Herman Goldstein Award Submission 2023

Familiar Faces

Submitted By Supt. David Coxon of Durham Constabulary & Trish Slack (NHS)

Name: Superintendent David Coxon

Email: **David.Coxon@durham.police.uk**

Telephone number**:** 07803032413

Address: Police HQ, Aykley Heads, Durham, UK, DH1 5TT

Name: Trish Slack - NHS Programme lead Tees, Esk & Wear Valley NHS Trust

Email: trish.slack@nhs.net

Telephone number: 0191 4415788

Altogether Better Policing

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Herman Goldstein Award Submission 2022

Familiar Faces

Summary

Scanning

Police calls associated with mental health crisis have risen internationally. This trend is replicated in County Durham where, during 2018, a total of 21831 incidents were recorded, and police detained 161 people for medical assessment (s.136 Mental Health Act). Scanning found a small number of individuals were responsible for many repeat calls, in fact 21 individuals were associated with a third of all s.136 detentions. A partnership between Police and Health services was formed to share and improve the accuracy of information so services could be improved and thereby reduce repeat calls for service.

Analysis

Practitioners from 9 agencies who represented police, health and care professions followed a problem solving methodology to highlight a range of obstacles which led to sub-optimum service delivery. Workshops and in-depth consultation found: a lack of understanding of health terminology and procedures; manipulation by some callers who wanted a specific service; an inability to access appropriate health advice out of hours; ineffective care plans; disputes surrounding identification of priority patients; lack of information sharing; poor agency co-ordination; no effective referral mechanism; and no evaluation.

Response

The 'familiar faces' programme was launched in 2019 to take a multi-agency team-based approach to the problem and continues to date. It is UK National Health Service led with a dedicated co-ordinator and administration. It is supported by a core group representing nine agencies, including

the police. The most significant interventions include: a systematic and tiered referral system; a formal agreement to share information; an inclusive approach when devising care plans; partnership agreement to adhere to the agreed care plan delivery; agreement that no decisions are made without both health and police representation; a joint process to support repeat callers who do not consent to MH assessment.

Assessment

The assessment has been done a number of ways. First, case studies illustrate how the new process for care management plans have improved lives. Second, a quantitative evaluation compares 14 repeat callers 18 months before and after the intervention shows a 69.4% reduction in incidents and a 73.7 % reduction in time spent by the police. Further, police led MH detentions (s.136 detentions) reduced by 50% since the intervention commenced. Also, the level of no further action following these detentions has reduced by 32%, illustrating more accurate identification of need. Finally, when compared with two neighbouring police forces (also covered by the same NHS agency), the reductions are much more significant.

400

Familiar Faces

Description

Scanning

Mental health (MH) crisis has generated increased police demand across the developed world. In the UK, between 2014 and 2018, there was a 28% increase in MH related calls (Jones 2019), and between 2017 and 2020, a 33% increase in s.136 (Mental Health Act 1983) detentions[1]. Research shows MH incidents, that come to the attention of the police, are tangibly different to non-MH incidents. They are more likely to be dealt with as an emergency. Further, sufferers are more likely to be detained and take longer to deal with (average 38 minutes). They are also more likely to be released with no further action taken, and less likely to receive an alternative disposal[2] (CoP, 2020). National increases in demand are said to be caused by an actual rise in the number of people experiencing mental health problems (Mind, 2021); the decline of health provision (i.e. fewer beds and less out-of-hours support); and greater awareness among the public and police (HMICFRS, 2018). All studies relating to this problem highlight the need for police and health services to work more effectively together.

At the time of this study Durham Constabulary had 1214 officers to cover a 527,0356 population. During 2017, a failed attempt to reduce a 34% increase in calls from a MH hospital found police and health staff had widely different perspectives and did not work together to solve the issues. It was

[1] In the UK the police can detain someone under the Mental Health Act if they are thought to be in mental health crisis. The police take them to a place of safety where they must be examined and assessed by a medical practitioner. Often the police officer will stay with the patient until this assessment can be undertaken.

[2] A criticism from health professionals is many of the people detained are not suffering mental illness but have exhibited behavioural problems. In terms of crime and disorder the UK police have a variety of methods to dispose of the case, outside the traditional charge or release. They can issue fixed penalty fines or cautions / conditional cautions. However, there is little evidence of their use in this type of incident.

realised the problem required a more strategic approach and the first stage was to define the problem more accurately.

