Reconciling mental health, public policing and police accountability

Abstract

The paper evaluates a range of policy documents, parliamentary debates, academic reports and statutes in an attempt to contextualise the condition of mental health policing in England and Wales. It establishes that mental health care plays an important role in public policing and argues that police organisations need to institute urgent reforms to correct a prevailing culture of complacency. An unethical cultural attitude towards mental health care has caused decision-making and the exercise of police discretion to be neither well-informed nor protective in many cases, resulting in the sub-standard treatment of people with mental health problems. The paper argues that changes introduced by the Policing and Crime Act 2017 and the revised College of Policing mental health guidelines do not go far enough and that more extensive root-and-branch reforms are needed.

Introduction

Sir Ian Blair (2016), the former Commissioner of the London Metropolitan Police, evoked a sense of moral panic when he argued that the duty of the police 'to protect the community from crime and terror is being jeopardised by the time they spend on people in crisis'. Local authority and central government rationing of funds for mental health services was responsible for leaving the police 'to pick up the pieces of Britain's mental health cuts', in his opinion (ibid). Numerous other articles and reports depict similar images of a haphazard, disjointed, fragmented, unpredictable, dysfunctional and deteriorating approach to mental health provision, which they attribute by and large to significant funding cuts and staff shortages across the health services (HMIC 2015; HAC 2015; IPCC 2016; Dodd 2016; Campbell 2016; Quinn et al 2016). This paper draws upon a range of policy documents, parliamentary debates, academic texts and statutes to argue that the present condition of mental health provision has been caused not only by funding cuts and inadequate inter-agency working but by a persistent and deep-rooted degree of confusion and uncertainty which surrounds the provision of mental health care as a function of public policing. It establishes that mental health care plays an important role in public policing and argues that police officers and the wider policing organisation need to reverse a prevailing culture of complacency by taking more 'operational responsibility' for mental health-related encounters.

Mental health as core police business

As a point of departure, it is important to establish that it is a normal occurrence for police officers to encounter individuals who are experiencing mental disorders on a day-to-day

basis. Police officers are often the first public service to reach someone who is experiencing a mental health crisis (IPCC 2016). Bittner's (1990: 251) famous aphorism that it is the 'unique competence' of the police to intervene in events which can be characterised as 'something-that-ought-not-to-be-happening-and-about-which-someone-had-better-do-something-now' was premised, in part, on his observation that 'the official mandate of the police includes provisions for dealing with mentally ill persons'. This official mandate '… is not limited to persons who for reasons of illness fail to observe the law. Rather, in suitable circumstances the signs of mental illness, or a competent allegation of mental illness are in themselves the proper business of the police and can lead to authorised intervention' (Bittner 1967a: 278). This distinct 'social services' nature of police work encouraged early academic commentators to label police officers as 'peace officers', 'peace keepers' and 'streetcorner politicians', rather than the more idealised 'crime control' and 'law enforcer' characterisations that were traditionally associated with policing (Banton 1964: 7; Bittner 1967b: 699; Muir 1977: 62).

The lineage of these social tasks can be traced back to the duties of early 19th century constables who routinely administered first aid at accidents and even drove ambulances, amongst other duties (Emsley 1996; Punch and James 2017). Encounters which could be considered bizarre or abnormal, where anxiety, fear, confusion or disorientation was the primary concern, often required police officers to take more innovative approaches than simple law enforcement (Jones and Mason 2002). Murphy et al (1971) found that roughly 80 percent of policing activities in the late 1960s and early '70s were devoted to 'social service' rather than 'law enforcement', presenting the police with significant opportunities for mental health-related interventions. Similarly, Punch and Naylor (1973) observed that most calls for assistance were not crime-related but were more often concerned with issues of public health. One sample survey of schizophrenia sufferers, carried out in the late 1980s, found that the police were the most highly-rated service when it came to caring for the mentally ill within the community; rated more highly than doctors, psychiatrists and social workers (Smith 1990: 1117).

