AUSTERITY, DECENTRALISATION, AND LOCAL GOVERNANCE: EXAMINING INTERAGENCY WORKING IN THE CONTEXT OF A NEW FINANCIAL MODEL IN THE UK

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Abstract

Compelled by a model of decentralisation and the retrenchment of budgets, regional authorities in the UK have found themselves re-inventing forms to 'do more with less' hoping to cope with an increasing demand for front lines services. In this article, we explore the case of policing and mental health crisis policy-making in North Yorkshire, an intertwined problem that has put law enforcement agencies to deal with a multitude of strange bedfellows. Our analysis of such practices explores how the current financial model shows little concordance with the needs for interagency and problem-solving capacity of the institutions on the ground. We argue that these actors have found three main obstacles to pursuing long-lasting partnerships in light of the current austerity measures: i) the complexity of introducing new governance arrangements and the extent to which they have been formed in relation to specific functions; ii) the capacity for political resistance within organizations to radical change; and iii) the unintended consequences and new demands created by expenditure cuts. The paper builds on comprehensive fieldwork carried out by the authors and provides accounts from police personnel, public services managers, local authorities, and representatives from the voluntary sector.

Key words

Network governance; Police; Mental Health Crisis Care Concordat; Street Triage; North Yorkshire and York.

INTRODUCTION

The economic crisis of 2008 has caused many countries to face up to new and more pressing social problems in the context of a much more restrictive financial framework. Before 2008 government's used the relatively lax international credit regime to fund substantial expansion in welfare spending. In the UK the period up to 2008 was in many ways a golden age with significant increase of spending, particularly in health and education (see Smith 2014). The subsequent economic crisis has resulted in a policy of austerity being adopted in many countries (Blyth 2013; Mendoza 2015). In the UK there has been a conscious effort to reduce and reconfigure the size and functions of the state (see Smith and Jones 2015) and in many ways the government believes that financial necessity will drive reform in the provision of public services.

The aim of this paper is to look a specific case of the ways in which austerity is reshaping the delivery of public services. Through a detailed and in-depth cases study of policing and mental health we demonstrate that there is a residual conflict between the strong desire for reform and the embedded institutional arrangements which make reform difficult. The paper demonstrates that whilst in terms of how services are organised we have seen the development of network governance, there has not been similar institutional adaptation. Consequently, the forms of governance are increasingly out of sync with the patterns of institutional arrangement. In particular, the inability or unwillingness of public sector organizations to rethink budgeting (particularly in the context of cuts) makes radical realignment of service delivery difficult. The paper begins by outlining the macro-political situations, it examines a model of decentralisation and then examines the empirical evidence of

local governance responses to austerity by looking at the management of policing and mental health in North Yorkshire.

AUSTERITY AND THE REALIGNMENT OF PUBLIC SERVICES

The period since 2010 has seen considerable cuts in public expenditure. Overall public expenditure has been reduced from 44 percent of GDP in 2010 to 40 per cent in 2015 (IFS 2015) and of course cuts have not been distributed equally. Some departments such as the Home Office have seen very large cuts in spending of about 20 per cent (see Figure 1). In this context certain services, in particular local government and the police, have seen much more significant cuts with around 20 per cent for the police and about 27 per cent for local government by 2019 (Local Government Association 2013) (see Table 1). Yet the argument that has been developed within the government is that public services can adapt to the challenges of resource constraints by being much more effective and efficient in how they provide services.

FIGURE 1 HERE

Reform of the public services under the Coalition between 2010-2015 and the Conservative Administration from 2015 is based on an idea that market pressures create innovations that produce much more affective service delivery. As David Cameron (2015) has stated:

> Put simply, we proved that you could do more with less. In these areas, our reforms followed some general rules. State monopolies should be broken and

> new providers with great ideas should be welcomed in. Those providers should be paid by the results they achieve. Professionals should be free from central control – but their performance should be transparent and their actions judged against clear minimum standards.

There is a presumption in the government's approach to austerity that budget cuts will drive change and produce more efficient outcomes. This supported by a belief that in many cases satisfaction with public services does not seem to have declined since the economic crisis (see OECD 2013).

The position of the Conservative government is an ideological belief that the state should be smaller and a small state can be more effective in terms of service delivery (Smith and Jones 2015). In other words, through radical thinking, the reconfiguration of services, increased role of partnership and a greater role for the private and voluntary sectors more effective services can be provided at a lower cost. Work with the think tank Reform has been based on developing new and disruptive models of public service reform that use innovative behavioural techniques and digital technology to produce much more efficient public services. Many police forces such as Lincolnshire and West Midlands have been developing innovative relationship with the private sector as a mechanism for re-engineering policing organizations (see White 2015).

This approach to public sector reform is an economistic model which sees necessity as the mother of intervention. Economic constraint is the catalyst of public sector reform. However, what such approach fails to appreciate is both the nature of institutional constraints and the impact of unintended consequences. The austerity model of public sector reform is based on the idea that resource constraint does two

things. One it reduces demand as individuals take increasing responsibility for the own actions (as in Universal Credit and benefits reforms) or they turn to the voluntary sector (as is the case of food banks). The second is that economic pressures produce institutional reforms – so as you cut police numbers the private sector and improved back office service mean that this has little impact on front-line services.

However, this model ignores three variables. One is the complexity of introducing new governance arrangements and the extent to which they have been formed in relation to specific functionality; the second is the capacity for political resistance within organizations to radical change and third is the unintended consequences of, and new demands created by, expenditure cuts. So for example cuts in the provision in one service may not have a dramatic affect if demand is simply shifted to another service, or the improvement in service delivery and outcomes may create more demand. Hence, in this research we examine how austerity is affecting the delivery of mental health service in relation to the police and creating new governance arrangements. We examine how the austerity driven governance affects the nature and delivery of the service. What is clear is that all agencies have explicit commitments to improving the quality of services but they do not always control the outputs that derive from the overall policy framework. The police provide an excellent laboratory for testing the impact of austerity because they have been affected by direct cuts but also because cuts in other services (local government and the voluntary sector in particular) have produced greater pressures on the police in relation to mental health.

