk on their own, risk and care plans should be jointly agreed across organisations together with the service user/carers.

Joined-up professional development across agencies

Many police officers, and staff from across criminal justice agencies said they wanted more knowledge and awareness of Mental Health, Autism and ADHD conditions. Many received very little training, that was often one off and therefore not current, which had limited input from service users or Mental Health practitioners;

5. All criminal justice agencies should receive improved basic knowledge of Mental Health conditions, Autism and ADHD and understand what impact they have on other's behaviours and experiences. This should include for frontline practitioners

different communication skills, low arousal or de-escalation techniques.

6. To develop a long-term programme of development, throughout someone's career. Training should be designed with, and involve service users and Mental Health practitioners, delivered in person or via technology, tailored to different teams/ areas need.
7. Multi agency training should be undertaken where possible to gain a greater understanding of roles and experiences across the Criminal Justice System and health.
8. Improve knowledge of what support and services are out there for people and families with Mental Health issues, Autism or ADHD. To increase awareness of how referrals can be made and where they can seek advice e.g. professional advice centres/phone lines- CAMHS professional telephone line. For each organisation to have a list of those who have received advanced training to seek advice if needed.
9. To rotate officers and staff in dedicated roles dealing with issues relating to Mental Health, Autism and ADHD, including movement across agencies for professional development.
10. To establish a project involving service users and carers looking at recruitment processes across the Criminal Justice System to understand if qualities such as compassion, empathy, being non-judgemental and respect are considered upon appointment of frontline roles.

Reduce gaps in service delivery and support

There needs to be greater support for prisoners upon release and some service users described facing homelessness and breaching licencing conditions by having no fixed abode and having no address. Therefore it is not surprising many people will reoffend or it makes their Mental Health worsen, or they will return to drug or alcohol abuse. The community rehabilitation company also commented that they receive no information about Mental Health needs of prisoners that are released after shorter sentences;

11. The Mental Health Criminal Justice Board should work with local prisons to ensure information relating to Mental Health needs are provided to relevant criminal justice and Mental Health support organisations. To review the Mental Health support that prisoners should receive after prison and identify if any additional services need to be put in place.

Several ex-offenders discussed the importance of receiving support alongside punishment to have the best impact on their Mental Health and their likelihood of reoffending;

Executive Summary

12. To build on existing pilots (e.g. Mental Health treatment requirements) and consider sustainable rehabilitative options for offenders at all parts of the Criminal Justice System e.g. from custody, at court etc.

Service users explained difficulty in accessing support at critical times of need such as; the impact of missing appointments meant they could no longer receive treatment for an addiction, or access to medication whilst homeless; Service users also explained the difficulties of services dealing with mental needs and substance misuse needs separately. It is positive that the new substance misuse contract includes support for people with both Mental Health and substance dependencies.

13. To ensure Mental Health service user feedback informs and shapes current and future substance misuse services.
14. To continue to embed the Keep Safe Scheme and raise awareness of its broaden scope to include Mental Health and Autism.
15. To review the process of discharge from hospitals with service users and their carers to understand how communication can be improved.
16. To improve support on discharge from hospital to ensure an appropriate plan is in place, and also so that families are as involved as much possible so service users no longer feel “exposed to the world” upon discharge, but understanding their new pathway for support.

Currently parents/carers of autistic children or adults are encouraged to telephone the police if the person they are caring for becomes violent, but the parents/carers do not want to criminalise them and do not think the police is an appropriate response as it could escalate the situation.

17. For social services to work with the police and parents/carers about the most appropriate alternative response or action that reduces criminalisation of autistic people.

Raising awareness & knowledge of services and routes

People are trying to navigate through a system without anyone directing them where to go, transitions between services needs improvement, others do not receive enough information about why decisions were made and why support was not given, or information is not updated so they have to tell their story again and again. Service users are still reporting that they are waiting months for assessment and for treatment. Professionals are also not aware of support services available particularly for carers. Frontline practitioners should all be made aware of the support that can be offered to the whole family not just the patient/client.

A number of referrals are made through GPs and it can be dependent on the information that is included as to whether someone is put through for assessment. However often service users can either self-refer or add information in that they think is relevant, although they are not always aware of this;

To continue to reduce time waiting for assessment and treatment. Develop two way communication methods to; ensure families know what is happening and do not feel forgotten, to inform where additional support can be provided during the waiting period, and health services can be kept updated by service users if any changes take place that need more immediate support.

18. To review the thresholds for being eligible for early help or crisis intervention.
19. To ensure referrals to child and adult safeguarding services that do not meet the threshold are appropriately referred onto Mental Health, ADHD or Autism support services.
20. To design a campaign to raise awareness of Mental Health, Autism and ADHD support services across frontline practitioners within the Criminal Justice System, health and service users and carers, with the aim of providing support before crisis point.
21. To raise awareness with GPs regarding the importance of the detail required when making referrals and to ensure service users are aware that they can self refer and add relevant information.
22. To consider a one-stop-shop for Mental Health services (to consider the role of the NHFT referral centre) where service users and carers can explain their needs and be sign posted to the right services. So that referral mechanisms can be explained, where service users can access where they are on waiting lists, to introduce ways in which individuals only have to tell their experience once, and then this information be passed on, and where they are advised of alternatives for support whilst they are waiting.

Wider engagement with young people

Further engagement is needed with young people who have experienced the police or wider Criminal Justice System. Limited engagement was achieved through partner agencies promoting the Time 2 Listen survey to young people on our behalf

23. For the Police and Crime Commission Youth Commission members to work with the Commission on obtaining the views of their peers on their experiences of Mental Health, Autism and ADHD services. With the aim of co-producing activity based on the outcomes of the consultation.

Executive Summary

24. Therefore Northamptonshire Police and Crime Commission will use creative methods similarly to those in the youth Time 2 Listen competition (e.g. art, rap, poetry, filming etc) to help explore young people's experiences, who have had a direct experience of the police and wider Criminal Justice System.

Shared vision and collaborative commissioning

There has been differing views particularly from professionals about their role in Mental Health and a lack of responsibility. With the outcome being service users and professionals are passed from one service to another.

25. To establish an overarching 3-5year vision of how vulnerable people's needs will be addressed within the criminal justice pathway by aligning existing police, health and social care strategies, that demonstrate outcomes and benefits for the whole system in Northamptonshire. This vision should include agreement that Mental Health is every organisation's responsibility and an action plan should be developed with clear owners and should include commitment to joint commissioning arrangements.
26. Establish a full understanding of the criminal justice pathway and how it works with relevant Mental Health, substance misuse and learning disability services. Protocols between each organisation should be produced to clarify for professionals the role of each organisation, what their responsibility is, and how referrals can be made. So that professionals have a better understanding of what services can and cannot provide. These protocols should be fully communicated to frontline staff.
27. To consider how out of hours services, particularly in mental crisis teams, can be more effectively resourced, to better enable more appropriate support to service users rather than a reliance on emergency services.
28. To establish operational meetings across the Criminal Justice System and health and social care to jointly address problems in practice, identify where learning can take and to improve communication between organisations.

Both professionals and service users spoke about the lack of preventative services

29. To jointly commission and pilot a greater number of preventative services actively addressing groups (particularly young people) with risk factors related to Mental Health, criminal justice and victimisation. This includes working with current preventative services to achieve this.
30. Establish a pilot for partnership working at a locality level to help prevent crime at its root by delivering early interventions. Police should work closely with Mental

Health, substance misuse, learning disability services to identify and collaboratively support people in the community with Mental Health, learning disabilities or substance misuse problems involved with low level offending.

Improving processes across the Criminal Justice System

31. To support the recommendations set out in the Op Alloy evaluation and particularly the change of hours to the service, to better meet the demand and to develop a consistent team to make it even more effective.
32. To review provisions and processes in hospitals to seek alternatives for officers spending significant amounts of time with patients waiting for assessments.
33. The local data captured around Mental Health needs improving particularly around policing. Currently we still do not have a full picture of Mental Health demand on policing services. There has also previously been a lack of consistency in Op Alloy related data which needs rectifying to understand the full picture.
34. For the Mental Health Criminal Justice Board to oversee the Liaison and Diversion service to ensure consistency of service from police custody to court. This oversight should include establishing joint working protocols to maximise efficiency.



**Literature Review,
National & Local Context**

Literature Review, National & Local Context

People affected by Mental Health conditions and learning disabilities experience greater difficulties when accessing justice, as well as being exposed to greater discrimination, disadvantage, and stigma (Mind 2001).

Community Mental Health service resources are not always able to fully meet the needs of people affected by Mental Illnesses, and this results in an increase in contact of those individuals with the criminal justice system (CJS) and prisons, creating criminalisation of those who are mentally ill (Chaimovitz, 2012). Wood et al (2011) stated this increased pressure on police forces, who are not trained enough.

In police custody, between one-third and one-half of detainees might be experiencing Mental Ill Health (McKinnon, Srivastava, Kaler & Grubin, 2013; Payne-James et al., 2010). A 2007 review of police custody records in a London police station found that 46% of detainees had a history of Mental Illness (Payne-James et al., 2010), and another study reported how 39% of London detainees presented some form of mental disorder (McKinnon, Srivastava, Kaler & Grubin, 2013).

In 2011, the government published a Mental Health strategy setting six objectives, including improvement in the outcomes, physical health and experience of care of people with Mental Ill Health, and a reduction in avoidable harm and stigma. However, despite these initiatives, challenges with system wide implementation coupled with an increase in people using Mental Health services has led to inadequate provision and worsening outcomes in recent years, including a rise in the number of people taking their own lives.

Over the last five years, public attitudes towards Mental Health have improved, in part due to the Time to Change campaign. In turn, this increased awareness has heightened understanding of an urgent need to act on improving the experiences of people with Mental Ill Health, both within and beyond the NHS.

In this context, NHS England and the Department of Health published, Future in Mind in 2015, which articulated a clear consensus about the way in which we can make it easier for children and young people to access high quality Mental Health care when they need it.

The independent report of the Mental Health task force (Feb 2016) describes a 10 year journey towards prevention and transforming NHS care. More than 20,000 people were consulted and their priorities were Prevention, Access, Integration, Quality and a Positive experience of care. The taskforce report makes more than 60 recommendations in three key areas;

- Parity of esteem between mental and physical health for children, young people, adults and older people
- Where wider action is needed to achieve the main ambition of people to have a

Literature Review, National & Local Context

decent place to live, a job and good quality relationships in their local communities

- Tackling inequalities as Mental Ill Health disproportionately affect people living in poverty, who are unemployed and who already face discrimination

Furthermore, the taskforce made specific recommendations for the health and justice care pathways;

- Develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed.
- Build on the national roll out of Liaison and Diversion schemes (including for children and young people) across England by 2020/21 and the increased uptake of Mental Health Treatment Requirements (diversion through court order to access community based treatment)

It is felt by some that as a result of the criminalisation of people with Mental Illness, the CJS has been the default provider of Mental Health support (Fenge et al., 2014), and recently the focus has been on the diversion of offenders with Mental Illness to appropriate Mental Health services (Bradley, 2009).

The Bradley Report highlighted the need for a pathways approach and saw the Criminal Justice Mental Health Teams (CJMHTs) it proposed as having a role beyond the police station or court. Lord Bradley became keenly aware that many of those people who might benefit from Liaison and Diversion could have benefitted from many opportunities in the community but these had been missed. (Liaison and Diversion is where Mental Health-trained specialists are located at police custody suites or courts in order to accurately diagnose and refer on to more appropriate Mental Health services outside of the justice system.

The Bradley Report also highlighted that people with Mental Health problems face considerable stigma still and those who have 'offended' face a double jeopardy of stigma, including in the very public services that should address their needs. "Still too few community services see the police stations, courts and prisons in their communities as parts of their communities." (The Bradley Report 5yrs On, An independent review on progress to date and priorities for future development 2014, Durcan, Saunders, Gadsby & Hazard)

The RAND Corporation completed an evaluation of the offender Liaison and Diversion trial schemes (2016). The evaluation found that stakeholders from partner agencies and those delivering L&D services were overwhelmingly positive about the national model. It was perceived to have resulted in an increase in useful information about vulnerabilities being provided to decision-makers in the CJS and closer working between Mental Health and other professionals, and the police and courts. However

Literature Review, National & Local Context

further evaluation is needed has to fully understand its impact on health outcomes and the outcome of the information being passed on to the CJS.

In 2014, the Mental Health Crisis Care Concordat was launched: a joint statement agreed by health, social care, police and all local government agencies, setting out how public services have to work together in order to help people in a Mental Health crisis (Reveruzzi & Pilling, 2016). This document directly regards the nine Street Triage pilot scheme funded by the Department of Health as a possible model of how the principles of the Crisis Care Concordat could be put into action (Reveruzzi & Pilling, 2016).

Analysis of the quantitative data collected from each police force involved in the pilot showed that the Street Triage pilot led to a reduction in the use of s136 detention (Section 136 is an emergency power which allows a person to be taken to a place of safety from a public place, if a police officer considers they are suffering from Mental Illness and in need of immediate care), with an overall reduction of 11.8% with reductions of 21.5% and 19.4% in the Metropolitan Police Service and North Yorkshire.

Overall, police forces have been given autonomy to implement Mental Health triage services at a local level. The majority have a deployable street triage team for face-to-face assessment and liaison with response officers on the ground. Some forces opted for a control-room based telephone model. Moreover, most forces have, after the national pilot, moved to a 7 days a week service, covering most hours of the day.

All the schemes seem to have two main features to be pursued and valued in the future: the improved training for officers, and the improved liaison with Mental Health services.

Local context

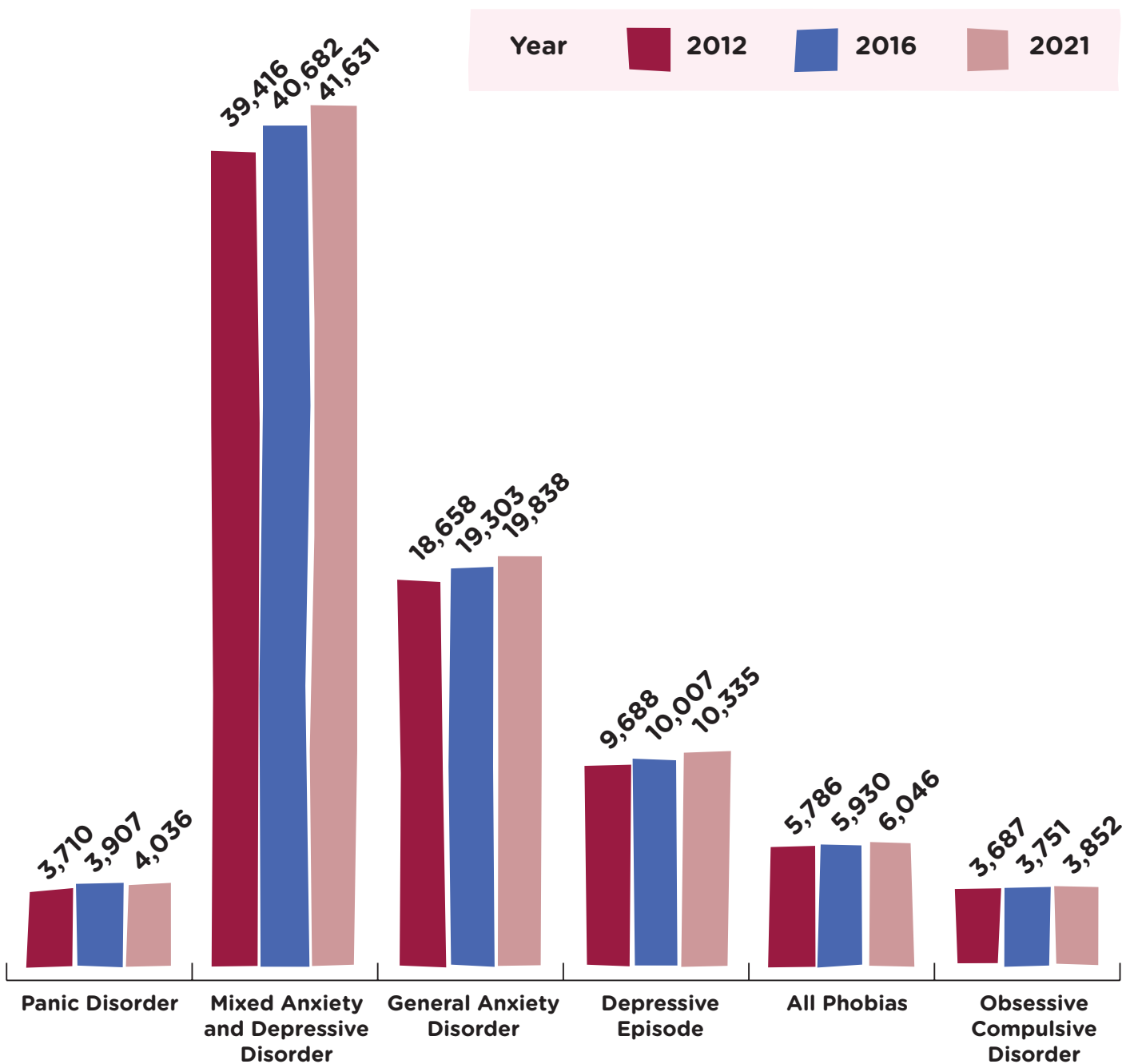
The Northamptonshire Health and Social Care system is under unprecedented financial pressure, which is further compounded by the local demographics of national and international centres such as St Andrews Healthcare and providers of a range of residential placements. This increases the demand on local services due to the highly complex Mental Health and dementia cases they import to the area.

Local data within Northamptonshire shows us that there are a number of risk factors for children with mental disorders (CHMD) identified by Public Health England including; homelessness, higher risk drinking, low physical activity, use of outdoor space exercise/health purposes and relationship break ups.

Literature Review, National & Local Context

Prevalence of CHMD is expected to increase over the next 5 years with more than 41,000 people estimated to have a CHMD by 2021.

Prevalence of Children with Mental Disorders (CMD)



Literature Review, National & Local Context

As well as the likely future increase in young people with Mental Health disorders, the police are facing a demand for Mental Health related incidents. In 2017/18 3.5% of incidents were recorded by the police as having Mental Health involved, which represents around 6500 incidents. This is likely to be a significant underestimation of policing demand due to a lack of consistency in how it has previously been recorded.

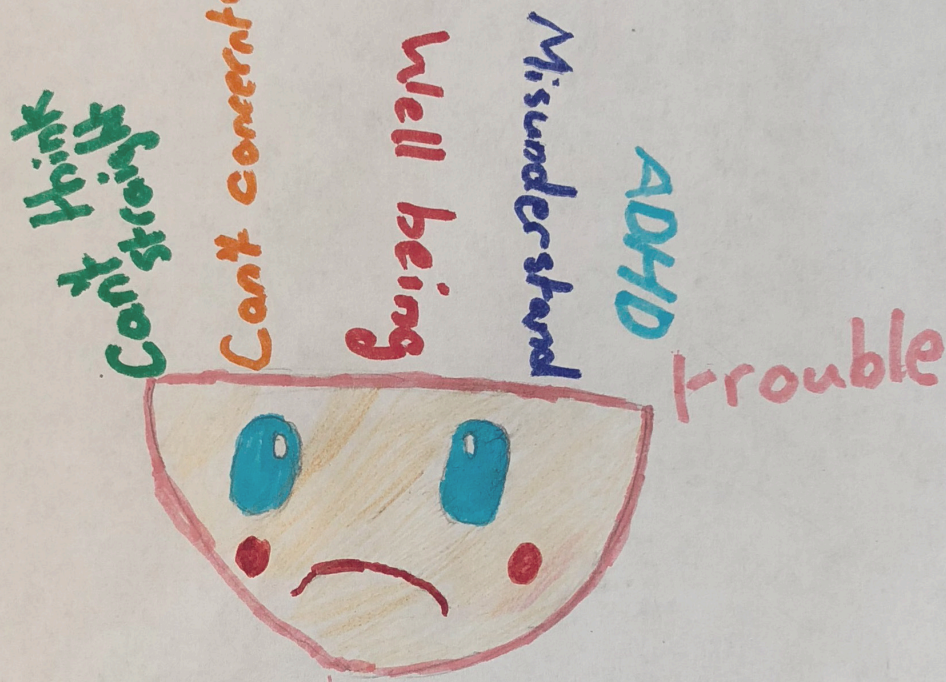
We know through police data that the number of people being sectioned under 136 of the Mental Health Act has reduced from 421 in 2016 to 337 in 2017. Northamptonshire was in the top five forces with the highest proportion of 136 detainments per 100,000 population compared with other force areas in data from 2016/17. It is unclear as to whether this decrease is distinct to Northamptonshire or similar to other forces (therefore the decrease may not change the county's overall ranking), and national comparisons are yet to be available.

Of those who are sectioned under a 136, 50% are young people aged 10-30, the majority (68%) are sectioned as they are suicidal. There are variations in prevalence across the county, 44.9% from Northampton but only 4.5% in Corby. This is interesting in light of Corby having the highest rate of suicide in the country with 17.5 people in every 10,000 committing suicide (Office of National statistics, number of suicides by local authority, England and Wales, deaths registered 2002 to 2016).

However data relating to Mental Health in the criminal justice system is not data rich, particularly in policing. There is also a need to better understand victims' and offenders' experiences of the service provided by the police and the wider criminal justice system and whether it meets their needs. Police officers spend significant amounts of time in the community, in the control room and in custody interacting with people with Mental Ill Health. Yet there is little understanding of what their experiences are, how effective partnership working is, and what barriers or issues they face that might hinder them from delivering effective services.