An upward trend in the number of encounters between the police and individuals who are experiencing mental health problems has been attributed to the government's policy of 'de-institutionalisation', dating back to the 1960s (Sims and Symonds 1975; Laing 1995; Lamb et al 2002; Wood and Watson 2017). Designed initially to stimulate more effective forms of community-oriented treatment as an alternative to the traditional asylum system, the process has been frustrated by a lack of appropriate community-based services and accommodation to meet the demand (Chiswick 1992; Laing 1995; Bradley 2009; Peay 2010). Moreover, as societal understanding of mental health problems has improved, it would appear that more people are being diagnosed and identifying as having mental health problems (Kane et al 2017). The police logs of one police force show that between 2011 and 2014 the number of mental health-related incidents recorded by police officers rose by a third (Quinn et al 2016). Another police force reported in 2015 that 40 percent of the people passing through the custody suite had some kind of mental illness (HAC 2015: 7-8). Although there is no national system for recording and collating the nature and outcome of every mental health-related encounter, the Home Affairs Committee (HAC) has indicated that on average between 20 and 40 percent of police time now involves a mental health element (HAC 2015: 7-8). In other words, responding to incidents with a mental health factor represents the largest category of incidents and 'the number one issue' for some police forces (HAC 2015: 5-7; Punch and James 2017). Yet, it would appear that policy-makers and the wider public may not fully appreciate or understand this function of public policing. When Lord Adebowale was invited by the Metropolitan Police Service (MPS) to chair the Independent Commission on Mental

Health and Policing in 2012, he admitted that he thought that mental health had 'little to do with policing' (HAC 2015, 7). However, by the end of his review he had come to the realisation 'that mental health is core police business' (ibid).

The mental health function of public policing is more acutely reflected in section 136 of the Mental Health Act 1983, recently amended by section 80-3 of the Policing and Crime Act 2017. Section 136.1 of the Act provides that: 'if a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety…'. A 'place of safety', in this sense, is described in the preceding section as any residential accommodation provided by social services, a hospital, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient (s.135.6 of the Mental Health Act 1983). Associated guidance stipulates that police stations should only be used as a 'place of safety' on an exceptional basis or as a 'last resort' in the absence of other alternatives (PACE Code G; Home Office Circular 66/909). Conditions in police custody are more likely than the alternatives to exacerbate fear, distress, agitation and feelings of loss of power and control, which can amplify the extent of mental health trauma (Jones and Mason 2002).

The Act further provides that before a constable decides to remove a person to a place of safety, the constable 'must, if it is practicable to do so, consult a registered medical practitioner, a registered nurse, an approved mental health professional, or person of a description specified in regulations made by the Secretary of State' (s.136.1c). Once detained, the person can be kept at the place of safety for an initial period of 24 hours, 'for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment of care' (s.136.2). The initial period of detention can be extended by a further 12 hours upon the authorisation of a registered medical practitioner, primarily for the purposes of completing the assessment (s.136b). The power of detention pursuant to s.136 is reportedly being used increasingly by police officers, amounting to a 50 percent increase over the past decade in some police areas (Blair 2016).

Reconciling 'police discretion' and mental health

Section 136 of the Mental Health Act 1983 is not designed to address all manner of police encounters with individuals who are suffering from mental disorders. Although black-letter-law typically consists of a range of obligations, prohibitions and offences, the law cannot define the dense web of social values, meanings and actions which a police officer must navigate on a day-to-day basis (Manning 1977). Rather than zealously adhering to the letter of the law in every case, police officers are expected to use their own intuition, communal values, sensibilities, pragmatism and common sense to meet the ends of justice and order by interpreting and 'fitting' the law flexibly to resolve the encounters and conflicts they face (Wilson 1968; Reiner 1985). The resolution of a domestic or business dispute, an altercation between inebriated persons, the unintentional harm of a child by a parent, or damage to property by a person suffering from a mental disorder may often be best addressed by police officers imparting advice or issuing a caution instead of arresting the transgressor with a view to prosecution (Muir 1977; Reiner 1985; Waddington 1999). The use of 'soft skills', such as a soft tone of voice to calm an aggressor or employing humour to encourage individuals to