As table 1 illustrates the police have seen significant cuts in the number of officers carrying out front line duties. Of course, the problem for the police is that unlike most other services they are rarely in a position when they cannot respond to a

request for help. The consequence of this is that not only are they faced with their own constraints on resources but where other services are cut (for example 24-hour crisis care) then people with a range of problems call on the police.

TABLE 1 HERE

In principle then the police are faced with increasing demands at a time of reduced resources. It is estimated that police interventions involving individuals with persons with mental health illness can use up to 87% more resources than interventions involving non-persons with mental health illness (Charette, Crocker and Billette 2014). This increasing demand as a result of austerity is, however, layered on top of a longer term trend for the deinstitutionalisation of mental health which means mental health issues are increasingly dealt with in the community. Police officers have frequently found themselves in situations where they, without proper training, are making judgments about whether people go into medical treatment or the criminal justice system (see Lamb, Weinberger and Walter 2002). Scholars Normore, Ellis, and Bone (2015, p. 2) make an important point:

> As persons with mental illness and law enforcement becoming frequently entangled, the collaboration between mental health service providers and the police has become critical to service the needs of those individuals facing crises (Watson and Fulambarker, 2012). This has caused several progressive agencies to break through traditional barriers and develop better connections to other entities serving the aforementioned groups where collaboration leads

to increased problem identification and adequate responses to issues affecting cities throughout the USA (Borum, 2000).

Hence, there are strong pressures both in terms of changes in the treatment of mental illness and cuts in service provision to change the way that police approach mental illness and develop a collaborative approach. At the moment police are spending considerable time on mental illness firstly because of increased demand but secondly because when the police are dealing with issues of mental illness they often fail in recording incidence and referring them on to other services and as a consequence demand is very difficult to control. Hence, there is a strong requirement of interagency working as a way of better managing mental health incidents and ensure that people who need help receive treatment rather than being processed through the criminal justice system or left to their own devices. However, as the paper demonstrates whilst there is a strong rhetorical commitment to interagency working, and a number of examples of good interagency practice, the reality is that institutional constraints, or more particularly an institutional misalignment, provide a strong restraint on the austerity pressure for innovative forms of interagency working. The rest of the paper highlights the difficulty in using economic pressures as a mechanism for reforming public services.

One of the central features of the 'austerity rationale' is that has resulted in a considerable push for the localisation of service delivery. This is partly related to the broader devolution agenda (see Richards and Smith 2016) but is also independent. The rationale is that local services have better tacit knowledge for dealing with the problems they face (see Zurbriggen 2016) and so are able to develop innovative solutions in the context of budget pressures. Theoretically, Cameron's 'big society'

narrative to modernize its administration and public services in light of the austerity age has followed a mixed between traditional and non-traditional rationales to Conservatism. While at the core of the 'big society' rested on the reduction of the state –at whatever unorthodox means- the overall Conservative strategy for cutting public spending meant more social enterprise and more private sector dependence for societal service delivery (Smith 2010). Since the Coalition governments, the remorseless and continuing cutbacks have led police numbers to fall to levels similar to those seen in 2001. Authorities have find suitable to decrease the size of the police forces as crime continues falling in the UK (Newburn 2015). In other sector, despite the electoral promises of maintaining of even raising social and welfare spending, the Conservative's promises have 'watered down' (Smith 2010, p. 827) as the financial crisis put the party's in a stalemate stressing a lack of ideological coherence and policy consistency (Kerr and Hayton 2015, Dommett 2015).

As Stoker (2011, p. 7) noted:

> Networked community governance frames issues by recognizing the complex architecture of government. In practice there are many centres and diverse links between many agencies of government at neighbourhood, local, regional and national and supranational levels. In turn each level has a diverse range of horizontal relationships with other government agencies, privatized utilities, private companies, voluntary organizations and interest groups. The model retains a strong role for local government as a coordinator in order to join up and steer a complex set of processes.

We argue that austerity and the shift to complex governance has brought more confusion than clarity to the partnering of services. Such perplexity has occurred in

light of the growing demand for intertwined public services that have caught both central government and local institutions under a financial model for providing services that does not match reality. There is a lack of consistency in the top-down steering from government; while on the other, there is an incongruence of institutional objectives that impedes agreement on bottom-up policies. The problem is that these developments have often been contingent rather than statutory and consequently governmental and institutional responsibilities are difficult to define, most notably, when in face of policy issues demanding complicated and interlocking policy responses.

The austerity rationale implies that public services need to improve performance while demanding less resources (Hood and Dixon 2015). To do so, the Conservatives have refreshed the Thatcherite New Public Management (NPM) style of strong 'managerialism' through a 'hard-headed, business-minded, cost-conscious, and data- driven approach to government makeover' (Hood and Dixon 2015, p. 15). Thus, and hand in hand with decentralization, came a budget-driven approach. Government focus now is very much on the costs of policy, whilst at the same time shifting in governing and delivery responsibilities to local authorities who become responsible.

AUSTERITY AND LOCAL POLICYMAKING

Decentralisation – within a national framework – has been seen as a mechanism for reconfiguring public services within the context of austerity. This is partly about more effective policy making but also about blame shifting (Hood and Dixon 2015). Responsibilities for policymaking in the communities have encouraged regional stakeholders 'to develop local policies, in response to national policies' (O'Driscoll

2007, p. 124). A good example is the issue of policing mental health related incidents. A governmental policy called the Mental Health Crisis Care Concordat, established in early 2014 by the Department of Health and the Home Office, set up a broad framework for recurring practices between health staff, police officers, and other mental health professional (HM Government 2014). The Concordat placed policing within a form of network governance occurring within a plethora of actors outside the boundaries of the criminal justice sector. It was intended thus to create a framework for a multi-agency approach to service delivery.

