Co-creation of five key research priorities across law enforcement and public health: a methodological example and outcomes.

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Co-creation of five key research priorities across law enforcement and public health: A methodological example and outcomes

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Accessible summary

What is known on the subject?

- Between policing and health, there are many shared issues. Mental health distress and crises and caring for people who may be vulnerable are priority areas.
- Working together in partnership is challenging, and fragmented systems and processes are the result. This leads to poor experiences for the police, health professions and the public.

What the paper adds to existing knowledge?

- This paper describes an event that brought together 26 stakeholders involved in law enforcement and public health.
- The aim of this work was to identify the biggest shared challenges that they experience in their day to day jobs.
- The five key priorities were as follows: vulnerability; mental health crisis; decision-making around assessment and triage across professional groups and professional roles; peer support and organizational well-being; and information and data sharing.

What are the implications for practice?

- This paper demonstrates the strength of bringing partners together throughout law enforcement and public health, making proper time to actually discuss the "big issues" which affect them, how they each experience these issues, and how they might have overcome these within their own professions.
- Only through working together as partners and having everyone on the same page with the shared priorities can we really start to make a difference in the areas and with the people who matter.
- The focus on "vulnerability" and "mental health crisis" demonstrates the complexity of the issues between the professions, and that they *need* to find effective ways to work together to support people.
- No one professional group can solve inter-professional challenges alone.

Abstract

Introduction: Law enforcement professions now assume more responsibility for tackling mental health issues alongside public health colleagues than ever before. The term "vulnerability" is frequently used within Law Enforcement and Public Health (LEPH) to identify those requiring emergency mental health care. However, there are ongoing challenges within LEPH to determine whose responsibility this is.

Aim: To co-create the most important priorities for LEPH research in Scotland.

Method: The paper describes a collaborative workshop which brought together an Expert Advisory Group (EAG) of 26 senior stakeholders, from academia, policing, mental health nursing, psychiatry, paramedics, emergency medicine, people with lived experience, policy makers and third sector.

Results: The five key priorities included: vulnerability; mental health crisis; decision-making around assessment and triage across professional groups and professional roles; peer support and organizational well-being; and information and data sharing.

Discussion: The paper discusses the EAG group event as a co-production process, focusing on how key LEPH research priorities were derived.

Implications for practice: This paper demonstrates the inextricable link between co-production and co-creation of value via EAG group consensus on LEPH research priorities. Shared vision and professional will are not enough to ensure progress: there must also be shared policy, knowledge and access.

K E Y W O R D S

co-creation, collaborative working, health, inter-disciplinary, policing

1 | INTRODUCTION

One in four people in the UK have a mental health problem at any given time, with mental health problems accounting for 28% of the overall UK disease burden. The emerging Law Enforcement and Public Health (LEPH) field seeks to bring together those in police and health practice touch points, with a growing recognition of the extent to which policing and public health share common ground. This has, however, been challenging, given the differing remits, underpinning theory and ethos of different professional groups, a lack of common language, budgetary differences, issues with data sharing between different information technology systems and data protection concerns with sharing information of those accessing services. There is a growing sense that partnership working within public services can lead to positive outcomes for those accessing or providing care. This stance is echoed in theory, such as from a National Health Service, Social Care and Third Sector perspective (Tait & Shah, 2007) and also in practice (Berry, Briggs, Erol, & van Staden, 2009; College of Policing, 2018a; Fincken, 2011; United Kingdom Council of Caldicott Guardians, 2012). Considering LEPH practice, there has been recognition of need for partnership working (Christmas & Srivastava, 2019). However, few studies have explored partnership working from a LEPH theoretical lens (Enang et al., 2019; Shepherd

& Sumner, 2017), and so there is relatively little empirical evidence about combined public health and policing interventions. This paper adds to the scant empirical evidence in this area, by extending the discussion on the imperative for partnership working across LEPH, as reported by Heyman and McGeough (2018) and Martin and Thomas (2015) in the Journal of Psychiatric and Mental Health Nursing.

To address this gap, the current project brought together a national Expert Advisory Group (EAG) of 26 members, hosted by five academics. The remit of the group was to inform and support the development of a co-constructed programme of LEPH research, capitalizing on research opportunities of urgent relevance to frontline services. The group identified the top five priority areas for LEPH research in Scotland and planned a pathway for follow-up ongoing collaborative research in one of the five key areas.

The current paper describes the process through which the EAG was formed and brought together with the aim of establishing the national priority areas for LEPH research in Scotland. This will provide key learning and insights into this successful initiative for others facing similar challenges and ambitions to bring together professions for priority setting and co-creation of valued work practices. To begin, an overview of the need for co-creation of value in LEPH will be presented to provide the underpinning context for the reader. This will be followed by an overview of vulnerability research

across LEPH. Vulnerability has no shared definition in the LEPH literature (Enang et al., 2019), and for the purposes of this paper, a broad definition will be adopted: everyone can be vulnerable and this will vary depending on the context, the situation and across the person's lifespan.

Throughout this paper, we use "Law Enforcement" in a broad sense, to refer to the sector, rather than imply that this is the core function of the police or other criminal justice system aligned professions. We recognize that the role of policing professionals is much broader than enforcement. We therefore include working with the public and other partners, and community engagement, within our operational definition. Similarly, our operational definition of Public Health is purposefully broad, including any health and social care professional who works with individuals who could be considered or who consider themselves as experiencing vulnerability.