The Tees, Esk & Wear Valley NHS Foundation Trust (NHS) covers Durham and two neighbouring police force areas (North Yorkshire and Cleveland). In the Durham Constabulary area, the Health Service serves 27,679 registered MH patients with only a small proportion coming to police attention. An accurate identification of where NHS and police responsibilities coincided was not straightforward. In 2018 Durham police tagged 21831 calls as relating to mental health (average 58 per day /11.8% of all police calls). However, health staff challenged these figures, arguing such incidents were interpreted too widely (it included any incident involving someone with mental disorder / mental impairment). NPCC clarified incidents should only be identified as such if MH was core to the incident, or it required the police to do something extra. A 2019 review found the NHS challenge was vindicated as using this criteria MH related calls dropped to 7.4%. Whilst the reassessment provided a more accurate picture of where NHS / Police MH demand overlapped, it did not change the high number of s.136 detentions, which totalled 180 during 2018, each incident tying up two officers on average for 2 hours 54 minutes. MH interventions also have a wider monetary cost:

- A GP surgery visit - £32[3]
- A call to police (111) - £16.00
- Deploying 2 police officers and 1 car per hour - £115.00
- Deployment of an Ambulance - £200
- An A+E Dept. visit £83.00
- Cost of a basic MH assessment - £800

[3] Due to the strength of the $ and weakness of the £, these sums are also similar to the cost in $

- In patient bed - £360.

This cost increases significantly if a patient is detained in another area as costs are borne by the home location (National NHS Data).

To increase the manageability of the problem there was a focus on repeat service users. The police system was unable to identify repeat MH subjects or those who moved between jurisdictions. This created disputes between police and health on which individual should be prioritised. This was rectified by each organisation sharing their data and discussing who should be prioritised for focused attention. For example, a major police concern related to repeat s.136 detentions (see Appendix Table 1), which shows a third of detentions (60) related to 21 repeat individuals.

In summary, poor responses to patients suffering MH crisis increase the likelihood of harm experienced by the subject as well as consuming extra police and health resources. This project brought all relevant partners together to improve MH services, with a particular focus on repeat subjects who come to the attention of the police. It led to three joint objectives:

- Improve outcomes for vulnerable persons in the community, whilst reducing the risk of death or injury.
- Improve sharing of, and access to, information between professionals to better support this vulnerable cohort and those professionals that encounter them.
- Reduce repeat demand for service.

Analysis

During Autumn 2019, the police organised a meeting with NHS managers (both inpatient and community care) and local authority (council service) representatives. This led to a wider meeting involving representatives from Street Triage, Liaison & Diversion, Psych Liaison, A& E, Ambulance

Service, Crisis Team, and Emergency Duty Teams. The police explained the problem-solving methodology to the group, and it was agreed no responses would be suggested for the first three meetings. This became a standing joke, as participants called out 'let the analysis inform the response' when interventions were suggested. During those early meetings, representatives from each specialism were asked to go away and come back with information to assist a joint in-depth understanding of all relevant issues, e.g. the police discussed it at Command team meetings and focus groups. Four further meetings occurred in the following weeks, supplemented by email discussion. A summary of the main points is as follows:

1. The police had limited understanding of health terminology or patient diagnosis. This meant:
    a) Police officers were unaware of the implications / risk surrounding different diagnosis/disorders, the behaviour it induced, or the response that should (or should not) be provided.
    b) Police officers reported they often felt manipulated by the subject. First, the subject was sometimes detained (s.136) because the officer feared personal liability if the subject injured themself e.g. WP[4] reported feeling suicidal when in fact he was homeless and wanted a hospital bed. Second, suspects were released (e.g. assaults in the community or on MH staff), because they claimed/ displayed MH issues and the officer confused mental health illness with capacity surrounding intent. These actions frustrated MH professionals as police actions were contrary to medical advice and often increased /sustained the patient's problem.
    c) Police officers were regularly called out of hours to MH incidents. However if the subject refused to engage with services appropriate support could not be arranged and officers lacked knowledge where to signpost them.

[4] Initials are used for the patients to maintain their anonymity

2. Poor communication meant the police and NHS had little or no understanding of each other's priorities, policies and procedures. Each had unrealistic expectations of the other, leading to frustration and conflict.

