'Always on a catch-up': joint working across the police and mental health

Introduction

This case is about the partnership working involved in a Police Liaison Committee (PLC) working in a specific area. The committee involves the police together with health and social care professionals and users/carers involved in the local Mental Health Trust. This PLC was formed from two previous committees covering north and south of the borough, and has been in existence for around 15 years. In the last couple of years, Nicola, a manager in mental health, has taken on chairing the committee and this case takes up the PLC story from that point on.

This partnership works with the tension that society places on the police and mental health professionals of safeguarding the public while achieving the integration of people with mental health problems within the community. At the same time key national policy concerns for the police prioritise their crime prevention and detection role through strict targets alongside their role in public safety. Resource pressures predominate. Both NHS and social services staff also experience the target culture and the pressure on resources this has produced as well as the tensions of achieving appropriate risk assessment as well as good clinical practice for people with mental health problems. Bringing all these tensions together in the PLC sharpens the issues and emphasises the different cultures of these agencies. How the police support the Mental Health Act assessment process is one key activity the committee addressed.

People in this case

From the police:

Mike is a Chief Inspector and the senior management lead on mental health for the borough.

Dan is a Police Sergeant working in the integrated borough operations office where requests for help on mental health issues are routed initially

Bill is the Beat Officer for the area where the key mental health hospital and related services are located.

From the Mental Health Trust:

Nicola manages a Community Mental Health Team. She is chair of the Police Liaison Committee

Janet is the Mental Health Trust's specialist nurse advisor on violence

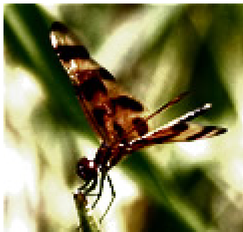
From Social Services:

Mo is a Senior Social Services Manager and the Local Authority lead for mental health. His line manager is a health employee and the Borough Director for the Integrated Mental Health Service. He is located in the hospital where he is also the Trust's social work lead.

Issues in these stories

Mike's story

Mike is a Chief Inspector and the senior management lead on mental health for his borough. He explains that he has an officer who leads on mental health too and they would normally go to the joint committee. As currently if there is no one doing this then he goes. He has been involved for over two years and compares the style of the meetings under the previous Chair:



'the meeting structures were very woolly and the Chair used to start saying 'are we all ready to start the agenda? But if you'd like to raise other issues ..?' The new chair has made it more formal and less woolly – there's a published agenda which we stick to and the minutes come out on time. All that really helps.'

Mike still finds it hard that people turn up late to the meetings which is very much at odds with what he is accustomed to in the police: 'the meeting is for 11am and people are still walking in the door at twenty past!' But he is emphatic that the police are committed to partnership work although 'health get more benefit than we do' and comments on how the new chair, Nicola, works:

'She's got a better grip and we need that structure. It goes well when we talk. We've got to know each other and undertake some business outside the meetings too. For example, when we changed our command and control system our response to requests for police help with community based assessments deteriorated which led to people putting us on the spot in the meeting. I met the Chair separately and we sorted out new arrangements incorporating pre-planned assessments with fixed appointments. I also started a process to fully audit all requests which identified that a significant number of appointments were cancelled by

health staff. I was able to provide feedback at subsequent meetings. Having the panel means we build a working relationship and know who to contact to get things done.'

Mike feels the meeting still needs clearer structures however in order not to become a 'talking shop' rather than a working group:

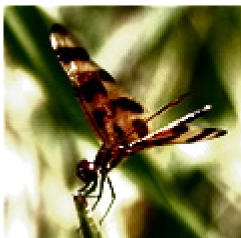
'It's never really been clear who's invited - we get a whole host and variety of people from health. I don't know why they are all there as there's no clear membership and terms of reference. We are the minority, one of us to usually 8 or 9 health people. We don't mind but not sure where they are all coming from. Membership hasn't been discussed, it has evolved. There was an email just today to a whole shed-load of people. It would help just to clarify it. Now there is a service user coming, which is a good thing, but we and the social workers realised she was years out-of-date in what she thought we all did. We had to put her right on some things.'