1.1 | The need for co-creation of value across LEPH

The Equality and Human Rights Commission Inquiry (2011) have argued that the Criminal Justice System (CJS) needs to increase responsiveness and accessibility to victims of crime and disabled people to provide more effective support. A range of policy responses to well-being and vulnerability has been enacted following this proposition. As such, the Police and Fire Reform (Scotland) Act 2012 makes the "safety and well-being of persons, localities and communities a core policing principle for Police Scotland" (The Scottish Parliament, 2012), with the police increasingly being considered as the gateway to the CJS for many people experiencing vulnerability and mental health issues. Well-being and consequently vulnerability and risk management therefore lie at the heart of the CJS. Given that police officers are frequently the conduit to mental health assessment, it can be argued that officer decision-making can be further challenged when supporting people with multiple vulnerabilities. Equally, health practitioners, as frontline workers, are necessarily engaged with public protection and public health challenges such as violence, sexual exploitation, substance use and curbing the spread of blood-borne viruses. It is imperative, then, that inter-agency working is facilitated and supported in this area.

Despite the numbers of vulnerable people in contact with the CJS, there is very little work exploring the impacts of decisions in the CJS on people with vulnerability, and to the best of the authors' knowledge, there is no work exploring the impact of these decisions on the individuals concerned. This is particularly important in the context of policing, with the police being increasingly relied upon as an emergency mental health service (Dodd, 2016). Indicating this shift in focus within modern policing from crime- to person-focused, Police Scotland's Strategy 2026 highlights the importance of having people with vulnerability at the heart of all policing decisions, indicating the increasing acknowledgement of the need to work between the intersect of law enforcement and public health.

There is little doubt that there has been an escalation in police and health practice touch points, with a growing recognition of the extent to which policing and public health share common ground. This has brought about significant changes, to consciously "join forces" to more effectively and efficiently co-create value across LEPH by addressing the complex needs of vulnerable people and communities, with one example of this being the Scottish Government's newly established Health and Justice Collaboration Improvement Board (est. 2017). Although such imperatives have drawn agencies closer together, such unions are complex. In this rapidly emerging field of LEPH, there remains a gap to bridge within the collaborative policing and public health research agenda. This entails building a robust evidence base to support informed, effective, efficient collaborative policies and partnership practice. This position must shift to mobilize research that is specifically relevant to frontline collaborative police/health practice and to inform joint strategy and policy initiatives. The current paper hence describes an initiative to develop a cross-sectional EAG to explore the LEPH intercept, particularly around mental health, distress, vulnerability and risk.

1.2 | The need to focus on vulnerability across LEPH

Despite vulnerability appearing within a myriad of policy documents, directives and being noted as a priority area for LEPH professions, as detailed above, there is, as yet, no shared definition of vulnerability across LEPH research or practice (Enang et al., 2019). This, at best, means that shared understandings will be muddied and a loss in meaning may occur. At worst, it may indicate that service users who are deemed as having vulnerability in both law enforcement and public health services will receive fragmented services, potentially at odds with each other. This has potential to cause unintended negative consequences for people seeking support and those working at the LEPH interface. This section will provide a brief oversight of vulnerability research across the LEPH field.

As already noted, vulnerability is a key and growing concern within LEPH (Murray et al., 2018), with an increasing recognition for the need to prioritize the identification, assessment and management of people with vulnerability—both as victims and as perpetrators of crime (College of Policing, 2018b; Department of Health, 2014). To this end, the Police Scotland Strategy 2026 stated that their primary priority is to protect vulnerable people (Police Scotland, 2017).

Effective vulnerability assessment may prevent unintentional harmful health and criminal justice consequences and manage the negative impact of such cases where prevention is not possible. For example, effective shared collaborative assessment of vulnerability may include a community psychiatric nurse, local police officer and a person who experiences mental health distress. Shared understandings of needs, strengths and external supports may prevent unnecessary out-of-hours admission to psychiatric inpatient care, or at worst safeguarding in police custody. However, there is a dearth of empirical evidence on effective vulnerability assessment, or indeed understanding on what is meant by vulnerability within the two contexts, or by people regarded as vulnerable by police and health services. Examples of the few scholarly studies on vulnerability across

LEPH include Bartkowiak-Théron and Asquith (2012); Bartkowiak-Théron, Asquith, and Roberts (2017); Paterson and Best (2016). However, despite these key papers' attention to LEPH, the primary foci of the work have been on policing and/or criminal justice. They do, however, represent an important development and progression into LEPH and inter-professional working in the context of working with people with vulnerabilities.

The core messages emergent from the important work of Bartkowiak-Théron and Asquith (2012), Bartkowiak-Théron et al. (2017), and Paterson and Best (2016) when considered in consort, are that of maintaining the concept of vulnerability as a socio-cultural construct to avoid barriers to inter-professional responses and working. One unity between services may be the element of protectionism and interventionism seen amongst policing and health; but how these are operationalized may differ, with the focus in law enforcement focused professions being on context-specific aspects, while health-focused professions may be able to facilitate through incorporating early intervention and a person focus. Another key message and shared goal within LEPH emerging from these papers are that of improving inter-professional working to become more pro-active, preventative and to support people through using the most appropriate service at the most appropriate times. This ambition continues to be challenging in practice and even in academia.

In a recent scoping review, Enang et al. (2019) identified that there was no clear or shared definition of "vulnerability" used across LEPH. They noted that the definition of vulnerability and operationalization of processes, assessment and policy using the adopted definition varies depending on the different LEPH professional perspectives. Specifically, law enforcement professions tend to adopt context-specific definitions (i.e. that people are vulnerable due to the situational context that they find themselves to be in) while public health professions seem more comfortable with a person-focused definition (with the emphasis being on the "vulnerable person" as a characteristic of the person). The current discussion therefore adds to the existent research conducted on vulnerability across LEPH, thereby consolidating the empirical (and international) platform that seeks to further establish vulnerability in policing and LEPH.