comply with instructions and advice, can be more effective and fair than arrest, detention and prosecution (Bayley and Bittner 1984). Factors such as the condition and expectations of the victim and the age and behaviour of the offender can, and often should, inform the officer's decision (Souryal 2015). This administrative freedom, which allows a police officer to choose the fairest course of action from amongst a number of lawful courses of action, is known as the exercise of 'police discretion' (Lustgarten 1986).

Since the publication of Banton's (1964) ground-breaking study of the activities of police officers within a number of Scottish and American police forces, it has become common convention that police officers will spend most of their time exercising their discretion to defuse situations rather than enforcing the law and arresting offenders. Minor crimes and public order disturbances, which are invariably handled by patrolmen and response officers, constitute the vast majority of reported crimes and, unlike serious and violent crimes, are subject to a wide degree of police discretion and 'under-enforcement' of the law (Banton 1964; Wilson 1968; Bayley 1994). Instead of rigorously enforcing the law, as they are expected to do for serious and violent crimes such as murder, police officers in democratic societies will spend the majority of their time trying to come up with innovative solutions to the residual problems of society by assisting 'people in trouble and troublesome people' (Bittner 1974). Rawlings (2011) conveys that the exercise of police discretion has always been a fundamental tenet of 'policing by consent' and can be traced back to the ancient Norman constable of the Middle Ages who regularly employed discretion when dealing with public order disturbances and mental health-related incidents. The common convention of 'police discretion' can be found within English law as an implicit tenet of early internal guidance to the public police, within the *obiter dicta* of tangential criminal and civil cases and, more recently, within the College of Policing Code of Ethics (2014). It is also reflected in s.136 of the Mental Health Act 1983. The words 'may, if he thinks it necessary to do so …', explicitly refers to more than one course of action which the police officer 'may' take.

The statutory framework does not attempt to cater for the wide range of mental health-related situations which a police officer might encounter on a day-to-day basis, even in a crude or principled way. It provides only for the simple removal by force of a person to a place of safety. It does not mention the alternative approaches which the constable might take, particularly where the principles of 'necessity' and 'immediacy' are not met. Moreover, it is far from clear what forms 'care' or 'control' could take. The etymology of the words would suggest that they could involve different processes and outcomes, but, if so, they are not defined. Furthermore, although constables are required to consult with a relevant mental health specialist if practicable, the Act says nothing about the other solutions which the specialist might recommend. Applying the statutory provisions to these 'social' tasks would suggest that there is a serious mismatch between the mental health-related statutory powers available to the police officer and the situations that they are likely to encounter on the ground.

It is submitted that a lack of procedural clarity is contributing to a palpable degree of uncertainty and apprehension amongst police officers, particularly when they encounter an opportunity to exercise their police discretion. Research would suggest that police officers are sometimes so uncertain about what action to take to bring a situation under control that arresting a vulnerable person rather than leaving them untended is considered by some to be the most risk-averse course of action (Paterson and Best 2016; Wood and Watson 2017). Moreover, police officers reportedly have a limited awareness of common mental illnesses such as chronic anxiety, depression, dementia, post-traumatic stress disorder, psychosis and

self-harm or associated de-escalation techniques, safe restraint methods or inter-agency joint protocols (Stone 1995; HMIC 2015). The possibility that a drug or alcohol problem might be masking the presence of mental health issues, known as a 'dual diagnosis' is also rarely considered (Bradley 2009). The new requirement to consult a mental health specialist pursuant to s.136 of the Mental Health Act 1983 is designed to address this issue, but it only works if police officers consider the possibility of a mental health problem in the first instance. If police officers do not consider the possibility of mental illness, they may be more likely to describe an individual who is showing symptoms of mental or personality disorder as 'behaving badly', which suggests a coercive police response, rather than describing them as 'not being rational', which suggests a more compassionate mental health response (Martin and Thomas 2015). This misinterpretation may ironically cause police officers to 'go in hard' when dealing with somebody who is showing signs of mental illness, such as schizophrenia, rather than taking a more conciliatory approach (de Tribolet-Hardy et al 2015).

