Public Health England

Protecting and improving the nation's health

Policing and Health Collaboration in England and Wales

Landscape review

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Foreward


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Duncan Selbie, CEO Public Health England

The factors which lead to poor health such as adverse childhood experiences, poverty, social exclusion and addiction are also the factors which increase the likelihood of being involved in crime.

Police forces and health organisations serve a common purpose and by working together we can improve outcomes not only for individuals, but for wider communities.

This landscape review provides a comprehensive picture of the ways in which we are collaborating as we strive to improve public safety, reduce crime and improve health outcomes.

Building on the range of case studies in Police and Public Health: Innovations in Practice: an overview of collaboration across England, the review supports and underpins the consensus statement, Policing, Health and Social Care: working together to protect and prevent harm to vulnerable people, which sets out our ambition to go further and faster by working together in the public interest.

Andy Rhodes, Chief Constable Lancashire Constabulary

The dilemma facing decision makers in policing is how best to adapt our response to new threats whilst staying true to the Peelian principle of "The test of police efficiency is the absence of crime and disorder, not the visible evidence of police action in dealing with it".

Throughout austerity we have seen worrying signs that the investment in prevention is proving hard to sustain yet the landscape review which underpins the consensus has identified much innovation with our partners from health. We are seeing practitioners adapt, moving from collaboration to integration with a shared purpose to take action early. We estimate 80% of police demand can be described as working with client groups who have complex needs and we are slowly starting to realise that health interventions supported by health data hold the key to not only preventing escalation of need but also crime. There is a clear and unequivocal link between health inequality and crime.

The consensus is a clear statement of intent about our shared purpose, it is not a burning platform but a burning desire to build on the innovation we have found, further develop the evidence about what works and scale up to meet the challenges of the future.

Executive summary

Introduction

The links between health, offending and policing are complex but inextricable. Collaborative working between the police and health has a long history but is still not commonplace. This landscape review aims to consider the breadth of the subject, and also to look at emerging themes and to influence future approaches.

Methods

A survey was distributed to all police forces, offices of the police and crime commissioners and various national and regional organisations. A mixture of quantitative and qualitative analysis was undertaken, identifying themes and coding quantitatively for descriptive and visual statistics. A number of respondents were contacted for more detailed information about the work they had described in their responses.

Findings

Respondents were asked about areas of past, current and future collaborative work. Mental health, health in custody and drugs were identified most frequently for past and current work. Social isolation, homelessness and adverse childhood experiences (ACEs) scored highest for future work. Examples of collaborative work were given, and these fell into a number of themes: mental health problems, early intervention, substance misuse, violence prevention and sexual abuse. These corresponded well to the organisational priorities and main areas of demand that respondents described. Notably, the demand was centred on vulnerability rather than traditional types of crime and disorder, which corresponds to national estimates of demand. There was a mixed picture of engagement with health and wellbeing boards. Barriers to collaboration and to information sharing included risk aversion and IT systems. Enablers included shared goals, relationships and information sharing.

Collaborative working

This section of the report discusses the themes emerging from the landscape review in more detail and uses case studies. Key areas for future discussion and action include further developing the approach to ACEs, applying an early intervention lens to more areas of work, filling gaps in research and spreading good practice and innovation.

Conclusions

The landscape review provides a snapshot of the breadth and depth of collaborative working between police and health colleagues in England and Wales. The responses indicate an increasing police focus on vulnerability and a commitment to prevention across all partners, which now need to be systematised. Looking ahead, this work will influence the current debate on the future of local policing; and the benefits of collaborative working.

Introduction

This report presents the findings of a landscape review of collaborative work between police and health in England and Wales.[1] A landscape review captures what is going on in a particular field to inform stakeholders and other interested parties about the subject.

This landscape review was designed to consider the breadth of the police and health collaboration, but also to look at emerging themes in some depth to influence future approaches. The landscape review was carried out by a small multiagency group on behalf of the Policing and Health Consensus national working group. It is designed to underpin work to develop and implement a national police and public health consensus by reflecting the system-wide picture of collaborations between policing and health currently, identifying gaps and contributing to understanding of the system conditions which support collaborative working especially around early intervention. It is also designed to assist in the design and delivery of a new local policing model.

The report begins with an overview of the academic literature and policy context for joint working between police and health before presenting the methodology and findings of the landscape review. Themed areas of work are then discussed in more detail using case studies and examples.

[1] In this report 'police' refers to police forces in England and Wales, and offices of police and crime commissioners. 'Health' refers to NHS provider organisations, private and third sector healthcare organisations commissioned by the NHS or local authorities, NHS England, Public Health England, Public Health Wales, and local authority public health teams.

Context

This section of the report is informed by a literature review. Papers were identified using the search terms ‘police’ and ‘health’ and were excluded if they were not published within the last 10 years. A separate search for policy papers and other grey literature was undertaken using the snowballing technique.

Vulnerability, offending, health and local policing

The links between health, social inequality and crime are complex. Offenders suffer significantly worse health than the general population and are also more likely to be victims of crime (Anders et al, 2017). People in contact with the criminal justice system often have multiple and complex health and social needs which are interlinked with a propensity to offend (ibid). By working to address the social exclusion and health-related problems related to criminal behaviour, crime can be prevented. For example, it is estimated that around one-third to a half of all acquisitive crime is committed by drug users (NTA, 2009). Tackling the ‘causes of the causes’ involves looking beyond the immediate health need to understand why that has arisen in the first place. Approaches such as adverse childhood experiences (ACEs) highlight the physiological changes and lifelong negative effects that childhood stress causes and argue for trauma-focused interventions to improve health and social outcomes, thereby reducing crime (Bellis et al, 2013). Prevention of ACEs in the first place sits alongside this.

Recent policy papers for both policing and public health continue to highlight the need for cross-sector partnership working to enable and prioritise upstream intervention. Two examples are ‘From evidence into action’ (PHE, 2014) and ‘Policing Vision 2025’ (NPCC, 2016). The former sets out 7 key priorities for the public health community to focus on including ensuring every child has the best start in life, reducing harmful drinking and reducing dementia risk – all of which have a direct impact on policing. ‘Policing Vision 2025’ looks towards a developing local policing model with proactive prevention and where the police support multiagency neighbourhood projects. Both documents highlight the evolving makeup of communities, developing technology and societal changes. In their 2016 report, Her Majesty’s Inspectorate of Constabulary identified concerns about the lack of focus on neighbourhood policing. The recommendations for addressing this centre around prevention, engagement, and multiagency working (HMIC, 2017). Increasingly, a locality-based approach with whole place commissioning rather than individual services is being discussed and developed (NPCC, 2016; GMCA, 2017).