While this difference is expected upon considering the approaches and academic literature underpinning their evidence base, that is, law enforcement professions (traditionally sociologically/criminological based) and health professions (traditionally person-centred care/psychological focus), there are important implications for working practice between the groups and the lack of shared operational definitions. Poor understandings of and assessment of vulnerability inhibit shared understandings of what vulnerability means at the intersect of policing and public health, and makes the identification, assessment and management of vulnerable people challenging between LEPH professionals (Enang et al., 2019). Having such a shared understanding of vulnerability has the potential to improve communication, decision-making and management of vulnerable people with complex needs throughout the criminal justice and health systems.

This is just one example of an often considered "universal" construct which can be so differently interpreted and applied within working practice. It is therefore vital that LEPH professional groups are united and facilitated in coming together to identify areas of shared practice, shared concerns, shared understandings, and to identify and act upon areas of shared priorities for research and evidence-based practice. This co-creation and use of shared understandings and perspectives can only stand to improve the care and service provided to the public and to patients (Enang et al., 2019).

2 | METHODS AND FINDINGS

The findings of the current paper are focused on how to run a similar event to the one described and discussed here, and the outcomes from the event; hence how the key LEPH research priorities were developed and what these priorities were. The paper therefore reports on the evidence collated from this fieldwork. The findings do not suggest models of service provision, nor were they intended to.

This section will first present a description of the core methods used to bring together the EAG to co-produce the key LEPH research priority areas, and the outcome of this process. While this is not intended as a methods guide, as each group of stakeholders will differ, as will organizational structures internationally, the description may serve as a "roadmap" of a successfully executed priority setting exercise involving multiple key stages. The literature on these types of exercises is not large, and for the future development within both the LEPH field and others which may aim to carry out complex tasks such as this, the authors' hope that this paper will serve as a genuinely useful guide and description.

2.1 | Bringing together the EAG to establish the top research priorities for LEPH

2.1.1 | Expert advisory group event

A one-day event brought together the 26 EAG members from the academic sector, people with lived experience, the Scottish Ambulance Service, Police Scotland, the Scottish Police Authority, epidemiologists, the Scottish Government, two organisations who work with people to reduce reoffending and improve quality of life, emergency medicine, mental health nursing, adult nursing, psychiatry, midwifery, psychology, criminology, and the Scottish Centre for Telehealth and Telecare. We acknowledge that the views of key stakeholders like the charity/third sector and street-based health and social care agencies are relevant and are not fully represented here; in particular, those with a focus on homeless, street-based health and social care, and alcohol and substance rehabilitation. During event planning, the research team drew a list of 87 potential attendees and organizations to be represented. Due to constraints of space, lack of replies and invitees' lack of availability on the date of the event, we could not include everyone on the day that we had hoped to.

We fully acknowledge this constraint as a potential limitation and suggest that almost any event being run may suffer the same issues. Future event organizers may wish to consider running a concurrent online presence (e.g. using social media or video-conferencing) to allow a wider range of attendees; passive or engaged. Another potential solution would be to either carry out a formal post-event Delphi study to consult more broadly on the themes developed from the event, though this has funding implications. Finally, in hindsight, a simple solution would be to consult pre-event with all invitees, not just confirmed attendees, about the topics to be discussed at the event in a similar manner as described in the later sub-section of the current paper "Pre-Workshop Priority Areas" to allow the wider range of views to be represented and included. These suggestions are key learning emergent from the current paper for future event organizers.

Further, the current project was part of a series of work, divided into two key phases to begin a broader programme of work. The first phase is captured in this paper, which focused on key LEPH partners and research priorities in Scotland. The second phase was literature review focused, developing a scoping review and a systematic review, and these pieces of work address this limitation somewhat through consulting not only with the EAG to develop the reviews' aims and methods, but also beyond this group to include some of those missed from the current paper's sample.

2.1.2 | Logistics, planning and managing dynamics

This section will discuss the challenges and solutions that we used when managing the logistics and planning leading up to the day; and managing inter-professional dynamics during the discussions of complex topics.

In regard to logistical planning, this is a challenge when inviting so many stakeholders with complex schedules. As discussed before, the reality of managing to bring together every person/group relevant to a complex, 1-day, inter-professional forum such as that discussed in the current paper is simply not feasible nor likely. The team discussed at length, with input from some of the future attendees, which date would be most suitable for the event to maximize attendees' being able to be there. This was led by one of the team (IH) with significant input from another (ND). The allocation of key responsibilities to a smaller subset of the research team for this task allowed greater autonomy and specific points of contact for external advisors. It was agreed that these team members would also act as the invitation senders and handle pre- and post-event queries and feedback to maintain consistency. The selection of the key contacts within the team for this task was based on who from within the team were already well networked and known to the majority on the invitation list and/or the LEPH community: a personal invitation from a known source was assumed to be more enticing than a "cold call" invitation to an event.

Managing uncertainty and complexity in the planning for the event was a central component. Part of this was simply accepting that uncertainty is a part of event planning and to expect and plan for unexpected alteration. Planning the event involved the whole team with input from a senior Professor at the host institution. All of the team were experienced in running and planning external, inter-disciplinary events and so used the lessons learned from past events to inform this one. Event plans for the activities on the day were outlined early in the process and were then tailored and refined when the team knew who would be attending. This allowed certain central tasks and timings to be organized and "set" while still allowing for some flexibility in the running tasks of the day. Some examples of the set and tailored tasks are as follows:

