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THE LANCASHIRE VULNERABLE CALLERS PROJECT

Lancashire Constabulary
police and communities together

uclan
University of Central Lancashire

SUMMARY

Whilst 17% of calls to the UK Police relate to crime, calls relating to public safety and welfare are rising significantly (College of Policing, 2015). Increasingly, the Police are viewed as a free and accessible service, providing wider social support. Although UK Police are now assessed on their ability to assist the vulnerable (HMIC, 2017), the method in which the vulnerable are identified and assisted remains ambiguous. This dilemma appears to be an international trend.

Scanning: Lancashire Constabulary define a vulnerable caller as an individual who frequently calls, or relies, on police services. Between April 2015 and December 2016, using a two stage process, they identified 1546 high intensive vulnerable callers. One of these called the Police, on average, 94 times a month. Many called other services as well, primarily relating to Ambulance, Social Services, and Mental Health.

Analysis: The Constabulary trained contact management staff and those assigned to dedicated Early Action Teams (EAT) in methods of engaging with the vulnerable callers. Members from the EA team would visit each 'vulnerable caller' and analyse the underlying causes that generated the call. Whilst individual to the caller, force wide analysis found these issues clustered around three themes: Youth, Elderly and dynamic risk factors. Within these general categories, a variety of issues were discovered, including:

- Alzheimer's disease or Dementia;
- Victims of Child Sexual Exploitation (CSE); or Domestic Abuse;
- Being isolated or lonely;
- Suffering poor mental health;
- At risk of self-harm;
- Engaged in substance abuse.
- Missing from Home

Response: Each vulnerable caller was assigned a Lead Professional accountable for coordinating a tailored response to tackle the underlying cause of the vulnerability (generally a multi-agency response). The aim was to reduce the harm to the individual as well as reducing demand on public sector agencies. Examples are provided in the main text.

Assessment: A before and after impact evaluation found repeat calls to the police were significantly reduced (-26%[*]), with the highest reductions associated with Mental Health issues (-21.5%[*]). Police deployments were also reduced, albeit to a lesser degree (-6.2%). Interviews and focus groups with practitioners found success was aligned with five factors:

- A clear definition of the underlying cause of the problem;
- An action oriented, evidence based plan;
- Effective implementation;
- A Vulnerable Caller motivated to change;
- A skilled and committed practitioner who can engage effectively with the caller.

Word Count 385

[*] These findings were statistically significant

SCANNING

In 1977 Goldstein summarised the functions of the Police, one of which was to, "Assist those who cannot care for themselves: the intoxicated, the addicted, the mentally ill, the physically disabled, the old and the young". The College of Policing (2015) point out only 17% of all Police calls, relate to crime, whilst other categories of calls (public safety and welfare), are rising. Society increasingly appears to be turning to a visible and available policing service, free at the point of access, to provide wider social support. HMIC (2015:13) argues that those at the "greatest risk of harm" need police protection and support. However, identifying who are 'the vulnerable' and deciding what assistance they require is problematic. The British Medical Society (2011: 20); argue several factors contribute to vulnerability, including:

- Older people who are particularly frail;
- Those suffering from mental illness, including dementia or a personality disorder;
- Those with a significant and impairing physical or sensory disability;
- Those with a learning disability;
- Those with a severe physical illness;
- Unpaid carers who may be overburdened, under severe stress or isolated;
- The homeless;
- Those who live with others who abuse drugs or alcohol;
- Women who may be particularly vulnerable because of isolating cultural factors.

Of course, whilst many individuals experience these factors, they have the capacity and capability to reduce its negative impact (British Medical Society, 2011:20). Unfortunately, a significant minority do not have this resilience and either they, or someone associated with them, contact the Police - or other public sector organization - for assistance.