There has been several examples in the national media which specifically point to poor service from the CJS to those with ADHD and Autism, who have similar vulnerabilities to those with Mental Illness groups. Therefore local ADHD and Autism local support groups were approached and they were keen that the OPCC widened the remit of Time 2 Listen to capture the experiences of those with ADHD or Autism and their carers.

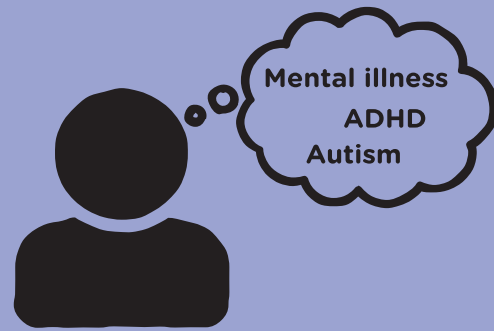
Mental Health



The police need to be more Aware of mental health because people could do something without realising that it's wrong. When the police come the person will probably get scared or angry so I think that the police need to know who has mental health as well as knowing the best way to deal with people who suffer from mental health.

The aims of Time 2 Listen were:

To **consult** with people who have a **Mental Illness, ADHD or Autism** and their carers about their experience of the criminal justice system and support services that work alongside it.



Capture **experiences** of those **professionals and support agencies**, to understand the mental health pathway and service provision

Capture **experiences** of those who work in **frontline roles**, and how effectively organisations **work together**.



The consultation aimed to; collect both positive and negative experiences, identify learning, areas of improvement, gaps in services and where good practice is taking place.

Aims and Methodology

Service user experience

Enabling Time 2 Listen to be as accessible as possible to service users and carers was essential to reach people from a range of demographics and backgrounds. This included aiming the consultation at adults and young people, both victims and offenders, whilst also meeting the needs of people with a range of disabilities and difficulties.

Overall 1274 people were engaged directly through focus groups, events, one to one interviews or via surveys feedback or social media comments.

Three different surveys were designed and were available online or in hardcopy. One survey was aimed at adult service users and their carers, one specifically for those with Autism designed to ensure questions were as concrete as possible, and one aimed at young people. All were consulted in the design of the survey with support organisations that work with these service users or with service users themselves.

The online surveys were promoted through paid Facebook adverts, and through partner organisations across the CJS, health and third sector organisations promoting them on our behalf to their members. A learning point that arose from the paid adverts were that some people preferred to comment on the message rather than complete the survey. In future we will look at posting individual questions to gather responses in addition to more formal surveying approaches.

Focus groups were held with service users where appropriate. However the approach most requested was a one to one conversation (semi-structured interview). To capture the views of those seldom heard, engagement included visiting: homeless shelters, day centres and hostels across the county, speaking directly with female and male offenders accessing support and probation services, service user support groups and carers' groups for Mental Illness and Autism, visiting supported living housing for people with complex needs, engaging with organisations supporting people with Mental Health and additional needs returning to work, and by attending sessions held by third sector organisations who provide practical and emotional support for Mental Illness, Autism/ADHD. A full list of organisations who supported the Office of the Police and Crime Commission (OPCC) with this consultation can be found on the acknowledgements page at the end of this report.

It was also important to take into account the level of sensitivity needed in these one to one interviews due to the vulnerability of some of these individuals. Several of the people that were interviewed became upset when describing their experiences therefore it was important to ensure support services were in place afterwards.

When capturing views of young people a range of methods were used that encouraged

as much participation as possible. Therefore a competition was run in schools and youth clubs to gain a greater understanding of what young people thought Mental Health/Autism or ADHD meant to them, they were encouraged to feedback through art, poetry, a story or a rap. The honesty and rawness of the feedback from the young people is shown throughout this report, young people shared what it was like for themselves or friends or family. Disclosures were made in some of the youth groups that we attended of issues affecting young people's Mental Health that were previously unknown, demonstrating the need for these subjects to be openly discussed in a way that is comfortable for them.

Many organisations across the county supported the Time 2 Listen consultation by promoting the various ways people can take part; including Voice – Northamptonshire's victim and witness service promoted the Time 2 Listen consultation in every letter to victims within the consultation period. Additional promotion was made through local community newsletters, and information was sent out to all GP practices and pharmacies and large libraries.

Professional view

It was important to understand the views of those working in and around Mental Health provision in the CJS, both at a strategic level and at the frontline. This enables a better understanding of the Mental Health pathway and the issues they face day to day, whilst building on successes achieved to date by informing the planning and implementation of work to be done over 2018-19 onwards.

The Police and Crime Commission asked Wayland Lousley, an experienced Mental Health nurse and commissioner, to undertake a review of the Mental Health pathway within the CJS, a workshop was run with attendees of the county's Mental Health Criminal Justice Board and additional interviews were held with professionals who are working in the CJS, current Mental Health commissioners, frontline Mental Health practitioners and support services. Both statutory and third sector providers contributed to this project to better understand the current processes and service provision for people with a Mental Illness, ADHD and Autism.

The following services were within scope:

- Mental Health Street Triage (control room Nurse/Operation Alloy-Northamptonshire's approach to street triage),
- Police custody Liaison & Diversion and Custody Healthcare,

Aims and Methodology

- Youth Offending Service (and how it works with Child and Adolescent Mental Health Services CAMHS)
- Court – Community Sentence Treatment Requirements and High Intensity User initiatives.

Prison Mental Health care was not within the scope of this review.

In addition to this review the OPCC devised an online survey to capture the views of frontline practitioners across the Criminal Justice System, Mental Health services and third sector organisations.

In addition focus groups were held with police officers in response roles to gain a greater understanding of their experiences.

Several other pieces of work were also commissioned by the Police and Crime Commission in similar timeframes including an evaluation of Operation Alloy and a project exploring Mental Health within the force. Separate reports have been produced but links will be made where appropriate within this report.

Number of respondents engaged by method:

Service Users



228

Surveys



46

Interviews



54

Focus Groups



287

Facebook
Comments



589

Engagement
events/meetings



70

Competition entries

attended 6 youth groups
additional and 3 schools took part

1,274

**Total number of people
engaged face to face or
who had direct contact with**

Social Media Reach



202,199

**OPCC Facebook
adverts**

(includes 4155 click
throughs, 1186 emoji
responses, 367 shares)



1,500

OPCC twitter



90,000

**Reach through
Northamptonshire Police
facebook**



11,749

**Reach through partner
promotion**

305,448

**Total people reached via
social media**

Professionals



**Focus group with
CRC probation
officers**

12 attendees



**Interviews to
inform review
with senior
practitioners and
commissioners**

10 People



**Frontline
practitioner
focus groups in
Northampton and
Rushden**

16 People



**2 Workshops with
criminal justice and
health partners to
inform review**

28 attendees



**5 Focus groups with
police response
officers**

51 attendees

262

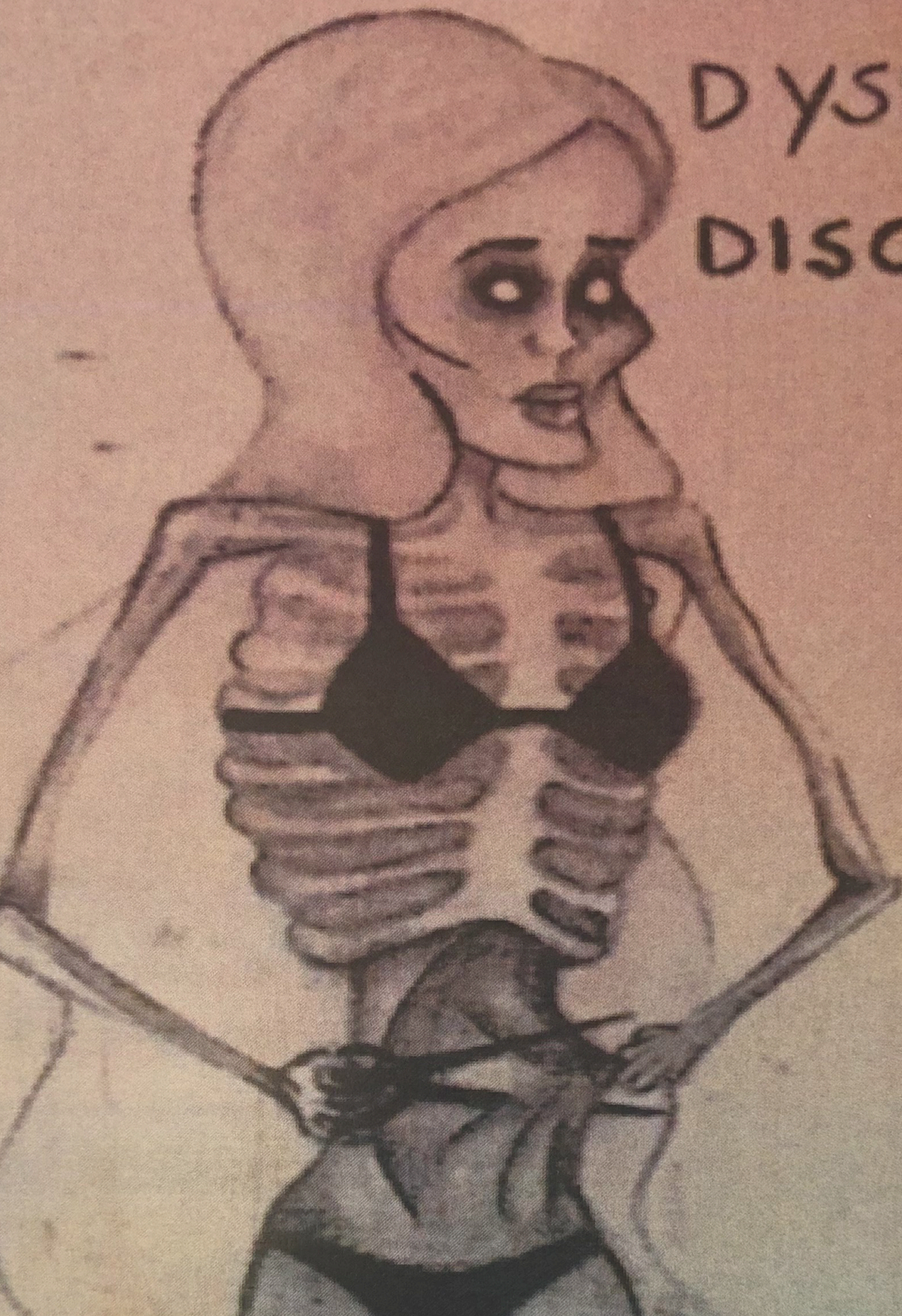
**Total number of frontline
professionals consulted**



Frontline survey

145 respondents

BODY DYSMORPHIC DISORDER



**What does Mental Health, ADHD
and Autism mean to me?**

What does Mental Health, ADHD and Autism mean to me?

Many people described what it is like to live with or care for someone with Mental Ill Health/Autism or ADHD and how this can impact their day to day lives;

Young people described their experiences through poems and personal stories:

My Brother and I

My brother is Autistic

He was diagnosed when he was 6

I was only 3 at the time

We used to be best friends but as he got older we
drifted apart

He would lose control sometimes and let his anger get
the best of him

He would take this out on me most of the time

This was by hitting me

He slipped away

As he grew up he got worse

He was kicked out of 7 different schools, 5 of which
were boarding

I remember going to school once with a large bruise on
my chest,

Because he got so angry he threw me across the room
into the corner of a marble top

I have spent most of my life trying to not get hurt

He stopped for about a year but it doesn't mean it
doesn't happen

The thing that hurts worse than a bruise or scare is
knowing I can't help him

What does Mental Health, ADHD and Autism mean to me?

Another described how their Autism effects their school life

I was diagnosed on the 13th March 2018 with ADHD and I am still being assessed for Autism. I have struggled on and off at school and home for my whole life. I am writing this, to tell you how I have been feeling over the last few years.

I really like being by the water and I am very keen on sailing and swimming. The water really helps me feel calm and I find it very therapeutic. Swimming and sailing also help tire me out and this helps me sleep much better. I also really like soft fluffy items, like the blanket on my bed, my toy monkey Bobby and our very soft, rebrety dogJester. Just the touch of the softness against my skin makes me feel relaxed and helps me to unwind. When I do want to unwind I like nothing better than going to my quiet bedroom where I can climb into bed, cuddle the dog, listen to music and turn on my lava lamp or star projector.

There have been times where I've got so cross and upset that I've wanted to kill myself. I talk a lot about how I don't want to be alive when I get frustrated with school or when I am not having an easy life at home. I can laugh more or be happier when I spend more time in my room and keep myself to myself. When I am in my room I can't get into trouble, cause headaches or unhappiness to my family.

I never ever mean to hurt anyone but sometimes I can do things which can end up with someone getting hurt. When someone does get hurt I feel bad for them, even if I wasn't the one that caused it. When I do get upset I try not to show my emotions, so I am not teased for it.

One of the biggest things I struggle with, is understanding long... detailed instructions or briefings. Which is bad because I'm a sailor I need to be able to listen to briefings.

I spend a lot of time worrying. Some nights I worry so much about being organised for school the next day, or getting ready for sailing, that I can't get to sleep till very late. Because I spend so much time worrying I forget about other things I must do.

Another thing that really upsets me is losing things. I remember losing the speedo on my bike, I think I lost it when it fell off my bike or someone might have taken it off my bike at the shop.

Life had got a bit better since I left my first secondary school. I felt I was punished badly for things I couldn't help doing or things I didn't know I was doing. If you were internally excluded for a day it was horrible, you had to sit in a small dark cramped room for an entire day which often gave me very bad headaches and nose bleeds.

What does Mental Health, ADHD and Autism mean to me?

Since I started at my new school life has got much better and a bit easier. In year 9 I started having strategy meetings with a very nice lady called Mrs Cox, as result of these meeting my behaviour and work have improved immensely. I am now starting my silver diploma and I have just started my Bronze Duke of Edinburgh, which I am excited about.

I still have moments where I don't want to live, but I soon get over them with help from my school, family & friends.

A mother spoke of the impact of her son's Autism and Mental Health and the difficulty of services identifying additional needs when they are not visible;

"my son's a teenage boy and we've been going through a really awful time actually. He's been diagnosed since he was six, not been in the right services, so the mental health issues he's got on top. He was attacking me every minute of the day. He was attacking my daughter"

She went on to say "And that's hard because if you're in the community and you're in the police and you see someone doing that to their mum, you're not going to know what you're up against and that's hard. I keep saying this to my son, you're autistic, nobody knows you're autistic because you can't see it. You can only see it when you're having your meltdown and that looks like challenging behaviour and then if somebody sees that, then all they're going to do is protect"

What does Mental Health, ADHD and Autism mean to me?

An adult spoke of the stigma around Mental Health

“For people who suffer with mental health, yeah I’m still suffering, yeah I get up and down, end up happy, end up in a crisis. Like last night I ended up in a crisis but I didn’t do anything, I managed to battle my way through it. There is help, it’s just a matter of it takes time to get that support. No one listened to me the first 100 times that I was 136’d. When things got more serious, they took a more listening approach. It’s not the answer to do something stupid, to try and end your life. You’ve got to keep going, you’ve got to keep fighting on because it’s us with mental health, you can help end the stigma. There’s not enough of us who are willing to stand out and talk which we need more of us. We need people to stand up and be like I’ve got mental health. It’s okay to employ me. I’m an okay person. I’m not an angry person. I’m not aggressive. If people just listen to it and then it could help everyone who’s in a crisis.”

“It’s really, really hard for people with mental health to say everything because you just feel like a freak, when actually it’s quite common everything that you’re going through and everything that you feel and you think that you’re going to get sectioned if you tell people stuff... It’s really not a nice place. The level of support is good when you’ve got people that understand. It’s getting over that fear to tell people exactly what’s going on in your head and the other person understanding it and not being judged.”



People with
MH can be talked
to and get given
a card to show that
they live with MH.

Care

Mental Health

Attention
Deficit
Hyperactivity
Disorder

People with mental
Health may look
fine when you look at
them but inside they
might not be.

Autism

Autism is a lifelong
development that affects
how people act and
interact with others.
Autism can't be 'cured'.

Understand
People
with....
Mental
Health

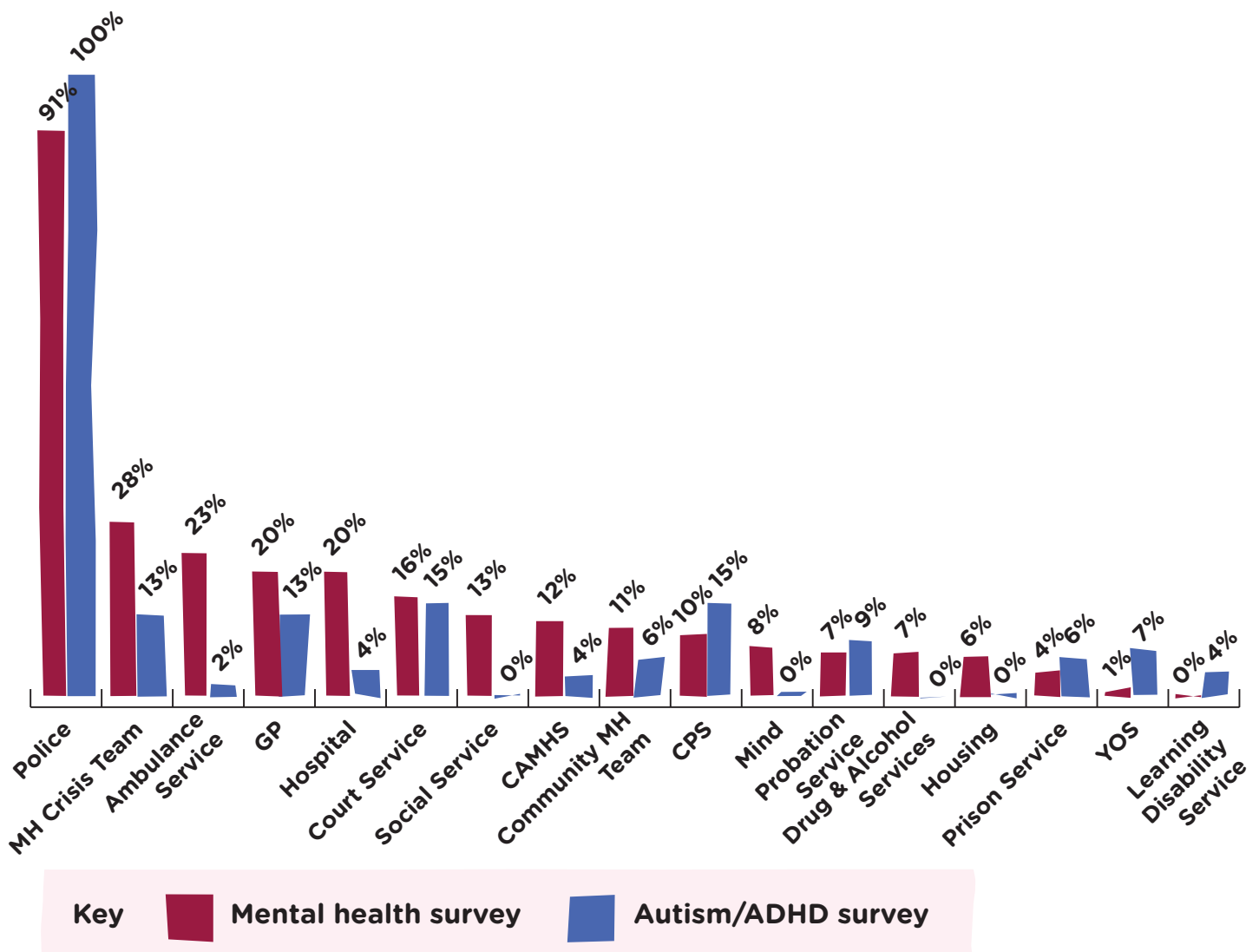
Do not leave people out with
Mental Health and understand
they can be different to

Service User Experience

Service User Experience

From the Time 2 Listen survey data the service most commonly involved in the individual's experience was the police. Multi-agency involvement was more likely to be reported in the Mental Health survey compared to those that completed the ADHD/Autism survey. Agencies not included in the graph below are the Hope Centre, Together, a youth service, Crime 2 Christ and Autism Concern that were involved in 1-2% of cases.

Services involved in incidents participants were completing the survey about



Of those who indicated that the professionals involved were aware of their Mental Health needs, 46% indicated that their Mental Health needs were taken into consideration. However, 42% indicated that they were not, while 12% either did not comment, it was unclear or they had a mixed experience. The top five reasons given for why they felt that their Mental Health needs were not taken into consideration were:

They felt that they were not taken seriously, listened to or in some cases believed

“I’d recently made a suicide attempt - I was homeless and I’d just gone through a divorce. I was just seen as a drunk guy being a nuisance”, “Because they think that if you have mental health needs your families’ version of events is true and not yours, mental health needs do not make criminals, that’s all you see”

They were not offered support, help or the issue was not addressed.

“I said I had PTSD but nothing was said or any help given”, and “There was no support, careless in the way it was done and handled. Left me feeling abandoned and vulnerable. No follow up or support”

They did not feel that the way they were dealt with was appropriate or helpful.

“I was treated like an object and kept unaware of what was happening”, “He was asked complicated questions that he didn’t understand due to learning difficulties” and “They didn’t help to reassure me, they kept touching me without explaining what they were doing which was making me anxious”

They did not feel that the professionals seemed like they were trained or prepared.

“I found the police were often clearly not very informed in how to deal with individuals with mental health. Therefore, at times it would make me feel more restless as they were not very understanding and seemed very rushed in their service. As if they wanted to rush the process and move on.”