Multi agency working

Public sector partnership working in the UK is not easy to define (Cook, 2015). It ranges from strategic level partnership to multiprofessional working. The characteristics of multiagency working include:

- the structure and/or way of working involves 2 or more organisations
- these organisations retain their own separate identities
- the relationship between the organisations is not that of contractor provider
- there is some kind of agreement between the organisations to work together in pursuit of an agreed aim
- this aim could not be achieved, or is unlikely to be achieved by any 1 organisation working alone
- relationships between organisations are formalised and are expressed through operational structures and the planning, implementation and review of an agreed programme of work (Cook, 2015)

This is a useful working definition, because it distinguishes partnership working from other forms of joint service delivery such as integration at 1 end of the spectrum, and informal day to day co-operation between agencies at the other.

Policy context

While multiagency working has been part of the public sector approach for many years, the focus on partnership working intensified in the late 1990s and early 2000s with policy drivers around efficiency and seamless customer experiences (Vangen and Huxham, 2003).

Statutory requirements for police and health to work together came in the Children's Act 1989 and the Crime and Disorder Act 1998. The latter established community safety partnerships in each local authority area in England and Wales with 'responsible authorities' including police, local authorities, fire and rescue services, probation and health. Section 13 of the Children Act 2004 requires each local authority to establish a local safeguarding children board for their area and specifies the organisations and individuals that should be represented. They have a range of statutory roles and functions, with the purpose of co-ordinating and ensuring the effectiveness of local work to safeguard and promote the welfare of children. Health and wellbeing boards were established in England as part of the Health and Social Care Act 2012. They are a formal committee of the local authority and oversee a joint strategic needs assessment and joint health and wellbeing strategy for their area. Police forces and police and crime commissioners are not required to be members, although this is encouraged (Rudd and Hunt, 2016).

Further examples of multiagency arrangements incorporating policing and health include the national mental health crisis care concordat, which has been signed up to by 27 national bodies and commits them to working together better to support people when they are having a mental health crisis (HM Government / Mind, 2017). More recently, sustainability and transformation partnerships (STP) have been set up across local health economies, with the purpose of improving quality and developing new models of care, improving health and wellbeing and improving efficiency of services (King's Fund, 2017a). Their impact on policing and health collaboration, prevention and early intervention is as yet untested.

In 2016 a summit organised by Public Health England (PHE) and Lancashire Constabulary gave a mandate to develop a policing and public health consensus to define how the police service and health and social care services will work together to improve people's health and wellbeing, reduce crime and protect the most vulnerable people in England and Wales.

Benefits and complexities

The Home Office (2013) identifies 3 common principles of multiagency working: information sharing, joint decision-making and co-ordinated intervention. The motivations behind collaborative working include cost saving, effectiveness and improved experience for the service user. Vangen and Huxham (2003) propose a concept of collaborative advantage and collaborative inertia. Collaborative advantage is where working together achieves something that 1 organisation alone cannot achieve. Often this is the primary motivation for collaborations. The advantage is derived from the different perspectives, skills, resources and opportunities the different organisations bring. However, these very differences can make it much harder to actually achieve meaningful outcomes: collaborative inertia.

Work to unpick the facilitating and challenging factors for general multiagency working has resulted in the following list of theme: role demarcation, commitment, trust and mutual respect, understanding other agencies, communication, clarity of purpose, planning and communication, organisation, information exchange, funding, staffing and time (Atkinson et al, 2007). More specifically examining police and health collaborations, observers highlight the constant risk that partners will 'fall back' into their traditional roles particularly in areas of work where policy goals and approaches are very different, such as illicit drugs (Collier, 2017).

The complexity and fragmentation of the NHS in England is also frequently cited as a barrier to partnership working with colleagues both within and outside the health system struggling to know who to approach (King's Fund, 2017b; House of Commons Health Committee, 2016).

What works?

A rapid review by Berry and colleagues considered the evidence for the effectiveness of partnership working in a crime and disorder context. It highlighted the mechanisms found to be associated with effective partnership working, using examples mainly from the United States. These mechanisms are: leadership, data sharing and problem solving focus, communication and co-location, structures and experience (Berry et al, 2011). Alongside the need for a shared vision and purpose, these mechanisms are commonly identified across the literature on policing and health partnership working in the UK (Vangen and Huxham, 2003; Crawford and L'Hoiry, 2015; de Viggiani, 2013; Horspool, 2016; Collier, 2017). A forthcoming document from the Centre of Excellence for Information Sharing demonstrates effective information sharing and the mechanisms behind it (CEIS, unpublished). The need for nurturing leadership is also a recurring theme. An international commentator concludes with the view that "holistic models of community safety and wellbeing are the future", but that systemic change is necessary to achieve this (Collier, 2017).

Methods

Survey

A survey was designed using some closed, but primarily open questions. Sections included demographics, information about collaborative working, organisational priorities and governance, workforce development and information sharing. It was designed so that 1 person could complete it on behalf of their organisation. Two versions were created, 1 for police forces and offices of the police and crime commissioners (OPCCs) and 1 for other organisations. The questions were the same, but wording was altered slightly to reflect the different nature of the respondents (force vs organisation). The survey was developed and sense-checked by a working group that included police, public health, and academic colleagues. Surveys were sent to all police forces and OPCCs in England and Wales and a smaller number of national/regional bodies such as NHS England, PHE, Public Health Wales (PHW), and the College of Policing.

Responses

A total of 54 full and partially completed surveys were returned, 40 from police forces and OPCCs (‘police’ surveys) and 14 from other organisations (‘regional/national’ surveys). The full list of contributors is included in Annex 1. In all, 29 of the 43 police force areas (67%) in England and Wales were represented. Ranks of responding police officers ranged from police constable to chief superintendant, and areas of work varied considerably. Of the respondents from the regional/national group, 6 worked in regional roles and 8 in national. Seven national and regional organisations were invited to participate and 5 of them did so (71%), but there was more than 1 response from 2 of these organisations.

Case studies

Once all the surveys had been returned, a number of the respondents were contacted for more detail about work they had mentioned, and 2 police forces that had not submitted survey responses contributed additional examples of collaborative work. The case studies included have been chosen to reflect key themes in the landscape review, but are not intended to imply that these projects are necessarily any better than others.

There were many other case studies we would like to have included had we had the time and space. Case studies around liaison and diversion schemes were not included as this is part of a national roll out and they are documented elsewhere (NHS England, 2017).

Analysis

A mixture of quantitative and qualitative analysis was undertaken, identifying themes and coding quantitatively for descriptive and visual statistics.

Strengths and weaknesses of the landscape review

The decision to survey police forces, but not equivalent NHS mental health, acute and provider trusts or local authority public health teams and community safety partnerships was taken for practical reasons (number of contacts to find), but also because we judged that asking 1 element of the multiagency team would be sufficient and would avoid duplication. When contacted for further details, a number of the forces referred the researcher on to partners which indicates that this was successful. Surveying national and regional health and policing bodies was done to get a different perspective by including commissioner and policy organisations. However, the 2 groups are not comparable and the survey was not designed for them to be contrasted.