A lack of police awareness and a narrow use of police discretion is reflected more particularly in the methods of restraint that have been used on people with mental disorders in recent years. Her Majesty's Inspectorate of Constabulary (2015) reported that individual police officers have been observed resorting to the restraint methods which are most convenient and in which they are trained, such as leg restraints and body cuffs, rather than employing the method of restraint which is most appropriate to the situation (the Inspectorate, referred to here as HMIC, recently assumed responsibility for the Fire and Rescue Services, to become known as HMICFRS). Similarly, the Independent Police Complaints Commission (IPCC) (2016: 53-4) has identified cases in which the decision to use force was made 'too early without a full evaluation of the behaviour of the person and the threats posed', often with an over-reliance on previous experience rather than an evaluation of the current situation. Moreover, instead of classifying periods of restraint as 'medical emergencies', which necessitates the immediate dispatch of clinically-trained nurses or paramedics to assess and treat the individual, officers are not routinely considering the implications of possible underlying mental health issues or medical problems such as heart conditions, asthma and epilepsy, which can intensify a person's inclination to struggle against a restraint (HMIC 2015). The application of restraint in some cases has been described as 'the worst possible course of action' to take (HAC 2015).

The issue of misinterpretation comes into sharper focus when police officers employ tasers and firearms during encounters with individuals suffering from mental disorders. The IPCC (2016) found that the use of force, including the use of restraints, tasers and firearms, is far more likely to be used on persons who are suffering from mental health problems. The Commission found that almost every time that a taser was drawn during an interaction with a vulnerable individual, it was subsequently discharged and most often towards the back of the individual's body (IPCC 2016: 46-8). Firearms were also discharged in the majority of instances they were drawn, resulting in a number of fatalities (ibid). The justifications typically revolved around the need for the police officer to arrest the person for drunk and disorderly behaviour, breach of the peace, anti-social behaviour, criminal damage, threatening behaviour, violence against the person, theft, drug possession and resisting arrest; or to prevent them from injury or self-harm or for the protection of others (ibid). The Commission concluded that people with mental illnesses were ultimately four times more likely to die after police use of force than any other demographic (ibid: ix).

The net result is the 'over-policing' of vulnerable populations, leading to unnecessary and unjust uses of force, criminalisation and victimisation (Paterson and Best 2016). Instead of

finding the help that they need through police intervention, individuals with mental disorders may be subjected to excessive force and arrest during a police encounter, often for minor offences. Rather than exercising their police discretion to identify innovative and fair solutions to the residual problems of society, a significant degree of misunderstanding appears to be responsible for inappropriate, and sometimes fatal, outcomes. Cummins (2012) warns that the approach of police officers can become even more insensitive where attempts are made by police leadership and management to pressurise police officers to make arrests for certain high-priority crimes, such as public order offences or domestic violence. Police officers operating under such conditions, often referred to as 'zero tolerance policing', can be encouraged to arrest suspects regardless of mental health or welfare considerations (Loader and Walker 2007; Cummins 2012). Anti-Social Behaviour Orders (ASBOs) and the Code of Practice for Victims (2014) have also been used by police officers to control and criminalise people with mental disorders in the pursuit of managerial priorities (Bradley 2009; Crawford et al 2012). Rather than exercising their discretion to reach justiciable outcomes, insensitive police practices can accelerate the displacement of large volumes of vulnerable people, who may have little understanding of their wrongdoing, into the criminal justice system (Wood et al 2011).