The project was implemented by the Lancashire Constabulary. Lancashire is an area of 2000 square miles in the North West of England, located between the cities of Manchester and Liverpool. It has a population of about 1.5 million divided between urban (Blackburn, Preston), rural (Lancaster) and tourist (Blackpool) locations. The Lancashire Constabulary, is the 11th largest of 43 police forces in England and Wales. Structurally it comprises a HQ (which comprises administrative and specialist support services), and three operational Divisions (North, West and South), who are themselves divided into smaller geographical areas. It has 2889 Police Officers, 1920 Police Staff (of which 330 are

PCSOs[1]) and a growing number of Special Constabulary Officers[2], Police Cadets and Community Volunteers (Lancashire Constabulary website).

The Lancashire Constabulary defines a vulnerable caller as an individual who frequently calls or relies on police services. The Lancashire Constabulary lists several vulnerable groups, including those who are:

- Suffering Alzheimer's disease or Dementia;
- Victims of Child Sexual Exploitation (CSE);
- Disabled;
- Victims of Domestic Abuse;
- Elderly;
- Isolated or lonely;
- Suffering a learning disability;
- Missing from home;
- Suffering poor mental health;
- At risk of self-harm;
- Engaged in substance abuse.

The Lancashire Constabulary argue that if an individual is frequently contacting the police and is aligned to one of the above groups, they may be at increased risk of being (or becoming) vulnerable. Therefore, they may need specific interventions to address the root cause of their difficulties and increase their capability to cope with their vulnerability. Previous analysis of contact management data by Lancashire Constabulary has found that some frequent callers may contact the police 50 times or more in a month. It has also been discovered these individuals can be high intensive users of other services, especially Ambulance, Social Services and Mental Health Services.

The process to identify vulnerable callers commenced in April 2015, and was finally implemented during September 2015. Initially, a HQ analyst collates all call data from those using 101 (non-emergency) and 999 (emergency) numbers and identifies the highest frequency of repeat numbers. Telephone numbers associated with businesses, care homes, hospitals, ambulance service and public 'phones are then removed. The name and address of the top 100 repeat numbers are then identified

[1] Police and Community Support Officers are uniformed non-sworn officers. They generally deal with low level neighbourhood incidents and have limited enforcement powers.
[2] These are volunteer uniformed officers who have full police powers.

and researched. Details are then distributed to locally based *early action teams* (*EAT*[3]). It is the task of the *EAT* to use local systems and professional knowledge to identify which individuals appear to require additional support. Each *EAT* maintains a vulnerable caller spread sheet as a working document. Each month this is submitted to a HQ based analyst, for monitoring and for new vulnerable callers to be added.

The table below shows the vulnerable callers divided across the different areas of Lancashire between 1st April 2015 and 1st December 2016. Initially, 1546 repeat callers were highlighted, however after further local research this discovered only 866 (56%) of the subjects were deemed 'vulnerable'. As with crime incidents, this was not distributed proportionately. Specifically, Blackpool, the most deprived area within Lancashire, appeared to be a peak location, comprising 23.3% of the callers (n=202).

Table 1: Breakdown of identified vulnerability by locality.

Locality	High volume callers initially identified	Callers identified as Vulnerable by Early Action Teams	%Callers identified vulnerable following local research
Blackburn	178	73	41%
Burnley	114	77	68%
Hyndburn	63	27	41%
Pendle	87	36	41%
Ribble valley	22	12	55%
Rossendale	57	32	56%
Chorley	85	41	48%
Preston	181	109	60%
South Ribble	80	40	50%
West Lancashire	80	50	63%
Blackpool	306	202	66%
Fylde	62	30	48%
Lancaster	123	76	62%
Wyre	108	61	56%
Total	**1546**	**866**	**56%**

It is important to note an existing system was in place to monitor vulnerability. This meant when such an individual or family was found a Protecting Vulnerable Person(PVP) form was submitted. These

[3] The Lead Professionals are explained in the response section.

were sent to a Multi- Agency Safeguarding Hub (MASH[4]) who shared information to try and ensure the family/individual is referred to the correct agency. Analysis showed 87.3% of those identified as Vulnerable Callers, were previously known to the police through the PVP notification process. This illustrates most of the callers identified in the sample were previously highlighted as vulnerable but their problem had not been effectively addressed.

