

Policing vulnerability through building community connections

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Policing Vulnerability Through Building Community Connections

Introduction

The relationship between the police and a multitude of vulnerable populations has been widely documented yet the policing of mental ill-health has, until recently, remained in the peripheral field of vision for many police commentators. This context is changing with a raft of recent reports on policing and mental health (Metropolitan Police Service, 2013; Australian Review, 2014; House of Commons, 2015). Current estimates indicate that approximately one third of people who come into contact with the Police Service in England and Wales have an identified mental health problem (Her Majesty's Inspectorate of Constabulary, 2015). This figure rises to 60% and above when identifying unusual or anti-social behaviour which is often compounded by substance use and dependence (Paterson and MacVean, 2007). Policing involves the routine management of public health risks by police officers who act as 'mental health interventionists' (Wood, 2014) and assist in prevention alongside community agencies. This article provides a review of recent policy developments, identifies service gaps, and assesses the potential of assertive linkages, community integration and inter-agency partnerships to align security and health governance.

Policing mental ill-health

This first section identifies commonalities in recent policy developments across the UK, North America and Australia, in particular attempts to develop integrated delivery models to support people experiencing mental health crises. The conflicting priorities of multiple criminal justice, health, and mental health agencies and processes can lead to confusion around the need to secure justice at the same time as protecting the citizen and generate a security deficit alongside further marginalisation of vulnerable people (Barthowiak-Theron,

2011; Wood et al., 2011). These problems are not new (Bittner, 1967) and have not been addressed despite continued requests for reform.

In the UK, it has been recognised that there has been an over-reliance upon the advice of the forensic medical examiner (FME) who, often for resource reasons, is limited to making decisions about fitness to interview or charge and whose work is limited to the custody suite. Thus, there is inconsistency in the quality of provision from FMEs and unclear pathways for individuals on release (MPS, 2013). Police officers continue to act as gatekeepers to appropriate care services but the tendency for mainstream mental health services to withdraw from involvement in this area and to be replaced by specialist forensic services has presented, until recently, an unrecognised challenge for police organisations. The London Metropolitan Police is now recruiting forensic psychiatric nurses but further work needs to be done to integrate services for people on release from custody (Bradley, 2009).

In addition to the patchwork of service provision provided by police and health agencies, we argue that the police's role should be more focused on direction and guidance of individuals towards appropriate community services. The 2013 Review of Policing and Mental Health commended the police's development of the mental health liaison officer role whilst recognising resource restraints on training and consequential uneven implementation. In order to fill existing gaps the review recommended that forensic psychiatric nurses should be available at all times in custody suites and this approach has now been embedded across the MPS. The more complex areas of change remain significant obstacles - in many cases due to the difficulties arising from budgeting and commissioning relationships and the need for the police to show evidence of value and efficiency in a time of reduced resources.

One of the most significant gaps relates to referral pathways on release from police care and the effectiveness of bridging into a range of community agencies and services. The 2009

Bradley report recommended that police custody suites should have access to liaison and diversion services yet this reform requires a shift of budgetary and commissioning responsibilities for healthcare in custody from police to NHS which has been only partially implemented. Similarly, in Australia, the 2014 Review of Mental Health Programmes and Services recommended the establishment of mental health, social and emotional wellbeing teams which would be attached to primary care teams and specialist mental health services.

The most widespread example of integrated service provision is the evolution of crisis intervention teams (CIT) across the United States, Canada, Australia and the United Kingdom that include specialist officers trained in the de-escalation of threatening behaviours and alternative modes of resolution. The first CIT was established in Memphis in 1988 as a direct response to the police shooting of a man suffering from serious mental ill health and sought to improve police officer identification of, and interaction with, vulnerable people experiencing mental health crises. Alternative models include mobile crisis teams where a mental health clinician is called as a secondary responder (Reuland and Margolis, 2003) and community service officers where individuals with social work experience complete a six week police training course before joining a police unit (de Tribolet-Hardy et al., 2014). Yet, despite widespread implementation of the CIT model across the United States there are inconsistent conclusions from evaluative studies about its efficacy (Fisher and Grudzinskas, 2010). Steadman et al. (2000) found that the CIT was able to provide the greatest breadth of coverage to support mental health crisis situations and to facilitate handovers to clinicians although, due to a lack of specialised support, they faced challenges in resolving front-line incidents and securing referrals.