1. Central "set" tasks which remained unchanged from the original event planning included:
   a. An opening address from a senior Professor from the host institution, who was external to the research team, with extensive experience of applied inter-disciplinary working. This was purposeful as it set the tone from an esteemed expert with less perceived bias than would be the case had a member of the research team opened the event in a similar way.
   b. A keynote address from an international expert who was central in establishing LEPH as a field. This was included as it demonstrated the international importance and influence of inter-professional, partnership working within LEPH beyond the Scottish scope. It also demonstrated that this can be achieved.
   c. A brief keynote address from a senior member of Police Scotland discussing their experience of working with academic and health partners. This was viewed as an essential inclusion as it moved the focus away from academics and research to discuss the real-world experience of LEPH partnership working, again making the task feel achievable and meaningful.
   d. Finally, at the end of the day, a concluding session "bringing the discussions together" led by the Dean of School. This session tied the key discussion themes together and acted as a sense check that the note taking by the research team had captured accurately what was discussed. Having this be led by the Dean of School also demonstrated senior level "buy-in" from the research team's institution, once again indicating that this was an important piece of work that would be followed through and not "just another event."
2. The tasks which were tailored were those which actively involved the attendees (the EAG) to participate in discussions. The actual tasks are described in the next sections. Discussion around what these should be and how to engage people included:
   a. Decisions about whether to record discussions or note-take (we decided upon both to allow our findings to be cross-checked and to be able to return to the discussions during analysis).
   b. Decisions about the format of the discussions. We considered different formats for the discussions, including the use of "props" such as post-it notes, human barometers, and other active learning and discussion mechanisms. However, given

the seriousness of the topics being discussed and the seniority of the attendees, we decided against this and to use more simple methods: some key discussion questions to get the conversation started; a note taker on the table; the note taker acting as a table facilitator to keep the conversations on track and to probe for more detail; and each group feeding back to the room after the discussion tasks were complete. While this was appropriate to our event, we do emphasize that different approaches ought to be considered and the most suitable used depending on who the attendees are and what the aim of the event is.

c. Who should be in which discussion group? We decided to place people on tables rather than allow people to choose their seats. This allowed us to not only ensure that all discussion groups contained a mixture of representations and avoid "professional silos" occurring, but it also allowed us to consider inter-personal dynamics, as will be discussed next.

A large part of planning the tasks for the event involved considering inter-personal and inter-professional dynamics. While inter-professional and partnership working exists across LEPH and has done for some time, this still must be considered. Both intra-professional hierarchies and either real or perceived inter-professional hierarchies can impact on who contributes to a discussion and how. At our event, we attempted to place people within the same profession but at different levels of seniority within different discussion groups to allow people a greater sense of freedom to open up and not to feel that they had to defer to their senior. In this sense, this was relatively simple to manage.

Perceived inter-professional hierarchies are more difficult to manage as these are tacit. This was similar with inter-personal dynamics, though when we were aware of any potential conflict or between members of the EAG we placed people at different tables to avoid discomfort (though, in truth, this was not a major issue for our group though is something to consider). During the group discussions, it was first emphasized that everyone's views mattered and that no one had a perfect answer; it was the discussion and variation of viewpoints and ideas that would benefit the discussion. Throughout the discussion, facilitators would interject if someone was taking over the discussion when needed to open up the space for others to speak and would ask people who had not spoken for some time if they would like to add anything. This allowed everyone to contribute if they chose to. The use of pre- and post-event communication (described later) also allowed people to contribute further in private, ensuring that there were opportunities for all to have their voice heard.

2.1.3 | Guided discussions at the event

The event aimed to identify the top priority areas for research in LEPH in Scotland as identified by the EAG, with the ambition to identify five key areas. There was a core focus on addressing the complex issues that limit individual disciplines and academic communities'

efforts to develop strong cross-agency police and public health research. By building on and developing original multi-agency partnerships, common research priorities can be ascertained, unions can be established, specialist expertise can be shared to more effectively leverage cross cutting research and limited resources. This was facilitated through guided discussions in four smaller groups within the room, each facilitated by a member of the project team, and these small group discussions were summarized and later brought together as whole group discussions led by a session chair. Groups were composed of people crossing the professional memberships and therefore represented an inter-disciplinary approach within the discussions.

The first guided discussion focused on identifying areas of shared organizational challenges associated with LEPH. The second focused on distilling the key problems, challenges and the identification of the research priorities per table. A final session brought the groups together as a whole to consolidate the key findings of the discussions. The table discussions were audio-recorded and each of the table facilitators within the project team took detailed notes of the discussions. Both the audio-recordings and the notes taken on the day were used to inform the key findings.

2.1.4 | Key findings from the EAG

Pre-workshop priority areas
Prior to the event, EAG members were invited to send their priority areas for LEPH research via email, and an anonymized summary of these pre-workshop findings was shared on the day within an information pack to help inform discussions. A full list of the pre-workshop priority areas findings is contained in Appendix 1. Overarching, summarized categories present within this precursory list included:

1. The importance of those with vulnerabilities, including people with mental health, communication and substance misuse issues and missing persons;
2. The need for technology to enhance collaboration and communication, and to enhance and support assessment and decision-making;
3. The need for intra- and inter-service collaboration and education, both for formal education and in day to day practice such as risk assessment and management; and
4. The need to consider the mental health and well-being of staff in addition to people, families, carers and communities.