The impact of 'police culture' on mental health policing

The prevailing problems are largely attributable to wider cultural issues. Bittner's (1967: 281-8) ground-breaking ethnographic research indicated decades ago that there was a profound tension between what police officers 'were authorised to do in handling situations and what they often chose to do to dispose of matters and move on to the next problem'. He observed that, although police officers acknowledged that dealing with mentally ill persons is an integral part of their work, they did not view it as a 'proper task for them' or 'accomplished craftmanship' since it did not involve the 'skills, acumen and prowess that characterize the ideal image of a first-rate officer' who can quickly dispose of matters (ibid). The process of bringing people to hospital, where officers 'must often wait a long time in the admitting office', was a 'tedious, cumbersome and uncertain procedure' (ibid). Doing so was incongruous to 'one of the respected rules of police procedure' which is to 'take care of things in a way that avoids protracted and complicated entanglements' (ibid: 281).

Another deterrent to hospital admission, or 'repercussion' as Bittner (ibid: 279) described it, was the expectation that the police officer should be able to answer any question asked by the hospital staff and be able to provide justification for bringing the individual to hospital with reference to the psychiatric illness present and the 'serious police problem' that it created. In an effort to limit the opportunity for their own judgment to be placed in doubt, police officers tried to 'disavow all competence in matters pertaining to psychopathology' (ibid). The police, he observed, will 'avail themselves of various forms of denial when it comes to doing something about it'; often relying on the easy defence of 'how could they have known' (ibid: 280). Instead of taking proactive action to ensure that an individual received the care or control that they needed, doing nothing was considered to be a prudent course of action in some cases because it was unlikely to be challenged or reach public attention (Wilson 1968; Muir 1977). These attitudes appear to have permeated the police hierarchy over time, becoming part of the informal 'operational code', 'working rules', 'craft rules', 'management rules', values, norms and perspectives which police officers have developed to interpret duties, statutes and the situations they encounter (Punch 1979; Reiner 1985).

The view that dealing with mentally ill persons is not a proper police task or emblematic of accomplished craftmanship is still clearly identifiable within the policing organisation. The 'messy, intractable' nature of the tasks is still considered by some to be 'unworthy of attention', and 'rubbish' work (Reiner 2010; Punch and James 2017). Koskela et al (2016) found that a lack of appreciation of mental health problems has resulted in police officers disrespecting and disempowering people with mental disorders during even the most routine encounters. Police officers were found to be actively disbelieving, discrediting and even blaming people with mental health problems (ibid). The researchers found that the sense of frustration, shame, emotional distress, loss of self-esteem, disempowerment and isolation caused by this stigmatisation, prejudice and victimisation served to worsen the pre-existing mental health problems of some service users (ibid). The perception of ill-treatment and stigmatisation can even be heightened in cases where the person is a member of a minority ethnic group against which there has been a history of discrimination (Towl and Crighton 2012; HMIC 2015). Some police officers can be so preoccupied with demanding the respect of the people they encounter that they may even resort to more authoritative styles of policing and use 'excessive' and 'unnecessary' force when they are not shown the respect they feel they deserve, irrespective of whether the person concerned is mentally impaired (Reisig et al 2004, IPCC 2016: 59, 60). Constables who do engage proactively and frequently call the mental health services for assistance have reportedly been pilloried for their efforts (Horspool et al 2016; Punch and James 2017).

Crucially, the prevailing attitudes towards mental health have resulted in the creation and maintenance of an inadequate training regime around mental health awareness and response. Police constables in England and Wales typically receive a minimum of two days of training in common mental health illnesses, de-escalation techniques, the use of safe restraint and the approaches of partner agencies (HMIC 2015). Some police forces provide officers with the option to do a full-day training course on suicide prevention with the Samaritans, but this is far from ubiquitous (HAC 2015). A small number of forces have assigned police officers to specialist 'street triage' teams, where they receive more intensive mental health awareness training, but only a small proportion of officers volunteer for such teams (Cummins 2013). Joint training between police officers and mental health nurses, paramedics and Approved Mental Health Professionals rarely occurs (ibid). It would appear that the institutional approach to mental health policing is a classic exemplar of Schulenberg's (2015) maxim that 'culture eats training', contributing to the inaccurate and self-perpetuating viewpoint that police officers are not qualified or the right people to deal with individuals who show signs of mental health problems (Bradley 2009; Cummins 2012; HAC 2015).