The policy developments outlined above have largely been developed in response to challenges faced along the front-line of policing which require targeted investment. The following two sections extend the scope of discussion to incorporate a range of strategies

that can be utilised, firstly within police organisations, and secondly, beyond the police to build organisational engagement, manage risk and draw on a much broader resource base to support mental health challenges in the community. This discussion heeds the recent call from Bartkowiak-Theron and Asquith (2015) to retain a focus on the broad concept of vulnerability as a socio-cultural characteristic of people who come into contact with the police and other criminal justice agencies to avoid unnecessarily siloed responses to diversity and cultural awareness.

Policing vulnerable populations

Most people who come into contact with the Police Service can be described, in some way or other, as vulnerable. As well as mental health problems, there are elevated rates of homelessness, substance misuse and other forms of social exclusion. Victims, offenders, witnesses and bystanders are all exposed to social conflict when the police are required to restore order. Thus, while vulnerability is context-specific it is largely defined via deficit frameworks that view individuals and groups as marginalised or disadvantaged and requiring immediate intervention, a model that may contribute to disempowerment and loss of self-esteem and social capital. This framework has the potential to encourage criminalisation and risk-averse behaviour from the police and other agencies that are tied into mandatory responses and to create antagonistic attitudes in those with whom they engage. The resultant dichotomy of over-policing and security deficits experienced by vulnerable populations leads to unnecessary criminalisation and dissatisfaction with criminal justice agencies that are not perceived to be procedurally just. This inflexible process can be improved via earlier intervention and diversion to local mental health services, although this requires improved inter-agency working and partnership approaches.

It is an old theme in policing research that much front line work does not involve the direct enforcement of law and legal authority provides a background of legitimacy for governing

problematic people and situations via the flexible use of individual discretion by front-line officers (Bittner, 1970). Hence, much of day-to-day policing incorporates normative judgments about individual or collective behaviour and the decision about where and how to exercise regulatory controls. The contested nature of the police role has been increasingly recognised by police organisations across the globe and strategic developments in areas such as public reassurance, procedural justice and the pluralisation of service provision demonstrate a continued shift of the role and function of policing agencies beyond reactive functions and towards problem-solving and interactive community crime prevention. This is based on recognition that policing effectiveness rests on community support, the perceived legitimacy of policing activities and an ongoing negotiation with professional and community groups at a local level.

These policy trajectories remain uneven both within and across jurisdictions with the 2013 Independent Commission on Policing and Mental Health in the UK identifying a continued absence of partnership work during the development of police standard operating procedures and policy. There remain a number of challenges to policy development and implementation with policing discourse retaining a focus on repressive control functions ahead of the potential to care and support (Moore, 2011) and potential partners disengaging due to challenges presented by limited resources and perceived dysjunctions in organisational missions, culture and values (Skinns, 2008). These challenges are not insurmountable and, from a police perspective, relate to inter-agency and engagement challenges with outside groups and communities who, in a health-based context, are often concerned with how to backfill the security and transportation functions provided by the police prior to appropriate referral (Herrington and Pope, 2014). This often leads to procedural barriers around issues such as information sharing and project leadership that can result in delays and missed opportunities.

The conclusion of many observers of the police and mental health nexus is that a more centralised and comprehensive response is required that re-aligns funding and inter-agency priorities (Ibid., 2014) but this is challenging in environments where resources are being reduced. Between 2010-11 and 2014-15 it is estimated that mental health trusts in England and Wales experienced real-term budget cuts of approximately 8% alongside an increase in referrals of around 20% (Community Care, 2015). Furthermore, as McKnight and Block (2010) have argued in the context of community development, community problems are not resolved by more professionals (either within or across organisations) but by more effective partnerships with local communities.