ANALYSIS

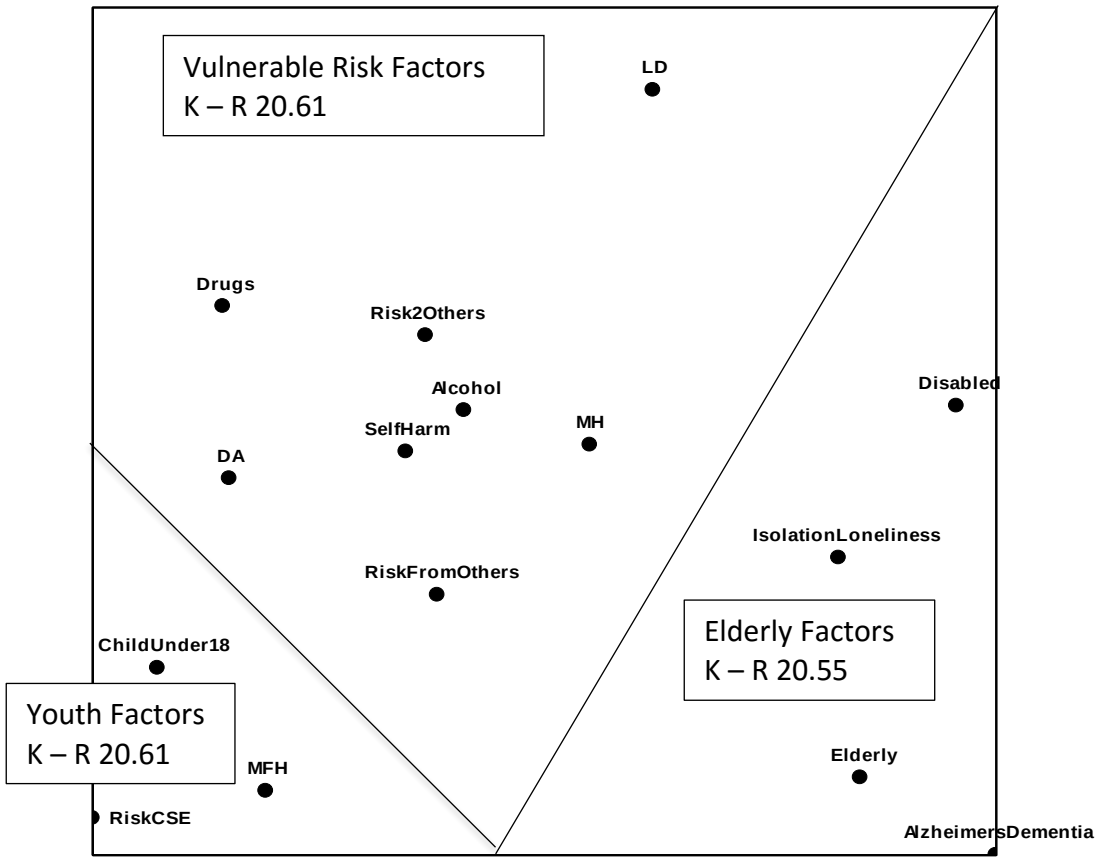
There were two stages to the analysis. The first stage was to look across the cohort of vulnerable callers to see patterns in the information provided. This used a technique called *Smallest Space Analysis* (SSA), which provides a graphic illustration of co-occurring factors. This dataset was based on the key characteristics of 1352 vulnerable callers identified between October 2014 and August 2016. Any behaviours not mutually exclusive, or occurring in less than 3% of cases were excluded from this study, leaving 15 vulnerability factors (coded as present or absent in each case).

SSA, is a non-metric multidimensional scaling procedure. It examines the co-occurrence of each vulnerability characteristic and ranks these associations, depicting them in an abstract "space." Whilst sounding complicated, in visual terms, the higher the correlation between two co-existing behaviours, the closer they will appear on the spatial plot. So, by way of example Figure 1 shows the *Elderly* are unlikely to be associated with *Child Sexual Exploitation* (CSE), as these points are distant from each other. Conversely, *Alcohol* often co-occurs with *Self-harm* incidents, as such the two variables are close to each other. The spread of the variables indicates three themes.