It seems to be person-specific.

“They were not taken into consideration by everyone so it seemed it depended on the person involved rather than a policy”

Service User Experience

Of those who indicated that the professionals involved were aware of their Autism/ADHD, 39% indicated that their ADHD/Autism had been taken into consideration, however, 50% indicated that it had not, while 7% were unclear and 4% had mixed views. The two key and interrelated themes why they felt that their ADHD or Autism was not considered were:

No adjustments were made, for example - adaption in communication style, no responsible adult offered or allowed to take medication.

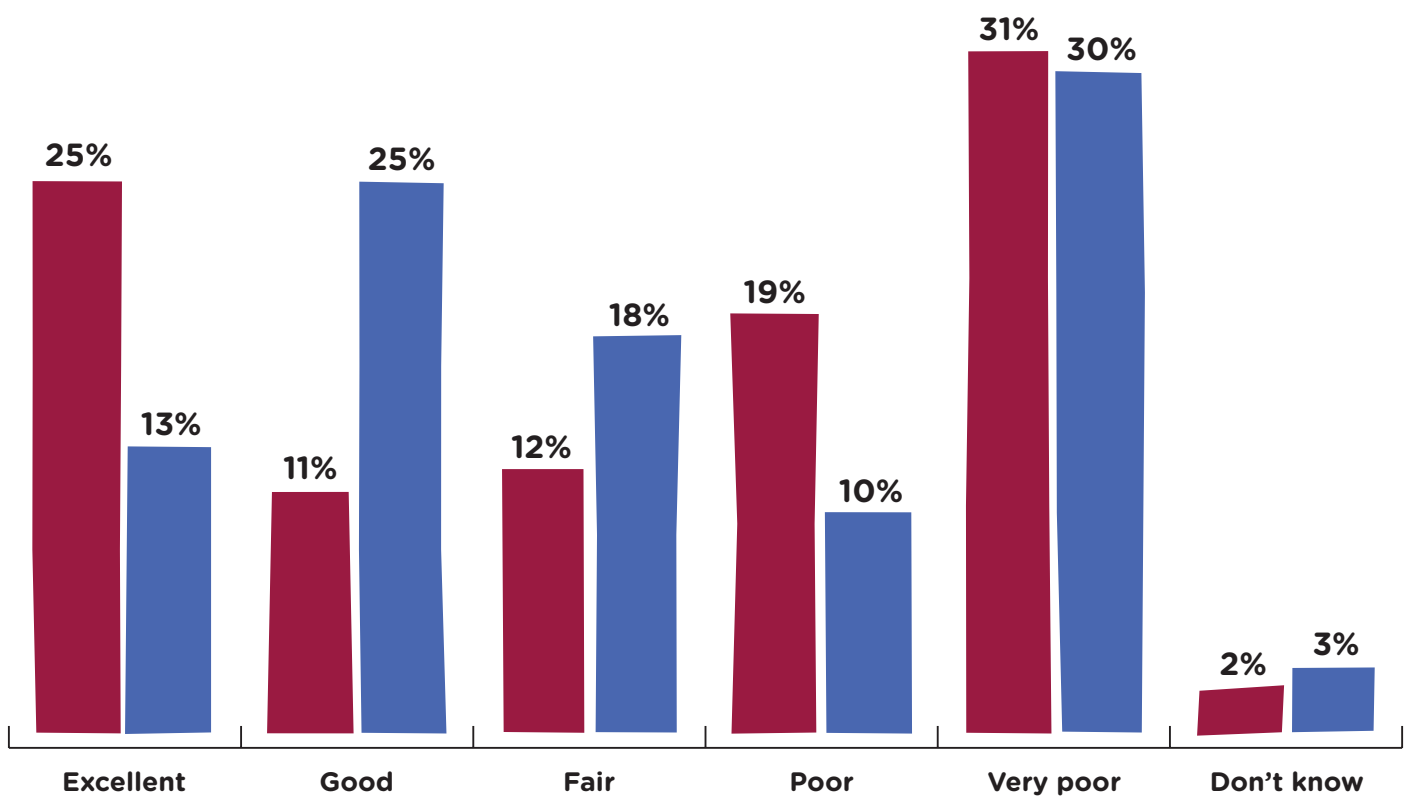
“Didn’t want to know. No responsible adult offered.”, “Failed to fully listen and to fully do my requested reasonable adjustments”, “Lack of understanding and approach in question wasn’t done correctly, officer came across as very arrogant and patronising” and “I required medication during my detention mum supplied the medication police refused to give medication until doctor had seen me the doctor did not arrive before release 5 hours later”move on.”

They did not feel that the professionals understood the needs of individuals with Autism or ADHD.

Comments included “The police didn’t understand the communication difficulties or that the reasons he was agitated or not eating or drinking for 24hrs. They didn’t understand sensory processing difficulties” and “Apart calming the whole situation.” “The police didn’t understand the communication difficulties or that the reasons he was agitated or not eating or drinking for 24hrs.”

Overall experience

Survey respondents were asked 'Overall please rate your experience of the Police and the Criminal Justice System'. The graph below shows the breakdown of responses given.



Key



Mental health survey



Autism/ADHD survey

Service User Experience

Participants were asked 'how could the service have been improved?' The top 3 key themes of improvements that could be made across the two surveys were:

1. Increased awareness and training relating to mental health issues and ADHD/ Autism

"All of them need to know how to deal with mentally ill people in a way that isn't going to make it worse"

"All officers should have ADHD and ADD training"

"Police assumed he was drunk and disorderly when he suffers from ASD and mental health difficulties and communication difficulties"

"...Training of Autism and it's many presentations is urgently needed. Particularly training around people who have Autism and higher intelligence - agencies should be aware that higher intelligence does not mean that the challenges related to Autism do not exist or are less - there is no link between intelligence and social cognitive deficits."

2. Effective communication

The second most common suggested improvement was better communication and follow-up. For example:

"Police- I felt it was very rushed and that the process was not explained well to me. I don't know if it was all done in the best way so that justice could have been done or not. There was no feedback and I wasn't told what would happen or what else I could do"

"Provide more information when incidents happen feel like I'm left in the dark. Police officer investigating only works part-time but she is very good and helpful"

"He was terrified of police following the trauma of the psychosis and detention at Berrywood. We (family) had no idea what was happening at the time. Needed to debrief."

"Police could have followed up on the case following receiving the report from the Learning Disability and Liaison and Diversion Teams. Neither client nor professionals were contacted again to advise on whether charges were being pressed."

3. Provision of appropriate support

“CAMHS are underfunded and in crisis and the police often have to intervene when MH services would have been more appropriate. CAMHS did not listen to someone who knows her the best and failed to provide adequate support and treatment to prevent her condition from escalating until she was on the side of a multi-storey car park. Then police had to be involved as critical condition”

“More support and information for long term support”

How organisations work well together

Participants of the surveys were asked ‘how much do you agree that the organisation who were involved worked well together?’ to which 32% agreed, comments included:

“The Crisis Team communicated well with the police – and the police understood the situation quickly and acted professionally”.

“They were quick in treating me and taking me to a hospital to be assessed”

However, 48% disagreed with the remaining 20% neither agreeing nor disagreeing. For those that disagreed comments included:

“Disjointed, no information handover, nothing done in a timely fashion”

“Suicidal - called various services including GP, crisis team, urgent care and assessment team and I have still not seen anyone about how I feel. Awful that services that are supposed to be there to help you, do not help you.”

“Nobody communicated anything to each other. Mum was finding out stuff via social media as agencies not telling her”

“Each organisation has funding issues, we are left struggling, these are lifelong disabilities that no doubt will present further problems throughout their lives.”

Service User Experience

Consistency of approach

The 1:1 semi structured interviews enabled us to obtain an in-depth understanding of service users and their carers experiences which further enhanced the feedback obtained through the surveys.

Experience of the Police

In 1:1 interviews service users experiences of Northamptonshire Police widely ranged and was very dependent on what officer they had interaction with. Even within the same incident they reported officers responding with differing levels of service;

“You have some really good officers that really do get it and not only support my daughter but also a little bit of reassurance for the family and whatever because of some of the situations we’ve been through. You get someone who really gets it and really supportive, and the last couple of occasions, September and December, fortunately one of the officers that turned up to both incidents was one and the same and he was very good first time and he was even better the second time because he knew my daughter, he knew the traits that she was displaying, and that’s kind of the Ying and the Yang of it. You’ve got some really good officers and some really poor ones.”

“Some officers are understanding and other officers call you pathetic, attention seeking, call you simple, call you not right in the head, which just gets you down really. And then you get one officer I ran into said it would have been better if you’d just jumped, which obviously then I went straight to the bridge again...”

“but the guy (officer) who’s come a couple of times and really supported, kind of talked to my daughter and really gets her on board but one of his colleagues standing there saying, ‘if you don’t soon hurry up, we’re just going to throw you in the van.’ So all of the good work... so even when there is someone that is very good, it frequently is actually diminished by an idiot.”

When people spoke positively about their experience they described key qualities and attributes including;

non-judgemental listening having patience respect

respect showing compassion

showing empathy

patience being respectful

showing compassion

listening

showing respect empathy respect

treating people

listening as individuals

being non-judgemental compassion

respect patience officers taking the time

Service User Experience

“Some of them were very empathetic. Like at the general, sometimes they would have to wait with me for a few hours for my blood tests and that to come back to make sure I didn’t abscond. Some police officers kept me on the go by just communicating, just talking about general everyday stuff, distracting my mind a bit. Whereas some police officers were just sitting there quiet, which strained me a bit more, getting bored and thinking more of my negative emotions.”

A young person told us the police were;

“very helpful, caring, and compassionate police officers. They were informative but calm, and listened to my anxieties in a way that felt supportive.”

Another young person explained;

“I was violently assaulted by a girl who has been bullying me for ages and the police officer who came round to take my statement was really patient when I had mental blocks and was understanding when I needed to use coping mechanisms. The bully was charged with common assault and a Community Resolutions Order was put into place.”

One person spoke of the benefit of an officer telling their own experience and how it gave them hope for the future;

“I had a bit of a breakdown and done something really silly... The police got called and they turned up at my house about an hour later and the guys, they didn’t judge me. They wanted to come in to make sure I was safe...And then they took me to get the help that I needed and one of the officers actually said about their experience because I was worried about people judging me. But it was nice to know his story because even people in that profession have mental health issues and when you’re in a different situation and you’re training for a job, it’s nice to know that you can actually get somewhere in life, even though you’ve got all this stuff going on.”

This was supported by feedback from a police officer when responding to the professional's survey, who stated the benefits of sharing their own Mental Health experiences where appropriate, but mentioned the lack of support from fellow colleagues;

"A lot of police officers I have worked with do not agree with me sharing my personal experiences with other sufferers who I meet day to day at work. I don't know if this is because they do not know how to react to what they hear me say, but I have found on the occasions where I have felt it appropriate to tell someone a bit about me, that it has helped the situation. I recently went to a mental health patient and when she started to say no one understands, I was able to say "yes I do." Because I could say that and I could tell her why, she found it easier to communicate with me than my colleague and I genuinely feel that it helped resolve the situation she was in much quicker and with less stress for all.

Now please don't mis-understand me, I do not tell every mental health job I go to about myself because it is not usually appropriate. However I am not ashamed to be able to tell someone I understand them. But it upsets me when colleagues have said to me after "I wouldn't have told them that, they have no right knowing." But to me it makes me more human."

Others spoke positively about officers communication skills in times of crisis;

"He seemed like to have a friendly approach about it. He didn't talk about it, he didn't ask what's going on or anything like that. He just diverted the whole conversation like, 'where do you work, what are you doing in your free time?' And just saying like, 'I don't even know you but you're a nice lady and it's just a shame that you're going through this right now,' which that does make you feel better, instead of them just talking about the crisis that you're in."

Service User Experience

Some spoke about the police changing their behaviour to meet the needs of the individual;

“and I just said to them, he’s ADHD as they left and as soon as I said that, everything just changed. I just didn’t think to tell them because it’s so long since we’d had any involvement. But that just changed everything because the attitude towards him... because he’s a bit gobby and he goes anti-authority and all the rest of it and when you first hear it, you think... but then when you realise that actually he’s impulsive and there’s other things behind it, and their attitude just changed completely and it’s like right, they stopped treating him like he was just being an arse and treated him more like actually you’re probably saying this because of something else going on. And very pragmatic, very unemotional and practical was the attitude and then right, we need to get the appropriate adult in and all the rest of it and they were fantastic from there on in... I think they’ve been superb. Considering what he’s done, I really think he’s been dealt with very fairly.”

However there were many cases described when the police did not demonstrate they were listening, showing empathy, compassion or being non-judgemental;

One service user described not being listened to by the police. The service user described an incident when a particular officer reminded her of an abuser, and felt her request for a different officer to deal with the situation was ignored;

“It’s just weird how, when you’re in a crisis and you don’t know what’s going on, how everything can change and then you feel like no one understands you. It was like I was shouting for another officer. I was shouting to get him away from me and not one officer there listened to me. I think that’s what they need to do, start listening to some people.”

One individual described being in hospital with his suicidal daughter and hearing officers outside of the cubicle describing a complete lack of empathy to the situation they were in.

Officers said;

“it’s an absolute waste of our time...she should have done the job properly and finished her life and whatever, and things like that are very raw when you’re in that situation. So that’s a complete either misunderstanding of mental health and very just disrespectful as a public servant to be doing that in a public place where not only my wife and could hear but presumably, and I don’t know who it was said for, my daughter could hear it and so could other nurses.”

A foster carer spoke of the police’s attitude to a young person in her care when she went missing who had Mental Health issues;

“It’s like oh, here’s another care kid, oh god, here we go. We’ll go out and do a proper job and stuff. So it’s quite a bad attitude and I think that’s bad for her because one day she will want the police and she will want somebody to keep her safe and if she thinks that they’re just like urgh, dismissive of her, she’s probably not even going to ring ‘em. She’s probably just going to think no, what are they going to do? They’re not going to help.”

A parent described the negative experience of her son who is autistic with non-verbal communication and the police not listening to requests from parents;

“he’d got put in the back of a van to be taken home and it was sort of sirens and lights on, which basically took him from a state of agitation, that heightened the sense of agitation having sirens and lights flashing as well. So we both sat in the back but then they were driving like lunatics and they’d got the sirens on and I was like, ‘can you slow down and turn your sirens off and your lights because you’re making everything worse for him,’ and they’re like, no... It was as if they were showing off, we’ve got the sirens on, we’ve got this and that and I was like, ‘you’re making him worse. You’re not helping,’ but they didn’t stop. Three of them took us home, three cars in the end. We never needed all that. “

Service User Experience

She described the importance for people who are autistic to be in an environment where de-escalation techniques are used;

“the more shouting, the more aggressive, the more heightened elevated adrenalin which is projected to the situation, the worse it’s going to be...From my point of view, the main talking points are attitude and approach and being aware the potential of the non-verbal, they’re not going to answer you back and not necessarily understand words that you’re saying, whereas pictures or...Some people don’t respond to verbal, they respond more to pictures and stuff like that. If somebody’s in meltdown, the whole thing is just de-escalating the whole situation.”

Other service users and carers described their frustration when interacting with the police control room the long wait (some of over 45 minutes to get through) the lack of updates received so the need to ring back and then having to retell their stories time and time again;

“Another thing was every time you phoned through to the control room, I had to tell the whole story again and that must have happened six times throughout that time. Not just when you talked to the control room but when you talked to every part of the control room. So if they then put you through and said, you need to speak to this person, put you through to somebody else, you then had to start again. I think when it went through to CID, the people in the control room then couldn’t read the notes. So then we were having to tell the whole story all over again... The whole thing every time, apart from the very first officer who came out, the first one who responded, it felt like you were inconveniencing the police in what they were doing and you were getting in the way of them being out policing.”

Another stated they did not know what type of service they would receive each time they contacted the police;

“It’s all about a consistency really. I think we can handle that things (service received) are bad or things are good but it’s just when sometimes they’re really, really bad or really good and it’s a lottery. Something happens the next time, I don’t know what service I’ll get, I don’t know what reaction I’ll get from either the call handlers when we call it in, through to who’s going to turn up, whether they can really be arsed because sometimes it seems like it’s just another job and just another inconvenience.”

The same parent described the emotion of having to continually go through the description of his Daughter when contacting the police control room when she goes missing;

“it’s kind of quite painful, an emotionally worrying kind of time when you’re going through a load of questions and bits and pieces. So about seven / eight years ago I had a sit down with, the local Inspector and it meant that I had a reference number that I used to phone through and I gave that, which cut out all the what size are her shoes, what colour eyes, what this, what that because they had it. They pushed a button and all of the details popped up. They’d got a photo, they’d got all her likes, her dislikes, things to do, popular places she may be, traits and whatever, and that was absolutely brilliant. Then you changed the force system, so we go back to where we started...Brilliant, absolutely great idea. But then that was on the old force system and it’s five/six years ago since you changed it, I guess.”

Training

The concept of giving police officers further training on Mental Health, Autism and ADHD has already been raised within this report through the survey feedback, however in the one to one interviews service users and their carers described what this might include. They wanted to ensure staff were regularly kept updated around Mental Health issues, Autism and ADHD.

A young person said;

“Police want to protect the public. I think they need to be offered more in-depth training to enable them to protect the public in a way that they feel confident from. I know that when some people are experiencing a psychotic episode, they might become physically dangerous to others around them. I would like for a police officer to have had training that would help them to feel safe in such circumstances. I see on the television that the police are having to increasingly work with people with poor mental health, and it is just common sense really that the police are provided with more training to help with that.”

“I feel that when they’re doing their police training they need to do... in mental health as well and have a brief update every so often, like you do in cookery. And just have a brief update every time with each officer. That’s the main thing, keep them up to date, cause I know things change.”

Service User Experience

A parent with an autistic son said they had even offered to provide some training to their local police officers but were not taken up on it;

“We were told to contact the police and they would listen. We could even bring (her son) along and do a talk because the way that he was treated was shocking... When I said to them and everything, they were like yeah, none of us know about Autism and would you come and do a talk at the police station. Constantly, constantly trying to contact them and sort it. Nothing. Nothing ever came from it. It’s absolutely disgusting.”

A foster carer said:

“I think because we probably as foster carers do use the police quite a lot, we probably are quite known, it would be nice to actually have a training course or something where you can say, this is what happens with foster kids, this is what they’ll do. They will kick off, they will run away, they will arrogate stuff, they will come out with some... just to get you on their side and all that sort of stuff and this is what you do. This is how you handle it and this is how you talk to them and also as well it’s not going in, that they’re vulnerable”

Another spoke about the level of vulnerability children with Asperger’s face;

“it’s really important that Asperger’s teenagers have confidence in figures of authority. That they feel safe and if they have got a problem, especially people who are bullied, and a lot of people suffer hate crime and they don’t know what to do about it and they’re scared to say anything. But if they felt they could tell the police they could do something about it and if the support was there it would help.”

Young people explained;

“I got mugged in Kettering and when I told the Detective who interviewed me that I was autistic she didn’t really understand that so kept asking me a bunch of questions all in one go and that made me feel confused and I was already scared so the detective scared me even more. The young person said that their needs were met by the control room “the dispatcher on the 999 phone call handed the fact that I had Autism really well”, but suggested more training was needed when working with people with Autism “Detectives and officers should have a bit more training when it comes to dealing with special needs/autistic people.”

“About a year ago I tried to take my own life, the police and paramedics were involved and had to address self harm, they told me they hadn’t been trained on how to deal with self harm and mental health issues. They weren’t trained to deal with them and first aid wise they weren’t trained how to treat them. There were two female police officers involved of which made me feel even more uncomfortable at the scene. The two male officers who attended tried their best and so did the paramedic but it was clear they were way out of their depth.”

From the feedback gathered it can be seen that services delivered varied greatly, and that officers are not always skilled in how they interact with service users with different needs. They are not consistently demonstrating behaviours that are based on compassion, empathy, trust, being non- judgemental and seeing people as individuals. This is concerning as people with Mental Illness, Autism or ADHD are often highly vulnerable within our communities and are more likely to be at risk and become victims of crime.

Service User Experience

These issues are not new and have been identified in previous consultation with victims and also within an internal review by the police itself. An internal review in 2009 into user dissatisfaction, poor service and public confidence identified key areas of work;

- The need to train people about “those basics, of politeness, civility, putting yourself in the victims shoes, have never really been addressed, though we’ve talked about them a lot. We teach a lot of assertion, train people in UDT, but not a lot around manners.”
- Lack of skills to ‘talk situations down’ – a belief that some officers lack skills in ‘talking down’ scenarios and ‘taking the heat out’ of situations. Some expressed a feeling that our officers are considerably less skilled than prison officers and probation officers in this arena and that many officers may have something to learn from PCSOs, many of whom are perceived to be more skilled in this area.
- Lack of empathy – basic sense of listening and showing care, concern, sympathy and understanding for the situation of the person in front of officers is required.

These findings are supported by the Police and Crime Commission’s **Victim’s Voice report** undertaken with a cross section of victims in 2013. It was found that;

“The attitude of the police officer or member of police staff that victims and witnesses come into contact with is the biggest complaint. This falls into three broad categories; 1) not being listened to or not being treated with courtesy and respect; 2) officers making judgements and the victim or witness feeling they are not believed; and 3) the crime or incident not being treated seriously and the impact minimised.”

“police need to explore how to shift culture to be more strongly victim-focused, empathic, considerate of victims circumstances and needs, and more appreciative of the perspective of victims.”