Mike is moving on to a new post and hopes the committee will pick up an issue he feels is key and which would really help the police to benefit:

'there needs to be a single point of contact in health – we get calls from different bits of health who all feel their thing is a priority. If we had a single person they reported things through we could get a clearer priority set.'

Dan 's story

Dan is a police sergeant who is part of the team which supervises police operations in this area, including the call centre. The work is extremely varied, responding to operational



needs in the area at any time. This includes dealing with issues relating to mental health assessments.

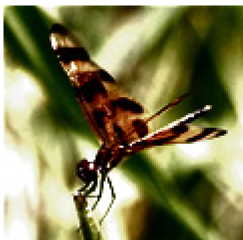
Dan has been going to the liaison committee for a while, three meetings in all. He feels the police have a really good working relationship with the mental health trust. He explains how the idea of the joint meeting together with the approved social work people was to deal with any problems in working together. '*We needed to explain why we do stuff in a certain way, or not.*' It was to create a direct positive link and not rely on phone calls. He tells how the social workers can raise issues which he can then take back to the operations team to sort out and vice versa.

One issue early on was concern over cancelled appointments for mental health assessments. Social workers seemed to feel that the police *'were always cancelling them'.* So the police started to log requests and audit what happened and *'it turned out that health people cancelled as many appointments as we had.'* So although things had been difficult, this led to a new system for appointments being agreed, which Dan feels has much improved the situation and considerably helped working relationships. He describes what happened and what has changed:

'We used to get all sorts of calls, 20 – 25 requests a month. What they didn't know was it meant two hours of paper work for an officer each time. If it was a TSG [Territorial Support Group] call-out [for the most violent cases], that meant 14 officers, an ambulance, and for me a week of my time. Once we explained all this they were surprised. So now they do a risk assessment first, and we are getting about 8 or 9 a month. I can't remember the last time we had a TSG now. It's all really friendly now. We know the system works so we can be more receptive to their concerns – the ratio of attendance to requests is now very high. It saves a lot of resources for all of us. Basically we use the meeting to sort out procedural things. Between meetings I do talk to the senior ASW [approved social worker] if needed. And I know my inspector talks to the Chair of the committee. We sort out a bit before the meeting which of us will go, it varies depending what's going on, but someone always goes.'

Bill 's story

Bill is the Beat Officer for the area which includes the main mental health hospital site and has been in this post for two and a half years (he points out how this continuity contrasts with more senior officers who often stay in post for only 8 or 9 months before moving on).



Bill has attended 3 or 4 meetings of the Police Liaison committee in the recent past but does not attend currently. His senior officer, the mental health liaison officer, had felt his input was not needed. He does attend occasional site meetings at the hospital if required. Bill comments:

'I think they saw me putting barriers in the way. I talk to the nursing staff on the wards and I was raising problems as they and I saw them, from the ground. Especially about assaults on staff which they are complaining about and which I think we could do more to deal with through prosecuting people. I don't think the managers from either side wanted to

go there – too many cans of worms.'

Bill feels his colleague PCs are not dealing properly with mental health issues e.g. they don't liaise with the doctors as they could, but equally the doctors he feels don't want to comment on violent patients and how far their actions are a result of mental illness or not. He recounts an incident where a nurse was bitten badly by a patient who had to be restrained: this was only reported a couple of weeks later and the psychiatrist would not comment on it.

Bill had not been part of the mental health awareness training the committee set up and was sure his colleague PCs had not done it. His overwhelming view of the liaison committee is that it is:

'…where a lot of people are having a partnership conversation but then they don't do anything. There is no feedback down to the PCs and the people on the ground like us. Lots of pleasantries but nothing done or resolved. I can't remember a single email about dealing with mental health in a different way. Meanwhile people are getting assaulted and NHS managers are saying to staff 'what do you expect if you work in mental health?'. The trouble is having mental health offenders in custody is a nightmare – the custody sergeants don't want it, it takes a lot of resources.'

He recognises some of the problems of joint work:

'there's internal 'jobspeak' on both sides! Plus on the wards they should have the joint protocols with the police, but no one ever knows what they are or where they are. We have got them, but it's not surprising we can't communicate.'