1. Youth related factors.
2. Elderly related factors.
3. Vulnerable risk factors.

[4] The MASH is a system which has been in England for about 10 years. Evaluations have shown they often find it difficult to manage the demand. It is suspected officers often submit forms to show they have taken action and to remove their accountability should something happen to the individual.

Figure 1: SSA of behavioural themes of Vulnerable callers (see table 2 for explanation of abbreviations)



The most common occurring behaviour within vulnerable callers was *Mental Health* (23%) followed by *Risk from Others* (20.9%) and *Domestic Abuse* (20.7%), which were all contained within the Vulnerable Risk Factor theme. Within the Youth related theme, *Child Under 18* occurred in 17% of Vulnerable Calls, with 3% of calls identifying *Risk from CSE*. The Elderly related theme contained 8.5% that were classified as *Elderly* and 6.9% highlighting *isolation and loneliness.* Of concern is the elderly category (which is a static risk factor), as this is a population predicted to grow across the world. As such, demand will increase in this area unless effective interventions are put in place. The frequency of the risk factors is shown in table 2 below.

Understanding underlying themes allows for more considered training for the police staff, and better partner agency understanding as to problem complexity. This ultimately assists in considering effective responses at policy and practitioner levels.

Table 2: Character Composition of the Three Themes.

Vulnerability theme	Characteristic	1352 subjects exhibiting 2105 behaviours	% of subjects showing behaviour
Vulnerable Risk Factors	Mental Health (MH)	311	23%
	Risk From Others	282	20.9%
	Domestic Abuse (DA)	280	20.7%
	Alcohol	190	14.1%
	Risk to Others	105	7.8%
	Self-Harm	100	7.4%
	Drugs	81	6%
	Learning Disability (LD)	59	4.4%
Youth factors	Child Under 18	230	17%
	Missing from Home	103	7.6%
	Risk From Child Sexual Exploitation (CSE)	41	3%
Elderly factors	Elderly	115	8.5%
	Isolation & Loneliness	93	6.9%
	Alzheimer's & Dementia	61	4.5%
	Disabled	54	4%

The second stage involved the vulnerable caller being visited by a designated lead professional (see explanation of LP in response section). The lead professional would meet and interview the individual to understand the underlying cause of their current vulnerability, the impact it had on them, and what they wanted from the Police/ other agency. Whilst experiences were specific to the individual, the following case studies provide an example of the type of issues encountered.

Case Study 1 related to a young male, who suffered from Asperger's syndrome. His mother frequently contacted the police due to him going missing from the family home. This often occurred following confrontations with his drunken step-father.

Case Study 2 related to a lady who was diagnosed with bi-polar disorder and resided in an assisted living scheme. She was identified by the vulnerable caller team due to the erratic behavior of her alcoholic son. During the analysis phase, it was found they both consumed high levels of alcohol, although the caller was initially reluctant to admit this.

Case Study 3 focused upon a female alcoholic who suffered severe personality disorder. Frequently, the individual would ring the police (and the mental health crisis team) threatening to commit suicide. However, when agencies attempted to help the individual he would become verbally and physically abusive. The analysis found the individual had suffered significant trauma and abuse in her past.

Case Study 4 involved a female who had been repeatedly ringing the police for many years. She shared the house with her two sons (one of which was disabled), her grandson, and one of her

son's girlfriends. Both sons had an alcohol dependency. The family suffered domestic abuse from her husband, (who had been diagnosed with Alzheimer's).

Case Study 5 related to a young male who suffered from anxiety, drug and alcohol use, with a history of suffering domestic violence. Additionally, the individual had been diagnosed with mild mental health issues, although referrals to relevant agencies were often missed. The individual lived with his mother, three sisters and girlfriend. All had diverse needs; for example, his mother suffered from depression and had been the victim of domestic abuse, whilst his sister's children had been taken into care.