The survey deliberately did not define concepts like ‘health’, ‘mental health’ and ‘vulnerability’ to avoid limiting people’s responses. Inevitably however, there was some variation in interpretation of the questions which makes it harder to draw firm conclusions from some of the analysis.

It is possible that those who have responded represent organisations that are more committed to collaborative working and so they may not be completely representative of organisations across the country. However, efforts were made to ensure as large a response rate as possible, for example extending the deadline for return of the survey, and sending reminders to organisations that hadn’t originally responded.

Although the questionnaire was designed to be filled in by 1 person on behalf of their organisation, many respondents were only able to talk about work they were personally aware of, so there will be gaps.

Findings

This section of the report presents and discusses the general findings from the survey.

Health and wellbeing boards

Police forces were asked whether they were represented on health and wellbeing boards. The majority said yes. Fifteen respondents named the health and wellbeing board(s) that their force is represented on. However, others went on to describe partnerships which were not statutory health and wellbeing boards, indicating that the question may not have been specific enough. Structures in Wales are different and Welsh colleagues sit on public service boards. Membership of health and wellbeing boards can be a contentious issue as police and OPCCs are not statutory members, and in some areas of the country they have not been offered a seat.

Completed, active and future collaborative work

Respondents were provided with a list of potential areas for collaborative work between police and health, and asked to indicate those areas where they had completed collaborative projects; were involved in active collaborative projects; or considered they may be involved in collaborative work in the future.

Overall, the most popular areas for collaborative work were mental health, health in custody and drugs (Table 1). The same 3 areas came top in completed and active work; however, social isolation, homelessness and ACEs were the top 3 for possible future collaborations. This shift potentially indicates a move towards earlier intervention and prevention from a policing perspective.

Table 1: Areas of collaborative work, in order of total number of mentions

Area of work	Completed work	Active work	Possible future work	Total
Mental health	17	43	12	**72**
Health in custody	18	37	10	**65**
Drugs	16	38	8	**62**
Alcohol	15	34	9	**58**
Prevention of offending and reoffending	13	32	12	**57**
Child sexual exploitation	13	30	11	**54**
Suicide prevention	10	33	8	**51**
Safeguarding	11	31	8	**50**
Domestic abuse	10	31	8	**49**
Dementia	9	24	12	**45**
Violence prevention	7	24	13	**44**
Sexual health	7	19	13	**39**
Missing from home	7	22	10	**39**
ACE (adverse child experiences)	3	17	17	**37**
Homelessness	2	16	19	**37**
Sex workers	8	17	12	**37**
Modern slavery	6	21	10	**37**
Neglect	5	20	12	**37**
Radicalisation	8	15	10	**33**
Social isolation	1	8	20	**29**
Long term conditions	2	7	15	**24**
Physical activity	1	6	16	**23**
Obesity	1	5	15	**21**
Migrant health	1	4	16	**21**

Overall, the most popular areas for collaborative work were mental health, health in custody and drugs. The same 3 areas came top in completed and active work; however, social isolation, homelessness and ACEs were the top 3 for possible future collaborations. This shift potentially indicates a move towards earlier intervention and prevention from a policing perspective.

Good practice examples

Participants were asked to give brief details of a collaborative policing and health project that they felt represented good practice. Thirty-eight examples were given. Most respondents also listed a number of other projects they had been involved in. Project areas are listed below. Many were mentioned more than once.

Mental health problems:
- street triage
- mental health first aid
- high intensity user care packages
- suicide prevention
- enhanced training
- OPCC criminal justice & mental health forum

Substance abuse:
- liaison and diversion
- support for street drinkers
- say no to drunks
- drug and alcohol referral schemes

Sexual abuse:
- Sexual Assault Referral Centre (SARC)
- child sexual exploitation (CSE)
- CSE prevention
- engagement and safeguarding of sex workers

Violence prevention:
- multiagency tasking and co-ordination (MATAC)
- violence prevention alliance and network
- women's support workers

Early intervention:
- ACE
- multiagency early intervention pilot
- Early Intervention Foundation partnership

Others:
- concern for welfare
- dementia projects
- building community capacity and resilience
- custody healthcare
- LGBT victim support
- vulnerable victims support
- proactive vulnerability engagement team
- information sharing and data focus
- modern slavery
- research collaborations
- trauma-informed risk management
- missing persons

The lead agencies for the headline projects varied considerably (Table 2).

Table 2: Lead agency in 'good practice projects'

Lead agency	Number of projects
Police	14
Public health / health	9
Home office	1
OPCC	1
Community safety team	1
Health and police joint lead	7
Name of the multiagency partnership given	2
Police and other	3

Overall, the number of police and non-police leads seems fairly balanced in number, which does not support the suggestion that police tend to volunteer or be relied upon to lead because of their command and control culture. It is not clear whether this is reflective of wider practice. The way these responses were written implied some 'leads' were simply the commissioners and many respondents put down more than 1 agency. This might indicate that no single agency is leading intentionally, that the people driving the project and leading day to day are from different organisations, or simply that the person responding on behalf of their organisation was not familiar with the detail. However, it may indicate a lack of clarity about leadership within some projects which is potentially concerning given the importance of leadership to the success of collaborative working.

A long list of partners involved in the good practice projects was compiled from the responses. These include universities, licensed trade, third sector and several national government bodies. This is a reminder that the common problems health and police are working together to address are also within the remit of many other organisations from different sectors and at different scales.

Funding for the majority of projects came from more than 1 partner, with 19 of 32 projects where funding information was provided being jointly funded. A further 6 were health funded: 3 Home Office, 3 OPCC and 1 police. Four were cost-neutral or had no additional funding provided.

Measuring impact was generally done via collaboration with academic bodies, through evaluations and/or by using outcomes frameworks. Evaluation was mentioned more frequently by the regional/national group, and academic collaboration more by the police group, although this may have been a terminology issue as there were a number of examples of academic organisations undertaking project evaluations. Academic collaboration was a particular feature of the more in depth case study discussions, with several participants able to share external reports.

Organisational priority areas and demand

Respondents were asked to identify the priorities of their organisations that related to policing and health.

Six key areas emerged:

- mental health problems
- vulnerability
- sexual crimes
- violent and abusive crimes
- substance misuse
- offender healthcare

Mental health was listed by more than half of respondents. Although no definitions were contained in the survey, it is likely that it refers to mental health problems, and encompasses both diagnosable mental disorders and mental health problems that do not meet diagnostic criteria. Further discussion about this can be found on page 23.

Police participants were also asked to describe the areas of greatest demand (either volume or severity) and/or concern for their organisation. The question did not specify that these were to do with collaborative working, but even so the most common responses were mental health, vulnerable people, violent and abusive crimes, substance misuse and child sexual exploitation, all of which link to vulnerability. These match well against the force and organisation priorities. Again, mental health was listed by almost every respondent.