The key problem is that, particularly with cuts to services, police officers frequently attend incidents where it is suspected that a person may have mental health issues (in other words where there is service failure a police officer may find him/herself dealing with an incident that may have nothing to do with criminal justice). Officers then have to assess what is the best pathway resolution to that person ranges from the emergency crisis teams, ambulance personnel, hospital nurses, carers, general practitioners, community psychiatric nurses, and family members only to name a few among a list of endless points of help. The core problem here is that the service which is often called to deal with issues of mental health has little training for dealing with the problem and this mishandling of issues can exacerbate the situation or result in the wrong solution. For instance, police officers have little knowledge in terms of assessing suicide risk and may spend considerable amount of time with a person they deem at risk which would not necessarily be the case with a mental health professional. The concordat is meant to resolve this problem by improving interagency working and making police officers more conscious of the needs of those with mental health problems. The belief is that this will reduce costs by resolving

mental issues through correct interventions rather than allowing people to end up in the criminal justice system that can exacerbate and prolong problems.

The next section of the paper aims to provide evidence that austerity driven local governance is a long way from accomplishing the objectives of decentralisation under the current financial model. By exploring the case of the policing practices for mental health incidents we argue that local governance is stalled by three obstacles: i) the complexity of introducing new governance arrangements and the extent to which they have been formed in relation to specific functions (Stoker 2011); ii) the capacity for political resistance within organizations to radical change (Lowndes and McCaughie 2013, Bogason 2000); and iii) the unintended consequences and new demands created by expenditure cuts (Dunleavy 2015). Before we concentrate in the analysis of these factors, we set out briefly our methodology used during the data collection stage.

POLICING AND MENTAL HEALTH SERVICES IN NORTH YORKSHIRE

In order to examine the empirical evidence of the austerity measures in local governance we looked at the management of policing and mental health from a perspective of North Yorkshire Police. The paper uses data collected from different sources of information, both oral and written. The research is part of a larger inter-disciplinary project looking at the reform of policing practices and that includes the delivery of training and an academic review of organisational practices. The core narrative driving the study was taken from elite interviews conducted with policy decision makers from services across the region carried from September 2015 to March 2016. Even though North Yorkshire is divided is different local authorities and public services are scattered across its topography, the police force is a unitary

institution that faces common challenges of interagency governance with the wide spectrum of services being delivered in the region (see Figure 2). In order to take consideration of this broad range of services and their relations with the police force, we aimed to conduct unstructured interviews with decision-makers from the most representative policy sectors (see Table 2 for a detailed account). We also conducted research acting as observing participants in public and private work meetings where policymakers from different fields gathered to discuss the provision of best practices for mental health. In order to complement their stories, we used cross-checked with governments documents and other regional public services reports.

FIGURE 2 HERE

TABLE 2 HERE

DECENTRALISATION, AUSTERITY AND LOCAL NETWORK GOVERNANCE

First obstacle: Introducing new governance arrangements is complex, much more in a context of austerity

When the Coalition government introduced the Mental Health Crisis Care Concordat, policing institutions across the United Kingdom were required to abide by a new set of policy rules. The government's idea that a broad programme would improve practices in the police and the health sectors was certainly well intended. However, the current model of decentralisation in the context of austerity suggests that it was

more difficult than policy makers expected. When thinking about introducing new governance arrangements, two factors need to be taken into consideration: first, the degree of autonomy and decentralisation that reigned previously, and second, the disappearance of incentives (mostly budgetary) as a consequence of austerity.

The Concordat was introduced as an umbrella type of policy. It was informative regarding policy reform, but lacked detail in terms of specifying how policy was to be implemented. The Home Office, sticking to its hands-off, decentralised approach, relied on the regional authorities to fill the execution side by encouraging them to agree on their own priorities and processes to assess to mental health crises. In a sense, the Concordat was so extensive that it made it difficult for autonomous regional actors to deliver actions expected by the centre (Smith, Richard, Geddes and Mathers 2011). For the police, such situation is paradigmatic. The Crisis Care Concordat's chapter for North Yorkshire and York was organised as a tier structure composed of five different levels where a multitude of public services were represented, including those in the policing and mental health deliver and response network presented earlier.

FIGURE 3 HERE

The Concordat's streamlined structure aimed to promote collaborative and inter-agency responses from the institutions involved. Guidelines for policy were to be steered from top to bottom, however, consensus and co-ordination for policy delivery remained a matter belonging to the horizontal relationships created in each tier. The overall structure favoured increased deliberation in the decision-making. However, the institutional complexity of trying to arrange network governance became an an obstacle to policy implementation. Local actors struggled to overcome receding and

constrained budgets, organisational remits, hierarchical and layered bureaucracies, and their different interests and expected benefits from partaking in such governing engagements. Such obstacles to network governance have been further undermined by a lack of steering dynamics to stimulate policy cooperation. Network governance has turned then to depend on the trust put in informal personal relationships. However, these have not embraced an established delivery of governance practices.

Police authorities to some degree fit uneasily within the network since almost all other Concordat's signatories are either health policymakers and managers or officials in local authorities. On top of the governance structure sits the Health and Wellbeing Board compromising high ranked officers at a strategic level. All the way down the next tiers, police representatives assist to meetings and workshops to debate and agree better practices. These meetings are led currently by a senior manger from the Partnership Commission Unit (PCU) that embodies the four Clinical Trusts providing health services in the region. Initial policymaking efforts seemed very straightforward as other actors were keen to see the police take a lead in the discussion and potential execution of new practices that blended health and policing services. A senior PCU representative highlighted the latter situation.

> If we are talking about urgent care, absolutely the police should be there because they play a very significant part.

Another health policymaker argued in the same line.

> The police are often the first people to see somebody in crisis, so it makes sense that they actually consider how effective they are at being able to support that person.

Police participation in the Concordat came as well to put greater focus on discussing what role the police delivers today in public services. For instance, local authorities would press on the issue that police officers are moving away from a criminal justice perspective to a social care responsibility. The issue was highlighted as well by managers in the Police and Crime Commissioners office.