Therefore a radical approach to improving police interaction with the public, and particularly the most vulnerable, is needed. This culture change will need to feature throughout the police; in how new officers are recruited and assessed to ensure attributes and skills such as compassion, empathy, and listening are sought and included in all training. Regular continuous development within the force is needed to achieve this from Police Constable level to senior leaders to ensure a true behaviour change is demonstrated throughout the force and into communities themselves.

Keep Safe Card

When service users were asked what do you think would help others in the future who were in a similar position to you, people spoke of the need for emergency services to identify their needs quicker and easier. One service user explained;

“Like some police force, I don’t know what police force it is but if you’ve got mental health, they give you something like a mental health ID card to carry around with you. Maybe that’s what Northamptonshire need to start rolling out where, if you’ve been diagnosed with mental health, you get this card and you have to keep it on you at all times. So then if you’re ever in a crisis or anything like that, you can hand this card to officers so they know or have it on your system so if you’re in crisis and you can say I’ve got mental health. The police could then radio in, get your check, get your symptoms, get your triggers, get what would make it worse. That would help.”

Many other people thought that a card scheme was a good idea particularly when their needs may not be visible;

“Yes. My friend, who is autistic, she can’t always communicate and yet if you see her, she can get up in a room and talk to 250 people about a specific subject but if she goes on the train and she gets sensory overload, she can’t communicate with you. So that becomes a problem then. So she’s got something... I can’t remember what it’s called. It’s like a carers card and I think you tap into it and it tells you what she needs and how to communicate. That sounds like a really good plan, as long as our child will have it on them which I think is really important. That’s a good idea.”

Service User Experience

A support worker discussed an incident where additional needs should have been identified at an earlier stage which could have been prevented if the support worker had been asked for the service user's needs or a keep safe card shown;

" Yeah something happened a couple of months ago where I was supporting a young man who was different, he doesn't dress like we would. He was followed home by a PCSO because he tends to wear masks and stuff like that. He wears the masks because it's part of his image but also to hide behind. Just a black mask because he doesn't want people to see him. Then the PCSO obviously followed us"

They were followed to the service user's house by the PCSO where the support worker described;

"So obviously this guy I was with was getting really stressed out because he's in his house it's his space and he was just hiding behind this mask you could see his eyes. He didn't take the mask off while the PCSO was there that would have frightened him even more...

I just felt we were targeted in a way by those officers in the street. Why follow us all the way home?"

Another officer attended the service user's house later in the day, where a support worker had to speak on the service user's behalf;

"I had to because he didn't understand. But the reason the police came back out again was because they thought he was part of a terrorist group because he's got a certain flag in his room. I don't know how they seen the flag because the flag was on his other wall. I don't know what the flag means and nor does this person, he just bought it because he liked it. It was fully investigated by the police and then by another team...

...It could have all have been dealt with if you know, if I showed them my ID in the first place and explained to the police what was going on."

In Northamptonshire a Keep Safe Card Scheme is already established by the Learning Disability Partnership. With additional funding provided by the Police and Crime Commission it has recently been relaunched to anyone who has a disability or may be vulnerable including those with a mental illness. The Keep Safe Card can then be shown to ask for help whenever people feel lost, bullied, in crisis, when worried about their safety or in need of assistance in any way. The card provides frontline emergency services with information about people's needs, anything that should be avoided and emergency contact details for a carer/organisation that closely works with the individual. A number of voluntary organisations have agreed to sign up to the scheme as well as Northamptonshire Health Care Trust.

Internal communication across the emergency services is currently being undertaken and is key to the success of the scheme as reflected in this comment;

"Do all the police know about the Keep Safe card? That is something that needs to be in the training because I don't think a lot of them do...the police would know then know, as it's got all your information. How to communicate. How to approach, and who to contact. It's a marvellous idea but it really needs to be promoted. If the police know about the Keep Safe card and know how to deal with them when they're looking for them, especially a lot of children are verbal or choose to be non-verbal in a situation."

Service User Experience

Mental Health provision

Service users discussed a lack of access to services when not in crisis and preventative support.

This was shown through the lack of services provided by some GPs and the lack of hope when hearing they cannot help. Service users also discussed a scarcity of support after diagnosis and the how these can lead to crisis when they are trying to avoid it.

GPs

“the other GP, he’s got no sympathy for mental health. You go to him crying, saying you’re depressed and he won’t give you anti-depressants because he just don’t believe in them, which makes you worse. You know yourself then you’re feeling down, you know yourself you need anti-depressants and even your GP is not even listening to you...I’ve seen one doctor and he told me, what do you want me to do for you? I was like, just give me something to help me sleep, give me something to help me relax and he was like, there’s no point. I asked him, why and he was like, you’re stuck with suicidal thoughts, you’re stuck with hearing voices, you’re stuck with self-harming for the rest of your life and it’s like, why? He was like, medication won’t help you, therapy won’t help you, talking to someone won’t help you because it’s all part of your mental health condition. Getting told that, it sort of makes you on the verge to want to give up coz you know that you’re not going to get any better, you’ve just been told that by a doctor... “you could be asking for help. I have in the past and not one person helps you until you end up in a crisis and the police are called or you end up in hospital coz you’ve overdosed. It’s a shame that it gets to that matter, that you’re either in hospital or you’re 136’d before someone would actually listen to you.”

“I just struggle with my doctors at the moment, I don’t know how to change them, how to fix it. It seems that they’re happy to tell you eventually what’s wrong, and just throw some more pills at you and don’t look after you after that diagnosis.”

“Dr just gave me anti-depressants but didn’t deal with route of the problem “just take these pills and you will be fine”. Bills mounted up and just got in more and more trouble.”

There was a lack of awareness from some service users about current services available, many are in contact with Mental Health support services but not aware of the wider remit of Samaritans and thought you needed to be in crisis to call them. Others were unsure about the role of Crisis Cafes or did not feel current services were there at all times of crisis.

“Personally for me it is because you know you’ve got services who you can contact through the day which if you know someone’s there, for some reason you don’t tend to hit a crisis but I think that’s coz you know you’ve got support there if you do so it’s like a back-up plan. And then you have family but when they go to sleep and support lines close, the crisis café closes, it’s like you’re on your own then and I think it’s the worry and the fear that okay, no one’s there for you now. No one to talk to, no one to fall back on and I think that is what makes the middle of the night more crucial coz there is no one there for you.”

Mental health support from hospitals

Service users generally spoke positively about the treatment received once admitted to Berrywood or St Mary’s hospitals however others spoke about the barriers to accessing treatment or about the attitude of general hospitals;

“staff at the general hospital being too judgemental of mental health because they’re like, ‘oh no, not her again,’ stuff like that.”

At A&E;

“They do judge you. They speak down to you. They don’t deal with you the way that they need to deal with someone with mental health issues. The people that come into the hospital that assess you, they’re okay but it is the doctors at A&E, I don’t think they are trained in any way to know what to do. They don’t know how to control you and while this is going on, you’re waiting four or five hours in A&E.”

Service User Experience

“the police took me to Berrywood and then I sat there for five hours and they had a meeting, Berrywood had a meeting and they sent me home. They didn’t admit me or nothing. I went to hospital before Christmas and told them about my self-harming and suicidal and they said we ain’t got no beds for you, we’re not going to send you to Berrywood and I thought what am I wasting my time for? I walked out. You can’t do that to someone in my condition, you know what I mean. I feel like they make it worse for people like us, at the end of the day.”

“I was in Kettering and they sectioned me [medical profession] , well they didn’t give me a choice really they said you either come in or you’re getting sectioned and I said well that ain’t no choice then really is it? I’m gonna have to come in. There was no beds in St Mary’s and there was no beds in Berrywood so they wanted to send me to Somerset, so I said ‘oh can I go for a fag’ and they said yeah we’ll come out with you and as soon as they come out I was over 2 fences wasn’t I, I was gone. I wasn’t going to Somerset because they said I could be there for up to a month before a bed becomes available.”

Time taken to get a diagnosis/or for appointments

Others spoke of the long length of time taken to get a diagnosis or appointment and how this negatively impacted them

“Eight years I was told that you’re fine and you’ve just been through a bit of trauma. You’re just a teenager, you’re fine, there’s nothing wrong with you but I’m thinking why am I having these sick evil thoughts? I’m scared to go to bed because I don’t know how I’m going to wake up in the morning and you’re sitting there telling me that I’m fine and I’m f***** not. If I was depressed, give me a bit of Citalopram, I’d be fine. I’m not depressed and it weren’t till I moved to Northampton that I’m now under Campbell House with a personality disorder. So there really was... and I’m on anti-psychotics and they’re trying to tell me for eight years that I’m fine.”

“Mental health services are just not adequately funded, they just can’t do what they need to do. It’s taken us nine months to get a clinical psychology appointment.”

Support on discharge from hospital

Several service users and their carers spoke about the lack of support when being discharged from hospital and how a lack of a support package in place can put people at greater risk of harm;

“I think the people that actually work in St Mary’s Hospital, they’re amazing but you don’t get no aftercare. It’s when you’re let out, that’s it, you’re back into the world and you’re like whoa.”

A young person described that they felt they were discharged too soon;

“was allowed to leave hospital after a suicide attempt and excessive self harm two days in a row.”

The example below is taken from a one to one interview with a mother of an adult son who experienced Mental Illness;

“He was in St Mary’s and he went to (hospital outside of area) for a second trip and then back into St Mary’s for the third one, if I remember rightly. During this time, he was suffering from psychosis, drug induced psychosis but obviously being as anxious as he is, it was just all completely off the scale and what we were finding was, he would do a week in there, they’d give him something to stabilise him and then they’d send him on his way with a list of MIND and all of the other different addictions, the list of all the people who could help in the local area. The big issue I had with that was you were giving somebody who can’t wash, can’t leave his bedroom, doesn’t even think about eating and you’re giving him a list of phone numbers to go and get sorted for his future healthcare. That’s not a plan. That is not a care plan under any circumstances. So that sort of caused some problems because there was no engagement with anybody. He felt that he’d just been left to drift so, of course, his mental health just slid back downhill again...

They didn’t even tell us they’d discharged him. He’s over 18. I had a phone call... There was once, the first time possibly, he came out and he was absolutely frightened to death. He felt safe in there. He didn’t want to come out because he

Service User Experience

didn't trust himself. He couldn't cope with life and I think maybe he was in there for a fortnight. He got released 9.00/10.00 at night with the phone numbers. No call to family. Now it might well be that he said no, don't tell them and because he's over 18 but actually just because he's over 18 doesn't make it okay, because there's something that could be looked at there. His family could at least be informed.

I found out because he'd got a friend...He'd been in touch with her and said that 'I don't like it, I can't cope, I'm down the train station, I want to jump in front of a train.' So obviously he did want to but he didn't want to because he'd called this girl. So she went down there, she rang me, I went down there and there he was, pacing up and down the platform with a can of cider in his hand, looking at this train."

So we took him straight back to the hospital. His bags were still there and they wouldn't... they said no, we've discharged him... that's cruel, quite frankly. As I say, general care in there. The aftercare and passing between the coming out of hospital and getting into the system, there's just nothing. There's just a big void and if you manage to get across that void, it's luck. I think the thing for us, it might be their job, they might be used to seeing this. He's probably not anywhere near the worst case they've got in that hospital. They forget that relatives don't know all this and for us, it was the first time...We had a sit-in at the hospital and me and my dad, and we flatly refused to move until the consultant came to see us. So we sort of parked ourselves up and then we had the full team of six or seven people in there but what did we have to do to get them to actually talk to us? They wouldn't speak. The getting out bit is appalling and it's been appalling every single time."

Service delivery of community based Mental Health and Autism services

Some service users described their frustration at a lack of action from community based services or a difficulty in trying to make contact with them;

“I’ve asked my CPN to get me to the doctor’s and she’s like yeah, I’ll do it for you and then you still don’t hear anything back. The fact that it’s an emergency appointment, you should hear back within 48 hours, 72 hours and you still don’t hear anything back and then it’s like can you chase up the Asperger’s team and it’s like yeah, I’ll do it for you and then a week later, you’re like she ain’t so I contact my Asperger’s team myself and they’re like no, we’ve not heard from the CPN.”

Others described how a lack of action from services impacted recovery and stretched resources;

“I was like, what’s that for? She was like, to help with your drinking and I told her, I drink to help me sleep. I drink to help with my mood. It’s what you don’t understand and then she said, we’ll get you sleeping tablets. I was like, get me sleeping tablets, I’ll stop the drink. I need something to replace the drink. She was like, we can’t do it until you stop drinking and then I made an agreement, I was like, fine, I’ll stop drinking but you need to get me sleeping tablets. No referral to S2S was made because they wanted to see if I was actually stopped drinking first. I stopped drinking for about a week and there’s no sleeping tablets. In that time, things got worse again and I had to turn back to drink for my own safety and then the CPN asked me how my drinking was and I was like, back on it and she was like, why? I told her I’m not getting the sleeping tablets. She was like, I’m waiting for a doctor to contact me back, meaning don’t take a week to get something.”

“mental health service is again a bit flaky really. There’s just not enough of them. They’ve got too much of a caseload. So getting hold of the CPN or somebody when you need them is impossible really. Years ago it used to be a little bit better but even in the ten years I’ve certainly seen less availability.”

Service User Experience

Others spoke about treatment being offered did not meet their needs;

“Campbell House, no rubbish. I can’t do groups and they were only saying that yeah Campbell house are really c***. I can’t really do groups. I can talk to anybody but not groups, when you’re in groups and people are like ‘oh yeah, I’ve got PTSD and I do this that’s then put on my shoulders because I start worrying about people and you get told things about people so I said no I’m not going to groups and that’s all they offered me, so because they only offered me groups I didn’t attend it”

Another described the lack of empathy displayed by the Mental Health crisis team workers and the frustration of being turned away when they are trying to avoid going into crisis;

“[crisis team] Very dismissive. Because I’ve sought their help, I’m not suicidal. Because I’ve spoken out to somebody, I obviously don’t want to die which maybe 5% of me can understand that. If you want to die, you do it but they must know from me by now that it’s not to die, it’s like I’m at rock bottom, I have to show you that I’m here so I’ve done this. I want help but because I seek the help, they say you don’t need crisis, you don’t need in-patient, you don’t need medication, you’re discharged back to your GP and that’s it. So it’s crazy.”

Others described agencies not taking responsibility even at time of crisis;

[talking about suicidal son]: “So at this point, I ring a Crisis team. ‘You need to ring the police if he’s gone missing.’ So I ring the police and they tell me to ring the crisis team. So I ring the crisis team back and this table tennis, ping-pong thing went on for a good couple of hours and at this time, we know that he’s gone off somewhere to do something to himself. And what I just wanted was for someone to take responsibility for it.”

Thresholds too high or not being properly communicated

Several people spoke of thresholds being set too high or not fully understanding the roles and remits within organisations this was both from service users and professionals; A parent said she was not told why her son did not meet the CAMHS criteria;

I was never told why he's been referred to CAMHS twice and both times didn't meet their criteria. Well, what criteria do you need? You have a child with severe ADHD that is taking the quantity of meds that an adult should be taking. He had been excluded in year seven nine times from a school because he couldn't cope. School, bearing in mind he's got an education statement, he went in year seven and it took them six weeks to realise he was a statemented child and then for the rest of the year never put his provisions in place. So in year eight, it was like he really couldn't cope and never went back, even though he's still enrolled in this school. So you're going he needs help, help this family, help me. I'm sorry, you don't meet our criteria. We saw a CAMHS doctor at Kettering and he had a 2.5 hour assessment and that's how he was diagnosed with co-morbid depression. That's why he wasn't going to school, that's why he wasn't leaving his bedroom. Hence I then said to Service Six he needs CBT therapy, can you help me find it because he was then going to be referred again back to CAMHS to say this child needs his therapy and it was like you've turned my son down once, I don't trust you. Does that make sense?

This parent was already aware of Service Six through her profession and they did offer the CBT required which had a positive significant impact on her son.

Overall parents and service users appear to be desperately trying to navigate a system without anyone directing them where to go. Some receive very little information as to why decisions were made and also a lack of information about other more appropriate support services they could access, adding to frustrations and pressure they face.

Service User Experience

Organisations not sharing information

“It’s like once I got out of hospital, I went to my GP and I was like can I have another prescription please for my medication and he’s like what medication are you on? I was like, Citalopram and Quetiapine and he was like, how are you being prescribed that? I was like, I’ve been in hospital for the last seven months and my GP had no record of it. There’s no notes on there from my CPN, there’s no notes on there from the hospital saying I’ve been in hospital. He tried to call the hospital to say I am on medication, the hospital didn’t answer...

So then like all services don’t work together. You’ve got your CPN saying one thing, your GP’s trying to help but then it’s not on your records. The hospital either are not using the right system or not updating your records and they end up in like one vicious cycle. You run out of medication, you hit a crisis, you see your CPN, the police get called, you end up back in hospital, you end up back on medication and then you come out again and it’s still not in the system. It’s like some services don’t respond to each other. It’s like they’ve all got different views and opinions of what they should be doing with mental health and I think that’s probably what the main problem is. If they all agreed on we need to do this first, we need to do that next, maybe it could help. Maybe that is the answer to end the mental health stigma.”

Others discussed the lack of continued support when have moved from a neighbouring county;

“I’ve been in Northampton near enough five years and I’ve had no contact with the mental health team coz it didn’t transfer when I moved to Northampton. It should have done and I’m only just starting to get it now. In a way it’s affected me in a positive way coz I’ve had to learn to deal without medication but like 2.5 years ago, I had a baby while I was in Northampton and the baby got taken away from me by Social Services and because I’ve had no interaction with the mental health team in Northampton, that affected the baby.”

When asked what could have been improved she said:

“Proper handover from one mental health team to another. I haven’t had none of that, and then having to go to the GP and explain everything over and over and over again coz I don’t see the same doctor every day. Every time I go to the doctor, I don’t see the same doctor”

In some cases agencies are taking steps to work collectively with one individuals. A service user did talk positively about having a joint care plan;

“but it’s like ambulance, A&E, 111, police, they all link. So if I was reported to the police, it would come up that I have this care plan. It tells them who I am, what I’ve got, what helps, what doesn’t help... When they told me about that when they said we want to try you on this, I thought that would be amazing. That might be the end of the... it’s hard as well when you have to repeat everything to all the different... if I ring 111 and they say we have to send an ambulance, you get the ambulance service ring you, what’s the problem, what’s going on? You get to A&E, what’s the problem, what’s going on? And you just think I can’t do it. So if this care plan does get signed (service user was yet to sign it) and it works and it happens, it would be perfect.”

Many of the issues relating to Mental Health support services relate to barriers to accessing services, thresholds being set too high, lack of resources and speed, and poor communication with the whole family. Emphasis on communication needs to be placed earlier in patients contact with NHS services to prevent them having to get to crisis. Patients and families need to know for example why requests for treatment/support have been declined, and for greater support on discharge.

It appears too often that people are declined services and being told thresholds or criteria are not met but without any other support being put in place.

Increased communication through campaigns and with frontline services GPs and Mental Health practitioners clearly signposting people to what services are available in the community. A review of information given upon discharge from hospitals is required with clear communication about when and where other support services will offer help to help assist the transition period when an individual will not doubt be in a heightened vulnerable state.

For partners to prioritise jointly commissioned Mental Health preventative support services with other partners both with young people and adults so that they do not enter the crisis pathway.

Service User Experience

Lack of support for parents and carers

Parents of Mental Ill Health, Autistic and ADHD service users told us of the difficulty of looking after their children with additional needs and the pressure it can put on the rest of the family. Many spoke emotionally of the lack of support available particularly when their children turned into adults.

“No, there is no one out there that supports, that I’ve been appointed to, signposted to that supports parents of... my daughter, she’s not a child, she’s an adult, she’s 29 now, 30 this year. So they don’t talk to us because she’s the adult. We are paying privately for my wife to have some counselling and all that because this is how much it screws us up.”

Social services

Parents explained that they were actively encouraged by social services to telephone the police if they did not think they were able to manage their child’s behaviour, but they did not want to do this;

“Autism is difficult. ADHD is difficult. Challenging behaviour is difficult because behind challenging behaviour, there’s going to be a reason for it and if you don’t see that reason or you don’t know what that reason is, then how do you help? And I think a lot of parents are the same as me, they’re too frightened to call the police because that’s your child and you don’t want to call the police about your own child. My son physically abused me every day for a long period of time and that was hard and to be told to call the police on your own child is heart-breaking. So we never did it.”

Another parent told us;

You know you've got a very hard job when Social Services do turn round and say to you, if you want him out, that's what you've got to do, phone the police, get him arrested and you think you can't do that.

Interviewer: That coming from the Social Services, have you heard that once or...?

Parent: Loads of times. Oh yes, it's very common because they haven't got the resources to deal with him at weekends or after office hours. In fact, I don't think they've got the resources right from the word go. The older they get, the worse the service is, definitely.

Parent: We're finding that now, the older he's getting, the worse we're getting with help or anything like that with it because it's getting to that point. He's now 26 and he's getting to that age it's really hard to deal with and we're getting to an age now, we want him to move on and do other things and they're not helping with it because there's nothing more for him to go to.

It does not seem appropriate for Social Services to be encouraging parents to telephone the police, when they do not want their children criminalised, and police have a lack of alternative options in these situations.

A review should be undertaken of the police response in these situations, which will include the police, service users and their parents should be undertaken to consider alternative options.

A few parents spoke of positive support they received. A couple spoke of their approach to coping when caring for their autistic son they said;

"Just laugh about it, When I get really, really...when things get really , really tough, I just pop in and out of this organisation, but quite often we'll pick up the phone and we'll speak to (name of worker) from the Community Learning Disabilities Team and she's really good."