Lessons learned

Two key themes came out of the responses around lessons learned from collaborative projects: positive practice and infrastructure. Leadership was mentioned often in a positive light. IT systems were also frequently raised, often as a barrier.

Information sharing

When describing good practice projects, most respondents referred to information sharing agreements or protocols. A ‘common sense’ approach was also mentioned. They were asked to describe enablers and blockers. Themes were:

Enablers

- information sharing protocols
- IT systems
- joint vision
- good relationships

Blockers

- risk aversion and lack of understanding
- lack of national ownership
- IT systems

In addition to these themes, the complexity of the health service architecture and resources were both highlighted.

Barriers and enablers to collaborative working

These were similar to information sharing enablers and blockers, with shared goals being a key theme. Respondents also mentioned legislative frameworks as both enablers and blockers, with the Welsh Future Generations Act seen as a positive lever. The complexity of the NHS structures was highlighted as a challenge.

Leadership

Participants were asked about organisational leadership, recruitment and staff development initiatives to support collaborative working. Few responded, perhaps indicating this was not part of their remit. Examples included joint training and co-funded posts. However, strong leadership was mentioned often in questions about enablers to partnership working.

Summary of findings

Overall, the landscape review found a wide range of work with a wide range of partners, which reflects the priorities and concerns identified by respondents. Areas of work such as street triage and liaison and diversion were mentioned the most frequently, and seem to have acted as a ‘gateway’, allowing forces and health organisations to see the benefits of working together. Fewer examples of good practice around substance misuse were shared than expected given that it was rated highly on the list of completed, active and future work. This might indicate that the work is well established and didn’t come to mind when we asked for good practice examples, or might suggest that this is an area that could benefit from some revitalising.

Overall, most of the examples given were of reactive or crisis-led work. Innovative prevention-focused work such as that around early intervention and ACEs is emerging and was discussed with great enthusiasm by interviewees. It is anticipated as a future collaborative development in many force areas, which would suggest a much more upstream approach is likely to be much more prevalent in the coming years.

Collaborative working

This section of the report looks in more detail at some of the key themes that have emerged from the landscape review. Each theme contains some background information and some examples of projects that were shared as part of the landscape review. Some key questions for discussion are posed. These have emerged from the literature review, survey responses and particularly the interviews with participants. They are designed to provoke discussion and do not necessarily reflect the authors' or survey respondents' views.

Early intervention and adverse childhood experiences

Early intervention

An increasing focus for collaboration between police and health is in early intervention. Definitions vary, but include intervening as early as possible to tackle emerging problems, usually (but not always) with children and families (Early Intervention Foundation, 2017; National Audit Office, 2013; C4EO, 2014; Early Action Task Force, 2001; Allen, 2011). The National Audit Office (2013) identifies 3 types of early action:

- prevention (upstream): preventing or minimising the risk of problems arising, usually through universal policies like health promotion
- early intervention (midstream): targeting individuals or groups at high risk or showing early signs of a particular problem to try to stop it occurring
- early remedial treatment (downstream): intervening once there is a problem to stop it getting worse and redress the situation

The National Audit Office notes that high quality evidence about impact and cost effectiveness of early action is limited but concludes that shifting resources into early action would be beneficial. The Early Intervention Foundation summarises the existing evidence for early intervention from economics, sociology, psychology, and neuroscience. They argue that wide gaps in children's wellbeing that have significant long term consequences develop early in life; but can be influenced by timely interventions (EIF, 2014). These arguments are also developed in 'Fair Society, Healthy Lives' (Marmot, 2010) which proposes 6 policy objectives to tackle the social gradient in health, all of which are linked to early action:

- give every child the best start in life
- enable all children young people and adults to maximise their capabilities and have control over their lives
- create fair employment and good work for all

- ensure healthy standard of living for all
- create and develop healthy and sustainable places and communities
- strengthen the role and impact of ill health prevention

A particular area of focus is adverse childhood experiences (ACEs). An initial study in the US (Felitti et al, 1998) was followed by studies in the UK (Bellis et al 2013, 2014, 2015). These showed that stressful experiences during childhood such as physical, sexual or emotional childhood abuse, family breakdown, exposure to domestic violence, or living in a household affected by substance misuse, mental illness or where someone is incarcerated are linked to poor health and social outcomes in adults. Independent of the relationship with deprivation, the more ACEs a person has experienced, the higher their risk of adverse behavioural, mental and physical outcomes throughout their life (Bellis et al, 2013). The Welsh ACEs study found that those with 4 or more ACEs were 15 times more likely to have committed violence in the last month, 16 times more likely to have used crack cocaine or heroin and 20 times more likely to have been incarcerated in their lifetime than those with no ACEs (Bellis et al, 2015). This impacts on public health and policing on many levels, from how we deal with offenders, right through to the imperative to prevent ACEs in the first place.

Examples of early intervention collaborations are given below.

Breaking the generational cycle of crime: South Wales

Funded by the Home Office police innovation fund, this 2-year programme of work is the first of its kind where an ACE informed public health approach is applied with the police to address vulnerability and risk through early action. This is a collaboration between Public Health Wales, the Police and Crime Commissioner for South Wales, South Wales Police, NSPCC, Barnardo's and Bridgend County Borough Council. The programme aims to provide the police and other partners with the right knowledge, skills and support to identify children and families who are at risk of being affected by ACEs and respond to them in an appropriate and effective way at the earliest opportunity.

Creating a trauma-informed work force is a key step in reducing harm and preventing the transmission of ACEs to the next generation. Longer term, this approach could lead to resilient individuals and safer, stronger communities. We have an opportunity to connect people with appropriate and available services to provide them with a number of the building blocks required to protect themselves against the negative impact of trauma.

Five recommendations have been developed based on findings from extensive research undertaken by Public Health Wales and are being taken forward by South Wales police.

The recommendations are:

- pilot a structured multiagency, early intervention approach to vulnerability with Neighbourhood Policing Team (NPTs)
- pilot a training programme with ‘fast’ and ‘slow time’ policing on ‘ACE informed approach to policing vulnerability’
- work with the public protection department to develop an ACE informed approach to the existing public protection notice (PPN) process
- to develop with partners a 24/7 ACE informed approach to responding to vulnerability
- work with human resources to assist with the development of the wellbeing agenda within South Wales police, specifically focusing on how staff are mentored and supported to deal with vulnerability

Complementing the work with South Wales police, the programme also includes work with housing and education within the pilot area to ensure a whole system, place based approach to addressing vulnerability demand through an ACE lens. In addition, there is extensive engagement with many of the other services and agencies within the pilot area who also support vulnerable people to ensure they are aware of the ongoing work and can play their part in offering appropriate and effective help at the earliest opportunity.