These topics were not pre-empted or primed by the research team; the responses were true to the participants' views as far as we are aware. That said, we must also place these into context. At around the time of the event, and since, there has been national and local priority setting around mental health, vulnerability and substance use in Scotland. These had and have been set as priority areas by the Scottish Government, Police Scotland and NHS Scotland. This, coupled with the participants' knowledge of the research

team's own interests and the fact that the event was hosted in a Scottish Government building, almost certainly sets the scene for and influenced the pre-workshop priority area responses. Had the event been held at a different time, it is likely that the responses would have differed. This is not a limitation, however, as this kind of dynamic work must always be viewed as a product of context and of its time; priority setting is never a static process.
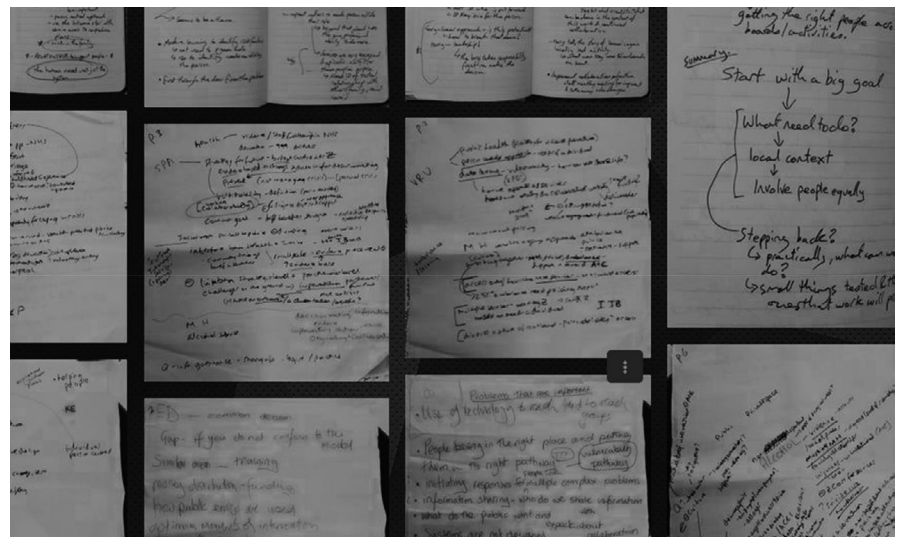
Findings from the EAG Event

The notes from the table and broader discussions were collated using "Padlet"; an online software which allows users to collate notes, images and other resources into an online "pinboard." Photographs of the notes were taken initially and posted to a private Padlet board to allow for easy visualization of the overarching notes and discussions held on the day. This allowed a full reading and viewing of the event's core discussion points in an accessible way. In total, 27 pages of handwritten notes were taken throughout the discussions. An example of the organized table notes within Padlet is shown in Figure 1.

The next stage involved one of the project team (JM) reading through each of the discussion pages and making a list of the (up to) three key points from each page. The meeting notes per table and the three key point summaries were then re-read while listening to the audio-recorded group discussions to assess for accuracy and validity, and if needed, alterations were made. A Padlet was again created and used to facilitate collation and ease of reading the summaries. The key points were then collated and considered across each group's discussion and across the whole EAG groups' discussions. A final set of discussions amongst the research team was held to determine agreement of the findings, and consensus was agreed. This was initially held via email discussions through circulating a summary of the data and findings as considered by the lead for this part of the project (JM). Several follow-up face-to-face meetings were held to discuss and debate the findings further. One element that was paid particular attention to was the desire not to couch the findings under any specific professional focus, which could have led to bias. As the research team is multi-disciplinary in nature (psychology, health, criminology, risk management), this helped to reduce the possibility of intra-professional bias in the findings. A brief report of the event and findings was also circulated back to the EAG after the event for feedback and views. All responders agreed that the findings were an accurate representation from the day's discussions.

From the outcomes of the EAG event discussions, there were several overarching findings. These related not only to the shaping of specific key themes and challenges for research, but also for the approach needed and the need for cross-professional collaboration. At the centre of all discussions, the way in which current systems are organized was considered to act as a barrier to cross-professional innovation. While it was acknowledged that this is difficult to change, and ideally a whole systems change would be preferable, cross-professional collaboration was acknowledged as possible. To achieve this, both higher level strategic ambitions (e.g. at head of service, head of profession or Government level) and buy-in from front line and managerial staff must be being met, with local and national priorities aligning. This echoes key messages resulting from the seminal work of Bartkowiak-Théron and Asquith (2012) and Bartkowiak-Théron et al. (2017) which discuss the need for inter-professional conceptualizations and responses to vulnerability across LEPH professions, where the onus is not only on the front line practitioners but also on those with responsibility at policy-setting and decision-making levels (e.g. heads of services and Government). There therefore must be a shared vision at the "top" to allow this shared vision to be operationalized at the practitioner level.

The ambition of a LEPH programme of research must therefore be "lofty" and broad reaching, but also be practicable and meaningful at the local level. Projects should not be conducted in "silos" but should be programmatic and interconnected within a wider-reaching strategic ambition. Discrete projects must also be collaborative, to include multi-agency partners, including the Police, Health, Academia, the Third Sector, and People with Lived and Living Experience. The Third Sector is considered to include non-government and non-profit making organizations such as charities, voluntary and/or community groups. Any research must be meaningful