3. Analysis of police data found many incident locations included hospitals, GP surgeries, NHS Trust premises, private care providers and sheltered (managed) accommodation. Here the subject would state they were at risk of immediate harm and ask for help, even if they knew this was inappropriate. If staff couldn't provide the specific care requested they either offered/ arranged unnecessary specialist support or contacted the police. On police attendance, the agency often blamed others for inactivity, and the police found it difficult to identify the most appropriate action. This would regularly occur out of hours when the subject knew their individual consultant was off duty. The police would often detain the person and convey them to a MH hospital for assessment. Some recently discharged patients engaged in this behaviour to return into MH care, even for the short term.

4. To tackle disputes between police and health representatives the police pooled their incident and safeguarding data with health data, to determine the top 10 repeat callers. This focused multi agency resources and it became evident there was limited proactivity in relation to these individuals, little co-ordination between agencies, and no information sharing on such things as discharge meetings or care plans.

5. Plans were put in place by single agencies, who often made assumptions about what other agencies should /should not do. For example, police would plan to detain for a mental health assessment, or MH staff would plan for the police to arrest for criminal matters, without discussing their background or aim. Also, when care plans were being developed not all relevant

parties (including the subject) were consulted. This resulted in care plans sometimes failing to incorporate all perspectives, or utilise the diversity of skills, resources, and powers available.

Response

The response was introduced in 2019 and named 'Familiar Faces' to accentuate the coordination of care and support for individuals who repeatedly encountered services. It aimed to ensure a consistent and proportionate response, which aligned resource to need. All partners thought a health professional should lead the programme and Trish Slack (NHS) became project lead, supported by a core group, which included representatives from the:

- Police
- Tees, Esk & Wear Valley NHS Foundation Trust (NHS)
- North Durham Clinical Commissioning Group (NHS)
- Darlington Borough Council
- Durham County Council
- County Durham and Darlington NHS Foundation Trust
- Community Peer Mentors
- North East Ambulance Service (NEAS)
- Emergency Duty Team (EDT)

Other agencies, including housing providers, probation and GPs were included on a case specific basis.

All potential responses were carefully considered. An example as to whether widespread MH training should be conducted across Durham Police was discounted due to a) the cost and difficulty in maintaining the approach, and b) the possibility of officers spending more time with patients and

potentially making an ill-informed assessment of need. The following points summarise the response.

First, it was felt important to take a sustainable and strategic long-term approach which coordinated all partners as a single team. The Clinical Commissioning Group funded the coordinator and administrative support for the programme and their existing Street Triage Team was also incorporated into the programme. The team of three are based in the police control room, between 12.00hrs to 00:00 hours and have capacity to attend incidents with the police. They provide relevant NHS information on patients and general advice.

Second, systems were improved to promulgate consistency, good practice and to prevent issues becoming resource intensive. Referral mechanisms have been improved to care for newly identified individuals or provide additional support to existing ones. Members of the Neighbourhood policing team receive information about all individuals who come to the attention of the police twice for MH. An automated system to track repeat mental health demand is also tracked in the Multi-Agency Safeguarding Hub (MASH). When an individual reaches a specific point a notification is sent to the NHS Access Team who refer it to the Familiar Faces coordinator. Within the FF programme there are four levels of support:

- Enquiry / referral level – to check if a service (i.e police/ health) is impacted upon.
- Becoming Familiar – if involved with up to 2 services
- Familiar Face – 2 or more services are impacted, and a multi-agency plan is required.
- High Intensity User – Even though an FF multi-agency plan is active, the individual continues to impact on 2 or more services. This triggers a review of the plan to identify why the plan is failing and allows strategic oversight of service provision or emphasises adherence to the agreed plan.

Third, a new planning process was specifically designed for repeat subjects, to improve relevance, governance and accountability. Wherever possible, all relevant professionals, including those who worked at repeat locations (I.e. hospital / residence) and the individual are involved. This assists in identifying existing provision and gaps. A formal agreement allows all partners to share information and commit to the plan delivery. As the analysis showed ineffectiveness and inefficiency was more likely when decisions were made by a single agency, the Green and Blue model was introduced. This mandates both green (health) and blue (police) representatives must be present prior to a Familiar Faces meeting being arranged. Joint visits also take place with subjects who are becoming familiar and, whilst not a formal assessment, they inform the early advice going forward. The model works to embed multi agency accountability and assists group members in adding to the plan if additional incidents arise. Those individuals covered by a plan are formally tracked by administrative staff and amendments or discharges are shared across the partnership

Fourth, particular emphasis was placed on helping those difficult cases where the person is not known to MH services or has been previously discharged. Such assistance previously required the individual's consent (rarely given) and a referral from their GP. Other options included a Mental Health Act assessment (although the criteria were rarely met), or an informal assessment by MH colleagues, which again needed the persons consent, and only took place in exceptional circumstances. However, the FF programme now allows for a police and MH practitioners to conduct joint reviews.