He feels there is no cascade of information to ground level to improve things. He comments – recognising openly how cynical he has become:

'Senior managers will only put resources into the performance indicators they are judged by. The clear-up rates for assaults are not affected by prosecuting mental health service users - once we know who it is and agree not to prosecute that goes down as cleared.'

Bill has many stories of assaults, of drug abuse inside mental health premises, of people committing assaults on mental health staff who are not prosecuted and who go on to commit crimes in the local area. He feels the Police Liaison Committee is not able (or willing) to take up these issues at all:

'It doesn't matter what I say at these high level services managers' meetings.'

Nicola 's story

Nicola is chair of the Police Liaison Committee (PLC) and manager of a Community Mental Health Team in the borough. She tells her story of the committee as a partnership across agencies:

'I took over as chair 18 months ago – very formal, very structured and very statutory led.

When I took over as chair, that was really all I was asked to do, was chair the meetings. These were meetings between mental health representatives, social services representatives and the police. Really it seemed a lot of it was to iron out difficulties and try and look at better ways of working together. But the role, what came up, partly as I was interested in it, was the kind of things that couldn't really be resolved in the meetings. So I've ended up doing a lot of extra work outside the meetings, looking at partnerships with the police.

'One-sided meetings'

The meetings were very one-sided, very often one person from the police and about 12 people from health and social care. The people from mental health were senior managers usually someone from an inpatient unit, people from the crisis services or the emergency clinic people drop into or where the police bring people that they pick up under sections of the mental health act, so people from there would come, And then people who manage the approved social work service and that's where a lot of the conflict was happening. Between mental health and the police where Social Workers were trying to assess people under the Mental Health Act in the community and needed police assistance. A lot of the difficulty was about the level of police assistance needed and differences of opinion about risk assessment and sometimes the police were heavy-handed, sending far too many people when they didn't need to and vice versa. At one point there was also a rep from each of the community mental health teams, 4 of them as well as me, and we are all talking about mental health assessments to this one police officer who probably felt quite intimidated and got at. There was also someone for the out of hours emergency duty social work team. And a nurse lead, a nurse consultant dealing with violence prevention in mental health services and a consultant psychiatrist and a manager from the substance misuse service as well.

So very one sided, and a set agenda which I inherited which involved going round with everyone giving feedback on their service and that usually involved them just complaining

about police input or lack of input and when it got to the police they would complain about us. Which I didn't think was very helpful really!

What is the committee for?

Although the PLC meetings have been going on for years I haven't been able to find anything out about, why it was set up, aims and objectives, who was supposed to be there. I spoke to a few people who had been involved before me and they all gave me different views about what it was there for, which is really interesting. So I've written some terms of reference for meetings so we now have got an idea of what we are there for! I've also looked at membership and look at who is and isn't attending. We reduced number of community mental health managers and increased the number of police reps – not easy but sometimes we don't only have one police officer there. Each police division has a mental health liaison officer and that was who came but the person in that role had changed lots of times, at least 3 people since I've been chairing the meetings – and quite often they've had nobody doing that role. Which has been really difficult as unless there is a lead person from the police it's really difficult to get anything done. We've also got a beat officer who covers the hospital area and he attends sometimes which is really helpful. And now there is a sergeant in the integrated borough operations office who takes the lead on requests for assistance and sometimes he comes which is really good as he's much more involved on a day to day level. We're also trying to get someone responsible for missing persons from the police, a special unit – they are due to come but haven't yet.

Getting service users involved

We also looked to involve service users and carers and finally after months of trying to get people to come along have now got two service user reps identified. One of them came to the last meeting. That's been really interesting – having them at the last meeting really changed the way the meeting happened. She was very vocal and had had quite difficult experiences herself with the police in the past, so it was really interesting having her there, but quite challenging for me as the chair, and for a lot of other people, that she was bringing a lot of her own personal experience which was useful. Also someone from the ambulance service will be coming along. I've been looking to get outside speakers to come as meetings can be dull, I want to make them more interesting!