RESPONSE

Prior to the initiative being implemented Lancashire Constabulary Chief Officers met with leaders from other public sector agencies across the County, to secure commitment to this approach. This, and other early action initiatives, are discussed at quarterly meetings at Police HQ. They are chaired by a Chief Police Officer and attended by leads from the following agencies:

- Office of the Police & Crime Commissioner
- Lancashire County Council
- Lancashire Fire & Rescue Service
- Blackburn with Darwen Council
- Blackpool Borough Council
- Lancashire Care
- Chorley & South Ribble Clinical Commissioning Group (CCG)
- East Lancashire CCG
- National Health Service (NHS) Blackpool
- NHS Fylde
- Rossendale Council
- Volunteer schemes
- North West Ambulance Service
- Lancashire Youth Offending Team
- Probation Service

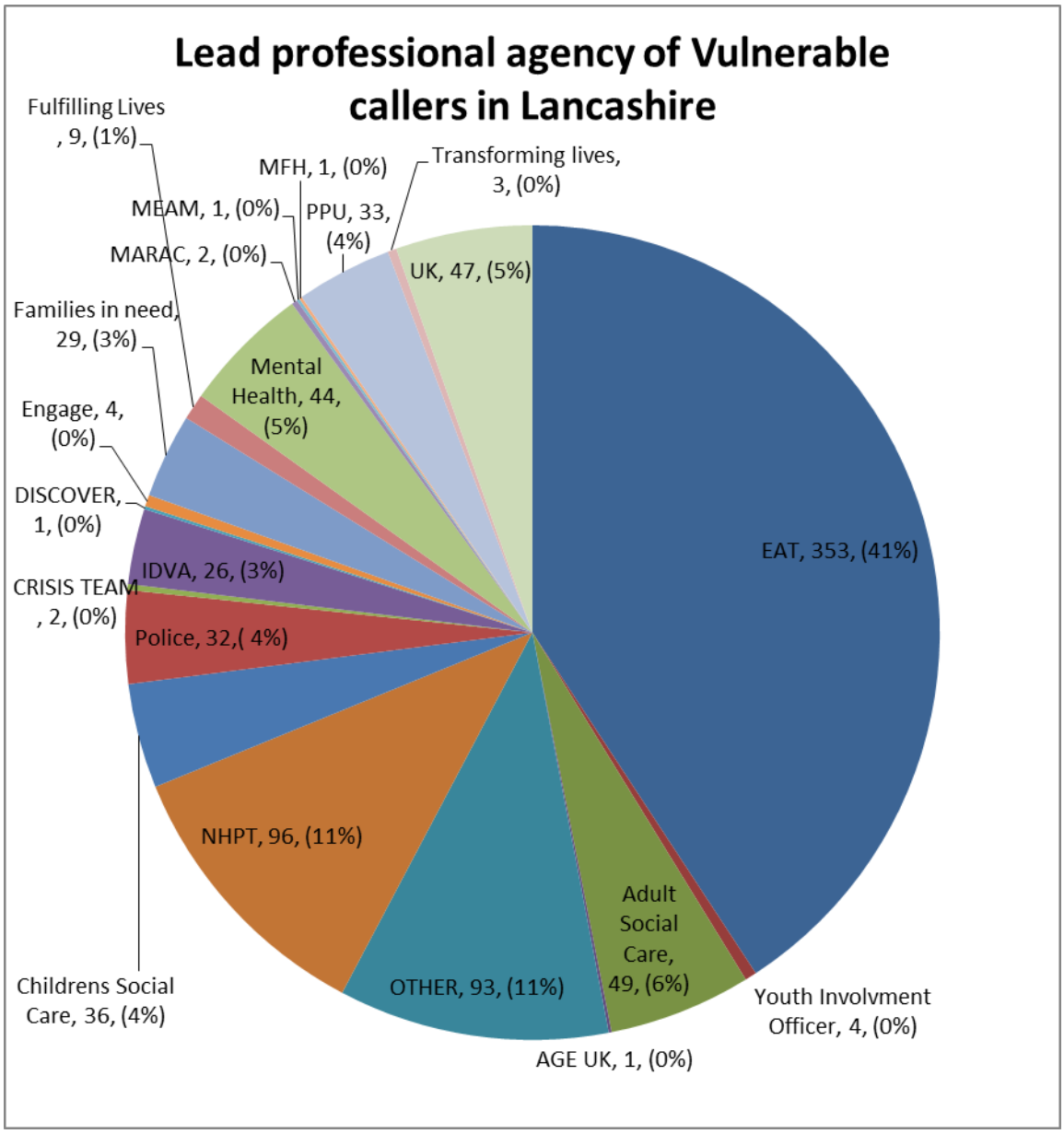
(other representatives attend as and when necessary)