<u>Two case studies show how the response can work:</u>

The first case involves a female who visited road and railway bridges and threatened suicide before being detained by the police. Once this pattern was broken in Durham she moved between London,

Edinburgh, Wales and Hull to guarantee her desired outcome - detention and access to crisis care. The pattern was discovered through the NHS data system and police/ health representatives met to assist her and help her to understand the impact of her actions. She began to engage with the Familiar Faces care planning process, which proved effective. Indeed, shortly after the plan was established a Scottish officer contacted the Familiar Faces coordinator as she regularly turned up during the hogmanay[5] festivities. They were delighted to hear she was no longer placing herself at risk.

A further example is BN, who was responsible for a significant number of police and ambulance call outs and A&E admissions. Compassionate officers would often spend hours encouraging her to seek support, which she refused. Unable to use s.136 MHA powers due to the incidents occurring in her own home, repeated referrals to safeguarding teams failed to resolve the situation. Whilst refusing MH services she accepted a joint Green / Blue visit, and whilst declining to view her actions compiled from 170 pieces of police body worn video footage, she was able to understand how alcohol impacted on her health, and the demand it generated across emergency services. Over time she engaged with support, and eventually became a community mentor volunteer. She used her experience to assist others and even spoke at a regional mental health conference.

Assessment

At the start of the project three objectives were outlined (see scanning section), which involved: Improving multi-agency information sharing to support vulnerable people; improving outcomes for vulnerable people; and reducing repeat service demand. These objectives have been assessed continually since the programme started in 2019. In fact, during January 2020, service leads from

[5] The celebration of new year is called Hogmanay in Scotland.

the NHS MH Trust, Police, Council, Social Services, Trust governors, A&E, CCG, carers, and service user representatives attended a two day workshop to assess progress and further improve services.

a) Information sharing

Improving processes and information sharing, for the benefit of vulnerable people, is well evidenced through the programme and discussed at length in the response section. Before, it was common for the actions of well-intentioned police officers to lead to unintended consequences. For example, an officer decided to spend hours with 'PB' every day. Whilst it reduced service calls it diminished available police resources and created more demand when the officer went on holiday. It also frustrated Community MH teams who were attempting to reduce her reliance on support services. The programme now designs and shares a clearly communicated care plan, which directs officers to provide an agreed evidence-based response. This makes it impossible for the subject to persuade an officer into a different intervention and the officer can also consult with MH staff 24/7, who refer to the same guidance.

The Familiar Faces system is well publicised within the force. It has been presented at two internal annual POP conferences, with the Chief Constable encouraging officers and staff to use the process. A multi-agency video briefing has also been provided to all Neighbourhood teams, which provides a detailed explanation of the process alongside its benefits.

b) Improve outcomes for vulnerable persons and b) reducing demand for services

As these two objectives are linked, they are described together. There were tangible service improvements made to people suffering MH crisis. Whilst some plans resulted in immediate positive outcomes, for more challenging clients (more chaotic individuals involving a greater number of

agencies) a number of plan iterations may have been required. It was found the earlier the partnership response the more likely a positive outcome.

The programme generated an unprecedented number of multi-agency plans to be formed for repeat subjects. In 2020 there were 124 enquiries leading to 40 Familiar Faces plans. In 2021 there were 128 referrals and 36 Familiar Faces plan. To 1st April 2022 there have been 30 referrals with 12 progressing to a Familiar Faces plan. The impact of these is assessed in three ways: case study, repeat service users, and overall number of incidents / s.136 detentions.