> Vulnerability is massive for the police force so I suppose the public would perceive that the police force's work is about finding criminals and detecting crime, but it's far larger than that, and wherever someone has a need or has a concern for someone and doesn't quite know how to address that, they will often call the police.

Another member of the PCC would argue in a similar way.

> Police are really risk-averse, so if they are presented with a problem with an individual that appears to be vulnerable, they feel that they have to resolve that issue, and they are risk-averse to walking away from that scenario.

Nevertheless, decentralisation and austerity came to play a big part. Because all related actors in the Concordat enjoyed so much discretion in their own services, the fact that budgets were being reduced, and some of its services were doomed to disappear or be reformed, finding agreements on shared services was difficult. In

fact, early on those police officers participating in the various policy meeting called by the Concordat realised the difficulties of agreeing on policy priorities and moreover what role should the police take on such endeavours. A high ranked police officer argued that many mental health crises should not fall strictly in the services provided by the police.

> For somebody with a mental health issue, for example, the policing involvement should be really relatively limited, even when they have committed a crime. A medical intervention is a better intervention than a policing or criminal justice intervention

Table 3 succinctly puts the most relevant issues that police officers evidenced when participating in the Concordat's governance structure.

TABLE 3 HERE

Police accounts revealed that austerity was hindering an effective compromise on the nature and form of service provision which was seen to be creating greater demand on an already struggling police force. Officers would often express frustration, anger, powerlessness and resignation with the referrals to the health services. As it occurs elsewhere in developed countries (Martin and Thomas 2015). In North Yorkshire, police personnel argued that emergency departments are reluctant to assess people in crisis that do not meet criteria for admission, or if admitted, they are quickly discharged. Thus, the question remaining is what should the police do with them. Because the police admittedly sat in the Concordat, it quickly brought the unexpected

consequence that some of the agreed outputs demanded extra resources from their part. To some interviewees, this reflected on the police feeling of duty towards those in need. One interviewee from the PCC mentioned,

> Police are really risk-averse, so if they are presented with a problem with an individual that appears to be vulnerable, they feel that they have to resolve that issue, and they are risk-averse to walking away from that scenario.

Second obstacle: Resistance within organizations opposes to novel forms of governance, more so in a context of austerity

Besides its participation in the Concordat, North Yorkshire Police had begun an internal review process of what aspects were essential to improve when handling the issue of dealing with mental health related incidents (see table 4). In part these weaknesses were in line to other forces being reviewed. In 2013, independent commission reviewed the Metropolitan Police Service policing and health practices and found three areas of most concern: leadership, the capacity of frontline officers, and interagency working (ICMHP 2013). North Yorkshire police went along and identified its own weaknesses. These were mostly in the identification, recording, response, referral and review of its mental health policing practices. Again, decentralisation and austerity have impacted on service delivery. North Yorkshire Police's attempts to overcome their lack of skills to identify and handle mental health incidents are costly and required extra resources that were not an item in the previous budgets. As well, because the police forces in Britain are regional institutions, the lack of centralised common protocols or guidelines towards addressing mental health became and issue that demanded extra resources as referral pathways to the health

services changed abruptly according to geographic patterns that did not necessarily match those of the police constabularies. Both local authorities and health policymakers would nonetheless highlight the lack of tools that current police officers have to deal with mental health issues. One local authority mentioned the following.

> Eighty per cent of their (the police) work isn't crime related, it's social care related. I don't know what the proportions are, but the vast proportion of that will be mental health. Well, are the police trained adequately in identifying and recognising that?

TABLE 4 HERE

Mental health problems including substance misuse and physical conditions require both emergency and routine care delivered by a mixture of public and private organisations (Rekrut-Lapa and Lapa 2014). However, to a large extent, caring for people with mental illness takes place outside of institutional care. Because the government has pressured to raise the threshold for when a person should be admitted in hospital, the people not reaching such levels are left to the care of the community sector. Truth is that people tend to rely on the police rather than on these services once a crisis is occurring. The gap between old requirements for been treated by the secondary care sector has undesirably fallen in the remit of the police. As well, assistance from the police is be required to commit the patient to a hospital for continued psychiatric treatment. Such issues were discussed by a NHS crisis services manager.

> The police are showing a much wider interest in the health status. Not only with street triage and urgent care but they're also interested in safer neighbourhoods for people with dementia, and safe places for people with learning disabilities. That feels healthy, because the community patch is the police. When you think about being safe in the community you think about the police.

Police officers desire greater cooperation with psychiatric care personnel and want to know more about mental illness and how to approach those with mental illness (Erdner and Piskator 2013). The literature examining mental illness training programs delivered to law-enforcement officers favours training using realistic "hands-on" scenarios (Krameddine and Silverstone 2014). However, creating empathy, communication skills, and the ability of officers to de-escalate situations takes time and expensive resources. A member from the voluntary sector argued that training for the police should be provided by those organisations with a greater expertise on mental health.

> I am aware that the police's main priority is the safety of the individual and community and I think it's about how do we equip the police to be more aware, more understanding, more empathic to people with mental health problems whilst still enabling them to do their job.

A local council authority put it in other way.

> The police are often the first people to see somebody in crisis, so it makes sense that they actually consider how effective they are at being able to support that person.

Even though, the Home Office was committed to the Concordat and expected that its policy agenda would come from the regions, it did not consider that public services, most significantly, the police forces, would have to re-think their policing practices and consequently come up with extra money to sort them out. More so, resistance inside organisations became difficult to overcome (see table 4). As it has happened worldwide, these are strange practices to the police that require time and political will if any change is to expected to happen (Herrington and Pope 2014).