Transforming Lives: Blackburn with Darwen and East Lancashire

This is a multiagency integrated ‘place based’ approach to dealing with vulnerability and risk in Blackburn with Darwen and East Lancashire. In the past, the majority of referrals to the multiagency safeguarding hub did not result in action, as thresholds for intervention were not met. This resulted in a cycle of repeat referrals, and effectively waiting for problems to escalate before intervening. Now, a multiagency panel assesses all referrals proactively based on the needs of the family or individual, the best action to take, and which professional should lead. Co-located multiagency teams then provide the required support with the aim of intervening early to prevent escalation. Partners are Blackburn with Darwen Borough Council, Lancashire Constabulary, Lancashire Fire and Rescue Service, Lancashire Care Foundation Trust, East Lancashire Hospitals Trust, Lancashire and Cumbria Community Rehabilitation Company, families health and wellbeing consortia – third sector consortia, and registered social landlords.

Key principles of the programme are:

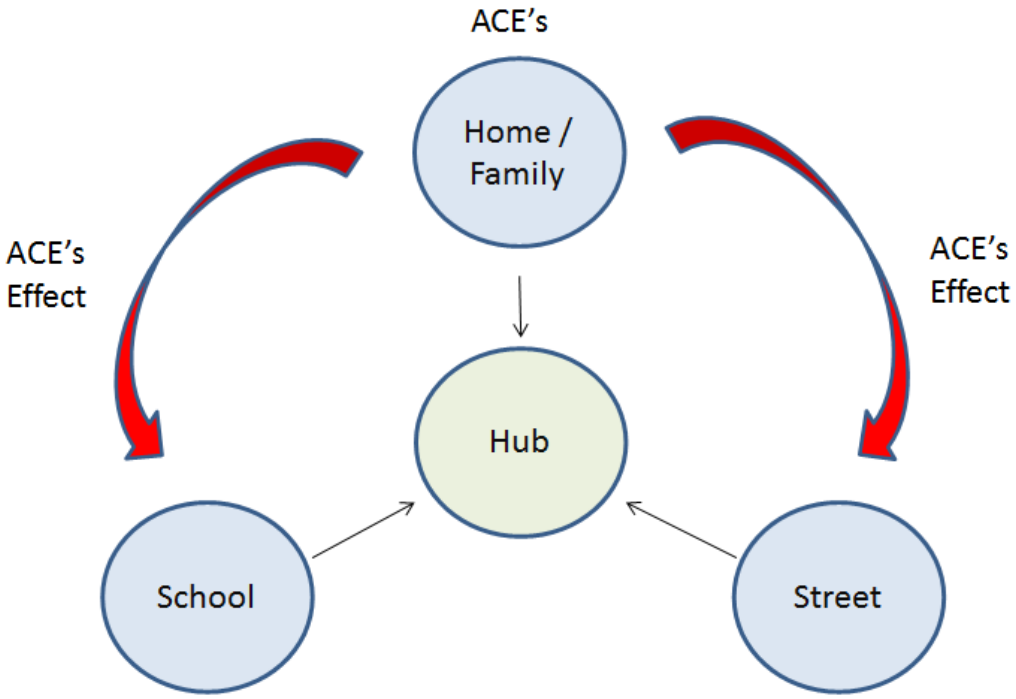
- early action and prevention
- shared approach
- holistic and fully person-centred
- concurrent upstream interventions
- better and sustainable outcomes

Evaluation by the Centre for Local Economic Strategies (unpublished) estimated that in the first year, the value of outcomes for each £1 spent was in the region of £6.93. They described an effective and systematic approach that was well regarded by clients and key workers and provides strong added value.

The Early Intervention Partnership Hub, Northamptonshire

This developing collaboration has a home-school-street model and provides support and early intervention for children who don't necessarily meet the criteria for social care involvement but are coming to the attention of agencies.

Figure 1: Northamptonshire early intervention hub model (source: Northamptonshire Police)



An early help mechanism had been available for some time locally, but data work revealed that often the agencies that had referred the child ended up being re-contacted, and in 70-80% of cases no actual action was taken. However, there were lots of re-referrals and escalation, indicating a gap in services.

A pilot locality hub is located in the area of highest demand. The initial focus has been with primary schools because of the prevalence of domestic abuse notifications issued, because it enables earlier intervention, and because of their nurturing approach. Secondary schools are also involved in the pilot.

Northamptonshire Healthcare Foundation NHS Trust is involved, as are the police, school inclusion team, adult and children's social care, youth offending, the local

domestic abuse charity and drug and alcohol services. The overall expectation is that existing commissioned services will be used more effectively within the hub model, and a Big Lottery bid to further develop the project is planned for later 2017.

Challenges have been the shifting public sector landscape and the development of information sharing agreements (now signed), but partners are keen and committed.

Suggestions for system wide discussion, intervention or investigation

Preventing ACEs occurring, intervening early in childhood when ACEs are beginning to happen, and intervention with adults who suffered adverse experiences in their own childhood are very different areas of work. Not all projects seem to distinguish between them. Is more work needed to pinpoint where the focus is now and where should it be?

The evidence for interventions appears to be limited. There is an opportunity to develop the evidence base including return on investment analysis.

How do we sustain support in the longer term for people with complex needs?

There is a debate around whether it's appropriate to screen for ACEs in circumstances when interventions aren't readily available: how do we ensure an ethical, solution-focussed approach?

What are the gaps in provision and how do we fill them?

How do we shift the balance from crisis-led towards preventative?

Mental health problems and vulnerability

Mental health was raised consistently through the landscape review as a primary area both of concern and of collaboration. Use of terminology can differ between police and health colleagues, so it is important to be clear about definitions. The Mental Health Foundation defines mental health as "more than an absence of symptoms of distress, it includes a positive experience of self, individual resources included self-esteem and optimism, the ability to sustain relationships and resilience" (Regan, 2016). Mental health problems "is an overarching term which covers the range of negative mental health states including, mental disorder – those mental health problems meeting the criteria for psychiatric diagnosis, and mental health problems which fall short of a diagnostic criteria threshold" (ibid). Despite using the phrase 'mental health' in free text, it appears most respondents are referring to mental health problems, and/or a lack of mental wellbeing.

Estimates suggest that 2-40% of police officers' time is spent dealing with incidents involving people with mental health problems. (Quinn et al, 2016; College of Policing, 2015). Eighty-four per cent of command and control calls are non-crime related (College of Policing, 2015). Models of policing are designed to tackle crime, yet the majority of demand is about vulnerability. This impacts on local policing, as although the police may not always be the best professionals to deal with the situation, they are the ones who are called.

An approach to enabling the police to deal more effectively to people in mental health crisis mentioned by almost all respondents is street triage. Models vary, but mental health professionals work alongside police officers in cars and/or in the control room to provide advice and information to enable an appropriate response. In 2012/13 it was recognised that a small number of forces including Cleveland, Leicestershire and Hampshire had developed collaborations with mental health colleagues that were reducing the number of Section 136 detentions[2] and decreased the amount of time officers spent dealing with people who had mental health problems but were not committing or the victim of crimes.