One parent told us that she received a lot of support from the schools her children attend;

Service User Experience

“The school is absolutely amazing. I’ve got two different schools... and the workers there are absolutely fantastic. I think they’re the ones that I turn to the most. When I’m low I go in there and I say I need to see someone and even if the family worker isn’t available, someone will come and talk to me.”

Another spoke very positively about the range of support offered by Northamptonshire Carers;

“It wasn’t until February / March last year and I saw a poster for Northants Carers in the GP surgery and I always thought of carers as the people who wipe bottoms and feed people and take you out in your wheelchair, I never thought of it as me being a carer because I just didn’t. Well, I just didn’t even think about it, I just wasn’t joining the dots up and it said something there about do you... and I thought oh, I do do that. So I gave them a ring and they were utterly fabulous, really very supportive but again the GP, the mental health team, the hospital, nobody had mentioned this at all. Well, it was only by chance and there’s a lady who lives near me, she’s got a husband with massive anxiety and depression and a physically ill mum and she’s on her knees, and I’ve told her about it but again, even though she’s got carers going in twice a day and they’re well in the caring system, still nobody had mentioned it to her. I had Reiki sessions which were absolutely fabulous. They do a suite of courses so I went on a mindfulness and all stuff about putting your energies back into you, sort of thing. They even paid for me to have a week away in a cottage by the sea. They were absolutely superb and I didn’t go to any of the cafes but there’s little things like they give you phone call once a week just to make sure you’re alright, and that...”

....Yeah, coz I did try going to counselling and I didn’t really realise until I met the Northants Carers that actually I was going to counselling and it wasn’t the right sort of counselling because they didn’t understand the nature of the issues that I was facing. Whereas when you can talk to somebody at the Carers’ Association who care for people with mental health problems, the relief of being able to say, do you know what, I really want to bury him under the patio today because he’s doing my head in and that being acceptable. There should be parent line, never mind Childline. So, yeah, the support that they gave was again utterly phenomenal but it’s not there as a matter of course. If you don’t know about it or it’s even a thing, you don’t think to go looking out or again like me, you think a carer is somebody who cares for physical disabilities or people who are so mentally ill that they can’t actually function.”

When this consultation was undertaken it was important to ensure emotional support was in place after participating in a 1:1 interview. A leaflet of support organisations was given at the end of the interview which included details of Northamptonshire Carers. The majority of people who we spoke to were not aware of the support provided by Northamptonshire Carers none, but thought that the support it offered sounded very positive.

The welfare of parents and carers is essential for them to provide ongoing support for their children or family. More needs to be done to offer support and making the wider community know how they can access these services.

Therefore, training for all frontline practitioners needs to include the support that can be offered to the whole family not just the patient/client.

Third sector support

People accessing specific third sector agencies were very positive about the services they offered and were very passionate about the staff and trying to keep the services that were currently in place;

“I made a self-referral to Service Six and straight away it was, how can we help? And then when he was diagnosed that he needed CBT, they turned round and said we’ll do it. We’ll find the right therapist, don’t even think of going anywhere else because it could take months and having picked the right therapist and within eight weeks, the therapist was all set up. He did five out of seven sessions and after the fifth session, he walked out of my house and went, ‘mum, can I come shopping with you?’ ‘What?! Yeah, let’s go!’

At the Bridge project a service user told us;

“Everyone supports each other and you get to meet people as well and the staff are good as well, they’re there to help you. They don’t turn you away. Keep busy and keep involved with things... you can look for jobs upstairs as well. You’ve got the job club as well. They’ve got loads of stuff that’s going on here that you can’t get anywhere else.”

“The services received was brilliant, after the police had spoken to me about what happened I had Bridge substance misuse programme involved and they helped me out so much, they were very supportive, couldn’t ask for a better team”

Service User Experience

Service users who we accessed through Mind were positive about the provision and ongoing support offered, many of whom had been using drop in services for many years. Another spoke positively of S2S;

“I felt like I was helped out a lot by S2S as they encouraged me to get more help for my mental health and they gave me a lot of knowledge about alcohol and how it affects me.”

Experience of the wider Criminal Justice System

A service user describes her experience of the court service and the impact it had on her life, by being seen as an individual, the positive impact of not being sent to prison and the importance of offering supportive rehabilitation alternatives:

She described her experience in court outside of Northamptonshire;

“this is where I think the court done well because they honestly listened to the victim’s side of the story and my actions toward her that night were certainly uncalled for and, do you know what I mean, it wasn’t fair on her but at the same time, the Judge did actually listen to my barrister when he explained what led up to that. So I was during that time homeless, pregnant, whilst being a cocaine addict so I was still doing the drugs whilst being pregnant, and then I’d had my family write me off. My ex-boyfriend left me and I couldn’t afford to pay for the house. So my life was in utter turmoil, to the point I had to even have an abortion of my own baby because I didn’t believe I could bring that child into the world, and my nan and grandad had always brought me up after my mum went to prison, and my grandad died and my nan went like really mental, really lost her mind. I’d come home and she’d be rocking on the floor in the dark with his picture. So I went to my boyfriend and that all fell apart. So I’d lost my nan, my grandad, my boyfriend, my baby, my home, absolutely everything and my best friend at the time said, ‘come on, I’ll take you up the city and we’ll go out.’

“The Judge had listened to everything my barrister had told him, he looked up and for the first time throughout the whole case, he looked into my eyes and he could see what a broken young woman I was...Like I’d been through so much and now I

was going to lose the last thing I had which was my freedom and when that Judge looked into my eyes...he said to me, 'when you come back, be ready to go to prison,' basically. He looked into my eyes and I couldn't believe it because he said, 'I'm sentencing you to 14 months in prison,' and I was just like that's it and he said, 'but I'm going to suspend it for two years.'

A family member suggested that she moved and lived in their flat in Northampton;

"I finished all my RAR (Rehabilitation activity Requirement) probation, I just go once a month. I've paid my compensation, I done my hours and being on a Community Order has really allowed me to rebuild my life in the community, although my offence should have really been punished with prison but I can tell you now, if I went to prison, I would have not ever come to Northampton so I'd never have found the support. I would not be housed. I would be so, so angry because I lost everything...and now I've got a room as big as this to live in and so how would I ever have got better? I would have come out so, so angry and definitely gone back on the drugs, a million percent.

"My probation officer has been absolutely fantastic. I can't praise her enough. She sat down with me and... we done a timeline of my life because from about 11 to 15, I couldn't even remember where I lived because I'd been from care to this house to that house, to this house, to my Dad's house, to my Nan's, to my Mum's, and I just couldn't even remember where I'd been half of the time. So we actually sat down and wrote zero to 20 and minus ten and plus ten, and we wrote all my good experiences through the years and all my bad, and where I was and who I was with, and it really helped me to put closure on everything that had happened and she said, 'you are responsible for the next 20 year timeline. You can't blame mum, dad, nan, do you know what I mean, it's you.' So that really helped me to... and I was a very nasty person. I was like 'don't talk to me. You can't tell me nothing, like this is what it is.' and she really broke me down and I started developing empathy, do you know what I mean? And it started to help me deal with things that I'd done over the years because I could let go a little bit, I weren't so bitter and resentful over it."

She accessed support from C2C (Crime to Christ);

"So I started here on 16 hours a week in the café and while I was here, they put me on trauma courses, let me come to the drop-in, do you know what I mean? So I could chat to women who had also been through stuff, and it really helped build my strength up to think some of these women have been through a lot worse than

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I have and they managed to get up and get on with their lives. So that's when my mindset really started to change.

"I believe that I'm lucky because I ended up in Northampton but I do think what if I didn't? Because what I think the issue is within criminal justice is the individualising, looking on an individualised basis at that person; not just the crime but looking at their life. It takes too much time and resources, I guess, but to actually look at everyone on an individualised basis and look at what led up to the offence. I think that's one issue. Secondly is definitely the use of women centres and places, because prisons don't rehabilitate people. We all know that, whether you're the highest up judge or you're the burglar that burgles every week. It doesn't work, it just doesn't."

This shows strong support for alternatives to prison and further evidences the need to pilot alternative approaches such as the mental health treatment requirement which is currently being evaluated. It also demonstrates that the appropriate punishment together with an intensive level of support by a range of agencies can significantly turn individuals lives around for the better.

Other court experiences

Another individual spoke positively about being offered an appropriate adult whilst in police custody but was not offered the same service in court;

"I wanted an appropriate adult (at court) but I was refused that because I didn't have any diagnosis. Though I was getting referred to services, no one thought maybe she just needs someone there to support her." Due to the time it takes to get a diagnosis there may be many people presenting at court with additional needs, without a formal diagnosis, that are not being met."

There was feedback about individual workers which showed the positive impact of mental health services working in criminal justice settings;

“On one occasion, I can’t remember which, (name of mental health team member) found him in the cells and basically plucked him out of the justice system and put him into the mental health system. Had she not done that, he would have been in prison, I’m fairly sure of that because nobody knew. He didn’t know, he didn’t understand and it would have just got worse and worse and worse. So that was a massive life changing moment. He’s very difficult about engaging and things like that. So getting him to engage with mental health was hard enough as it is.

An ex-offender described the difficulty of having a Mental Illness in prison, and the value of the key individuals in their progress to release and beyond into the community;

“In prison 4 of my friends killed themselves. Top Dogs make it hard for you, think you are weak if you self-harm, it leads to bullying. I was bullied because of self-harm but they wouldn’t have known I have mental health, would have been seen as weak as well. You can’t tell anyone about bullying otherwise you’re classed as a grass, then you’re in bigger trouble, as good as dead. We were offered the Samaritans phone but was concerned that person in the next cell could hear you and would make comments, call you a 20/52 case, you were considered weak. I was offered a listener, so said I would like one but they were a heroin user, couldn’t tell anyone or you’re as good as dead.”

He spoke positively about a prison officer;

“I worked 1:1 with a prison officer which really helped, he came with me to parole board, they asked him what he thought which he wasn’t expecting and he said really positive feedback.

I have mental health problems and had problems with drink and drugs. Mental health was undiagnosed until prison. (name of probation officer) – had her 12/13 years – can be honest with her about things. Got personality disorder, 2 types –

Service User Experience

borderline/paranoid. Moved into a unit for this whilst in prison when sectioned. If I carried on the way I was before I went to prison, I'll be dead. I was drinking 10ltrs of cider a day, on drugs - didn't want help back then - was scared and didn't trust people. Thought it was funny at the time.

I was horrible to (name of probation officer) at first but we get on really well now. Her perseverance and honesty, she told me what I need to do to change to get out of prison"

Whilst in prison they received support from a nurse.

"I was paranoid around people after being inside for 9 years. The nurse used to take me out into town, meet for a cup of tea to get me used to being in the community again. Would walk about and talk, had no-one else. No-one visited me in prison. Prison helped me to get a prison visitor, we are still in contact today.

It really helped that I knew the doctor and probation worker for so long and didn't have changes in support. Really helped me having same people involved like Dr and probation officer, meant I could talk to them and trust them."

They described the ongoing relationship and support from their probation officer and doctor as beneficial to their release and ongoing support once in the community. They described the value of the prison volunteer scheme and the visitor had assisted them with getting a job once out of prison.

Another individual spoke about their relationship with their probation officer and described how the different approach he took to work positively with this service user to engage them in the process;

“He helped me because he didn’t come across like he was above me. He was like, ‘sit down, mate, no bull****, what do you want to do? You want to do this?’ There was no beating around the bush.

Sometimes with the services for us males, sometimes we can be a bit brusque, sometimes we can be a bit anti but sometimes don’t pussyfoot around us. You can be real with us but be genuine at the same time. Lots of people understand this, it’s hard to get that balance but he was real and he was genuine. He was like, ‘look, this is what I can do for you but this is what you can do for yourself.’ So that experience told me up front. So that’s what I responded to you, that’s what I like.

He’s cool actually. So he was talking about the Prince’s Trust and how it can help me. So I did the Prince’s Trust. He just approached me in a way that I’ve never been approached before.”

Support on release

Similarly to the lack of support described upon discharge from hospital, several people commented on the lack of support after release from prison;

“But I think more support should be done when they get out. Not just put them on licence and give them strict rules; almost give them a Community Order on release so get them engaging with groups, get them engaging with things, do you know what I mean? And maybe not put such strict restrictions and deadlines on them because I think that’s where the anxiety is.”

Another person spoke of how this lack of support can lead to people continuing their drug addictions as there were a lack of options available to them;

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“you can’t force anybody to do anything they don’t want to do. If they want to go and find drugs, they will go and find drugs, but I don’t believe... they come out of the prison and they’re clean as a whistle and haven’t had any substances and they’re dry, no cocaine, or anything like that, heroin in their system, or whatever it is they take and they’re not suffering from any addiction, but as soon as they come out, it’s what they’re faced with. They could be homeless, they’re obviously jobless, and all those things go hand-in-hand. Now if the help or support isn’t there to guide them... I’m not saying that you have to hold them by the hand or nothing like that, but when they’ve reached a point where they are leaving prison and their instant reaction is to go and find their drug dealer...”

Overall people have spoken about how essential support is alongside any punishment they receive. The support might just be from one or two key individuals who have provided ongoing support or from a number of organisations. He described the need for practical support in housing and employment and emotional support. The value of workers being genuine and showing perseverance was also important to relationships. Nationally 90% of prisoners have some form of mental illness therefore a significant resource needs to be in place to ensure these people have continuous support to change their lives and the support needs to be tailored to individual need.

Homeless people's experience

A number of people we interviewed were homeless and they spoke to us about the difficulty of having a Mental Illness and being homeless. Several distressing experiences were described which further evidenced how vulnerable and at risk these individuals are:

A 21 year old told us;

"I was homeless, I had nothing I was living on the street. I was getting kicked and beaten by blokes because I wasn't giving them sex, I got p***** on, I had people sitting and laying on me. I was completely smashed out my nut pretty much nearly all the time I was on the street anyway, all I remember was I had blokes coming up to me asking me for things, to do certain sexual things and I said no and by the time I'd finished, by the time I'd actually got off the street, from there to there (indicates thighs - legs) my legs were just bruised, I had 3 massive bruises and my mate went oh yeah you got kicked up by some lad because basically you wouldn't give him what he wanted."

People described the added pressure of having a Mental Illness when homeless

"The detoxing itself is very, very hard - hard enough when you have a roof over your head let alone living on the street, and that can have some bizarre side effects - I can't think of the right word, so that can bring on all sorts of bad thoughts and wanting to die"

"My mental illness was related to my crime coz I was living homeless and it did have a great impact on me, like deteriorating and things like that. I was thinking that the police are after me or I'm thinking that I'm not good enough, I'm so useless, things like that you see"

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We heard several barriers to accessing support and medication:

“Interviewer: how did you find being able to access things like medication or support?”

Respondent: You can’t really. You can’t have a wash or nothing, you can’t do anything. coz they won’t trust you as well coz if you ain’t got an address, you’re not going to get your medication anyway coz they’d probably give it and you’d probably sell it or something.”

Others spoke of the inflexibility of some support agencies for example if they missed appointments they were struck off accessing support. Many were very distressed and did not seem to know which way to turn or how to access further help, which was further hindered due to their complex needs. Another stated that he was breaching his bail conditions as he did not have an address as he was homeless but did not feel he could not alter the situation he was in.

One person described the positive relationship the police had with the homeless in Northampton:

“When I’ve been homeless I’ve sat outside All Saints Church, because it’s dry on a Friday and Saturday night, some of the rubbish they have to put up with from drunks and lunatics and yet they’re always cheerful, I’ll be sitting there chatting about rugby until the next kick off, and that’s not rugby kicking off, and they’re helpful. I’ve never seen the police in Northampton using heavy tactics, I’ve seen them restraining people obviously, they have to, but I’ve never seen them abusive or violent, or even uncooperative.”

However there appeared to be different experience of services in Wellingborough;

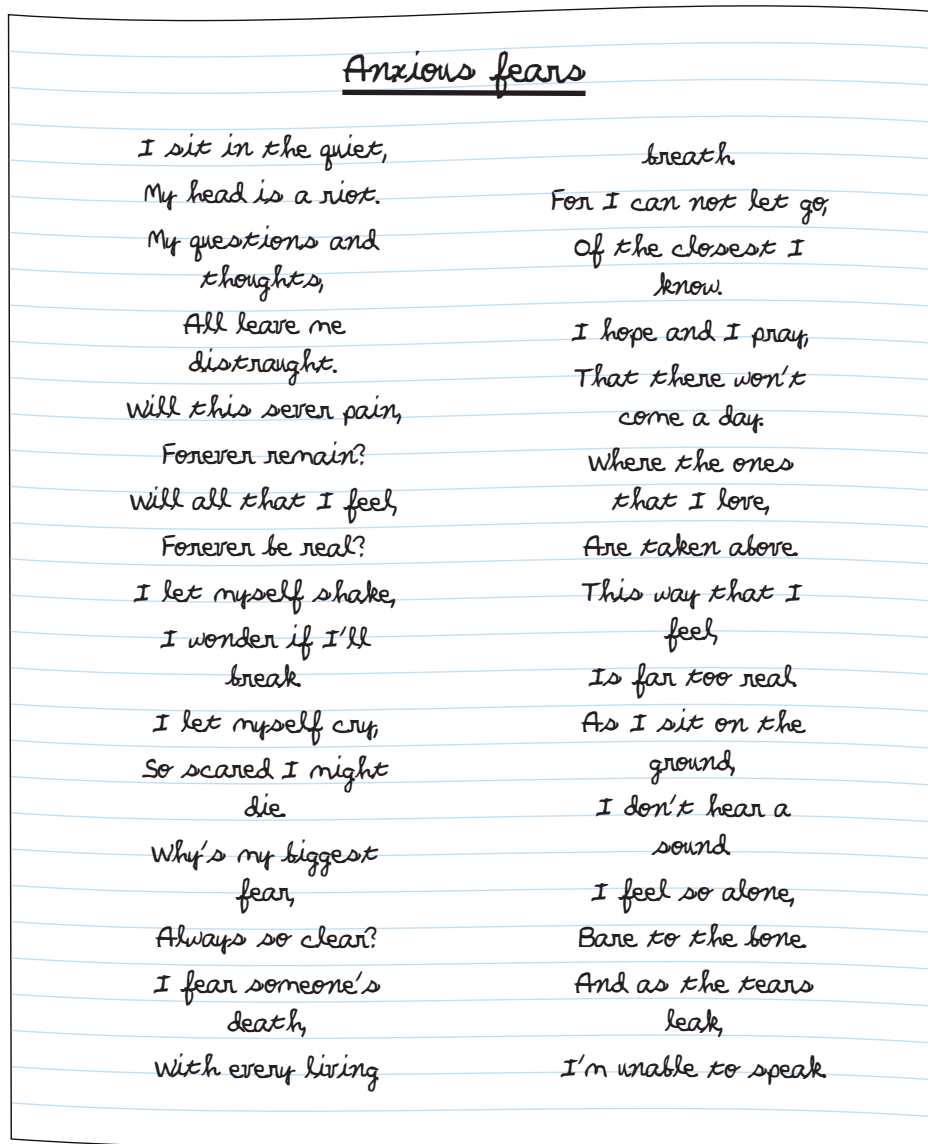
“Be (the police) a bit more patient and caring, a little more sympathetic. Spend a few minutes talking to them to show they are human, a bit more compassion wouldn’t go a miss. A bit more advertising to show they are there to help you not just nick you. Working together better, a lot more communication is needed - a lot, lot more.”

When undertaking this consultation homeless people in particular seemed very grateful just to have someone to talk who was independent of the services provided, they described feelings of isolation and experience of loneliness.

When commissioning future services for Mental Health and drug and alcohol misuse the flexibility of support being offered should be considered so as to not create a barrier for support.

Young people

Limited engagement was achieved through the Time 2 Listen youth survey with only 32 young people responding. However over 70 young people in youth clubs and schools took part in a competition where they were asked to describe what Mental Health, Autism or ADHD meant to them, through art, poetry a rap or video. This activity enabled us to build trust and develop positive relationships with young people disclosing real experiences to us that often youth workers had a lack of previous knowledge of.



A 15-year-old described their own experience of Autism, ADHD and dyslexia;

“I have Autism, ADHD and Dyslexia. I don’t suffer from these conditions because they are not negative, yes I have them and I am diagnosed but I am in no way suffering just because I see the world differently.”

“Autism is characterised by marked difficulties in behaviour, social interaction, communication and sensory sensitivities. Some of these characteristics are common among people on the spectrum; others are typical of the disability but not necessarily exhibited by all people on the Autism spectrum.”

My Autism is a part of me and makes me who I am and I wouldn’t want to change that for the world, and neither would my family. I know I am different from most people but I don’t see that as a negative or that it holds me back, in fact the opposite. I feel it gives me an advantage over other people if anything. I have shown Autistic traits since I was very young like things such as wanting to feel and smell my food before I ate it, feeling the need to touch things, not liking certain types of paper. When I set my mind to something I can’t do anything else until its done, chewing things all the time (not necessarily gum) and struggling with death. I know my brain works differently to others but it doesn’t make me less smart which is a big misconception.

Some autistic people struggle but they are the people with low functioning Autism meaning they find it difficult to converse, they are not as able to learn as easy as others. I don’t mean to cause any offence by saying this but there are different levels of Autism and it affects the way people’s brains work, differently. I have high functioning Autism meaning that I learn differently to ‘normal’ people and being in a mainstream school can make you feel less intelligent because school is designed to help ‘normal’ people learn and not autistic people learn. I find it difficult to manage environments where there are lots of people. When lots of people are speaking to me I find it difficult to know whom to focus on.

