Responses to the Notes and Queries from Ethics Committee Meeting December 2020

Predicting the Volume of Demand from Mental Health Related Police Incidents

Note Dated 18/02/2021

This is a note to explain and answer the specific questions raised by the Ethics Committee in the last meeting (December 2020). It should be noted that in a number of cases it might be impossible to give definitive answers, for example to questions of measuring the variability of reports as it is not possible to create such a counter-factual based controlled experiment. Each point is reported and responses given.

General Comments

With regard to the comment "*In particular, the Committee felt more detail was required around how policing data was assessed for containing references to MH incidents, …",* WMP have developed a plan on how the Force can better flag Mental Health incidents. In essence it will be a short term combination of Force Contact applying Mental Health Qualifiers and/or closures as well as frontline resources entering "MHRIX" into the log. Whilst we understand that this is not perfect, it should put WMP in a much better position to judge mental health demand and requirements. A recent three day snapshot performed by the Force revealed that only about 23% of the incidents are flagged and this new standardisation of the approach should improve this metric.

1. The types of mental health being recorded (e.g. evidence of psychosis, extreme distress or hallucination etc.) or the extent to which there is variability on how this is recorded or not, i.e. evidence of different levels of quality regarding how individual officers are reporting mental health issues – this is of course appreciating officers are not trained mental health professionals and would really be exploring the level of officer observation around these incidents;

   The identification is in the first place by officers, though there might be a MH professional either aiding or attending to help the classification. There is currently no "further diagnosis" in the data beyond what is entered by the officers and further medical information is not currently available to us. The degree to which there is variability is of concern but it is not currently measureable. Officers will mention that the person is "hallucinating" or "suicidal" but this is not a diagnosis in its medical sense. In a number of cases, officers will be faced with a situation where a person will say "*I am a paranoid schizophrenic but I have not been diagnosed".* This leads to a generalised degree of variability in the data.

   With the creation of the new mental health forms as discussed in the report, the variability should be reduced though not necessarily removed. In order to check officers' classifications against actual diagnosis a data sharing agreement will have to be entered into. This is a more medium term goal. An investigation of the officer level observation would be a significant undertaking.

   The purpose of the analysis is to understand the demand faced by WMP where calls for service relate to a mental health issue. To some extent, the accuracy of officer assessment of the type of mental health issue is irrelevant, because we still need to attend the incident in the first instance.

2. The kinds of 'behaviour' being interpreted as mental health, shedding light on where behaviour is deemed mental health versus criminal;

   Again driven by the officers' interaction with the people involved in the incident, given the proviso above.

3. The way mental health is recorded generally – literally more granularity on the 'terms and words' being used, or details provided;

   Key terms in report already: end note (ii).

4. Any intricacies around how mental health is described in relation to different groups such as different ethnicities;

   There is a brief split in the data based on ethnicity based on the new data collection forms. The main report focused on more aggregated data. In such a case, there is an argument that the ethnicity is largely subsumed into other factors especially in areas where there is homogeneity in the population (for example) in the area of question. There was no specific consideration of *how* an officer might describe mental health across different ethnicities as this was considered as outside the scope of the study.

5. Other circumstances typically recorded at the same time as mental health incidents or categories of mental health incidents, to see if that offers more useful insights.

   Information associated with the incident was also acquired pre- aggregation, only information that was used in the modelling was kept. This included factors such as crime types but not other environmental aspects. As the data was across a number of different systems it was rather mixed in the classification of records; efforts were made to group these using, for example, a Naïve Bayes model to match some of the records to other groupings.