Other forces were expressing an interest, so a national pilot in 9 forces was set up with funding from the Department of Health. Each area developed its own model. By the end of the pilot there were around 24 street triage schemes, and now almost all police forces have a form of street triage, with the remainder using agreements with local mental health trusts instead. Street triage service examples are outlined below.

Street triage service: Leicestershire

Leicestershire constabulary was an early adopter of street triage model. Concerns about the high level of S136 detentions and poor relationships between mental health and police staff led to a conversation about how to better manage risk, improve relationships and intervene further upstream. By the end of 2012 a triage car model was implemented, with reducing reliance on Accident and Emergency (A&E) and S136 detentions. The model has been developed further over time, and there is now a street triage service that is operational 10am-2am 7 days a week. A mental health nurse and a police officer work together to provide telephone and face to face advice covering the whole of Rutland and Leicestershire. The same nurses also staff the liaison and diversion service and have close relationships with the crisis team in the Emergency Department at Leicester Royal Infirmary.

Since 2012, the number of S136 detentions has fallen by 89% and is the second lowest nationally. The street triage service has improved both effectiveness and efficiency in

[2] Section 136 of the Mental Health Act 1983 gives police the power to remove a person to a place of safety, or detain them in a place of safety if they believe them to be mentally disordered and in need of care or control.

responding to mental health crisis situations, with an estimated 500 hours a week of police officer time saved. Access to patient information and good working relationships are the key.

Street Triage Pilot Service: Devon

Devon was also 1 of the 9 national street triage pilots funded by the Department of Health in 2014. As a large rural area, the decision was taken in Devon to develop a control room model of street triage rather than taking a car-based approach. Devon Partnership NHS Trust is the provider of the service. It consists of 2 elements: an out of hours service where a vetted mental health professional is based within the police control room, but can be deployed to the scene where practical; and an office hours phone service currently provided by Exeter and Central Approved Mental Health Professional (AMHP) Service. An evaluation of the service calculates that in 2016/17 277 S136s were averted by the street triage service.

Both funding and support for the project have been shared equally between the CCG and the OPCC, which has been an important factor in its development. Supportive leads within the control room have also been key to successfully embedding the arrangements. Funding has been on a 1-year fixed term basis which made traditional approaches to recruitment untenable, so a bank of specially trained and vetted staff with substantive posts elsewhere has been developed. An advantage of this has been that the staff brings a wide range of specialist backgrounds. They bring this experience into the control room, but are also able to take back their knowledge of the service to their substantive roles.

The street triage professionals have access to the police command and control system, so they are notified very early on of calls. This means they are able to ask for calls to be passed over to them if they recognise the caller, and can prevent police being deployed. IT systems are also a challenge, with different NHS trusts in the area using different systems which the service has had to negotiate access to separately. There is a balance to be struck between the number of different systems available and the need to be able to respond quickly. The police have developed 1 information sharing agreement, and there is an audit trail of each decision on both sides which evidences the judgements made.

The service continues to develop, with discussions ongoing about covering the whole of the Devon and Cornwall Police area in the future.

Suggestions for system wide discussion, intervention or investigation

Views about the appropriateness of police involvement in mental health concerns range from it being inappropriate and not part of the police role; through it being necessary to reduce demand; to it being a core part of the police's role in preventing crime and supporting vulnerable members of society. More work is required to spread communications about the modern policing role in mental health and how involvement in early identification and prevention impacts on policing demand.

Good practice and innovation from street triage provides an excellent example of how collaborations can work in practice and could be used to support wider learning to enable services to develop and improve.

Substance misuse

Substance misuse, including drug and alcohol misuse, ranked highly among the collaborative projects highlighted by respondents in the surveys. It overlaps with the theme of mental health due to dual diagnosis,[3] and with an ACE/trauma-informed approach looking at the underlying influences of substance misuse.

Almost two-thirds of sentenced male offenders and two-fifths of sentenced female offenders report hazardous drinking prior to going to prison, with about half of these having severe alcohol dependency (Prison Reform Trust, 2004). Around a quarter of male and a fifth of female sentenced offenders with an alcohol problem also have a drug dependency (ibid). On average, 55% of prisoners are believed to be problem drug users (NTA 2009). Increasingly, new psychoactive substances (NPSs) (also known as 'legal highs' even though they have not been legal since May 2016) are causing concern, but research on their short and long term effects is limited.

REST Centre: Liverpool

The Rehabilitation, Education, Support & Treatment (REST) Centre was developed to provide support and pathways for holistic support for street drinkers and also aimed to diffuse the anti-social behaviour associated with street drinking in the city centre. It was piloted over the summer in 2015, and ran again for 4 months from June to September in 2016 and 2017. The REST Centre is a safe, indoor space where clients may still drink, but are provided with opportunities for activities and supported to access relevant services such as registering with a GP, finding and retaining accommodation and alcohol treatment.

[3] Dual diagnosis refers to a person who has a diagnosed mental health disorder and also misuses drugs or alcohol.

The project has been evaluated. Economic analysis suggests that the REST Centre is cost effective, mainly based on the quality of life gains for individuals using the centre. The total societal benefit:cost ratio was estimated as £4.80 for every £1 spent. Data on clients' wellbeing showed improved scores between the first and second time they were asked to complete a short validated wellbeing survey. Specific changes in drinking behaviour were difficult to identify, but there was a reduction in street drinking whilst the centre was open.

The project was commissioned by the Citysafe partnership, Liverpool's community safety partnership. Agencies involved included GPs, the homeless mental health team, the police, street drinking/rough sleepers outreach team, drug and alcohol services and housing services.

Suggestions for system wide discussion, intervention or investigation

Can an early intervention and prevention lens be applied to substance misuse?

How might this impact on collaborative working?

Evidence, data, value for money and academic collaborations

Although this isn't a people-centred or 'what' theme like the others, the landscape review provided many examples of use of data to better target services, use of evaluation and academic collaboration. It was often raised enthusiastically by respondents and interviewees as an essential underpinning tool to the quality and effectiveness of their collaborations. It seems reasonable, therefore to have a 'how' theme as well.

Use of data: Northamptonshire

Northamptonshire is undertaking a comprehensive data approach to understanding past trauma in young people, using very detailed 'asset reports' from first-time young offenders to identify ACEs and to layer with school exclusion, social care and other data. This is live data that can be used to tailor support for the young person, develop an understanding of the circumstances of young offenders and also to provide internal challenge about the relevance and appropriateness of services. For example, the data focus has shown that bereavement is the main driver in 40% of youth offending service court cases in the area.

Connect - evidence based policing: North Yorkshire

The Connect project aims to build on partnerships already being developed in North Yorkshire to find better ways of dealing with mental health issues through increased

collaboration, the identification of ‘what works’, the production and sharing of research information and improved and more systematic training (Connect, 2017).