ADHD, what does it mean? “Attention Deficit Hyperactivity Disorder (ADHD) is a group of behavioral symptoms that include inattentiveness, hyperactivity and impulsiveness”. Long story short you are hyperactive and you struggle to concentrate. Unlike Autism, ADHD puts me at a disadvantage when it comes to school because staying in the classroom is a challenge and due to issues with concentration, living with ADHD is difficult at times because I never get to finish things because I lose focus. Like now, in writing this letter I have started to drift off into my own world and I am now thinking about my fish and how I am giving its

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tank a makeover...

I take medication to try to help me to manage my hyperactivity and inattentiveness. At the moment I am taking Clonidine (I think?). On a daily basis I feel tired and occasionally sick from taking this medication however I know that this is for my own good. Often because I have a fast moving mind I don't always think before I speak. This means that I sometimes offend people without meaning to. Culminating with the Autism I then struggle to know that I have offended someone as I find it difficult to read body language and facial expressions. Unfortunately, as I struggle to keep focused in school I often miss elements of the work and so feel that there is little point in trying to catch up as I am so far behind and this causes me distress and results in the presentation of a defeatist attitude. On a more positive note the hyperactivity helps me to stay healthy and have a good lifestyle as I always need to be moving around so engage in lots of sporting activities and exercise which in turn helps me to stay healthy.

To conclude although I have Autism and ADHD they make me who I am and I wouldn't change this for the world. They both have their advantages and disadvantages but in my opinion the positives outweigh the negatives.

Young people had similar experiences to adults in the majority of their feedback however there were individual feedback about the pressure of attending court and being a vulnerable victim and also a feeling of a lack of support when turning 18.

"I was raped when I was 15 and the police got my case into court quick but I had to go to Leicester court. I didn't know whether I was coming or going. I was supposed to give evidence over one day, and me giving evidence got put off for 3 days, so we had to check in and out of hotels every night not knowing whether we would be okay. I had to give evidence over 2 days which caused my anxiety to flare up. Evidence was missing and I was questioned about things that the evidence proved reducing me to tears multiple times out of frustration. I was scared and nervous and I now suffer with severe PTSD and hallucinations due to my perpetrator. Once court was over, all services but CAN young people's team dropped me including social services... CAN young people's team helped me cope with day to day life whereas CAMHS discharged me and now I have been under the service again and have 3 months to when I'm 18 where they want to kick me out"

Other pieces of research have been undertaken in other areas of the country to capture young people's experiences of the Criminal Justice System. The findings from a report into "Experience of Children and Young People Involved with the Justice/Care System" undertaken by the Patient Experience Network in 2017 for the West Midlands Clinical Networks and Clinical Senate, included:

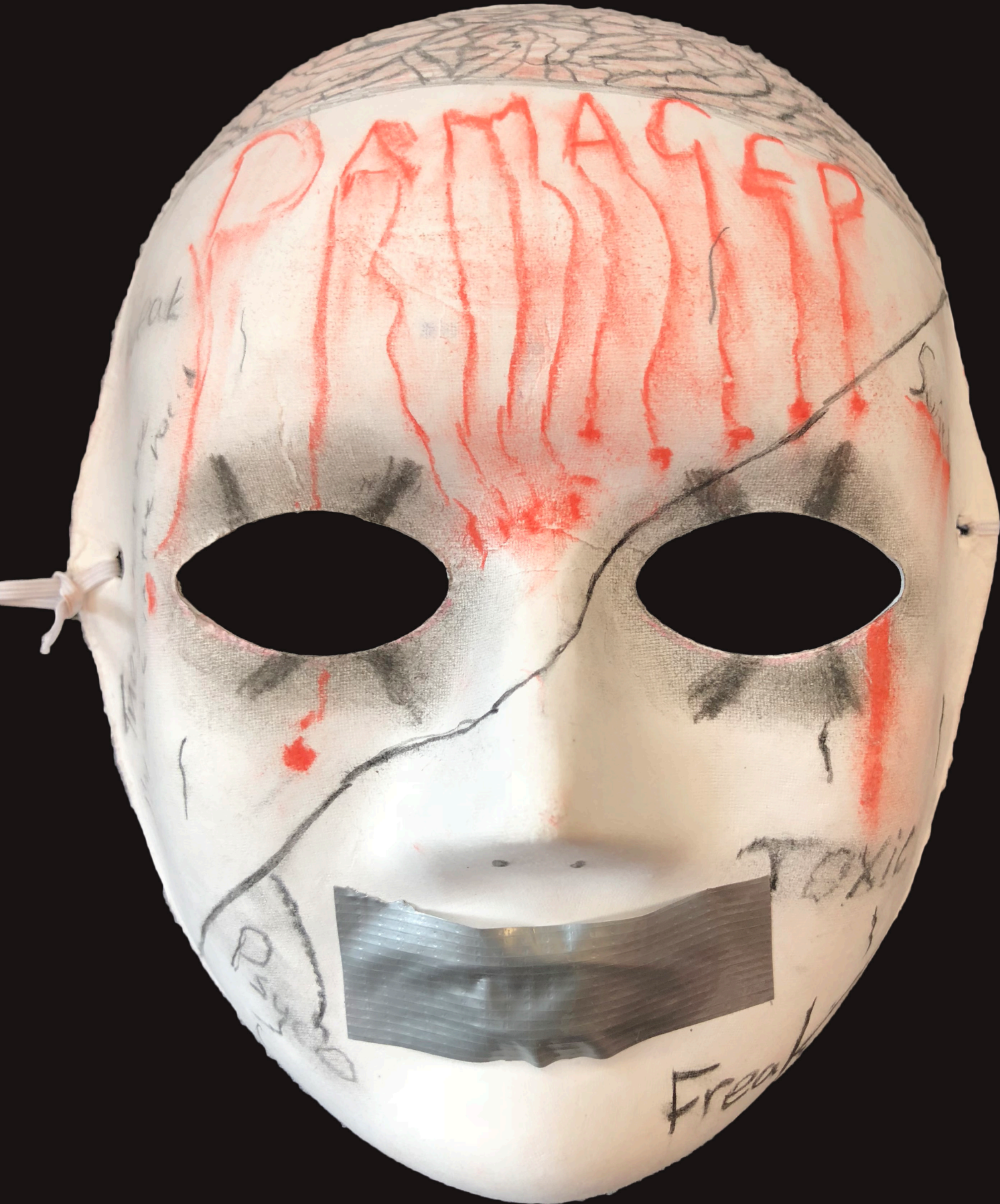
- Young people had a desire for having their voice heard and involved in how their ideas could be improved. Often this desire came from not being listened to or consulted by "experts" about what might be best for them.
- Several reported difficult or unstable home environments which mirrored the findings of other reports which have identified where early life experiences are important and are key to keeping young people out of the criminal justice system.
- Young people felt they were labelled and were treated differently because of this.
- Difficulty in identifying appropriate support from networks/organisations, and often those they did were not sufficiently funded, and to so when they did make contact often there were excessive waiting lists acting as a barrier.
- Trust- previous experience with organisations had affected their trust going forward
- Issues at transition from children to adult based services, where they felt let down or suddenly lost some of the support mechanisms they had become used to.
- Lack of integration of services, for example a young person spoke of their release from prison and had a lack of confidence in the future about what would happen to the immediately on release "almost inevitable that I will end up back in here."

Some of the themes above are similar to those collected from adults in the Time 2 Listen consultation. It is proposed that more focussed engagement with young people who have had a direct experience of the police or criminal system should take place using creative methods, such as what worked successfully in schools and youth groups to identify if similar themes arise in Northamptonshire.

Northamptonshire Police and Crime Commission are currently developing a Youth Commission of 30 11-24 year olds which will involve individuals from a range of backgrounds including those who have been victims, offenders and those with

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disabilities. Part of the role of the Youth Commission will be to consult their peers about police and crime issues, including the subject of mental health, and to co-produce activity with the commission and police based on recommendations resulting from their peer to peer engagement.



**Outcomes of Mental Health
pathway review and findings from
frontline practitioner consultation**

Outcomes of Mental Health pathway review and findings from frontline practitioner consultation

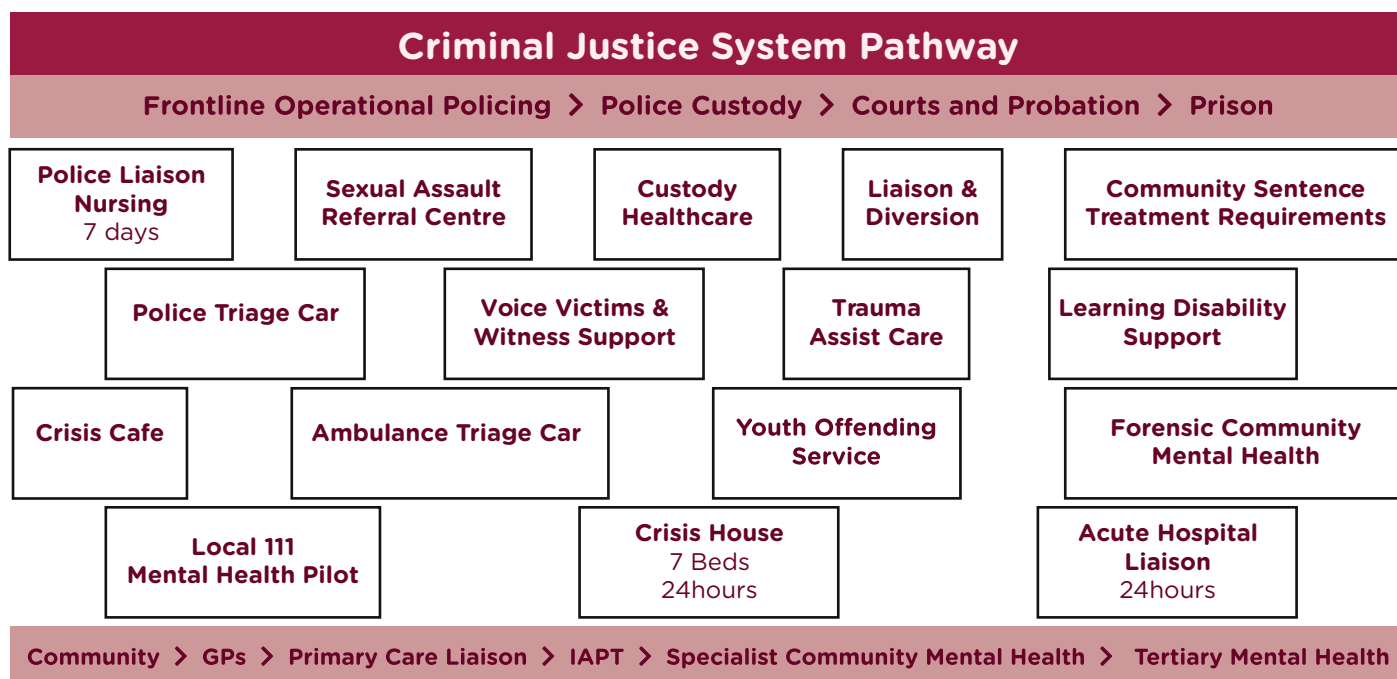
The results of the Mental Health pathway review undertaken by Wayland Lousley and feedback from frontline practitioners can be found in the next section of the report;

Pathways

The Criminal Justice System Pathway (CJS) consists of four main steps:



There are a number of associated activities to each of these steps along the pathway. Figure 1 highlights some of the mental health and wider provision that connects to the CJS pathway, demonstrating the complexity professionals deal with day to day.



Outcomes of Mental Health pathway review and findings from frontline practitioner consultation

The need for fast and effective communication between organisations has never been higher. Professionals from all organisations have consistently described needing a comprehensive directory of services in order to navigate people they see to the right person to meet their needs. Unfortunately, if one is provided it quickly becomes out of date and with the high turnover of staff any team knowledge is also quickly lost.

Professionals are acknowledging more needs to be done with 47% of respondents to the frontline practitioner's survey disagreeing that the needs of those with mental illness, Autism or ADHD are currently being met by criminal justice agencies.

The CJS pathway is but a small part of the wider Mental Health and learning disability pathway. However, Northamptonshire organisations and Northamptonshire Healthcare NHS Foundation Trust (NHFT) in particular, have to a small extent prioritised provision as evidenced by the fact that there are a number of initiatives and services provided at each of the 4 steps of the CJS pathway.

The issue is sustainability. Ad-hoc funding and small scale pilots have provided the initial local evidence to support further investment at scale. However, with such tight financial constraints across the whole health, social care and police system any approach to gain funding will need to demonstrate how the existing service provides value for money and how system savings can be achieved over subsequent years.

Professionals across all organisations contributing to this report have all stated "the need for close joint working, information sharing and joint operational protocols that support this approach". The Multi-Agency Public Protection Arrangements (MAPPA) and Multi-Agency Safeguarding Hub (MASH) are great examples of where this works well, but the same approach needs to be taken for those individuals who don't meet the MAPPA or MASH threshold inclusion criteria.

A key national drive is 'early intervention'. The more that can be done to prevent people from offending or re-offending in the first place will reduce demand on overstretched Police services. The same can be said for Mental Health and is best evidenced by Early Intervention for Psychosis (EIP) services. An approach that brings together health, social care and police at a local community level ideally linked to locality areas has the potential to deliver mutual benefits to the whole system by intervening early through jointly sharing intelligence and supported by joint operational protocols. This model would effectively deliver Lord Bradley's recommendation for partnership working by local neighbourhood policing teams with Mental Health, physical health and other relevant services to prevent crime and ensure people access the right care pathway to reduce their vulnerability and level of risk.

Outcomes of Mental Health pathway review and findings from frontline practitioner consultation

Mental Health Street Triage (Control Room Nurse & Operation Alloy car)

Professionals from the Police and the Northamptonshire Healthcare Foundation Trust (NHFT) all agree that the Mental Health Street Triage service is a great use of resource to effectively identify earlier and meet the Mental Health needs of people in the community, diverting people away from needlessly being taken to either a custody suite or a s136 suite.

The model implemented in Northampton has been developed and implemented by NHFT as the main NHS Mental Health provider for Northamptonshire. This service has not been commissioned, rather NHFT responded to the Police and service user needs by redirecting existing resource to address the high numbers of s136 Mental Health Act (MHA) detentions.

By doing so, they have reduced the number of s136 detentions that did not convert to an assessment or treatment detention, thus saving valuable inpatient resources. However, in consulting with the Police it is clear that whilst they greatly value the psychiatric nurse input to both the control room and going out in the police car, it is not a service they can rely on as core provision. This is mainly due to the reliance on a relatively small service with a few dedicated nursing staff working a shift pattern that doesn't neatly fit with the police shift patterns.

NHFT and Northampton Police staff both agree that the service is partially effective within the current resourcing constraints, but it is not realising the full benefits that a fully funded and properly commissioned Mental Health Street Triage service would deliver with more face to face activity.

Commissioners and providers would benefit from analysing the numbers and consequent savings across the system, and more specifically for both the Police and NHFT, that could be achieved by further investing in this service. Recognition, must be given to the sustained benefits that such a service delivers e.g. minimisation of detentions under the MHA s136, appropriate utilisation of community police resource and appropriate use of urgent and inpatient Mental Health care.

What professionals say is working well:

Professionals state that OP Alloy is reducing Mental Health Act s136 activity. Police staff also value the close working and instant access to psychiatric advice and guidance when available in both the control room and the car.

Response officers said:

Outcomes of Mental Health pathway review and findings from frontline practitioner consultation

“having access to a CPN (Community Psychiatric Nurse) their systems and intelligence has been crucial, has given us confidence we can make a decision.”

What professionals say is not working well, including barriers:

The Op Alloy service was not commissioned, so there was no clear service specification or mutually agreed outcomes to be achieved.

Due to the size of the service, police staff say they “cannot rely on it always being available, rather it is seen as an added bonus.” A lack of resilience was spoken about if a CPN is off ill.

This resilience was reflected by comments made by a carer:

“One of the better things that’s come out of recent years is... where the mental health practitioner comes out with one of your response officers, Operation something or other, I can’t remember what it is now. That’s absolutely brilliant when it’s on duty but that’s the problem, when it’s on duty. It was on duty in September and done a damn good job but wasn’t available in December.”

NHFT staff stated that:

“Street Triage was more effective when there were dedicated Police staff jointly running the service”

In addition both Police and NHFT staff both stated that the current training on mental health for police staff is not sufficient in order to fully realise the benefits of on the job training for police officers when working with mental health Street Triage nurses.

In the focus groups run with frontline practitioners and response officers, some officers described not being fully confident in the advice given by the CPN and felt that they carried around a great deal of risk when making decisions, “come back to haunt us if things go wrong” “don’t have protection or confidence and feel that they will be

Outcomes of Mental Health pathway review and findings from frontline practitioner consultation

“criticised and investigated.” A similar theme was found in the Op. Alloy evaluation described in its recommendations

Response officers thought that CPNs being deployable and based in the control room were equally important to its success. When deployed CPNs were able to offer face to face advice and support, however the draw back of CPNs being deployed were that they could not access their systems and be available to other requests from the police. A clear structure and policy about when they are deployable and what resilience in placed in the control room needs to be considered and communicated to the force as a whole. The majority of officers would like the OP Alloy service to be available twenty four hours a day, seven days a week.

NHFT staff stated that:

“there is a lack of Approved Mental Health Practitioners (AMHP) available for Mental Health Act assessments and CYP safeguarding with only one Social Worker available between 5pm and 9am for the county.”

Moving to a fully commissioned service may require additional funding and/or linked with other mental health services as part of a criminal justice pathway to enable the provider to have sufficient scale to deliver more robust and reliable services

A full evaluation of mental health triage has been undertaken by the Institute for Public Safety Crime and Justice. Recommendations from the report are included below:

- There has been significant progress since 2016. Operational hours have been extended, permanent CPNs has improved the effectiveness. The value of Op Alloy has greatly improved from the feedback obtained from control room dispatchers and response officers
- Evidence suggests Op. Alloy is achieving its aim of avoiding unnecessary detainments to people under 136 and examples were found where service users were diverted from a criminalising pathway to the support they required.
- Young people are a key demographic group contributing to a significant volume of demand within street triage.

However improvements have been suggested:

Outcomes of Mental Health pathway review and findings from frontline practitioner consultation

Currently Op Alloy is staffed by response officers put on the team at random, that changes shift to shift. This can also affect the buy in of officers and there has been cases where officers withdraw from the Op Alloy duties when inundated with response jobs. This again would account for why victims have such a range of experiences as some people will be bought into the value of op alloy and its benefits whilst others won't. It is recommended in the evaluation report;

R: To recruit a dedicated team of specialist officers to take ownership of the operational development of op alloy, in line with the strategic direction of the 136 board and work regularly alongside the CPNs in the force control room and on deployment.

R: To review the roles and responsibilities of officers assigned to Op Alloy as well as greater oversight of day to day duties.

Some of data collection around Op Alloy activity was poor and inconsistent

R: To document and review officer decision-making within incidents, recording alternatives considered prior to 136 being utilised

R: Develop better data capturing procedures for incidents where Op. Alloy has been involved or consulted.

R: Individuals should be accountable for providing data and better follow up processes where data are not recorded should be implemented.

Due to similar themes being identified about levels of risk and confidence in CPN advice it was recommended to;

R: Develop a strategy to improve response officer confidence in CPN advice.

Another similar theme was to review the hours that OP Alloy is active. It was found that if the hours were altered from 12pm-4am, this would capture an additional 10.5% of incidents reaching 85.8% of demand. Therefore it was recommended to;

R: Review the hours that Op Alloy is active so that the CPNs are available to better fit with demand.

R: Review AMHP involvement to seek to minimise the delay of assessment upon arrival at a place of safety.

The evidence suggested that the strategic group, in terms of its formation and purpose, would benefit from being refreshed. It has also been suggested that the strategic board requires a greater emphasis on practice development.

Outcomes of Mental Health pathway review and findings from frontline practitioner consultation

R: Refresh the terms of reference for the S136 Board and ensure all professions involved in the s136 process are represented and buy-in to its objectives.

R: Establish a scrutiny panel to extract learning from case studies of good and poor outcomes.

The proposed scrutiny panel could involve participation from response officers as well as officers and CPNs staffing Op. Alloy to review cases where s136s have been used and where they have been avoided.

The evidence highlighted how young people are a key demographic group contributing to a significant volume of demand within Street Triage. This is reflective of key trends and patterns within Northamptonshire's documented profile, especially in terms of substance misuse and self-harm. Furthermore, strategic reviews in the county have indicated the significance of demand created by high-risk and problematic anti-social behaviours of young people. A comprehensive strategy to prevent and reduce the demand created by young people is critical, as future demand, if following the same trend, it has the potential to become unsustainable.

R: Work with NHFT, local authorities and the third sector to develop a broader and deeper strategy addressing the needs of young people to prevent and address mental ill health.

The evidence presented highlighted how intoxicated individuals, whilst comprising only a small volume of s136 detainments, account for a disproportionate level of demand within the service user profile. Health professionals have suggested that intoxicated individuals should never be taken to a place of safety as identifying genuine Mental Health distress is not possible under these conditions. Alternative courses of action should be developed to enable Officers to manage incidents involving an intoxicated individual.

R: Review Officer practice expectations when resolving incidents involving intoxicated individuals who exhibit behaviours suggestive of Mental Health crisis.

R: Review provisions of, and access to, support for intoxicated individuals.

The evidence provided suggested that Officers would benefit from a broader understanding of the wider crisis context, and the access to health-related provisions for people in crisis to reduce the use of s136 powers. Services such as the Crisis Cafes' set up by the Mental Health charity, Mind, are an example of alternative pathways that Officers

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might divert individuals in crisis to.