Third obstacle: Unintended consequences and new demands created by expenditure cuts further stress local service delivery

Because police officers have embedded in the response from public services to mental health incidents, their resources for this kind of interventions has risen in time, human personnel, and material resources. Studies in other developed countries have shown a trend that police interventions involving individuals with mental health illnesses can use up to 87% more resources than interventions involving the non mentally ill users (Charette, Crocker and Billette 2014). Experiences worldwide have proposed various frameworks relevant to policymakers across the public sector in order to draw the map for a collaborative mechanism between levels of policy. The key component identified has been the role of an integration coordinator: a person who is able to facilitate relationships and ensure effective information flows. North Yorkshire Police

has followed such model piloting Street Triage teams where police officers attend incidents in conjunction with a nurse or paramedic who acts as a liaison to the health and crisis services (see table 5). A member from the voluntary sector was keen in seeing clinical personnel working inside the bureaucracies of the police as the most recent Force Control Room Triage initiative aimed for.

> You need specialist trained mental health workers to be part of the police force and not working in partnership with them but actually in the police force.

However, having in house clinical personnel and the triage experiences are costly and a big part of the resources come straight from the police's pocket. This, despite that they are taking a wider role in services that should be provided as well, or at least financed in conjunction with the health sector. For health managers, however, the situation is different as they benefit from the spill over of services.

> When we get something such as street triage, which has a huge positive impact on one agency, the police. However, we also have secondary gain through inter-mental health services.

The triage initiatives were aimed to lower the number of detainees under the Section 136 Mental Health Act 1983. A recent report on the Scarborough, Whitby and Ryedale (SWR) Street Triage pilot found no support for that idea 'though the rates were already low' (Irvine, Allen and Webber 2015, p. 2). Police staff try to avoid taking vulnerable adults and children into the custody suite and have arranged a Section 136 Suite with qualified personnel in a clinical environment. However, when

other services are not available to support them custody seems the only option. As it happens in other constabularies in England, the lack of shared information between the police and other other agencies from the healthcare services 'has meant that police officers often respond to vulnerable individuals, and make decisions on whether to arrest, with little background knowledge of the individual's circumstances' (HMIC 2015, p. 18). From January to September 2014, out of the 255 people detained in North Yorkshire under the mental health act 57 per cent were taken to 'places of safety', 13 per cent to accident and emergency units, and 30 per cent went into custody. Even though there have been resources spent in places of safety in two regional hospitals (£400,000 in York's Bootham Park Hospital and £250,000 in Scarborough Cross Lane Hospital), police gets referrals refused mostly when detainees are considered too violent, and sometimes when units are full (Liptrot 2014). The different Triage initiatives in North Yorkshire have been intended to resolve this situation but budgetary constraints create uncertainty over whether the services will be retained in the long term and mean that the form of integrated services is effectively a temporary measure depending on ad hoc funding.

TABLE 5 HERE

The interagency policymaking amongst police officers and other crisis services has resulted in positive and negative outcomes for local governance. The police's enhanced awareness of how other local services has decompressed the burden of their services. As well, initiatives like the Street Triage have diverted people from going to crisis services, emergency departments, or inpatient hospitals. However, local network governance has been challenged by the disadvantage of certain actors in

relation to pre-stablished policy networks. The NHS health community has achieved over the last decade a greater inter-agency collaboration between practitioners and managers (North 2001). These linkages have not translated into working with other actors such as the police, or the local authorities in councils and districts. Organisational characteristics, accountability structures and resource limitations have hindered the integrated front line delivery of mental health. One senior police officer was able to identify at least two consequences of such an issue.

> We don't have that strategic buy-in, we're not using the power of commissioned services or commissioned funds jointly so the commissioner in North Yorkshire has quite a significant amount of money to put into commissioned funds. The health service has a lot more money to put into commissioned funds. If those were pulled and targeted, then I think that could be more effective. Tactically, we're not sufficiently joined up, we should be closer aligned.

The de-centralised and pluralistic decision-making in sectors such as health, community services, and the voluntary sector has clashed with the more hierarchic and centralised approaches of public actors such as the police and other emergency services. A typical result of the latter situation is that actors end up agreeing policy programmes that once in its delivery are very hard to pull together.

ANALYSIS AND PROPOSALS

Breaking with the old: Austerity and the Decentralisation of Policymaking

This paper illustrates the difficulty of using austerity as a driver of political reform.

There is little doubt that in our case tighter budgets have forced agencies to work together in order to find ways of improving service delivery with reduced budgets. The joint working is complex, multilayerd and to a degree overalapping. As we have seen, the devolution of policymaking, the reduction of central bureaucracies, and the abolition of top-down accountability has produced that local governance is now conducted more seriously through the steering of new regional boards, quasi governmental agencies (quangos), and fora for policy programmes that agree locally what needs to be done in the front line of services. For the public institutions this has meant that novel sets of rules brought have started to apply. For the case of North Yorkshire, the mental health and policing practices were rebooted as this new forum started to stress the need for pre-established institutional practices to readjust both to the new bodies on higher levels of strategic policy, as well as in response to the changing horizontal relations that police had have from before or those that were established in the recent years. For instance, North Yorkshire Police has a long standing relation with council and local authorities, however, with the voluntary sector, it has only recently agreed on information exchange frameworks. Ironically one of the impacts of austerity has been to reduce central government's role in steering. A set of horizontal arrangements have begun to develop but there is stress in the system because of a lack of clear central strategic direction. Local governance networks are having to fill the vacuum and develop mechanisms for steering policy. In the current scenario, it is difficult to forecast from where the power to enforce such relationships will come, and also, if institutions will abide in light of the myriad of heavy weight actors (such as the NHS or even the police) who are currently interlinked in the different areas of public service.