Connect is a partnership between the University of York, the College of Policing, North Yorkshire Police and Tees, Esk and Wear Valleys NHS Trust, York Teaching Hospital NHS Foundation Trust, North Yorkshire and York Forum, the Higher Education Funding Council for England, North Yorkshire County Council, Selby District Council, City of York Council, North Yorkshire Fire and Rescue Services, British Transport Police and Yorkshire Ambulance Service.

Workstreams include:

- systematically reviewing evidence of what works.
- developing a better understanding of interagency working
- developing and evaluating training of staff in mental health issues and research methods
- sharing learning nationally through the College of Policing and other agencies

The impact of the overall programme of work will be evaluated.

Suggestions for system wide discussion, intervention or investigation

There is sometimes a lack of service user voice in service evaluations and research generally – what are the barriers and how do we get round them to ensure a more holistic view of services is heard?

How do we systematise good practice and enable best use of the data and opportunities we have?

The evidence base for many of the developing areas of preventative and early intervention work appears to be lagging behind: how do we attract and make the most of opportunities for evaluation and research?

Conclusions

The landscape review has provided a snapshot of the breadth and focus of collaborative health and policing work across England and Wales. It indicates a shift in focus from crime and disorder to prevention, vulnerability and early intervention. The focus in this report has been on key themes which emerged of early intervention, mental health and substance misuse. However, there are lots of examples of good practice in areas like violence prevention, dementia, and addressing vulnerability that we would have liked to include given unlimited space.

The positivity, commitment and enthusiasm of those involved in the landscape review was palpable and bodes well for the future. Barriers to collaboration were not mentioned often, but are real and need to be considered. They include competition for reducing budgets, the difficulty of demonstrating the impact of prevention, enduring cultural and organisational differences, incompatible IT systems, and siloed approaches. The examples in this landscape review show how these can be overcome.

Looking forward, it is anticipated that this work can influence the redesign of neighbourhood policing and provide a resource for partners. The challenge is to systematise collaboration, prevention and early intervention so that working together in the best interests of vulnerable individuals and their communities becomes part of everyday practice for both police and health colleagues.

The landscape review has provided a snapshot of the breadth and depth of collaborative working between police and health colleagues in England and Wales. The responses indicated an increasing police focus on vulnerability and a commitment to prevention across all partners, which now need to be systematised. Looking ahead, this work will influence the current debate on the future of local policing and the benefits of collaborative working.

List of abbreviations

A&E	Accident and Emergency
ACE(s)	Adverse childhood experiences
CSE	Child sexual exploitation
EI	Early intervention
L&D	Liaison and diversion
MATAC	Multiagency tasking and co-ordination
NPTs	Neighbourhood policing teams
OPCC	Office of the Police and Crime Commissioner
PHE	Public Health England
PHW	Public Health Wales
PPN	Public protection notice
SARC	Sexual assault referral centre

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Annex 1: Survey respondents

The following organisations responded to the survey.

Bedfordshire Police	West Mercia & Warwickshire Police
Devon and Cornwall Police	West Midlands Police
Dyfed-Powys Police	West Yorkshire Police
Essex Police	Cambridgeshire Office of the Police and Crime Commissioner
Gloucestershire Constabulary	Humberside Office of the Police and Crime Commissioner
Greater Manchester Police	North Yorkshire Office of the Police and Crime Commissioner
Gwent Police	Dorset Office of the Police and Crime Commissioner
Hampshire Constabulary	Warwickshire Office of the Police and Crime Commissioner
Humberside Police	West Yorkshire Office of the Police and Crime Commissioner
Kent Police	Association of Directors of Public Health
Leicestershire Police	College of Policing
Lincolnshire Police	Public Health England
Merseyside Police	Public Health England – Alcohol, Drugs and Tobacco division
Norfolk Constabulary	Public Health England – Health and Wellbeing
North Wales Police	Public Health England – Public Health, Health and Justice
North Yorkshire Police	Public Health England South West
Northamptonshire Police	Public Health England West Midlands
Northumbria Police	Public Health England Yorkshire and the Humber
South Yorkshire Police	NHS England – Children and Young Persons Mental Health Team
Staffordshire Police	NHS England – Health and Justice
Suffolk Constabulary	NHS England – Older People's Team
Surrey Police	National Police Chief's Council - Missing Person Portfolio
Sussex Police	UK Faculty of Public Health

In addition, case study information was contributed by Lancashire Constabulary and Public Health Wales.

Annex 2: Survey questions and responses

The survey questions and statistical data on response rates are set out below, although the free-text responses are not reproduced. There are 2 versions of the survey. The first was sent to national and regional organisations, while the second was sent to police forces and offices of police and crime commissioners (OPCCs).

Thirteen completed questionnaires were submitted from regional and national organisations. An additional 15 partial responses were obtained. Of these, 10 were removed from the sample due to having no data entered and 4 were removed as only the agency and role were entered, but no other questions answered. This left 1 response where part of the questionnaire had been answered. Therefore, the total number of regional/national responses included in the analysis was 14.

Thirty-two completed questionnaires were submitted by police forces and OPCCs. In addition, 99 were partially completed. Of these, 57 were removed from the sample due to having no data entered at all; 34 were removed as only the police force and contact details were entered, with no other questions answered. This left 8 responses where part of the questionnaire had been answered. Therefore, the total number of police/OPCC responses included in the analysis was 40.

Identifying best practice between Health and Policing collaborative working

Information Sheet

Demographic information

1. Organisation / Agency completing the questionnaire?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	14
		answered	14

2. What is your role?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	14
		answered	14

3. Please provide your contact details:

		Response Percent	Response Total
1	Name	100.00%	14
2	Phone number	100.00%	14
3	Email	100.00%	14
		answered	14

Health and Policing collaborative working

4. Using the list below, please could you indicate the areas where your organisation / agency has been involved with, or influenced partnership work between health and policing. Please complete this regarding any completed, active or possible future work. Please select any that apply.

	Completed work	Active work	Possible future work	Response Total
Safeguarding	1	7	3	11
Alcohol	4	12	3	19
Drugs	4	12	3	19
Violence prevention	1	8	3	12
Health in custody	4	12	2	18
Prevention of offending and reoffending	3	9	2	14
Mental Health	4	11	3	18

4. Using the list below, please could you indicate the areas where your organisation / agency has been involved with, or influenced partnership work between health and policing. Please complete this regarding any completed, active or possible future work. Please select any that apply.