Policies & procedures

We've been working on policies and procedures like the section 136 policy where police pick up someone in a public place and take them to place of safety to be assessed. Has been lots of conflict about 136 and how it's used so we've been looking at the policy. We've also been

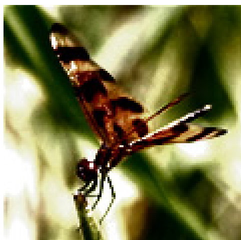
linking in with work being done with London Development Centre for Mental Health on pan-London protocols. So we've been discussing and giving feedback on those and how we can implement them in our borough. And we've reviewed the way we request police assistance at assessments and devised a form for Approved Social Workers to fill in. And out of that came some training for the police, mental health awareness training – I coordinated it for practically all the police officers in the borough from inspectors right down to Community Safety officers. It was really helpful, the police mental health liaison person was really keen at that point and he instructed all the officers to attend so the initial sessions involved him standing at the front in uniform telling all the officers they had to listen to what the Social Workers had to say!! Quite novel… But it was good – I got other workers involved in it and in developing the training pack. So they got to know a bit more about how the police worked and various people got to visit each others offices and see how things were done. The training has fizzled out a bit now – what we had done was an induction session for each group of new recruits to the division on mental health awareness, but that hasn't happened just recently for various reasons – we are looking to resurrect it. I have been to quite a few conferences with the senior police officer to look at how things are done Met police wide, other ways we can work together.

Problems with communication

Early in 2005 the police completely changed their call handling system in the borough – they were a pilot for this and this happened without any consultation. It just happened and then we were told about it. It caused absolute havoc and there was about a month around Dec/Jan where we were requesting police attendance at Mental Health Act assessments and were waiting 3 weeks for a response and so assessments were having to be cancelled over and over again or the police would say they would attend and then not turn up. It was a nightmare. What happened was the calls were being dealt with centrally and not coming through local centre, so we had no way of contacting the people on the receiving end of the calls directly, they were in the next borough so the officers who had had the training weren't involved. Absolute nightmare. I had loads of people ringing me complaining so I collated information about the particular problems and fed it back to the mental health Liaison officer then had a meeting with her and the Chief Inspector to try and sort it out. As a result of that, the police really took it all on board, the seriousness really of the problems, and the system's working much, much better since then. We reviewed the system, updated the forms and are looking at joint training between police and mental health workers and we have a much better system of monitoring how the police respond to our requests for assistance.

Overall it's been really interesting. What's helped me is I've got two brothers who are in the police – they talk to me about what it's like for them, that's helped my understanding and their frustrations really with mental health services . Them feeling they are doing our job, that care in the community is all very well but now they are the ones who are having to deal with what they see as our clients. A lot of the work is about shifting attitudes really, quite often the way we see things are completely different, the structures, the cultures, perspectives of risk are completely different so that's interesting looking at those tensions…'

Janet 's story



Janet is the Mental Health Trust's Nurse Advisor on safe and therapeutic services which means she focuses on issues of violence and aggression and managing these. She works to ensure the Trust, police and ambulance service all come together on policy and practice to ensure the safety of patients and staff. This involves tackling lawlessness and substance misuse on wards and prosecuting where necessary. She runs a violence and prosecution helpline. It involves focusing on staff's roles and supporting them. Her work means multiple links with the police, including being on the Borough Police Liaison Committee (PLC). She is involved in meetings at the hospital about ward safety and crime where custody officers also attend. She sees it as part of her job to help police officers understand more about mental health and has officers work-shadow her on occasion.

Janet comments:

'We now have a proactive and engaged member of the police working with us as mental health lead. Plus whereas before it was mostly about policy development we are now getting to the on-the-ground issues. For example we have just agreed joint training of nurses with police officers on tackling the new issues about 'appropriate adult' as a result of policy changes.'

She recognises that barriers to releasing staff for this may get in the way but is hopeful it will help with awareness on both sides.