In relation to this specific initiative, once the vulnerable person is identified a Lead Professional (LP) is appointed to coordinate a caller's intervention. Ideally the LP remains in the role for the duration of

the intervention, but in some cases this can change over time. Figure 2 below shows the allocation of LP's on the 1st December, 2016 (n=866). As can be seen the LP comes from a variety of agencies (albeit members of the Police *early action teams* show the largest proportion).

Some of the interventions were relatively straightforward. For example, a significant number of callers (especially the elderly) were confused and called the Police as a default mechanism, not being able to think who else to contact. In the new system, repeat vulnerable callers generated a flag when they contacted the Constabulary. This allowed the Police call operator to access a file note which provided information on the caller and the action plan. This provided advice on how to best assist the caller, often preventing a police or other public sector deployment. In other examples the LP may have placed a prominent note by the vulnerable callers 'phone, reminding them who they should call when becoming distressed (i.e. a friend/ family member/ care assistant). For others, the intervention was more complex and required referral to Mental Health Services or other professionals. It could also require assistance with rehousing, or counselling for alcohol or drug use. For example, in one case an elderly gentleman often contacted the police, complaining about neighbours directing death threats to him. However, it was found that the individual lived in squalid conditions and was hearing voices. Therefore, the allegations around problematic neighbours were dismissed, and he was assisted with re-location to more suitable accommodation (see case study 7). All cases are discussed at monthly meetings with local supervisors.

Figure 2: Lead Professional Agency of Vulnerable Callers.



Key to acronyms:
MARAC = Multi Agency Risk Assessment Conference
MEAM = Making Every Adult Matter initiative
MFH = Missing from Home Team
PPU = Public Protection Unit
NHPT = Neighbourhood Police Team
EAT = Early Action Team
UK = Unknown
IDVA = Independent Domestic Violence Advisors

The following case studies provide further information:

Case study 6: A 61-year-old male, although previously enjoying a senior professional position and a stable family life, had become homeless and alcohol dependent following the breakdown of his marriage. This culminated in domestic abuse incidents being reported to the police, resulting in the court ordering him to stay away from his wife and family home. During and after these incidents, whilst drunk he would often contact police or ambulance services, to seek help or contest the charges. Between 2013 and 2015, after losing contact with his family, he was detained three times under the Mental Health Act due when publicizing disturbed and suicidal thoughts. Moreover, he was reclusive and had let his personal hygiene slip due to his alcohol dependence. Following multi-agency discussions, he was found a place in a Mental Health facility. On his return home, he was supported by a LP who arranged a 6-month alcohol rehabilitation course. He received weekly visits from his LP, who provided additional support concerning depression and alcohol addiction, as well as helping him clean and decorate his home. Contact with his family was reinitiated and he remains sober. He has also had three volunteering roles with third sector organisations, helping other vulnerable individuals overcome their addictions and rebuild their lives after being released from prison. His contact with the LP has now finished as he realized it was no longer needed.

Case Study 7: A 48 year old male, repeatedly called the police for no apparent reason (apart from saying he liked to listen to police radios). Since cataract surgery in 2004, the individual is blind and wary of venturing outside as he feels isolated. Mental health issues are also suspected. During November 2013 to April 2014, this male unnecessarily called the police 565 times (94 times a month), as well as regularly contacting other agencies. It was estimated to have cost the police £33,867. In 2014, a member of the *Early Action* team began to work with this male on a one to one basis and started working through specific needs. One such referral was to a third sector organization, who provided the male with a mentor, enabling him to socialise more. He was also provided with contact numbers for phone lines that were specifically created to support individuals with poor mental health or who may be lonely. In addition to these referrals, the male was provided with a CB Radio which allowed him to contact his brother and listen to the radio, in the hope that this would divert him away from contacting the police. At the time of assessment whilst calls to the police continued, these are much less frequent (9 times a month).