Flexible institutions and coping with the new: Austerity and Policy Delivery

The paradox of austerity is that whilst the pressures of budget cuts are intended to create pressure for better joined up government, actually cuts in spending can have act as a major constraint on joined up government. The case of North Yorkshire's police has illustrated both the positive and negative impacts of austerity driven decentralisation. There are now structures in place and a strong willingness to improve joint working. Police co-allocation in 'safety hubs' has become essential as the demand for better cross-service assessment of anti-social behaviour has increased upon local authorities. However, police participation in these multi-actor forums brings unintended consequences for the good and the bad of law enforcement agencies. On the one hand, police agencies are encouraged to coordinate short term responses to complex cases of community safety. However, it has enlightened the fact that the decision-makers inside the force might lose accountability, communication, and the steering of their own resources, as local hubs get more intricate, independent, and institutionalised. Still, and on the bright side, decisions are often made together and there is a recognition across different agencies that solutions can only come with shared working. Through street triage and changes in operations, for instance, medical staff are often working with police personnel. However, there continue to be significant problems. There is a lack of a single authority able to make decisions and consequently, each decision on partnership is contingent, ad hoc and usually time limited. Budgets are not shared and so there are conflicts over who pays for which services and many of the joint working activities are paid for out of temporary sources of funding. There are still problems over data sharing – even within organisations with for instance the police having different systems for recording incidents. There are also significant overlaps of service provision spatially and a lack of clarity in terms of who has responsibility where. Ultimately, attempts to reconfigure services

shift patterns of demand without shifting budgets which results in agencies attempt to protect their services rather than create a joined up approach to mental health.

The research has brought to light that policy actors tend to fence their budgets and local collaborations are being restricted to specific and circumstantial sets of policies. Policy actors in the regions should expand their budget and organisational boundaries to create more intertwined services responses and financing alternatives for when new cuts come. In a sense, to cope with the new scenario of local governance under austerity and financial uncertainty, public service institutions should arrange for rethinking the old and proven ways of delivering services with the new untested formulas.

CONCLUSION

We have discussed in this paper the idea that new governance arrangements, resistance within organisations, and the unintended consequences of expenditure cuts have become three identifiable obstacles of local governance occurring within the context of an austere and decentralised Great Britain. The fundamental problem is that in the case of mental health, austerity driven policy is asking local service deliverers to take more responsibility for how services are organised on the ground. Within the legislative context, local services have considerable alternatives. This has led to some innovative policy approaches such as street triage and safety hubs. However, it does not propose a sustainable approach for local actors to purposefully assume co-delivery responses. The current model does pull public services on the ground closer, however the lack of synergy in the front line delivery is still handicapped by budgets and organisational constraints that seem hard to change as institutions embrace further cuts. We suggest then that local governance is capable of turning into a myriad of

self-governance arrangements answering only to institutional remits. Opportunistic solutions can cope with the model of cuts and decentralisation, however, the long term consequences of such dynamics will certainly inflict on the capacity of local institutions to allocate steady resources and create preventive measures towards social problems. The fundamental issue is that whilst network governance has become a mechanism for service delivery, the institutional framework remains one based on functional differentiation within hierarchical bureaucracies. Hence, there is a problem that lines of responsibility and accountability are blurred. There is no simple mechanism of decision making and budgets are not shared. This leads to a problem that it is individuals and not institutions that are working together and the policy depended on negotiations between individuals rather that a clear institutional framework. In this vein, the case study of the North Yorkshire Police and the provision of mental health services has enlightened our understanding of how specialised public services competencies have fallen into bigger and cross-cutting issues of public administration that the current model of governmental steering seems to neglect.

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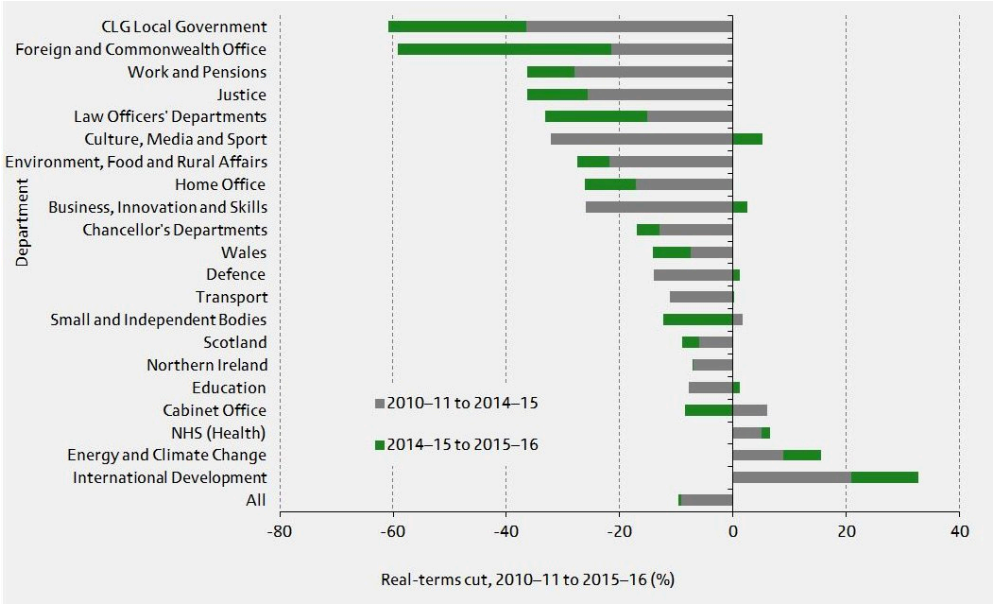
FIGURE 1 *Distribution of real spending cuts across departments*



Source: IFS (2015).