Janet feels the PLC has achieved a lot:

'We have achieved a sense of common ground. We are all able to acknowledge the common pressures of all being part of a big system where there is rapid policy change and a mass of developments. We are all always on a catch-up. There are always restraints on our capabilities and resources. And communicating the issues to our massive populations of staff

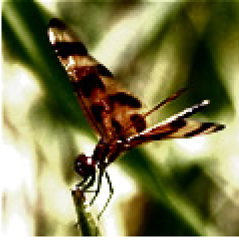
will take years! Only the tip of the iceberg are aware yet. But we do get the transport police and the ambulance people attending and we acknowledge where the system falls down. For example where our services' priorities simply don't link up – there is a policy about people being transported in an ambulance not a police van but ambulance targets and pressures can make that hard to achieve. So we try to support people's good intent and understand their pressures.'

Tangible achievements have also included being nominated for a clinical governance award by the Trust director and the police Borough Commander. Janet feels this really marks the progress made. Also Community Safety Training officers from the police attended a violence and aggression training at the Trust recently and 'had their eyes opened', they reported back to the police that they felt 'privileged' as the level of support and powers they had as police staff compared to mental health staff. Janet comments that there are a lot of myths about what mental health staff can do and in fact staff are pretty vulnerable and often unable to act: 'the police on the training going round the wards saw what we had to deal with and our lack of resource to do it.'

Janet feels the liaison meetings work well since there is a 'respect of each others' profession' and the user/carer representatives, while they attend intermittently, bring in a useful perspective, especially the emotional dimension of what the work is about and the issues of patient to patient violence, not simply patient to staff. The work is hampered by the police lead person not being full-time on the mental health brief 'as it should be'. Overall she feels the police attention to mental health underplays its importance in their work on crime and social order, both regarding criminals and victims of crime. 'They only get an hour on mental health at their Hendon training! Better knowledge and awareness could help them so much.'

The liaison meetings are also notable for focusing each time on feedback about issues raised previously which means both positive and negative results are discussed i.e. 'this worked really well' or 'we need to know what was going on there'. People can then follow up further. 'People feel heard and responded to.' Janet feels the need to take these discussions to the next tier of people below the people on the committee – the decision recently to develop a Trust based Police Liaison Committee will, she hopes, enable this. At the moment they try in the Trust to foster more links between police and staff by asking police officers who escort patients to stay 'for a cup of tea and a chat' before leaving if they can.

Mo's story



Mo is a Senior Social Services Manager who is the Local Authority lead for mental health and has a long history of partnership work in his borough. He is based in the local mental health Trust now that services are integrated and is the social care lead there. His line manager is a health employee and the Borough Director for the Integrated Mental Health Service. Mo also has responsibilities for public and patient involvement, mental health promotion, implementation of the Mental Health Act and was responsible for setting up the current structures of the borough's Mental Health Partnership Board. Mo comments that compared to the early days in 1991/92 'partnership now involves complex sets of agencies. While the police are obvious partners for us, leisure & sports and regeneration are also important for us and our work with users.'

Mo explains how the PLC developed:

'At first we had a rotating chair and went to their premises for meetings. Of course then health and social services were still separate. But when the police were the chair it was frankly a bit chaotic. If people came late to a meeting they found it hard to get into the police station, practical arrangements were not very smooth. Since we have had Nicola, the current chair, we agreed not to rotate it and there has been a lot more consistency which has really helped. We have been able to get regular attendance from the ambulance trust and have also got users and carers involved.'

Mo is very committed to user involvement which 'we have on most groups in the trust'. This is based on a 'pyramid' in which we engage a lot of users at the base of the system and train representatives from this group to contribute to different activities and meetings. He feels the aim on the PLC is to get users to give input on general points rather than on their own specific experience. The police have responded positively to this involvement. But user input needs developing. Mo feels:
'It's not easy for service users. We need more input from them. Perhaps to have a user-focused case or discussion to bring them to the centre of a meeting. I have found having an awayday has helped user reps on other groups. Perhaps we should consider doing this on the PLC.'