FIGURE 1 Excerpt from the Padlet used to collate and organize the EAG event table discussion notes (converted to greyscale for publication)
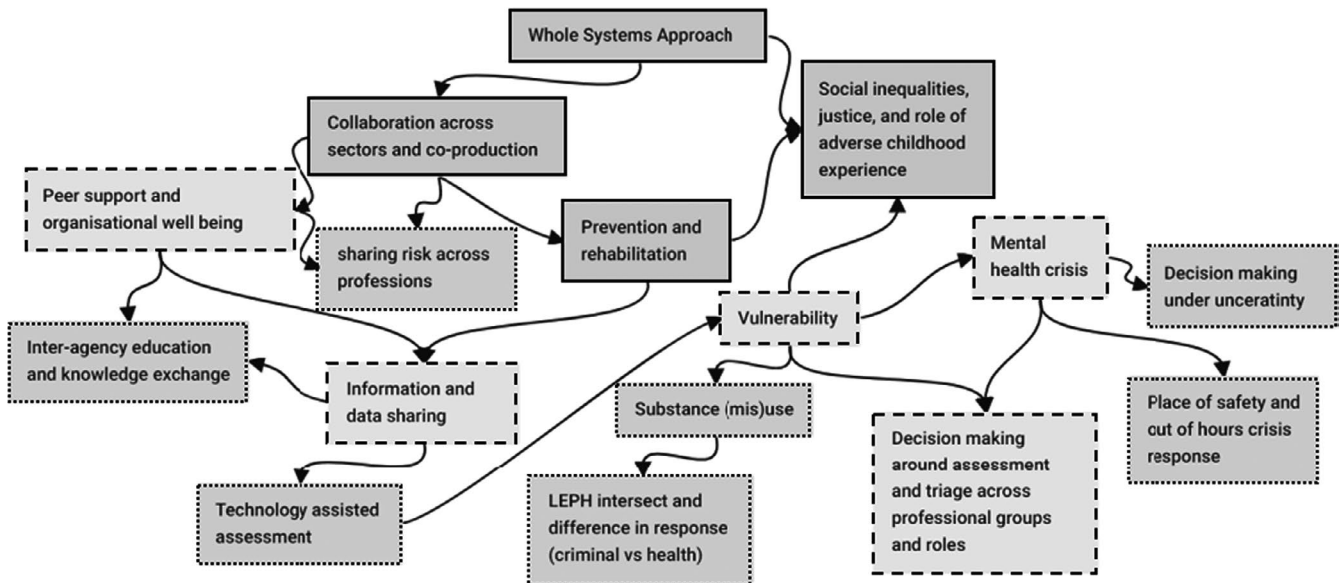
FIGURE 2 Map of the key research priorities from the EAG discussions. The solid-line border on boxes indicates an overarching theme; dashed-line bordered boxes are the key research priorities; and those boxes with a dotted-line border represent priorities and integrated potential project areas

to services, people, families, carers and communities, and should be carried out to identify, address and meet people's needs; there will be some difference between what is needed by services and what is wanted to be carried out; compromise between "blue skies" research and service focused and practical research will therefore be central to successful project implementation. One such example of this lies in the need for speedy projects and collaboration versus longer term research using evaluation methods, such as randomized controlled trials (RCTs), realist evaluation, feasibility or pilot studies: some projects or evaluations may be planned as longer term strategic initiatives, while others in the meantime use faster methods such as action research, tests of change, and/or implementation science techniques to achieve "small wins" which can be initiated and evaluated quickly and with little alteration to normal service delivery. There is acknowledgement that feasibility and pilot studies often are required prior to larger-scale and more complex research projects (e.g. RCTs). Understanding and developing exploratory work prior to evaluating an intervention are also often required. Ownership over the leading of projects within collaborations must also be discussed, and roles and responsibilities within these projects made clear.

The potential for secondary use of routine de-identified data was also discussed, as was information sharing between services, with the conclusion that data science had strong potential to inform more in real time whether shifts in practice were demonstrative of a desired effect. The group concluded that provided sufficient engagement with people with lived experience was carried out to inform changes in practice, existing data and other forms of evidence should be used to inform changes to avoid duplication of effort and potential for waste. Ideally, a repository or improved communication around local successful and unsuccessful initiatives should be established to help inform practice. This represents a sensible step in the use of data sharing and analysis to lead to impact, and "big data"

and data linkage research using existing sources of routinely collected data in the public sector has been a priority area in Scotland since 2012 (Scottish Government, 2012, 2015), with the Scottish Government (2020) outlining Scotland's international reputation for rich routinely collected public sector data and pioneering data linkage work within the health sector. However, despite there being tremendous progress in the establishment of ethical and legal governance and technical capacity for data linkage research, in addition to the strategic support (Scottish Government, 2012, 2015), accessing data in a suitable format for data linkage research from the social care and criminal justice sectors is challenging. Hence, while the vision, policy and professional will are there, there remain barriers to operationalizing this form of research across LEPH. These barriers are not, however, insurmountable, but this illustrates the need to work inter-professionally to share expertise, knowledge and access. No one professional group can solve inter-professional challenges alone.

Figure 2 illustrates the key research priorities identified at the EAG (within dashed-line bordered boxes), alongside the overarching themes (within solid-line bordered boxes) necessary to ensure the success of the programme of research using the five key priorities, alongside the important sub-areas identified as pressing areas required for LEPH research (within dotted-line bordered boxes).

In summary, and with reference to the data summary outlined in Figure 2, the research priorities identified the five key research priorities to be: vulnerability; mental health crisis; decision-making around assessment and triage between professional groups and professional roles; peer support and organizational well-being; and information and data sharing. As shown in Figure 2, there is overlap and intersects between these five priorities. If considered all together, this would allow a "whole systems" response to be investigated and applied, with inter-related and complex challenges

cross-professionally being identified and tackled at once. However, in reality, this would simply not be a feasible approach for either research or practice, as practice cannot halt while research carries on over the course of a multi-year project and then experience a period of extensive whole systems upheaval. Instead, the approach taken in the current paper—to identify and disentangle key themes but recognize their inter-linked nature—may allow future researchers and practitioners to see these areas as something that can be altered and worked on. While projects resulting from such work may then risk being created and viewed in a "silo," it is the researchers' strong recommendation that people working in these areas consider the wider picture and inter-linked nature of the topics identified, and to at least consider the implications of these. For instance, if making a change to one key theme/area, how might that impact on the others? This approach will then allow manageable research and practice initiatives to be feasibly carried out while maintaining some view of the whole systems approach and "bigger picture."