Case study 8: A PCSO used a holistic family approach when visiting an elderly male suffering with Alzheimer's disease. She confirmed the man was receiving relevant support from Mental Health

services and Social Services. However, the PCSO noticed that his elderly wife was herself struggling with her role as carer. The PCSO acquired support via Lancashire Wellbeing Services and n-compass (welfare initiative) and plans to obtain additional long-term support using volunteers. At the time this information was compiled the family had not felt the need to call the Lancashire Constabulary again, as they are receiving adequate support from the appropriate services.

ASSESSMENT

There were four elements to the evaluation:

Calls for Service

To measure potential impact on the Police service, 348 vulnerable callers were randomly identified, (89 omitted due to missing data). This left 259 individuals or families whose intervention commenced before April 2016, allowing post intervention impact to be measured. This was 32% of the total and at a 95% confidence level, provides a representative sample of vulnerable callers. Within this sample:

- 11123 calls were placed to the Police (999 or 101), 6 months prior to identification and intervention.
- 8231 calls were made to the Police (999 or 101), in the 6 months following the intervention start date.
- This shows a reduction of 2892 (-26%) calls to the Police contact management centre. This reduction was not proportionate as 180 of the 259 individuals/families displayed a decrease in the number of calls, whilst 79 individuals/families displayed an increase. The reduction was statistically significant using a paired samples t-test, t (258) = 3.466, $p < .01$.

Police Deployments

The same sample of vulnerable callers was subjected to similar analysis in relation to police deployments. Police contact management logs were counted to collate the number of times the police attended the address of the vulnerable caller six months prior and six months post initial intervention. It must be noted visits by the police at other locations, other than the home address, are not captured in this data, nor does it count the visits by other public sector agencies. Following data cleansing two individuals were removed from the initial cohort of vulnerable callers. This resulted in the known home addresses of 346 families/individuals being viewed in relation to information logs and deployments.

- 1857 deployments at the vulnerable caller's home address were identified during the 6 months prior to intervention.
- This reduced to 1741 incidents in the 6 months, post intervention.

- This relates to a reduction of 116 deployments (-6.2%). A paired t-test indicated no statistical significance (*p > .05*).

The Mental Health subset

It has been hypothesized that different vulnerabilities may generate different levels of need. To explore this, those who were identified as having some level of mental health (MH) issue (including dementia, n= 126) were compared with other groups. Using a Mann Whitney U analysis, it was established:

- Those callers with identified MH issues were significantly more likely to call at a higher rate (M = 38.06, SD = 64.59) compared to those with no identified MH issue (M = 23.30, SD = 45.18). This was statistically significant *p<.05.*
- Those with an identified MH issue had an average 48.49 calls six months prior to intervention (SD = 53.17), which reduced significantly to 38.06 (SD = 64.59), six months, post intervention. This was statistically significant, *t* (125) = 2.090, *p < .05*, indicating that those with MH issues were a group most likely to benefit from an intervention.

The difference in Lead Professional results (comparing Early Action Teams with others)

The distribution of the LP's allows a simple comparison to be made between police LP's and those from other organisations. Within the sample of 259 vulnerable callers with call data attached, 155 (59%) had a member of the police *early action* team documented as their LP at the time of analysis[5], whilst 104 families/individuals had an LP outside the *early action* team.

Table 3: A comparison of police lead professional teams with non-police teams in relation to calls for service.

LP agency	Number of calls 6 months, pre intervention	Number of calls 6 months, post intervention	Difference
Early Action Team	6395	4528	-1867
	Average = 41.3 calls per VC (6395/155)	Average = 29.2 calls per VC (4528/155)	Average reduction of 12 calls per VC (1867/155)
Not Early Action Team	4728	3703	-1025
	Average = 45.5 calls per VC (4728/104)	Average = 35.6 calls per VC (3703/104)	Average reduction of 9 calls per VC (1025/104)

[5] As at October 2016

This shows staff from the police *early action teams* are associated with a larger reduction in the average number of calls post intervention than non-EA teams. However, this difference was not statistically significant, t (257) = -1.112, $p > .05$. This is likely to be due to variances within the groupings (e.g. large variations within the caller group). A longer period of analysis would indicate whether this trend was consistent.