Utilizing interactive policy-making (Mayer et al. 2005), where the public are actively engaged as stakeholders far ahead of delivery or implementation, enables a conceptualization of programs that appreciate the lived experience of individuals and organisations, addresses security deficits and avoids the prospect of process-oriented co-option by individual organisations. The emphasis placed on individual well-being, positive social identity and inter-personal relationships avoids disempowerment and emphasises the role of active social agents. The Bradley Report (2009) advocated for the introduction of joint training packages which had been co-developed by mental health trusts, police officers and service users. This approach is supported by a number of international studies which point to increased empathy, decreased stigma and a build-up of confidence amongst police officers in managing mental health issues when training is co-developed with local organisations and service users (Pinfold et al., 2003; Krammedine, 2013). This is a mechanism for generating models that have stakeholder engagement which challenges insular and inward-looking organisational cultures.

The following section draws on this model for the integration of police work, health promotion and community engagement in line with Wood et al.'s (2013) call for a reform agenda that

aligns the missions and cultures of security and health governance and builds community capacity through a focus on public health asset based models. This helps build a model that uses a systematic process for identifying positive resources in the community and using those resources to build partnerships for problem solving and for strengthening the communities in which they are based.

Community capacity and assets-based models

The asset based model is drawn from the field of public health:

A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and wellbeing and to help to reduce health inequalities. These assets can operate at the level of the individual, family or community and population as protective and promoting factors to buffer against life's stresses. (Morgan and Ziglio, 2007, p.18)

One of the few examples of the application of asset based approaches in evaluative contexts is in Toronto, where researchers worked with four community areas to generate evaluative frameworks for exploration of the 'capacity' of the community. Drawing on health promotion models that move beyond the individual as the central issue, the work in Toronto took into account societal factors to identify and explore the 'capacity' of a community (Jackson et al., 2003). The resulting 'community capacity' model gives a framework to map the individual capacity and the socio-environmental conditions of a community that enable or inhibit local capacity. The underlying aim is to explore how far there is capacity within this community to generate assets that can be drawn on to improve the health and well-being of local people; in this case to provide support and guidance for people who come into contact with the police due to mental health problems and require positive community interventions to decrease the risk of harm.

Within an Asset Based Community Development model (Kretzmann and McKnight, 1993) problem solving is seen as occurring in the community and with active participation of

community members and is not externally imposed by professionals who have a limited stake in the community. This model generates ownership and engagement and a form of legitimacy and sustainability that cannot be achieved by professionally imposed solutions. In a further elaboration of this model, McKnight and Block (2010) identify a key role for 'community connectors' as individuals who act as the 'bridging capital' that links individuals, groups and organisations in creating community level problem solving to enhance community cohesion and shared ownership of community problems. This is consistent with the model for desistance outlined in the informal social control ties of Sampson and Laub (2003) in which it is suggested that higher levels of engagement by social networks imposes control through positive support and engagement in the change process.

Applying the McKnight and Block model of community connectors in a magistrates court in Melbourne, Australia, Best and Savic (2015) recruited a cohort of community connectors whose role was to link repeat offenders with underlying addiction issues to community support groups - including, but not restricted to, mutual aid groups like AA and NA. The model was highly successful in identifying both appropriate groups (football and fishing clubs, volunteering and educational groups) and community connectors leading to more effective ongoing support for this population of recidivistic, addicted offenders. A similar model is proposed here for police partnerships around engaging connectors to support those with mental health problems through coalitions of professionals and community representatives including family members. The idea that sits behind this approach is that partnership is more timely, more cost-effective and more likely to generate community goodwill when the partnership is directly between the criminal justice agencies and the community and does not involve costly and inefficient partnerships between professional bodies with contrasting priorities and cultures that have little impact in communities.

In this context, the current or previous use of substances, as well as the individual's health, housing situation and social networks are seen as 'conditions' that may facilitate or hinder recovery. This draws on the social capital models developed first in the social sciences by sociologists such as Pierre Bourdieu and James Coleman (Bourdieu, 1986; Coleman, 1988) and used by researchers in the addictions field as a theoretical framework for exploration of predictive recovery factors (Laudet and White, 2008). The idea of the wider 'ecology' of conditions has been described in the addictions field as the understanding of how:

“the relationships between individuals and their physical, social, and cultural environments promote or inhibit the long-term resolution of severe AOD [addiction] problems.” (White, 2009, p.147)

As in the Toronto Community Capacity Model below, the aim is to explore not only the individual's own capital, talents or skills, but also the community conditions that can be manifest in structures and processes. Thus, the development of skills (and so recruitment and training needs) is linked to organisational factors but crucially also to external conditions. In developing effective officers, the aim is to address gaps in provision at the level of community which requires a sensitivity to, and awareness of, the outside facilitating conditions in the local communities and the lived environment.