Below, the operational definitions of each of the priority areas, examples of central areas for future research investigation and the context in which this priority area was raised and discussed by the EAG are given:

1. Vulnerability: The highest priority area of investigation was the need to assess vulnerability, ways to do this meaningfully and identifying/establishing the evidence base for assessing vulnerability. The intersect between policing and health in assessing and triaging people who are vulnerable was central. The operational definition decided upon by the EAG was: "Everyone can be vulnerable and this will vary depending on the context, the situation, and across the person's lifespan." There was an additional focus on the consideration and treatment of people who use or misuse substances and whether vulnerability in this group should be considered under a health or a criminal model.

2. Mental health crisis: There was overlap between this theme and vulnerability, though the focus here was on assessing and managing people who are undergoing mental health distress. The investigation on how decisions are made and best practice (under realistic constraints) is achieved when all decisions are essentially uncertain was discussed. There was a need for training, particularly around the assessment of suicide. Triage was again central here, as was the need for identification of the most suitable place of safety and out-of-hours' service, and sharing information, sharing risk and sharing decision-making amongst the sectors. Adverse Childhood Events (ACE's) and the role of trauma in offending behaviours was also a core area of interest and tied back to the need to triage and treat the person appropriately at the earliest opportunity to improve outcomes for the person.

3. Decision-making around assessment and triage across professional groups and professional roles: Better working together and shared decision-making and risk practices/processes were needed. Appropriate triage of vulnerable people and people in mental health crisis as agreed across professional groups, ideally based on an evidence-based or evidence-informed model. Remote technology-assisted decision-making and assessment was further indicated as an area for exploration to improve assessment times and to reduce the need to attend an emergency department for assessment or take the person into police custody for safety/assessment reasons (e.g. through telehealth technology).

4. Peer support and organizational well-being: This theme encompasses supporting others both within professions and between professions. Examples include sharing the decision-making burden and risk across professional groups, making information available when possible to other professional groups if working with the same person throughout services, and sharing education and training. Through shared education and training between professions, the language and procedures used will be more aligned, leading to less confusion, inter-disciplinary tensions and replication of roles. This again aligned to the desire of appropriate triaging between services. Staff well-being, attention to mental health needs and developing supportive processes and procedures to ease workload burdens may help reduce stress related to work are central. Other elements such as sharing good practice in encouraging and supporting staff well-being (e.g. after an adverse incident) across the sectors were discussed.

5. Information and data sharing: The need for accessible information sharing, as easily and smoothly as is possible, across professions to inform decisions and person-centred care was discussed at length. Systems are complex and data protection and governance need to be considered, but it was acknowledged that in some cases "repeat callers" are often the same people across different services. Shared information could reduce response times, help to signpost towards the most appropriate service response for the person, and ultimately inform the best outcomes and reduce service burden. The use of innovative technology to help share information, keeping the person involved and central to information sharing, support decision-making, and share good practice was a priority area for research and practice across all services.

As with the Pre-Workshop Priority Areas task, these findings must also be considered in relation to the current LEPH context and time-point at which the data were collected. However, the themes and priority areas are broad sweeping and have consistently remained priority areas within the policy, practice and academic literature for some years, and have maintained their priority status since the event was run. They therefore maintain their relevance in the current LEPH policy, practice and academic landscape.

3 | DISCUSSION

The current piece of work brought together key stakeholders from different LEPH professions, people with lived experience and academics to co-create five key priorities for LEPH research going forward. The priority areas identified included: vulnerability; mental health crisis; decision-making around assessment and triage between

professional groups and professional roles; peer support and organizational well-being; and information and data sharing. Overarching these, the EAG identified broader themes or "values" which would need to be in place for any programme of research to become meaningful and able to apply to real practice. These included taking a whole systems approach, collaborating across the different sectors, focusing ideally on prevention and/or rehabilitation, and maintaining a focus or understanding of the impact of social inequalities, justice and ACEs on people's behaviours and experiences.

While the five priority areas were identified in silos, the reality is that they are often linked. Focusing on vulnerability, Keay and Kirby (2018) captured the inextricable relationship between some of the key priority areas identified at the EAG workshop in their discussions on the role of police officers in multi-agency triaging. The authors further highlighted need for partnership working and data sharing between police departments. Coliandris (2015) did the same in his discussions on policing. Central to the discussions by these authors is the emphasis that they place on the vulnerability conundrum that is the absence of and need for a uniform definition of vulnerability. Our discussions on "Advancing the agenda" further below echo this.

The ultimate ambition for this piece of work was to bring together key stakeholders from different LEPH professions and co-create value in the form of shared research priorities. This is the first time that stakeholders were brought together to discuss LEPH priorities nationally and represents a unique opportunity for agenda setting in this field. The resultant programme of research developed around the five key research priorities aims to facilitate and improve partnership working across LEPH and to push forward an agenda for research in the area. In line with the values and approach taken from the current paper, any resulting research must be collaborative, multi-agency and person-centred, with the ambition to improve mental health assessment and outcomes for LEPH staff and service users. To do this, local and national priorities must be considered and met, partnership working is absolutely essential with people with lived and living experience of the LEPH intersect included as equal partners. Integrating the research aims to policy and communicating findings across partners and sectors will be central to the uptake and use of the evidence generated. The research carried out ought to focus on preventative and rehabilitative care and assessment rather than be reactive, adopting a range of methodologies as appropriate to the projects emergent from the programme and their local context.

3.1 | Advancing the agenda

While this paper has focused on the EAG event and the co-creation of the five key LEPH research themes, partnership working is not a reality unless it leads to something more than discussions and co-created agendas. To ensure the progression of the partnership approach and the research agenda identified and agreed at the EAG event, the research team agreed to take forward one of the five priority areas to develop a programmatic workstream. In collaboration

with the EAG, it was agreed that the assessment of vulnerability within and between different LEPH professions, focusing on the frontline assessment, would be focused upon. To date, the research team has published a scoping review on definitions of vulnerability across LEPH (Enang et al., 2019) and have a follow-on systematic review on assessment of vulnerability, currently in review. The team is in the process of seeking funding to operationalize this literature-based work in developing an assessment tool/model.