	Completed work	Active work	Possible future work	Response Total
ACE (Adverse Child Experiences)	1	7	4	12
Domestic Abuse	1	5	2	8
Social Isolation	0	2	3	5
Homelessness	0	3	4	7
Obesity	0	1	4	5
Physical Activity	0	3	5	8
Sexual Health	0	3	4	7
Child Sexual Exploitation	2	3	4	9
Suicide prevention	2	10	3	15
Migrant Health	0	2	3	5
Sex workers	1	2	2	5
Radicalisation	1	3	3	7
Long term conditions	0	2	3	5
Dementia	0	4	3	7
Modern Slavery	0	1	4	5
Missing from home	0	1	4	5
Neglect	0	2	4	6
			answered	14

5. Please give details of any pieces of work that your organisation / agency is / has been involved with that have cut across both health and policing (regardless of whether an official collaborative partner was involved)

	Title:	Brief (to include aim of project and key agencies involved):	Response Total
Work 1:			
Work 2: etc…			
		answered	13

6. From the list of pieces of work noted in Q5 above, please select ONE project that you feel best highlights good practice relevant to health and policing, and answer the following questions: (State NA if not applicable):

		Response Percent	Response Total
1	Lead Agency:	100.00%	12
2	Other Agencies/Partners involved:	100.00%	12
3	Main aim:	100.00%	12

6. From the list of pieces of work noted in Q5 above, please select ONE project that you feel best highlights good practice relevant to health and policing, and answer the following questions: (State NA if not applicable):			
		Response Percent	**Response Total**
4	Duration (or expected duration):	91.67%	11
5	How was the work funded:	100.00%	12
6	Was this a local / regional / national project?	100.00%	12
7	How did you manage data/information sharing?	100.00%	12
8	How did you measure impact / what outcome framework was used?	91.67%	11
9	Any key lessons to be taken from this work?	83.33%	10
		answered	12

Organisational Priorities

7. What are the key priority areas for your organisation / agency currently that are relevant to health and policing? (please list what these priorities are, and include link if relevant)			
		Response Percent	**Response Total**
1	Open-Ended Question	100.00%	14
		answered	14

8. Thinking about the list in Question 4 (or any other areas that are relevant), which aspects of health and policing are responsible for the greatest demand (volume and/or severity), or concern for your organisation / agency currently?			
		Response Percent	**Response Total**
1	Open-Ended Question	100.00%	13
		answered	13

Governance, workforce development and information sharing

9. Please could you give details of any workforce development initiatives that your organisation / agency is involved with, which may impact on collaborative working across health and policing:			
		Response Percent	**Response Total**
1	Leadership:	75.00%	9
2	Developing employee skill sets:	83.33%	10
3	Recruitment:	25.00%	3
		answered	12

10. Regarding information sharing between health and policing, what have been / what do you foresee as:

		Response Percent	Response Total
1	Enablers:	85.71%	12
2	Blockers:	92.86%	13
		answered	14

11. What do you foresee as general enablers and blockers for collaborative working between health and policing?

		Response Percent	Response Total
1	Enablers:	100.00%	13
2	Blockers:	84.62%	11
		answered	13

12. Do you have any further comments regarding best practice / gaps / future visions to help inform future collaborative working between health and policing?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	6
		answered	6

Identifying best practice between Policing and Health collaborative working

Information Sheet

Demographic information

1. Police Force completing the questionnaire?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	40
		answered	40

2. What is your role/rank?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	40
		answered	40

3. Please provide your contact details:

		Response Percent	Response Total
1	Name	100.00%	40
2	Phone number	100.00%	40
3	Email	100.00%	40
		answered	40

Policing and Health collaborative working

4. Using the list below, please could you indicate the areas where partnership work between your Force and health has been undertaken (completed), currently undertaken (active) and will be undertaken (possible future work).Please select any that apply.

	Completed work	Active work	Possible future work	Response Total
Safeguarding	10	24	5	39
Alcohol	11	22	6	39
Drugs	12	26	5	43
Violence prevention	6	16	10	32
Health in custody	14	25	8	47
Prevention of offending and reoffending	10	23	10	43
Mental Health	13	32	9	54

4. Using the list below, please could you indicate the areas where partnership work between your Force and health has been undertaken (completed), currently undertaken (active) and will be undertaken (possible future work).Please select any that apply.

	Completed work	Active work	Possible future work	Response Total
ACE (Adverse Child Experiences)	2	10	13	25
Domestic Abuse	9	26	6	41
Social Isolation	1	6	17	24
Homelessness	2	13	15	30
Obesity	1	4	11	16
Physical Activity	1	3	11	15
Sexual Health	7	16	9	32
Child Sexual Exploitation	11	27	7	45
Suicide prevention	8	23	5	36
Migrant Health	1	2	13	16
Sex workers	7	15	10	32
Radicalisation	7	12	7	26
Long term conditions	2	5	12	19
Dementia	9	20	9	38
Modern Slavery	6	20	6	32
Missing from home	7	21	6	34
Neglect	5	18	8	31
			answered	38

5. From the list of pieces of work noted in Q5 above, please select ONE project that you feel best highlights good practice relevant to policing and health, and answer the following questions: (State NA if not applicable):

		Response Total
1	Lead Agency:	27
2	Other Agencies/Partners involved:	26
3	Main aim:	27
4	Duration (or expected duration):	27
5	How was the work funded:	27
6	Was this a local / regional / national project?	27
7	How did you manage data/information sharing?	27
8	How did you measure impact / what outcome framework was used?	27
9	Any key lessons to be taken from this work?	26
	answered	27

6. Please give details of any pieces of work that your Force is / has been involved with that have cut across both policing and health (regardless of whether an official collaborative partner was involved)

	Title:	Brief (to include aim of project and key agencies involved):	Response Total
Work 1:			27
Work 2: etc…			26
		answered	27

Organisational Priorities

7. What are the key priority areas for your Force currently that are relevant to policing and health? (please list what these priorities are, and include link if relevant)

		Response Total
1	Open-Ended Question	29
	answered	29

8. Thinking about the list in Question 4 (or any other areas that are relevant), which aspects of policing and health are responsible for the greatest demand (volume and/or severity), or concern for your Force currently?

		Response Total
1	Open-Ended Question	25
	answered	25

Governance, workforce development and information sharing

9. Is your Force currently involved / represented on any Health and Wellbeing Boards?

			Response Percent	Response Total
1	Yes		77.42%	24
2	No		12.90%	4
3	Not known		9.68%	3
		answered		31

10. Focussing on workforce development, what initiatives / strategies are currently being adopted within your Force to encourage collaborative working, specifically within the areas of:

		Response Percent	Response Total
1	Leadership:	85.00%	17
2	Developing employee skill sets:	85.00%	17

10. Focussing on workforce development, what initiatives / strategies are currently being adopted within your Force to encourage collaborative working, specifically within the areas of:

		Response Percent	Response Total
3	Recruitment:	45.00%	9
		answered	20

11. Regarding information sharing between policing and health, what have been / what do your foresee as:

		Response Percent	Response Total
1	Enablers:	92.31%	24
2	Blockers:	92.31%	24
		answered	26

12. What do you foresee as general enablers and blockers for collaborative working between policing and health?

		Response Percent	Response Total
1	Enablers:	92.59%	25
2	Blockers:	96.30%	26
		answered	27

13. Do you have any further comments regarding best practice / gaps / future visions to help inform future collaborative working between policing and health?

		Response Total
1	Open-Ended Question	14
	answered	14