For Mo one of the key problems for the PLC has been achieving consistent, appropriate and sufficient input from the police:
'This has been tricky in the past. Being the police mental health lead seems to lead to

promotion! - so we have had a stream of people. It's difficult when someone comes into post who doesn't agree with previous decisions. We had one officer who came in and said "I'm not allowing that!" and there was a stunned silence. But we did complain to the police about that person and it did help sort it out – they were less bullish in meetings after that. The Met generally is now recognising the importance of this role, and paying more attention to it. If we got someone with unhelpful attitudes in future we are an assertive bunch and I think we would complain to someone higher in the Police structures. Our continuity has helped us get it together as a group. Some police officers seem to see this as 'soft' policing and would prefer to be out there catching criminals. They vary and this is why we have got involved in the police training'

The PLC absorbs quite a lot of energy: 'we constantly have to put in work to keep it afloat and working effectively.' Mo talks about the stresses on the police of recent events such as 7/7 and other operational calls on police time that mean keeping their focus on the mental health agenda is tricky. *'So we try to do the small things, such as staff writing to say thank you to the police when they get good support, and giving positive feedback during the PLC meetings.'*

The PLC has also focused on systems and structures in order to deal with the dynamics of the frontline work for all the agencies and shift working in the Police Force which means people rarely can form lasting one-to-one links 'at the coalface'. Mo explains:
'We have got involved in police training for new recruits, although that is now on hold pending a central police training initiative on mental health. We have also prioritised having proper protocols for requesting assistance and for risk assessment. It's one thing having a policy though and another for it to happen everywhere. For example under the section 136 policy, we have agreed everyone should be conveyed to hospital in an ambulance not a police van, but I think there are still people who arrive in a van. So we have agreed to look at look at the stats for this and for other things like the waiting time for police to leave the scene and get back to other duties. This is important for all the agencies. '

'We are also pretty good at keeping each other informed of changes we are having, so they told us 6 months in advance of a police station closing for refurbishing and we are currently informing them about major changes to the emergency services. I think it's a sign of a healthy partnership – no surprises.'

But keeping the trust levels up is a constant challenge: 'it sometimes feels like keeping your finger in the dyke to avoid a deluge!' Explicit risk assessments are key for social workers and police officers in

planning joint work. So these are formalised – information sharing is good as people realise that between them they have better information. 'The police recognise their databases are not foolproof and we as professionals are more open to sharing full information in the cause of safe practice. Confidentiality is still a Gordian knot though.' But in many situations trust is needed for a fast response 'if someone is threatening to jump off London Bridge you can't give 2 days notice to assess them!' The problem for Mo's staff is in keeping up the relationship when they have enormous bed pressures which lead to cancelled assessments, which frustrate the police. For Mo these tensions mean that: 'we have to hang on to the relationships at the PLC level to ensure people at the coalface can work and the system can keep moving.'

Mo feels the achievements of the PLC are to ensure *'when people ask for police support they don't get a runaround, and that we are getting police involved beyond sectioning, to come onto the in-patient wards to support the staff. For example local neighbourhood watch officers are getting involved on the hospital site to support local portering staff and others such as modern matrons. But the Met still sometimes sends mixed messages to officers about what they can do in terms of 'laying hands' on people and they can still hold back sometimes even if staff have been assaulted. There have been particular problems with assessing elders as the police sometimes think that if someone is 80 they are not a risk, although they can be quite aggressive, so then it's hard to get police support.'*

Mo sees the actual PLC meetings as *'a forum to troubleshoot and acknowledge the positive stuff. Usually we get a couple of problem cases brought up and a couple of examples of where something has worked well. What would be nice would be to have more than one police officer, so we can get a broader perspective from them. The Police Liaison Officer usually comes on his own. A huge strength is Nicola's approach as chair – she is so good at conflict resolution and her consistency just makes me realise how important a role individuals play in making joint working work.'*

Issues in this case.

Cultural and procedural approaches to building the partnership

People's views on what has and could further strengthen the Committee and the work of the partnership clearly fall into either procedural or cultural approaches to change. (See Marsh and Macalpine 1995 Our Own Capabilities, King's Fund). For framework - Embedding Change - see Theories

Procedural approaches: for the Committee - Terms of Reference, clear membership, single point of contact within Health, working for more even numbers between the Police and the other bodies (Mike's story); collating information and presenting it to the other side where there are problems. Also building common procedures and agreements about joint approaches to clients/ people with mental health problems. But sometimes these did not work without the cultural approaches too. 'Plus on the wards they should have the joint protocols with the police, but no one ever knows what they are or where they are.' Beat officer (Bill's story) Notably people from the police are keenest on procedural approaches.