There is support for this from the frontline, a response officer stated that having greater knowledge of Mental Health and a person's Mental Health history through working with the CPNs "does increase the police contact time with members of the public with mental illness, previously would have just taken to Berrywood but now spend a lot more time with the person."

Therefore if more time is spent there is greater opportunity to direct people to other services and pathways

R: Provide Officers with information and training about alternative pathways available to them when dealing with an individual in Mental Health crisis.

R: In collaboration with the Clinical Commissioning Groups, review the relative investment into provisions available for Mental Health in Northamptonshire.

The analysis suggested that a series of opportunities are missed before an individual reaches Mental Health crisis point. This contributes to the demand faced by the Police, reflected in the volume of s136s in the county. Moreover, the evidence documented how some individuals were detained under s136 on multiple occasions. This brings into question the sustainability of care provided, either before or following interaction with specialised Mental Health services.

R: Conduct further investigations to identify why the packages of care provided to individuals do not achieve sustainable outcomes.

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Training across the Criminal Justice System

Nationally it has been cited that despite the demand on policing of mental health, police officers are often offered no training on the topic of mental health (Mind & Victim Support, 2013;

Police encounters with people with mental illnesses can be particularly challenging because they take much more time than other calls for service, they require officers to have special training and skills, they involve repeat contact with the same individual, and their success often depends on the availability of community mental health services (Reuland, Schwarzfeld, & Draper, 2012).

In the frontline practitioners' survey, 39% of respondents did not feel equipped to deal with people with mental illness, ADHD or Autism. The proportion was highest for the police with 51% saying that they did not feel equipped. Interestingly, even a quarter of those who spent 75% of their time working with people with mental health issues, ADHD and Autism felt they were not equipped.

The most common reason why people did not feel equipped was they felt that they needed more training on mental health and ADHD/Autism in terms of identifying conditions and effective strategies when dealing with people that have these conditions e.g. "No training on how to deal with specific conditions that we regularly come across.", "More training and awareness of what to look for and how to deal", "Relevant and up to date training is not up to standard", "No specific training on providing support to suspects with mental illnesses." And "More information, I don't deal directly with people with mental illness, Autism and ADHD, however I risk manage incidents and crimes which involve people with these issues and understanding them better would help me develop strategies to better safeguard"

52% of participants felt that they do not receive sufficient training to enable them to meet the needs of people with mental illness, Autism or ADHD (This was 73% for the police).

Police training

A broad range of views were expressed by police officers in focus groups, when consulted about their experiences of working with people with a mental illness, Autism/ADHD. It was concerning at the range of perspectives gathered. Around half of those consulted face to face wanted access to more training and thought having service users and mental health practitioners involved in it would be "invaluable", "we could understand what it is like from their perspective and what they want from us" and felt very frustrated that they were not given the proper skills and knowledge to deliver the most effective service.

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An officer responding to the survey said:

“I would love for us to have more training as frontline officers. The 1 day training I have had in my 2 years as an officer is not enough! And it is time that it was not a taboo to talk about. The general public see us as superheroes who know everything and can fix everything. They do not realise just how little training we are expected to work from.”

Others wanted more specifically on Autism and ADHD:

“As a police negotiator, I have dealt with two people attempting suicide with Autism and this showed a need to treat differently. Have also dealt with pupil excluded from school displaying classic Autism symptoms (misunderstood by school and others) and managed to get this addressed. It is clear to me that those with mental illness, Autism and ADHD occupy a lot of police time and more training would be helpful”

“I have had mental health first aid training but nothing to assist with dealing with people with ADHD or Autism”, “ADHD training signs and triggers.”

However some officers did not want any more training, as they felt their role was not to get involved with mental health related incidents and that it should be the role of mental health professionals. One individual stated;

“we do not have all day to assess their needs, we have to balance the individual’s needs against the wider public”

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Whilst it is acknowledged that police officers should not be mental health professionals, it appeared that some were using this argument as a reason for why they did not need to consider the different needs of service users. When it was discussed that some service users felt that they were not treated as individuals by the police, one officer stated:

“with all due respect they are just another job.”

These comments show a range of perspectives from officers and further evidence why service users may not be receiving a consistent approach.

Police Workload

In addition to the Time 2 Listen focus groups and survey, research was commissioned by the Police and Crime Commission and undertaken by the Institute for Public Safety Crime and Justice to gain a better understanding of internal wellbeing and resilience of Officers and Staff. Fifty-eight staff and officers from across departments, teams and levels participated, and additional questions were added to the Time 2 Listen frontline survey for Northamptonshire Police employees and volunteers to understand their experience and awareness of support provision.

Some officers expressed their concern at the time they spent dealing with mental health related incidents and how this impacted their workload. Frustrations centred on the time spent with patients due to the perceived lack of, or delay in mental health service provision from partners;

“It shouldn’t be the police’s job to babysit kids and to look after mentally ill people, We should get them at the point where they need the safeguarding, take them to a place and that should then be another organisation’s responsibility”

“But the reality is, when we take somebody into a hospital who’s mentally ill we are ending up sitting with them for hours. The hospital doesn’t streamline them to get them through to see a psych...There’s not a 24/7 psych on duty, or if there is, there’s one on the ward but they’re not going to come down because they’re doing their rounds. You are just sitting with somebody for fear that they are going to walk off and then become a high risk missing person, which then takes up the whole of your resources.”

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The Institute found that officers also expressed frustrations around repeated contacts with the “same people”, calling for greater accountability of partner agencies. These continued frustrations have the potential to lead to compassion fatigue, where there is reduced ability to feel empathy with individuals with mental health issues;

“And you know what? The mental health team who that person sits under, that should be their job. We can’t – as I say, I’m not a mental health assessor. I don’t know whether or not somebody’s on the verge of jumping or not jumping. A lot of people that we deal with, they say they’re going to do these things but they never do.”

What type of training would be most appropriate for frontline practitioners

It was commented by most focus groups of response officers that mandated training was very difficult to achieve due to abstractions and the impact that has on the organisation. One suggestion was to include awareness training into officer safety training which officers must attend once a year.

However other officers felt that the time needed would not be achieved. Instead they suggested making use of team training days and to have regular inputs “little and often” to keep people up to date. “These illnesses change over time; regular and frequent updated training needs to be provided”

Other suggestions were for an up to date list of different mental health conditions and a description of what they should be aware of that was short and to the point.

Others suggested having a list of staff and officers who have a greater level of training or experience professionally or personally within their own family of mental illness, Autism or ADHD that could be contacted when officers are seeking more awareness or advice.

Consideration must be given to developing a programme of training for police to develop their skills, communication techniques, awareness and knowledge of local services and not just general theory. Establishing core foundation training modules for new recruits that supports personal mental wellbeing as well as dealing with the general population is essential. Training cannot be allowed to finish there, these foundation modules need to have follow-up mandatory modules relevant to specific

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areas of work placements like the control room, custody or domestic violence teams and this would greatly improve implementation at a local level. This should be possible to achieve without impacting on abstraction rates.

The Police are taking steps to better equip managers to better support their staff and officers with their mental health needs, and is currently rolling out a half day mental health training for managers. This is a positive step, however this needs to form a much wider programme of work to enable a more compassionate and mental health aware organisation. Staff and officers are unlikely to be able to deliver a more consistent compassionate, respectful and non-judgemental service to communities if they are not experiencing these types of behaviours internally. Therefore it is vital that these skills and qualities are embedded to support better outcomes for the public and for staff and officers.

The police alone are not the only agency within the criminal justice system requesting the need for training. Therefore ideally, this training would be delivered jointly with multi-agency involvement to further enhance joint working across the CJS.

Northamptonshire officers from the Probation's Community Rehabilitation Company (CRC) spoke of receiving very limited training on mental health/Autism/ADHD. The training they did receive was online based, and tended to only be delivered to staff at their initial training. Staff requested more multiagency training on this.

Feedback from frontline survey respondents was that they did not think online training packages were very useful and suggested; "Classroom discussions so you can share your experiences and listen to how others dealt with situations" and "group training within mixed discipline environments definitely so that more knowledge and networking can be shared."

Again there was there was also suggestions in the frontline survey about having inputs from service users; "Talking to mental health sufferers to gain further understanding and empathy into the plight of sufferers."

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When frontline practitioners were asked how they tailor their behaviour to better meet people's needs there were many positive examples including:



Direct eye contact for prolonged periods can make people with these conditions feel awkward” and “More aware of body language and how that can come across”



Be patient, expect to be challenged and expect them to be direct in their expression.”, “More patient, aware of how myself and surroundings can affect communication” and “giving time and space, being empathetic.”



With some individuals, using different forms of communication such as visual aids - “photographs or picture to explain the issue and to talk about it before hand” Being aware of the impact of and adapting non-verbal communication -“Ask questions and understand thereby changing your approach to suit.



Changing the tone of the voice and language used being “Calm, listen, try not to enter their personal space, reassurance.

There are some really positive examples of where good quality service delivery is taking place across frontline practitioners but the real challenge is how this is made more consistent.

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Police Custody Liaison & Diversion and Custody Healthcare

What is working well

It was found that Liaison and Diversion services are improving their performance of national KPIs (as evidenced by the quarter 2 2017-18 report).

There is presence in custody 24 hours a day by both the Custody Healthcare and the separate Liaison & Diversion teams. This highlights the benefits of having the same provider for both services.

Two nurses based in the Youth Offending Service (YOS) provide an essential link with Children and Adolescent Mental Health Services (CAMHS) and enable the YOS to ensure they have a consistent presence in the youth courts.

Dual diagnosis (Substance Misuse & Mental Health) nurses provide essential liaison for Drug and Alcohol services across Northants with mental health services often solving issues where direct contact with the crisis service has proved difficult.

What is not working well & barriers:

Whilst performance is improving against key performance indicators, the quality of the team's interventions is not clearly measured, nor are the outcomes they are working to e.g. the number of people they refer to therapy services is captured, but it is unknown how many actually engage and complete that therapy and do not re-offend.

There is an inconsistent presence of Liaison & Diversion staff in the adult Magistrate's Court and lack of pre-sentencing information is a key issue for court staff.

There is also a limited opportunity for probation, court staff and Liaison and Diversion to meet operationally and address any presenting issues. Court staff say "when meetings do occur L&D commitment to resolve the issues is not forthcoming in action or results"

There is also a resilience issue, the Liaison and Diversion team is a small service, that means it is adversely affected by vacancies, sickness, maternity leave or annual leave.

Lastly custody healthcare is commissioned by the Police and Crime Commission, whilst Liaison and Diversion is commissioned by NHS England. Despite them having the same provider they are tendered separately without consideration for the impact on the overall criminal justice pathway.

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Youth Offending Service

Professionals from the Youth Offending Service and relevant voluntary organisations across Northamptonshire agree that there are good services in place and close interagency working for youth offending services.

It was found that Liaison and Diversion nurses based in Youth Offending Services facilitate a good working relationship with CAMHS and contribute to informing presentence reports for the youth courts

However there was found to be a restricted capacity in CAMHS, universal and tier 2 children's and young people's services across Northamptonshire. This creates pressure within the health and social care system and reduces professionals and relevant 3rd sector organisation's ability to provide early intervention.

Courts - Community Sentence Treatment Requirements Pilot for women offenders

What is working well:

Court staff said that "the Women's Community Sentence Treatment Requirement (CSTR) programme initiative with the Good Loaf organisation is already having a significantly positive impact with up to 25 women already receiving this sentence option where there was none previously (this has now increased to 40 since the review was undertaken).

The multi-agency joint working steering group meets regularly and professionals from all contributing organisations value the effectiveness of this approach to operational delivery.

Probation officers say that "they value the co-location of the forensic mental health and personality disorder team members when they are available". Improving awareness of mental health and referral pathways including criteria thresholds through close working and monthly brief training sessions.

Regular mental health and learning disability training for court staff is available and jointly provided by a Magistrate and Mental Health Nurse when available.

What's not working well and barriers:

Currently as the CSTR programme is only for women, magistrates are unable to sentence male offenders to this type of community order.

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Uncertainty regarding ongoing funding once the CSTR pilot ends and the need to expand the service to include all relevant offenders would require additional investment.

Poor and or inconsistent links between the courts including Probation services with both crisis and community mental health teams creates misunderstandings when referring or trying to gain advice.

The Youth Offending Court demonstrates how consistent presence in court by Liaison and Diversion workers enables better outcomes for offenders and the community. Adult Courts require a similar consistent presence and pre-sentence information to better support their sentencing options.

Court Staff interviewed remarked;

“The court is getting better at identifying Mental Health needs due to regular training for Magistrates, but adult Court staff frustrations are rising due to the inconsistent presence and response from Liaison and Diversion including there being little visible clinical treatment provision in place to divert people to.”

A Magistrate representative stated;

“the Northampton Women’s CSTR Programme is filling a huge gap in provision for Magistrates and is enabling more effective sentencing. This new programme has fully engaged the judiciary and given potential for 45 CSTRs per month, but it will require careful consideration to ensure that full implementation across six Northants courts can be achieved.”

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Probation officers interviewed said;

“Where there are established governance processes like MAPPA in place or with the co-location of teams like the Forensic and Personality Disorder teams effective joint working takes place. But when those teams or processes aren’t available it becomes extremely difficult to get the right support for our clients.”

During interviews with a range of Court and probation staff it was clear that improvements are required to the commissioning, management and operational delivery of Liaison & Diversion, Forensic, Personality Disorder and Mental Health Crisis services. Professionals suggested that “better accountability with monitoring of performance and transparency that includes 360 degree feedback from key stakeholders such as Magistrates and Probation Officers could provide a useful way forward for all organisations.

Magistrates and Court staff made other suggestions to consider:

- Liaison and Diversion team to follow through on individuals they sign post or refer to other services to ensure the person accessed and actually received help.
- Finally, there should be an offer of low level psychological interventions across the Criminal Justice pathway that will support the defendant whilst they access more detailed treatment, including support workers that would work with the offender’s social care needs in preparation to engage with treatment. Thus, fully expanding the CSTR programme to all Northamptonshire Courts.
- The court staff stated there should be a stronger set of therapeutic treatment requirements post court e.g. mental health treatment requirements (MHTR) should be available to men as well as the women on the pilot, requesting more lower level treatment options to be available.

High Intensity User initiative - based on the Isle of Wight model

Across the UK, emergency services are struggling to manage a small number of repeat callers with complex mental health needs. A very small number of known people (sometimes less than 10 individuals) will regularly cause up to one third of crisis mental health demand, not only placing operational pressures on police officers but also on other emergency and health care teams. These individuals are often chaotic and anti-

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social in their behaviour and occasionally criminal in their conduct towards relatives, friends, members of the public and public service personnel. In the most extreme of cases, mental health professionals describe these cases as 'unmanageable'.

Northamptonshire Police together with NHFT are developing a model for working with mental health users who are frequently use Northamptonshire Police services (high intensive users), based on the model in the Isle of Wight.

A police officer will be working together with community mental health nurses to show consistency, compassion and encouragement but also boundaries and consequences to behaviour. Results in the Isle of Wight model have shown reductions in: crisis calls made, emergency department attendance, response calls, reduced risk to the wider community or of suicide, improved relationships between mental health nurses and their clients, and service users being more motivated to engage with services and making healthier choices.

This service is in development and therefore a full evaluation of the new model will be carried out to understand the full impact of the pilot for both the police, NHS and the client themselves. The Isle of Wight initiative gives a clear indication of the success that can be achieved when a whole system starts to work together around individuals with complex needs to help them change their lives for the better, enabling them to achieve their personal goals and recovery.

How agencies are working together

There is a lack of joint decision making and ownership between agencies particularly around those with mental illness. Police officers feel they are carrying around too much risk. They do not feel they are trained enough to make decisions and that they are "filling gaps for other services". It was felt this was due to other services being able to "say no" to delivering services, but that the police were unable to do this. It was commented that the level of risk and responsibility increased when out of office hours and this was doing an injustice to services given to the public;

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“Firstly we are police officers, whilst health, wellbeing and prevention from harm, risk management is a responsibility of all we are not particularly well trained when dealing with M/H ADHD, Autism etc, yet we are expected to make decisions on individual’s mental state. Often the decisions made by police officers are done so to avoid any risk. Op Alloy is a help but at times they don’t wish to make an ultimate decision. I firmly believe that there is a reason why there are Mental Health Care Nurses/Psychiatrists etc, but find it frustrating that after office hours it is very difficult to have one attend an incident. There is great work done by police officers although I feel we often enter situations after which if we make the wrong decision we would be heavily criticised or worse. I find it ironic that the service which is supposed to be the lead on this type of care is not available when most suffer, this I believe it is out of hours when people are alone/don’t have access to MH workers.”

Instead of individuals or individual organisations carrying risk, many wanted that risk to be shared with other agencies. This was also reflected in a focus group with CRC staff. An individual discussed an issue with an offender who was in crisis which took place in the daytime, the probation officer rang 101 and then was told to ring 111 and was passed between agencies for four hours until it was resolved. They felt they are left holding the risk and person in crisis, and they did feel mental health agencies are taking enough responsibility “we need someone to handover to that is willing to do it” (take it forward).

Some service users acknowledged that mental health patients should not just be a police responsibility however they felt there lack of support from other agencies when in time of need;

“I know that it’s not the police’s responsibility to pick up mental health patients from around the county per se but there isn’t anybody else to do it, and I think that have we reached the point now where it’s about redefining roles and responsibilities.”

The need for agencies to take responsibility was a theme within the survey feedback. When professionals were asked what works well when working with partners, and what needs improvement similar themes arose in both. This shows that although progress has been made there is still a lot of work to be collectively undertaken.

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Working well	Needs to be improved
Communication Communication has improved	Better communication and liaison “Better liaison between professional organisations and the voluntary and charitable sectors”, “Communication to Neighbourhood Teams”
Information sharing “Information sharing is much better than it was when I joined the organisation.”	Sharing information “Open agreement for information sharing in urgent situations and “The willingness of organisations to share information”
Willingness to work in partnership and a belief that it is the best approach It seems to be more widely accepted that a multi-agency approach is often required.”	Agencies taking responsibility and ownership “Partners need to take responsibility, everyone seems to want to pass on to others as all services are under pressure” and “Accountability and responsibility, refusal to take a client because they are ‘with’ another organisation.”
The sharing of knowledge and ability to draw on specialist expertise	Listening and accepting expertise “When they don’t listen and take an approach that they know best”
Clear understanding of own and other responsibilities, roles and powers	Increased understanding of each services remit, what they can offer and their restrictions. “Understanding of police powers, what is a police power and our likely response, people get offended when you tell them we won’t be treating it as an emergency and put the work back on them”

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Needs to be improved

There is a need for increased resources, staffing or funding

“They all need more funding, the services are spread so thinly, you can’t get hold of people or they are off with stress. More funding, training, and the government caring about workers in its frontline services.” And “increased resources and decreased caseloads”.

Better understanding of different conditions

“Understanding of dementia by police force to minimise use of practices that escalate distress for people with cognitive impairment!”

Improving timescales

“communication and the speed of diagnosis and identifying support” and “In general all partners are under staffed and so the process is slow.”

Availability of specialists out of hours

“Out of hours availability of specialists. Crises don’t just happen in office hours, and there is farcical cover at weekends and BHs. Commissioning needs to be realistic”

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Other issues that arose from feedback

Waiting times

- Time taken for police to handover patients to hospitals - a substantial issue is the time officers are required to wait with a mental health service user when in A&E or a place of safety. They felt they were “babysitting people,” Either because the person was at risk of leaving the hospital or the person was required to be under constant observation many said the signing over process was too long.
- For Ambulances - this continues to be an issue particularly due to the wait for a double crewed ambulance. Therefore the police service “often becomes the ambulance service” by taking people to hospital. One officer had devised their own way round this by directly calling the ambulance control room who have sent a first responder to undertake a mental health assessment, and then they organise for someone to meet the officers at Berrywood, which they find is a much swifter process.

Thresholds and inclusion criteria – Are creating issues and barriers for transition or referral into services. Experiences of the Crisis Team not taking referrals from other agencies (e.g. probation, S2S) is a case in point, as the Crisis Team only accept a GP referral, but those other agencies find that they are not always able to get permission from service users to contact their GP. Therefore they are unable to get the right support or care for a person they are dealing with in a mental health crisis.

Safeguarding Referrals – Police officers spoke of referring people to safeguarding who they had mental health concerns about “All we that we can do is submit a PPN but that I am sorry does not work as we have to submit one for every person and they are getting back logged.”

There are also concerns from mental health services that if it does not reach the threshold for safeguarding that these referrals are not automatically passed onto them for mental health support. Others suggested needing “A direct referral for Autism/ADHD rather than a blanket safeguarding referral.” This referral process needs to be reviewed in light of these findings.

Community Mental health services - There appears to be a tension between agencies about how to work with people. The National Probation Service in some cases are being told by community mental health services that they won’t work with certain individuals, as there is too much risk involved, this means that probation staff are unsure what to do to get the right care for the person they are dealing with.

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Lack of a multi-agency strategy – Professionals state that there is not a coordinated strategy and that existing governance structures do not support a system wide approach to commissioning or providing services. Therefore, joint implementation plans for mental health and the Criminal Justice System have yet to be developed

Communication- Professionals discussed the lack of awareness or knowledge of services available for service users, both with service users themselves and professionals;

- Communication with service users - officers felt there was a real lack of information about what services people can go to, and they feel because of this they default to the police. “Easier access to help for them. Maybe a phone number that they can call in order to speak to a trained professional instead of calling 101.” These facilities already exist but the challenge is members of the public are made aware of what help they can access.
- Communication between agencies - There is poor communication and diverging expectations between professionals and organisations which creates numerous operational issues with no access to agreed processes to gain a resolution. Several criminal justice agency representatives and those outside of the CJS stated they would not know who to engage with mental health services to meet the needs of a person they suspected was vulnerable.