i) A case study

The response section has provided case studies which illustrate the benefits of the FF programme and another is presented here. WP experienced multiple traumas and abused alcohol to cope. He regularly committed crime when running out of money, and practitioners found him impossible to house due to previous transgressions i.e. frequent parties, failing to pay bills, fire setting and property damage. He was a high user of emergency and urgent care services - usually under the influence of alcohol and was unable to maintain abstinence following detoxification. However, his openness with regards his trauma history brought a compassionate response from professionals, who tried to solve his problems, rather than let him take ownership. Whilst WP thought he was engaging with services, it did not lead to sustained improvement in physical or mental health. When the police respond to incidents (following a crime or his behaviour whilst intoxicated), he often engaged in an act of self-harm or showed that intention e.g. he broke the neck off a bottle and threatened to cut his throat. He has been tasered in the past for his own safety. In such circumstances the police usually take him directly to A&E to have his physical health needs assessed or detained under s.136 and taken to the nearest place of safety. Sometimes he presents himself at A&E following an incident of self-harm and is assessed by the MH Liaison Team. To promote the

possibility of long term recovery for WP, the new care plan had to manage short term risks without reinforcing previous patterns of rescue. A concise summary of the plan is:

- Adopt a caring manner without being drawn into discussions about past trauma.
- Avoid problem solving on WP's behalf.
- Follow usual process, dealing with him as responsible and accountable for his own behaviour.
- Consult before any s.136 detention and avoid admission to hospital as this removes personal responsibility.
- Emphasis on being managed by criminal justice rather than by mental health services when he has committed an offence - even when he has engaged in self-harm or voiced suicidal intentions.

WP was assisted into housing and was helped to develop life skills around home management and budgeting. Following improvements his bespoke individual support was gradually withdrawn. This was associated with threats of harm and some further limited detention. He attended a FF review and he was subsequently discharged back into the community. Over a period, WP started to recognise his personal responsibility and no longer generates police or health demand.

ii) Repeat service users

To monitor the impact on repeat service users, a systematic evaluation was conducted on a random selection of 20 FF repeat subjects. Following data cleansing and the removal of those who had left the area, this left a sample of 14. Table 2 (see appendix) shows the individuals monitored in terms of service provision before and after the FF intervention. Table 2 shows these incidents progressively decrease over time, providing evidence that the individuals spend less time in crisis. When comparing 6 months before the intervention with a 6-month period a year later, there is a 69.4% reduction.

The evaluation also shows a reduction in police demand. Table 3 (see appendix) illustrates the hours and cost of police time spent on the same 14 individuals with a FF care plan. It shows a progressive decrease in officer hours being spent in relation to these individuals following the FF intervention. Specifically, over a 6-month period, one year after intervention there has been a 73.7% decrease in officer time.

iii) All incidents/ s.136 detentions

The next stage was to examine the total number of incidents and numbers of s.136 detentions (see appendix, Table 4). It should be mentioned that incidents were affected by the pandemic. During the initial lockdown period there was an initial drop in MH demand potentially due to subjects not wanting to attend the communal hospital setting. This was followed during 2021 by an expected spike in reports of MH crisis which were more complex in their presentation. This was broadly following the pressures on the NHS and reduced access to GPs. There was a nationally reported increase in MH incidents.

As s.136 detentions are the most significant factor in depleting police resources, this was specifically examined. These detentions reduced by 32%, when comparing the year before the intervention (2018) and 2021. The reduction has been consistent since the programme introduction and even though the Table 4 shows MH incidents rose by 3% during the lockdown period (2021), the s136 detentions reduced by 17%. When comparing the year before the intervention (2018) and 2021 there was a 32% reduction.

One of the benefits of working with the NHS trust is that they work alongside two neighbouring forces. As Table 5 shows (see appendix) there are some similarities in staff numbers and population, so whilst not a scientific control it creates some level of comparison. Table 5 illustrates that Durham

Constabulary show 46% less s.136 detentions than Cleveland and 50% less than the North Yorkshire force.

An important aim for the police is not to detain individuals inappropriately when using s.136 powers. One indicator is the number of s.136 detentions where the individuals is discharged without the need for further MH support. Table 6 (see appendix) illustrates two points. First the effectiveness of Durham police increased with the introduction of the FF programme, as s.136 detentions reduced by 50%. Secondly, in the TEWV MH Trust area, since implementation of the FF programme Durham have averaged 5 such detentions a year, when Cleveland average 52 detentions and North Yorkshire average 39. It is accepted the three police forces are not identical but serve as a useful comparison for benchmarking purposes.