At each of the key stages of the literature reviews that have been completed, a subset of the EAG with particular interest in vulnerability have been consulted. This included: establishing aims and research questions; refining search terms; and interpreting the findings. In maintaining the EAG's involvement with the research, the true value of co-creation and partnership working is embedded in the research produced, making it not merely an academically led pursuit, but a meaningful endeavour too for practice. To date, two face-to-face follow-on events have been held with the sub-group of the EAG and email communication has also been used. The whole EAG is updated on key milestones via short stakeholder summaries or bulletin style emails.

In regard to the follow-on vulnerability reviews, from a co-production and social innovation perspective, Whitelock (2009) stressed the need to develop a personalized definition of vulnerability that includes people with lived experience's voice as a critical step towards the care planning and support process. The current research and co-production innovation primarily sought to bring together relevant groups with expertise across LEPH, and it also included some incorporation of people with lived experiences' voice. Greater involvement of people with lived and living experiences at the key stages of a project, from the outset to completion is an area for development in future research in this area.

To support and inform decision-making and triaging, any development of vulnerability assessment models or tools must focus on a unified definition and understanding of vulnerability, should seek to include a range of LEPH professionals and people with lived and living experience, and importantly must be designed to work both within specific contexts and be useful throughout LEPH settings. Careful consideration for feasibility, acceptability and usability of assessment models for vulnerability across LEPH settings is essential and can only be achieved through co-creation of values and shared understandings.

3.2 | Potential impact emerging from the project

The current piece of work has resulted in the development of a LEPH thematic network involving universities, police, and partners from mental health nursing, psychiatry, emergency services, third sector, people with lived experience of the health/police intersect, health and social care in Scotland and internationally. This network will draw on the EAG's shared knowledge, expertise and experience to facilitate and continue collaboration with the academic team, and it is envisioned that this LEPH thematic network will drive forward

subsequent research projects to inform guidelines, policy, professional behaviours and real-world outcomes. In the shorter term, the findings from the current project will inform and develop LEPH practice through close collaboration and co-production, seeking to progress specific collaborative research projects focusing on tackling the themes emergent from the EAG event, and to seek funding for these with an intersect of partners involved. As this is the first time that data on LEPH have been collected in this way, this paper illustrates some of the opportunities and challenges with agenda setting in this way.

Ultimately, through co-producing research areas for progression through events which bring together key stakeholders and partners, such as through the current EAG event, this will increase the efficiency and practice relevance of the research process via the development of the network and identification of the five key research themes, enabling more efficient levels of activity across sectors. Through co-production and collaboration, there will also be a reduction in the time-period between the inception of research and the impact on policing, NHS, third sector and people's lives through engaged and active EAG members working together to put research into practice and develop practice-relevant research.

4 | CONCLUSION

It is our hope that researchers and stakeholders aiming to bring together diverse stakeholders to achieve a shared goal, whether this is research focused or practice focused, will find the "road map" of our approach described in this paper helpful and one that they can replicate. While co-creation of value and partnership working is often discussed, it is difficult, requires buy-in from all partners, and time and dedication to achieve the goals set. Through publishing reports such as this, some of the mystery surrounding co-creation and partnership working can be dispelled and real, practical advances can be made for the betterment of society.

5 | RELEVANCE STATEMENT

This paper is a response to the call for paper in the special issue on Law Enforcement and Public Health announced in the Journal of Psychiatric and Mental Health Nursing. This paper is of core relevance to mental health nursing practice as it describes and discusses the need for professions working in health, policing, the criminal justice system and the third sector to engage with each other and people with lived and living experience to work in partnership on shared priority areas. The paper identified "vulnerability" and "mental health crisis" as the two top priority areas co-produced by a multi-disciplinary group of senior stakeholders working within different law enforcement and public health professions. Only through partnership working can the best possible outcomes for people with experience of mental health distress be achieved.

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APPENDIX 1

PRE-WORKSHOP SUBMITTED PRIORITY AREAS FOR LEPH RESEARCH SUBMITTED BY EAG MEMBERS VIA EMAIL

Topic	Context (where provided)
Mental health	Mental health distress, staff well-being, triaging and other collaborative models, alternative Place of safety, suicide, self-harm
Technology-enhanced communications	Innovative technology enabled access to police/health assessments, decision-making support for new pathways of collaborative care
Collaborative education and training	Inter-agency learning, under- and post-graduate education, novice through to expert practitioners
Substance use/mental health assessment	Mental health assessment for those intoxicated and in crisis, alternative safeguarding options for those awaiting mental health assessment
Staff well-being	Mental health and well-being
Supporting those coming to police attention with communication needs	Including those with dementia, learning disabilities, epilepsy, autism, neurobiological brain injury, hearing or sight impairment, or unresponsive through injury
Information sharing processes	For operational police, safeguarding decision-making, unscheduled care
Missing persons	Looked after accommodated children and frequent absconding, mental health institutions, reasons for this and responses by services
Utilization of crisis services	Out-of-hours services
Vulnerability	Differing health and police perceptions of vulnerability, who is vulnerable, outcomes of being classed as vulnerable, assessing vulnerability
Custody health care	—
Collaborative risk assessment and risk management	—
Anticipatory care planning for those who frequently come to (multiple) services' attention	—
Data sharing processes for research	—
Adverse childhood experiences	—
School-based officers	—
Special Constabulary	—
Pathways of care for those outside safeguarding legislation	—
Violence	—