FIGURE 2 *Policing and mental health network for assessment and delivery of policy*

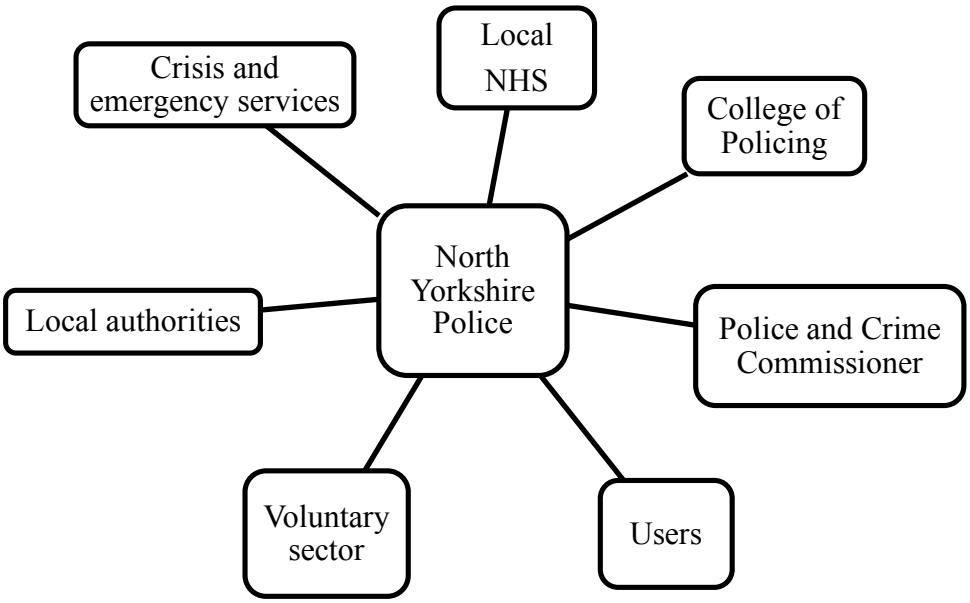
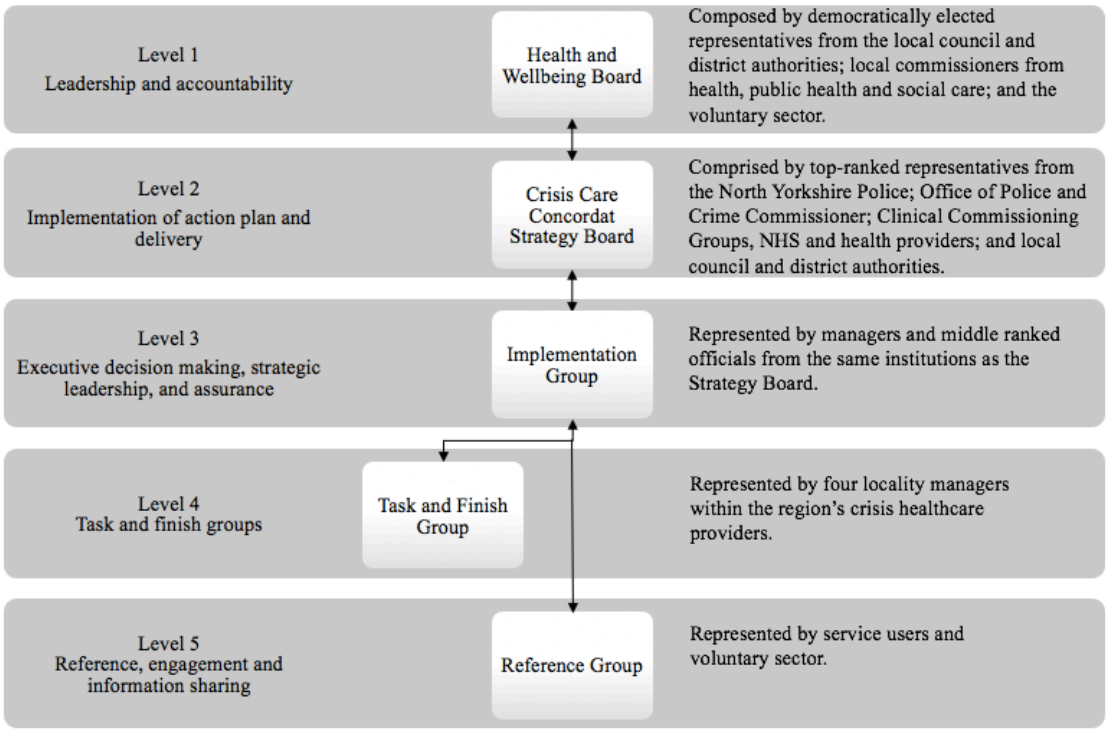


FIGURE 3 *Structure of the Crisis Care Concordat in North Yorkshire and York*



Source: http://www.crisiscareconcordat.org.uk/areas/york/.

TABLE 1 *Changes in number of Frontline police officers*.

Force	2010 (March)	2014 (September)	% reduction since 2010
Cleveland	1724.42	1342.52	22.15%
Staffordshire	2161.05	1683.76	22.09%
Humberside	2057.62	1640.75	20.26%
Durham	1507.14	1207.22	19.90%
West Mercia	2391.09	1915.40	19.89%
Lancashire	3649.26	2946.27	19.26%
Warwickshire	972.94	787.57	19.05%
Dorset	1486.47	1210.07	18.59%
Avon & Somerset	3301.55	2728.42	17.36%
West Midlands	8626.17	7154.87	17.06%
West Yorkshire	5758.30	4801.03	16.62%
Greater Manchester	8147.58	6843.75	16.00%
Hampshire	3747.58	3155.39	15.80%
Northumbria	4187.01	3542.72	15.39%
Derbyshire	2074.42	1770.85	14.63%
Essex	3605.93	3086.12	14.42%
Leicestershire	2317.08	1985.24	14.32%
Merseyside	4516.37	3882.87	14.03%
Devon & Cornwall	3556.01	3073.72	13.56%
Bedfordshire	1246.25	1082.00	13.18%
Sussex	3213.37	2794.64	13.03%
Wiltshire	1180.80	1027.89	12.95%
London, City of	852.14	743.91	12.70%
Nottinghamshire	2409.06	2105.49	12.60%
Cheshire	2155.19	1896.40	12.01%
Hertfordshire	2129.67	1899.12	10.83%
Gloucestershire	1308.73	1172.40	10.42%
Gwent	1437.05	1294.27	9.94%
South Wales	3147.59	2845.42	9.60%
South Yorkshire	2952.57	2671.32	9.53%
Lincolnshire	1206.25	1100.77	8.74%
Cambridgeshire	1471.32	1354.36	7.95%
Northamptonshire	1342.60	1241.71	7.51%
Cumbria	1238.19	1160.65	6.26%
North Wales	1589.73	1494.96	5.96%
Norfolk	1662.18	1569.81	5.56%
North Yorkshire	1485.67	1403.50	5.53%
Metropolitan Police	33366.55	31583.05	5.35%