One novel solution to this problem has been the recent introduction of the pilot programme known as 'street triage' or the 'triage car' (HAC 2015). The pilot is largely modelled on the American Crisis Intervention Teams (CITs) and Australian Mental Health Intervention Teams (MHITs), which aim to bring police officers and mental health specialists into closer alignment and avoid unnecessary uses of force and detentions in custody (Lamb et al 2002; Reuland 2010; Clifford 2010; Compton et al 2011). The model involves the dispatch of a response team, which typically consists of a police officer, a mental health expert and a paramedic, to a scene where someone appears to be suffering from a mental disorder and in need of care or control. The mental health expert is expected to help the police officer to assess the individual, to define the nature of the mental health problem and determine whether immediate mental health support is needed. Unlike the officer, who is accustomed to more traditional and authoritative policing approaches, the mental health professional is trained to 'manage aggression' by adopting de-escalation techniques which involve

discussion and 'space' rather than restraint and control (HMIC 2015; de Tribolet-Hardy et al 2015). Research indicates that a medical practitioner is also more likely to elicit appropriate information in comparison to a police officer who may be given incomplete, inaccurate or deliberately misleading information by an individual who is trying to avoid arrest (Payne-James et al 2010). Furthermore, the mental health professional can access mental health data and medical records to determine whether the individual in distress has a clinical history, any medication, or whether a care plan is already in place (HAC 2015). They should have a good understanding of the multi-institutional support available at the time, such as the availability of s.136 beds in various localities and the associated procedures for admission (HMIC 2015; Cummins and Edmondson 2016). This can speed up or 'fast track' the assessment process (ibid).

Most importantly, there is anecdotal evidence to suggest that the mental health specialist is 'less risk averse' than police officers when dealing with individuals who appear to have a mental disorder because they are more willing to leave someone in the community, in the care of family members, charities or substance misuse services (HAC 2015: 19-26). Police officers, in comparison, often bring individuals to inpatient mental health services or police custody suites due to a 'perceived lack of organisational support should an individual self-harm or attempt suicide after contact with police' (Horspool et al 2016). The scheme has reportedly led to a real reduction in the use of police custody suites as a place of safety and fewer s.136 detentions (HMIC 2015; HAC 2015; Heslin et al 2017). Moreover, reports suggest that police officers who are assigned to the 'street triage' team are actively learning from the mental health professionals and are beginning to adopt more conciliatory practices (Compton et al 2011; Horspool et al 2016). The confidence shown by the mental health specialists is being '… transmitted to police officers working alongside them', potentially rendering them less likely to endorse the use of force (HAC 2015: 19-26; Compton et al 2011).

Although 'street triage' demonstrates a commitment to supporting people in crisis, the scheme remains at a pilot stage (HAC 2015). The embryonic nature of the project is underlined by the fact that the format varies amongst the participating territorial police forces and relies on temporary funding from the Department of Health. Some police forces dispatch the response team in a police car, whilst others endeavour to dispatch the team in a paramedic ambulance due to the negative connotations associated with a police car (ibid). Mental health nurses in some force areas are based at the control centre so that they can give real-time advice over the telephone, referred to as 'phone triage', but this is not ubiquitous across every scheme (Cummins and Edmondson 2016). The tentative nature of the project and the differences in police force requirements, population, geography and commissioning means that the costs, savings and evidence-base associated with the scheme are largely speculative (Dyer et al 2015; Heslin et al 2017; Kane et al 2017).