Further analysis was conducted which showed where a member of the EAT is the Lead Professional (166 callers), there is a 16.5% (n= -143[6]) reduction in deployments. For those who have another agency assigned as Lead Professional (182 callers) the number of deployments in the six months post identification increased by 27 deployments (+2.7%). To put it another way those individuals assisted by the *early action teams* show an average reduction of 8.6 deployments, whilst other families are showing an increase of 1.5 deployments. However, although there is a clear trend that *EAT* related callers generate significantly less deployments, this is not statistically significant, t (344) = -1.385, $p > .05$.

Vulnerable Caller Wellbeing Questionnaires.

To establish whether a qualitative difference was being made to the 'vulnerable caller' an assessment framework, known as the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) was utilised. In this process the caller is asked 14 specific questions on topics including: optimism, usefulness, relaxation, interest in other people, energy, problems, thinking clearly, feeling good, feeling close to others, feeling confident, knowing their own mind, interested in things, and cheerfulness. Higher scores gained from the WEMWEBS indicate a better mental well-being than lower scores. *Early action* officers are requested to complete this wellbeing questionnaire on their first client visit and again every three months. The purpose of the questionnaire is to enable service users to think about their mental wellbeing, specifically their happiness, life satisfaction and psychological functioning, before and after receiving support (Putz et al., 2012). Practitioner focus groups highlighted the officers were not comfortable using these questionnaires for two main reasons:

I. As the service users often had very low self-esteem, the officers thought the questionnaire would only highlight and embed these feelings even more;
II. They did not feel that filling out forms, asking personal questions facilitated relationship building.

[6] 726 from 869

At the time of the evaluation only 47 questionnaires had been returned (only 13% of those expected), with only 7 individuals completing the questionnaire on two occasions. Most of the individuals captured in this process were female, with age ranging from 36 to 81 years (average 58 years). Overall, in this small sample, the average score at the start of the intervention was 38, and increased to 42. Based upon total scores, 5 service users (n=71%) indicated that their mental wellbeing had improved, since they first completed the questionnaire, whilst the mental wellbeing of 2 services users decreased (29%). Typically, the scores of the questionnaires showed the improvement in mental wellbeing was highest in the 36 to 56 year age category (Table 4).

Table 4: Overall WEMWBS Scores Based Upon the Age of the Respondent.

Age of Respondent	First Completion	Second Completion	Difference in Scores
36	28	53	+25
45	37	55	+18
47	40	60	+20
56	30	35	+5
58	45	14	-31
81	36	25	-11
82	52	55	+3

CONCLUSION

Police (and public sector agencies generally), across the developed world, are disproportionately affected by vulnerable high intensity callers (also referred to as super users). This study has identified themes amongst these callers. The elderly theme is of specific concern as the projected demographics indicate this population will grow, thereby generating further demand on public sector agencies.

This initiative used an explicit strategy, based upon the principles of Problem Oriented Policing, to both minimize harm to the individual and reduce demand on public sector organisations. The evaluation showed the interventions were associated with a measurable effect.

One counter-intuitive finding was that early action team lead professionals appeared to be associated with a greater impact, even though they had less experience and specialist skills than LP's from specialist agencies. The potential reasons for this were revealed in practitioner interviews / focus groups. Often professionals were constrained by thresholds and treatment pathways, whilst the *EAT's* could take a more pragmatic and problem oriented approach. They explained they were

less likely to be deflected by the caller, and more likely to persuade other agencies to assist in a timely fashion. Overall these interviews found success aligned with five critical factors:

- A clear definition of the underlying cause of the problem;
- An action oriented, evidence based plan;
- Effective implementation;
- Participation of a Vulnerable Caller who can be motivated to change;
- A skilled and committed practitioner who can engage effectively with the caller.

Word Count 3882

Agency and Officer Information

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