Cultural approaches:

Aspects that develop the cultural approach include:

- Building shared experiences, eg. staying for a cup of tea, police 'had their eyes opened' when they heard how few powers Health staff have (link this to Janet's story); Nicola knowing about police experiences through her two brothers in the police
- Spending time outside formal meetings; the PLC absorbs quite a lot of energy: 'we constantly have to put in work to keep it afloat and working effectively.' (Mo's story)
- Having a positive approach: 'We try to support people's good intent and understand their pressures.' and ensuring positive feedback is shared (Janet's story)
- Importance of consistent face to face work – 'continuity has helped us get it together as a group' in health and social care, compared with the police where those attending tend to change. 'How important a role individuals play in making joint working work.' (Mo's story) The PLC offers a face-to-face opportunity for people from very different cultures to explore what they were trying to do and create shared processes. The importance of physically meeting each other and experiencing each others' different realities helped the difficult process of creating shared meaning (Follett cited in Maddock and Macalpine 2006). Notably these points come more from the health and social care people.

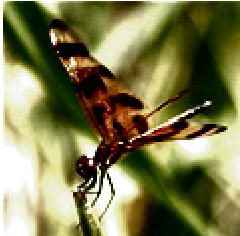
Professional (discursive) differences

As indicated above, the story shows extreme differences between the professionals involved and their professional cultures and assumptions.

Some examples include:

- risk 'assaults on staff which they are complaining about and which I think we could do more to deal with through prosecuting people' (Bill, beat officer) vs. 'sometimes the police were heavy-handed, sending far too many people when they didn't need to and vice versa' (Nicola, PLC chair)

- silence on some issues 'doctors don't want to comment on violent patients …a nurse was bitten badly by a patient ..the psychiatrist would not comment on it.'(Bill, beat officer) vs. myths about what mental health staff can do and 'in fact staff are pretty vulnerable and often unable to act' (Janet, nurse advisor)
- meetings culture: how lateness is viewed (Mike's story), how items are raised and how far action is taken (see differing views of Bill, Nicola and Janet)



The policy to integrate mental health services in the borough across health and social care had been pursued largely without linking the police in, although they are key stakeholders. On the other hand the police also made major decisions without consulting mental health colleagues. The PLC experienced shared training and visits to each other's work as helpful ways to combat these difficulties.

Leadership

The key role of Nicola and her approach as chair of the PLC shines through this story. Not only was her approach key to 'getting more of a grip' in terms of the procedural issues described above, but she also developed the connections between people that helped the cultural and professional barriers: developing work between meetings (see also Hope in the Sure Start story) and helping the PLC forge other links through training and visits. These helped her create more 'common ground' (Janet's story) and shared meaning between PLC members. Nicola's leadership is appreciated and is seen to emphasise the key role of individuals in partnership (Mo's story).

Involvement of users

Positive perspective from police ('a good thing' Mike) and mental health professionals: 'bring in a useful perspective, especially the emotional dimension of what the work is about and the issues of patient to patient violence, not simply patient to staff' (Janet) but also difficulty that some users focus on their personal experinces from the past. Positive approach within the Trust of a 'pyramid' - engaging a lot of users at the base of the system and also training representatives and carers – formed an infrastructure the PLC could draw on.

Communication/wider implementation

The story highlights the difficulty of transmitting the PLC's good work further into member organisations. How can the member organisations really learn and use what their representatives achieve in their joint forum? The need for more communication 'downward' is clear from both Bill and Janet. Bill is especially frustrated as a front line worker that little from his perspective has changed; while managers feel a lot has changed.

National policy: local implementation

The story illustrates some key tensions in translating national policy into local action: the local training is stopped due to national changes; national police targets make unhelpful local changes. Overall the people involved struggle with how to act to reconcile a high profile

national level 'hot topic' i.e. mental health and public safety with a humane local response to individuals in distress, severely ill or at risk.