Source: http://blogs.channel4.com/factcheck/factcheck-police-cuts-putting-public-risk/20073

TABLE 2 *List of interviewees by institutions and policy group*

	Interviewee	**Institution**	**Policy group**
1	Senior commissioning specialist; Head of service	Partnership Commissioning Unit	Health
2	Head of service	Partnership Commissioning Unit	Health
3	Service development manager	Tees, Esk and Wear Valleys NHS Foundation Trust	Health
4	Service manager	Leeds and York Partnership NHS Foundation Trust	Health
5	Locality manager	Airedale, Wharfedale and Craven Clinical Commissioning Group	Health
6	Clinical lead	Tees, Esk and Wear Valleys NHS Foundation Trust	Health
7	Deputy chief executive	York Teaching Hospital	Health
8	Group manager	City of York Council	Local authority
9	Officer	City of York Council	Local authority
10	Business development officer	Selby District Council	Local authority
11	Lead professional for mental health	North Yorkshire City Council	Local authority
12	Suicide prevention coordinator	North Yorkshire City Council	Local authority
13	Head of commissioning and partnership	North Yorkshire Police/ Office for Police and Crime Commissioner	Policing/ Local authority
14	Commissioning and partnership manager	North Yorkshire Police/ Office for Police and Crime Commissioner	Policing/ Local authority
15	Acting assistant chief constable	North Yorkshire Police	Policing
16	Superintendent	North Yorkshire Police	Policing
17	Inspector	North Yorkshire Police	Policing
18	Development manager	North Yorkshire Police	Policing
19	Reporting developer	North Yorkshire Police	Policing
20	Sergeant	North Yorkshire Police	Policing
21	Constable	North Yorkshire Police	Policing
22	Sergeant (a)	British Transport Police	Policing
23	Sergeant (b)	British Transport Police	Policing
24	Researcher	British Transport Police	Policing
25	Head of risk management	North Yorkshire Fire & Rescue Service	Emergency services
26	Operations and development manager	Together York Pathways	Third sector
27	Chief executive	York Mind	Third sector
28	Member	York Mental Health Carers	Third sector
29	User of policing and mental health crisis services	Private	Community

TABLE 3 *List of issues identified by police representatives when participating in the Crisis Care Concordat structure*

Strategy Board	• Not sufficient joined up strategic partnerships. • Better relations with local authority representatives than with those from the health sector. • Need to develop protocols with partners to hand over not police-related mental health issues.
Implementation Group	• A unitary police force working with various local government structures is a challenge. • The importance between policing and mental health practices is only recently becoming apparent.
Task and Finish Group	• There is a need to incorporate to other police officers the expertise gained by frontline staff working with partners. • Incident responses should be through quick actions based on intelligence sharing agreements. • A police-led style of meetings should be avoided and encouraged a partners-oriented type of discussion.
Reference Group	• Scarce prevention strategies for mental health crises and the constant referral of users from one service to another has hindered partnerships' work.

TABLE 4 *Pressing concerns to the Police when dealing with mental health issues*

Issue	**Proposed ways to overcome them**	**Extra resources needed**	**Obstacles for institutional embrace of desired practices**
Identification			
Identification of a mental health component has not been a mainstream issue for policing.	Training to police personnel.	Financing training and taking personnel off the street.	Preparation and delivery of training is time demanding and consuming.
Record			
Absence of a recording standard has caused under-reporting of incidents. Incomplete case recording of people/incidents (poor recording in-situ or though the control room).	Introduction of a flagging system to mark incidents or users as having potential mental health components.	Extra work (time and resources) for personnel.	Call takers avoid flagging incidents or marking people's records.
Response			
Poor knowledge of policing/societal interventions to mental health incidents. Discretion versus doctrine when applying problem-solving strategies.	Creation of co-located teams (hubs) for early prevention and intervention. Street and Force Control Room Triage pilots.	Financing the allocation of police personnel per local hub. Financing the pilots (see table 5).	Hubs have grown without central steering. Short pilots have not contributed to personnel absorption of triage practices.
Referral			
Need for better information sharing and hand over protocols between the police and the health and the social care sector.	Alliance with health, local authorities and voluntary sector for referrals.	More resources needed as demand for referrals grows.	Front line staff's awareness of referral pathways is limited.
Review			
Police's interest in creating data-based reports for review of practices is still limited.	Creation of mental health reports to be submitted for corporate performance and scrutiny.	Extra work (time and resources) demanded from personnel.	Influence of mental health data on the policy-making processes has been limited.

TABLE 5 *Recent police practices to improve responses to mental health related incidents*

Policy plan	**Location**	**Institutions involved in its delivery**	**Costs**	**Funded by**	**Results**
Street Triage Pilot	Scarbo-rough, Whitby, Ryedale	Police, Office of the Police and Crime Commissioner, NHS TEWVs Foundation Trust	£200,000	First year: Department of Health Second year and onwards: Police; Office of the Police and Crime Commissioner; Scarborough and Ryedale CCG	Program started in March 2014 and renews every 12 months
Street Triage Pilot	York	Police, Office of the Police and Crime Commissioner, NHS TEWVs Foundation Trust	£200,000	Vale of York CCG; City of York Council and North Yorkshire County Council	Program started in October 2014 and renews every 12 months
Force Control Room Triage Pilot	Based in York but operative county-wide	Police; Office of the Police and Crime Commissioner; NHS TEWVs Foundation Trust	£174,000	Police; Office of the Police and Commissioner	Program funded for 15 months starting January 2016
Path-ways Project	York	Together for Mental Wellbeing; Police and other referring agencies.	£287,000	Vale of York CCG; Lankelly Chase Foundation; NHS England	Program funded for 24 months starting April 2015