Figure 1: The Toronto Community Capacity Model here

In this approach, community capacity is a dynamic and interactive loop between officer development and the factors that facilitate and block the expression of talents within both the police organisation and the wider community. The switch in emphasis in the model is the increasing sensitivity, and response, to community strengths and gaps.

The aim here is to engage individuals who identify and mobilise community assets and who generate community ownership, which in turn creates community level capital for engaging in and solving community problems. The model works on the assumption that the assets available to people affect their recovery capital (Best and Laudet, 2011). Therefore, community assets influence, and are influenced by, social capital and this shapes personal capital and strengths. This process is based on the idea that individual wellbeing is predicated on a supportive environment to enable change; in this case, a community that is equipped to support mental health crises through community-based and community-engaged partnership working.

Community Connections and Asset-Based Policing

The model that Best and Savic (2015) have developed is based on the idea that community resources are not only a sum of the personal and social capital in an area but their collective mobilisation to engage wider community responses and ownership in problem solving. In terms of health geography such community partnerships are characterised through the idea of 'therapeutic landscapes' that would tie in with the Sampson and Laub (2003) model of community organisation / integration. Wilton and DeVerteuil (2006) describe the changes that took place in San Pedro, California, when a recovery presence became visible and active in the local community. The underlying principle is that active community engagement can fundamentally change local communities and alter the conditions for future generations attempting to solve their own life problems through visibility and activism.

The therapeutic landscapes model supports the transformation of both physical and social space into a supportive environment in which police officers feel more empowered to address mental health problems. Furthermore, the officers are engaged in community coalitions that mean they have access to the support that can provide the expertise, time and commitment to address these problems.

Police officers are assigned to work particular territories in which they develop a detailed understanding of a range of dynamic social problems. This position provides police officers with an opportunity to facilitate change and influence behaviour within that territory for the purpose of improved public health (Wood et al., 2011). Police officers can be understood as providing a guardianship role with a twin focus on behaviours (personal) and environments (social/community) that can be situated within broader thinking about health promotion as well as the management of crime. What is suggested here is an extension of the notions of community policing to a strategic model of community partnership that is designed to actively and systematically identify the NGO and community supports for mental health, that creates professional-community coalitions for addressing these problems, and that generates the confidence and ownership in the community to develop effective partnership approaches. This has profound implications for the leadership and training of police officers who will require considerably greater community engagement and awareness in taking a leading role in generating partnerships that transcend traditional partnerships. The model extends partnerships to include NGOs, peer organisations, community interest companies and social enterprise partnerships that are locality based. The authors recognise that these changes may meet with resistance from police officers who regularly move localities or are more attuned to an emphasis upon law enforcement.

What is being proposed here is a cost-neutral partnership model that builds on notions of asset based community development, extensively developed in the alcohol and drug area in the UK in recent years, and the principles of community policing to develop a scientific and systematic approach to effective community engagement. This creates a framework for building legitimacy through community coalitions and professional-peer partnerships that can generate meaningful community responses to crisis and recurring mental health problems.

This article has drawn on the recovery literature to explore the networks of support both within, and available to, vulnerable populations. While developing effective partnerships between policing and mental health services can be challenging, there is a clear evidence-base of initiatives that have been developed, implemented and evaluated. Yet, solutions based on police employing specialist mental health custody nurses or engaging in expensive training courses in mental health for beat and custody officers are increasingly unlikely as well as of debatable efficacy. What is proposed is a model that has been trialled effectively in the UK and Australia around substance using offending populations and suggests that this can be applied effectively for the management of acute and chronic mental health problems in the criminal justice system through partnership and strategic engagement with communities.

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Figure 1: The Toronto Community Capacity Model