In summary the assessment shows all three objectives have been met. A significant multi-agency partnership associated with MH crisis has resulted in processes and Information sharing being fundamentally improved. This improvement in joint working has been to the benefit of the service user. It has reduced the number of repeat incidents, s.136 detentions and calls for service. These sustainable outcomes for the service user, partner agencies and police have been achieved with no extra investment in police resources

This project, which has been ongoing for 3 years, has taken a systematic approach to improving the provision of police and health services to those suffering MH crisis. Assessment shows benefits to both the patient and the services themselves. Policing MH crisis is a problem faced by agencies across the world and the lessons here are thought to be transferable.

Word Count 3940.

APPENDIX

Table 1: showing individuals with repeat s.136 detentions.

Number of repeat s.136 detentions April 2017- March 2018	Number of subjects
2	12
3	5
4	1
5	2
7	1

Table 2: Number of incidents relating to 14 repeat subjects who suffer MH crisis.

Subject	**18-24 pre**	**12-18 pre**	**6-12 pre**	**6 pre**	6 post	6-12 post	12-18 post
BN	25	34	20	17	11	3	2
A C	25	14	29	15	8	9	2
T S	0	0	0	24	25	10	6
L M	0	0	0	10	3	0	0
D L	5	28	20	55	24	13	*10*
BR	4	0	1	3	6	1	3
MS	7	3	17	4	7	3	0
PB	10	12	7	27	12	20	*20*
LS	19	12	5	7	12	6	9
WP	18	0	0	18	8	33	2
RL	1	1	0	13	95	0	0
DR	20	32	5	32	10	26	10
JD	21	29	20	17	24	22	11
FF	0	0	0	3	4	12	0
	155	**165**	**124**	**245**	**249**	**158**	**75**

Table 3: Showing police officer hours before and after the intervention.

Subject	**18-24 pre**	**12-18 pre**	**6-12 pre**	**6 pre**	6 post	6-12 post	12-18 post
BN	89:52	118:40	59:28	75:05	38:17	1:50	3:56
A C	42:36	24:38	67:03	34:49	11:01	11:26	6:46
T S	0:00	0:00	0:00	89:26	69:38	50:20	5:46
L M	0:00	0:00	0:00	*	*	0:00	0:00
D L	27:13	87:26	34:36	113:29	74:31	16:00	*32:38*
BR	24:40	0:00	1:16	11:32	19:28	2:45	14:41
MS	79:01	16:21	156:41	63:07	46:05	17:13	0:00
PB	25:13	47:04	14:37	80:16	38:04	59:15	*47:18*
LS	40:47	23:05	4:34	15:14	12:10	17:17	11:56
WP	128:25	0:00	0:00	79:12	138:41	42:37	4:43
RL	1:40	1:00	0:00	36:42	302:44	0:00	0:00
DR	90:23	99:47	14:12	111:10	37:58	142:27	23:36
JD	84:40	104:25	65:51	73:17	96:55	202:40	56:16
FF	0:00	0:00	0:00	5:18	2:30	13:40	0:00
Total Time	**634:30**	**522:26**	**418:18**	**788:37**	**888:02**	**577:30**	**207:36**
Cost	**£15,862.50**	**£13,060.83**	**£10,457.50**	**£19,715.42**	**£22,200.83**	**£14,437.50**	**£5,190.00**

Table 4: Showing total MH incidents and s.136 detentions.

Year	Police recorded MH incidents	Police s.136 detentions
2017	17022	163
2018	21831	161
2019	18909	133
2020	16443	133
2021	17036	110

Table 5: s.136 detentions across the TWWV MH Trust area.

S136 in 2021	Jan - Mar	Apr - June	July - Sept	Oct - Dec	TOTAL
Durham Police area (1214 officers, population 527,035)	25	21	28	36	110
Cleveland Police area (1414 officers, population 554,000)	44	65	49	46	204
North Yorkshire Police area (1487 officers, population 824,054)	61	63	49	45	218
Total	130	149	126	127	532

Table 6: Individuals detained under s.136 MHA and released without any further action

Area	**2017**	**2018**	**2019**	**2020**	**2021**
Durham Police area (1214 officers, population 527,035)	18	10	5	5	5
Cleveland Police area (1414 officers, population 554,000)	73	53	70	45	41
North Yorkshire Police area (1487 officers population 824,054)	51	55	52	30	34