“Our role in local authority is to deal with the community complaints where these relate to those with mental health illnesses of any kind we can only do this with full support of partner agencies and we struggle with this. Our officers have basic safeguarding training and may benefit from basic mental health awareness training but what they need training on is which service to access, how to access them and what should be dealt with by those agencies” and “Outline of ways to work with people, greater understanding of their capability. Understanding the process for referrals and intervention.”

Others commented that they wanted a “professionals’ help line”. Throughout this consultation it has been surprising how little agencies outside of mental health services know about where to seek advice, how to refer and therefore are often left being frustrated and left feeling that they are managing the risk around an individual on their own with little mental health knowledge.

However it has been found that some of the support for professionals is already available. For example CAMHS have a phone line that can be accessed by professionals seeking advice about a young person. Again this needs to link into the training given which does not always need to be in the format of formal training, regular inputs are needed

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to keep information present and current, allowing staff and officers to be more confident in their roles and in turn delivering a better and more effective service to vulnerable members of the public.

Commissioning

In reviewing the mental health provision across the Criminal Justice Pathway for Northamptonshire, it is evident that it has been commissioned or delivered in a fragmented way, as either funding became available, for example upon Wave 2 Liaison and Diversion for police custody, re-allocation of NHFT resources for Street Triage or as a pilot development to meet a specific need e.g. Community Sentence Treatment Requirement (CSTR) for women. Whilst the individual services deliver some excellent care and results, all professionals agree that there is room for improvement.

Each of these services are relatively small, consequently the resources are spread thinly and adversely subject to reduced workforce capacity due to sickness, vacancy levels, recruitment issues or extended leave.

Sustainability of these services moving forward is therefore essential to support people with a Mental Illness, ADHD or Autism who either as an offender or a victim are in the Criminal Justice System Pathway. Consideration should be given to the required scale of service provision, which can include where similar services across the CJS pathway could be commissioned as a whole by a lead commissioner focussed on achieving clear system outcomes.

In addition there are a range of different commissioners who purchase different elements of both health and social care for Northamptonshire residents and/or people registered with a Northamptonshire GP:

- The Office of Northamptonshire Police and Crime Commissioner (OPCC) commissions the Sexual Assault Referral Centre (jointly with NHS England), Police Custody Healthcare, elements of community sentence treatment requirements.
- NHS England Midlands and East commission prison healthcare, Liaison and Diversion services, CAMHS Tier 4 beds and adult forensic secure beds.
- NHS Nene & Corby Clinical Commissioning Groups (CCG) commission all the physical health and mental health provision for the county through two main statutory providers and a range of small third sector providers e.g. MIND, Age UK
- Northamptonshire County Council commission substance misuse services and provide social care services amongst a range of various services for the county.

Having such a range of commissioning organisations with widely different approaches to procurement and contracting creates a complexity within the system, which provid-

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ers say is often difficult to navigate and can consume considerable amounts of time and resource in-order to prepare bids for tenders.

The Northamptonshire Health and Wellbeing Board could have a key role in governance across local systems. They have a population focus and membership from a range of stakeholders across the local system. However, their scope is broad and there are a number of different strategies in place for each organisation across health and social care settings. There does not appear to be an all-encompassing system wide strategy for mental health and the CJS. The Health and Wellbeing Board could provide the required overview and governance for the system as a whole.

Several commissioners interviewed stated “a collaborative and outcomes focussed approach to commissioning that includes key functions provided by the current services across the whole care pathway or criminal justice pathway would be beneficial to service users, carers, professionals delivering services and make better use of resources.”

There is a range of mental health service provision and pilot initiatives being delivered in the Criminal Justice System. These initiatives are producing some successful results, but they are at significant risk due to lack of sustainable funding. Professionals across the board highlighted that there appears to be a disconnect between performance reporting at a strategic level and what is happening on the frontline, day by day. They also identified the need for a regular multi-agency operational meeting where each organisation can gain resolution to these day to day working issues.

There has been differing views particularly from professionals about their role in mental health and a lack of responsibility. With the outcome being service users and professionals are passed from one service to another.

Summary of findings from Professionals' experience

There is evidence of significant progress being made by commissioners and providers in delivering better services for people with mental ill health, Autism or ADHD. However professionals universally agree that more can be done to establish more robust services with clear joint working.

The main areas for improvement are:

- System Governance, Joint Vision and Funding – Develop and deliver collaborative outcomes based commissioning for whole system pathways that consider preventative and crisis care.
- Communication and interagency operational working - Develop joint operational protocols, enabling regular multiagency operational meetings with a clear mandate to solve problems in practice. Develop and communicate clear referral processes and

Outcomes of Mental Health pathway review and findings from frontline practitioner consultation

increasing understanding of what support services are available.

- Workforce recruitment, development, retention and training – System wide approach to recruitment and retention with multi-agency training linked to joint working protocols and quick access to the right operational lead for each organisation
- Resources out of hours - Consider how out of office hours community mental health provision can be better resourced and funded.

Given the current financial challenges faced by the police, health and social care system in Northamptonshire many of the desired improvements will be difficult to implement. However, there are savings to be achieved by investment, implementation and delivery of desired outcomes

Lord Bradley recommended in 2009 that Local Safer Neighbourhood Teams play a key role in identifying and supporting people in the community with mental health problems or learning disabilities who may be involved in low-level offending or anti-social behaviour by establishing local contacts and partnerships and developing referral pathways. He went on to recommend that community support officers and police officers should link with local mental health services to develop joint training packages for mental health awareness and learning disability issues. Therefore, a priority for the Mental Health Criminal Justice Board is consideration of the development of a joint or multi-agency modular training package and events linked to joint referral and operational protocols.

In addition to training, the local safer neighbourhood teams need to be linked closely with GP practices, community mental health, drug and alcohol, probation and learning disability teams to develop a partnership approach to collectively supporting those individuals identified in their local communities. Information governance has always been used as a barrier to sharing information between agencies, but there are a number of initiatives e.g. High Intensity Users Projects around the country where they have overcome this issue.

Professionals continue to work in their teams and organisations, only when they come together operationally to deliver a joint programme of work such as the Women's Community Sentence Treatment Requirement, do we begin to see individuals achieve personal goals and recovery whilst the whole system benefits.

Professionals in the Youth Offending Service describe delivering effective services for the Children and Young People of Northamptonshire. However, sustaining service capacity is essential moving forward, along with increasing resources in services they rely on, such as, Children and Adolescents Mental Health Services (CAMHS).



Findings & Recommendations

Findings & Recommendations

The following recommendations will be overseen by the Mental Health Criminal Justice Board, some of the recommendations may be outside the remit of the board. Therefore close working will need to take place with the Mental Health Transformation Board (as well as the Crisis Care and Prevention Concordats) and Health and Wellbeing Board to ensure activity based on these recommendations is taken forward. Some elements of these recommendations need to become a focus of national attention and the OPCC will consider how best to take forward those elements nationally with partners.

Consistency of approach

There is a lack of a consistent approach to working with people with mental illness, ADHD or Autism. This report has demonstrated that there is some really good frontline staff who tailor their behaviour and approach to best meet people's needs however this is not consistent. The majority of the feedback in relation to this was in regards to the police (this may be because the majority experiences people spoke to us involved the police more than any other agency) but several examples were given in other criminal justice and health settings;

Recommendations:

1. Service users should be at the heart of all services and should expect a consistency of service.
2. There needs to be a significant culture change within the police and the wider criminal justice, health and those within social services, to achieve services that are compassionate, non-judgemental and treats people as individuals.
3. Organisations should work together to tackle issues and have joint measures of success based on the experience of service users so that joint responsibility is taken.
4. To ensure officers do not feel that they are carrying risk on their own, risk and care plans should be jointly agreed across organisations together with the service user/carers.

Joined-up professional development across agencies

Many police officers, and staff from across criminal justice agencies said they wanted more knowledge and awareness of mental health, Autism and ADHD conditions. Many received very little training, that was often one off and therefore not current, which had limited input from service users or mental health practitioners;

5. All criminal justice agencies should receive improved basic knowledge of mental health conditions, Autism and ADHD and understand what impact they have on

Findings & Recommendations

other's behaviours and experiences. This should include for frontline practitioners different communication skills, low arousal or de-escalation techniques.

6. To develop a long-term programme of development, throughout someone's career. Training should be designed with and involve service users and mental health practitioners, delivered in person or via technology, tailored to different teams/ areas need.
7. Multi agency training should be undertaken where possible to gain a greater understanding of roles and experiences across the Criminal Justice System and health.
8. Improve knowledge of what support and services are out there for people and families with mental health issues, Autism or ADHD. To increase awareness of how referrals can be made and where they can seek advice e.g. professional advice centres/phone lines- CAMHS professional telephone line. For each organisation to have a list of those who have received advanced training to seek advice if needed.
9. To rotate officers and staff in dedicated roles dealing with issues relating to mental health, Autism and ADHD, including movement across agencies for professional development.
10. To establish a project involving service users and carers looking at recruitment processes across the Criminal Justice System to understand if qualities such as compassion, empathy, being non-judgemental and respect are considered upon appointment of frontline roles.

Reduce gaps in service delivery and support

There needs to be greater support for prisoners upon release and some service users described facing homelessness and breaching licencing conditions by having no fixed abode and having no address. Therefore it is not surprising many people will reoffend or it makes their mental health worsen, or they will return to drug or alcohol abuse. BENCH also commented that they receive no information about mental health needs of prisoners that are released after shorter sentences;

11. The Mental Health Criminal Justice Board should work with local prisons to ensure information relating to mental health needs are provided to relevant criminal justice and mental health support organisations. To review the mental health support that prisoners should receive after prison and identify if any additional services need to be put in place.

Several ex-offenders discussed the importance of receiving support alongside punish-

Findings & Recommendations

ment to have the best impact on their mental health and their likelihood of reoffending

12. To build on existing pilots (e.g. mental health treatment requirements) and consider sustainable rehabilitative options for offenders at all parts of the Criminal Justice System e.g. from custody, at court etc.

Service users explained difficulty in accessing support at critical times of need such as; the impact of missing appointments meant they could no longer receive treatment for an addiction, or access to medication whilst homeless. Service users also explained the difficulties of services dealing with mental needs and substance misuse needs separately. It is positive that the new substance misuse contract includes support for people with both mental health and substance dependencies.

13. To ensure mental health service user feedback informs and shapes current and future substance misuse services.
14. To continue to embed the Keep Safe Scheme and raise awareness of its broaden scope to include mental health and Autism.
15. To review the process of discharge from hospitals with service users and their carers to understand how communication can be improved.
16. To improve support on discharge from hospital to ensure an appropriate plan is in place, and also so that families are as involved as much possible so service users no longer feel “exposed to the world” upon discharge, but understanding their new pathway for support.

Currently parents/carers of autistic children or adults are encouraged to telephone the police if the person they are caring for becomes violent, but the parents/carers do not want to criminalise them and do not think the police is an appropriate response as it could escalate the situation.

17. For social services to work with the police and parents/carers about the most appropriate alternative response or action that reduces criminalisation of autistic people.

Raising awareness & knowledge of services and routes

People are trying to navigate through a system without anyone directing them where to go, transitions between services needs improvement, others do not receive enough information about why decisions were made and why support was not given, or information is not updated so they have to tell their story again and again. Service users are still

Findings & Recommendations

reporting that they are waiting months for assessment and for treatment. Professionals are also not aware of support services available particularly for carers. Frontline practitioners should all be made aware of the support that can be offered to the whole family not just the patient/client.

A number of referrals are made through GPs and it can be dependent on the information that is included as to whether someone is put through for assessment. However often service users can either self-refer or add information in that they think is relevant, although they are not always aware of this;

To continue to reduce time waiting for assessment and treatment. Develop communication mechanisms two way communication methods to; ensure families know what is happening and do not feel forgotten, to inform where additional support can be provided during the waiting period, and health services can be kept updated by service users if any changes take place that need more immediate support.

18. To review the thresholds for being eligible for early help or crisis intervention.
19. To ensure referrals to child and adult safeguarding services that do not meet the threshold are appropriately referred onto mental health, ADHD or Autism support services.
20. To design a campaign to raise awareness of mental health, Autism and ADHD support services across frontline practitioners within the Criminal Justice System, health and service users and carers, with the aim of providing support before crisis point.
21. To raise awareness with GPs regarding the importance of the detail required when making referrals and to ensure service users are aware that they can self refer and add relevant information.
22. To consider a one-stop-shop for mental health services (to consider the role of the NHFT referral centre) where service users and carers can explain their needs and be sign posted to the right services. So that referral mechanisms can be explained, where service users can access where they are on waiting lists, to introduce ways in which individuals only have to tell their experience once, and then this information be passed on, and where they are advised of alternatives for support whilst they are waiting.

Wider engagement with young people

Further engagement is needed with young people who have experienced the police or wider Criminal Justice System. Limited engagement was achieved through partner agencies promoting the Time 2 Listen survey to young people on our behalf

Findings & Recommendations

23. For the Police and Crime Commission Youth Commission members to work with the Commission on obtaining the views of their peers on their experiences of mental health, Autism and ADHD services. With the aim of co-producing activity based on the outcomes of the consultation.
24. Therefore Northamptonshire Police and Crime Commission will use creative methods similarly to those in the youth Time 2 Listen competition (e.g. art, rap, poetry, filming etc) to help explore young people's experiences, who have had a direct experience of the police and wider Criminal Justice System.

Shared vision and collaborative commissioning

There has been differing views particularly from professionals about their role in mental health and a lack of responsibility. With the outcome being service users and professionals are passed from one service to another.

25. To establish an overarching 3-5year vision of how vulnerable people's needs will be addressed within the criminal justice pathway by aligning existing police, health and social care strategies, that demonstrate outcomes and benefits for the whole system in Northamptonshire. This vision should include agreement that mental health is every organisation's responsibility and an action plan should be developed with clear owners and should include commitment to joint commissioning arrangements.
26. Establish a full understanding of the criminal justice pathway and how it works with relevant mental health, substance misuse and learning disability services. Protocols between each organisation should be produced to clarify for professionals the role of each organisation, what their responsibility is, and how referrals can be made. So that professionals have a better understanding of what services can and cannot provide. These protocols should be fully communicated to frontline staff.
27. To consider how out of hours services, particularly in mental crisis teams, can be more effectively resourced, to better enable more appropriate support to service users rather than a reliance on emergency services.
28. To establish operational meetings across the Criminal Justice System and health and social care to jointly address problems in practice, identify where learning can take and to improve communication between organisations.

Both professionals and service users spoke about the lack of preventative services

29. To jointly commission and pilot a greater number of preventative services actively

addressing groups (particularly young people) with risk factors related to mental health, criminal justice and victimisation. This includes working with current preventative services to achieve this.

30. Establish a pilot for partnership working at a locality level to help prevent crime at its root by delivering early interventions. Police should work closely with mental health, substance misuse, learning disability services to identify and collaboratively support people in the community with mental health, learning disabilities or substance misuse problems involved with low level offending.

Improving processes across the Criminal Justice System

31. To support the recommendations set out in the Op Alloy evaluation and particularly the change of hours to the service, to better meet the demand and to develop a consistent team to make it even more effective.
32. To review provisions and processes in hospitals to seek alternatives for officers spending significant amounts of time with patients waiting for assessments.
33. The local data captured around mental health needs improving particularly around policing. Currently we still do not have a full picture of mental health demand on policing services. There has also previously been a lack of consistency in Op Alloy related data which needs rectifying to understand the full picture.
34. For the Mental Health Criminal Justice Board to oversee the Liaison and Diversion service to ensure consistency of service from police custody to court. This oversight should include establishing joint working protocols to maximise efficiency.



Acknowledgements & Thanks

Acknowledgements & Thanks

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AGE UK	Full Gospel Church, Rushden	Mental Health Transformation Board
All Northamptonshire GP Surgeries	Genesis House	MIND- branches across the county
Autism Concern	Groundsworks	NASS
Autistic Children Embraced	Hope Centre	Northamptonshire Association for Youth Clubs
BENCH CRC	Kettering General Hospital	Northamptonshire Court Service
Berrywood Hospital	Liason and Diversion Team	Northampton General Hospital
C2C	Local Offer	Northamptonshire Healthcare Foundation Trust
CAMHS	Local Strategic Partnership, Kettering	Northamptonshire Learning Disability Partnership Board
CAN	Lowdown	Northamptonshire Emergency Services Cadets
Community Mental Health Team	Maplefields	Northamptonshire Police
Daylight Centre, Wellingborough	Mental Health Crisis Concordat Board	
Early Help Co-ordinators (NCC)	Mental Health Prevention Concordat	
	Mental health crisis team	

Acknowledgements & Thanks

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Northamptonshire Youth
Offending Service

Parents talking Aspergers

S2S

Samaritans

Secondary Schools across
Northamptonshire

Service 6

Shared Voice Network

Shooting Stars (Disability
Forum)

Special Friends support
group

Spectrum

St Andrew's Hospital

St Mary's Hospital

Teamwork Trust

The Bridge project

The Gathering Circle (FGM)

The Sanctuary Night
Shelter

Time2talk

Together

University of Northampton

VOICE

Women's Aid

How others
see people
with mental
health?

Just because
you can't
see it doesn't
mean it's not
there

A person with
a mental health
condition is
still an person
and SHOULD
be treated
Equally!

How a pers
with a
mental
Condition
feel?

Crazy

Scared

Bizzare

degrading

Self
harm

unworthy

Nutter

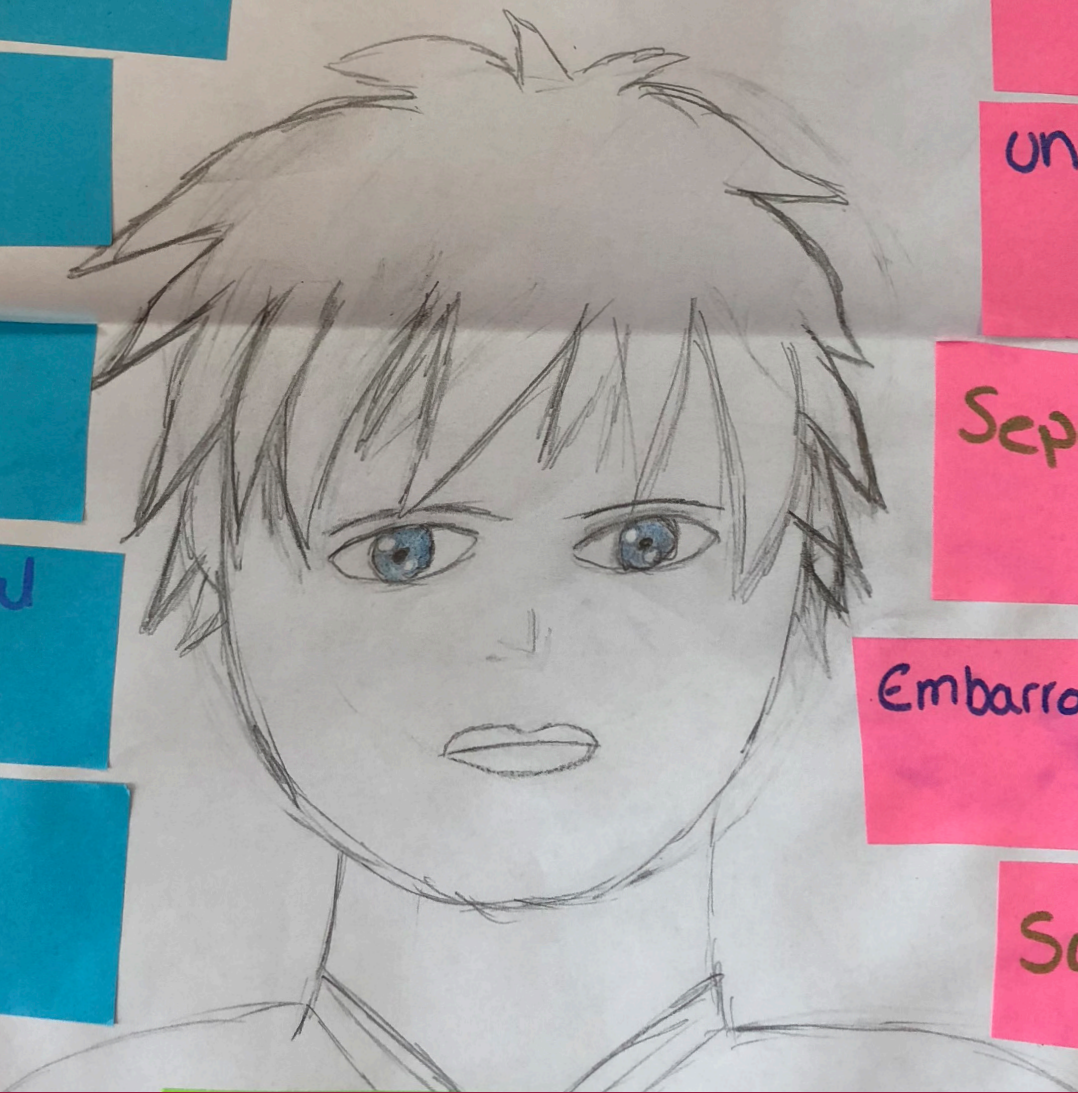
Seperated

normal
People

Embarrassed

psycho

Suicidal



The artwork displayed throughout this document are entries from young people across the county in to our Time 2 Listen competition, which asked for their take on Mental Ill Health, ADHD and Autism.



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