Without a more permanent national roll-out, the transient nature of police assignments means that the small number of police officers who have enhanced their confidence and adapted to the 'caring culture of the social tasks involved' in the 'street triage' scheme, will likely be moved to other posts and revert to more traditional styles of policing as organisational priorities change (Van Dijk and Crofts 2017). Similarly, the established procedures, meeting structures, methods of debating difficulties and joint training initiatives, which depend upon strong and structured relationships at the strategic and tactical levels, are easily lost when senior managers are reassigned, often without wider consultation (Dyer et al 2015; HMIC 2015). Rather than leading to a sea-change in policing, fleeting initiatives such as 'street

triage' may continue to be the purview of people in part-time roles who are part of temporary alliances which address only a fraction of the mental health-related problems that police officers encounter on a day-to-day basis. In the absence of permanent cultural reform and greater accountability and transparency, the 'street triage' initiative is arguably more symptomatic of the police organisation's 'poor institutional memory' which condemns it to 'cycles of unlearning and of anew rediscovering, at some cost and energy, the lost lessons of the past' (Punch and James 2017).

Taking 'operational responsibility' for mental health

The College of Policing recently published updated Authorised Professional Practice (APP) guidelines in an attempt to address the issue of poor mental health awareness amongst police officers more generally. The guidance states that 'early police recognition of the possible mental health problems, learning disabilities or suicidal intent of people they come into contact with is crucial to ensuring an appropriate and effective response' (College of Policing 2016a). It is reasonable, it states, 'to expect police officers and operational staff to recognise the potential medical significance of symptoms and behaviours associated with mental vulnerability' and take them 'into consideration', which may involve consultations with healthcare professionals where appropriate (ibid). This does not mean that police officers are expected '…to be able to identify the specific symptoms of mental ill health or learning disabilities or attempt to diagnose illness…' since '…police officers and staff are not medical professionals and are not expected to hold or maintain any level of clinical knowledge or understanding' (College of Policing 2016a). The guidance explicitly states that such determinations 'should be made by clinically trained professionals and not police officers' (ibid). This is largely because the officer will invariably be unfamiliar with the medical history of the person they are dealing with and cannot be expected to function as 'street corner psychiatrists' (Treplin and Pruet 1992: 139). Instead, they are simply expected to engage in discussion, negotiation and conflict resolution with individuals who appear to be experiencing a mental health crisis so that they can make the most informed decision or referral possible.

Procedurally, the guidance reflects the College's National Decision Model (NDM) which encourages officers to consider all available information and intelligence to support appropriate and proportionate risk assessments and decision-making. They should try to de-escalate situations informally by actively engaging in dialogue directly with the individual concerned with a view to drawing out explanations for apparently aggressive or odd behaviour before resorting to arrest and restraint. The guidance provides that 'the most important source of information will be the individuals themselves, some of whom will carry information about their circumstances and needs' (College of Policing, 2016a). Using simple language, short sentences and frequent pauses, officers are encouraged to probe whether the individual has difficulties which the officer should be aware of, whether the individual understands the issues being discussed and whether they can provide the name and details of friends or family who should be contacted (ibid). Allowing subjects to 'have a voice' in this manner not only leads to more informed outcomes but can generate greater public satisfaction (Watson et al 2004). A 'Vulnerability Assessment Framework' or Public Psychiatric Emergency Assessment Tool (PPEAT) has been incorporated to help police officers recognise mental disorders and record their observations using the structured typology of 'Appearance and Atmosphere'; 'Behaviour'; 'Communication'; 'Danger' and 'Environment' (Wright and McGlen 2012; College of Policing 2016a). Rather than relying on emotive, inaccurate and, often disrespectful, terms such as 'scary', 'hostile' or 'crazy' to

describe a situation, which may lend themselves more readily to determinations of 'bad behaviour', the typology encourages the methodical identification of objective factors and more justifiable reasons for action (ibid). De Tribolet-Hardy et al (2015) liken this approach to 'hostage situations', whereby negotiation, communication skills, space, time, support and rapport are used as tools to reach a peaceful resolution. Others have described it in terms of 'situational awareness', whereby officers are encouraged to perceive elements in the environment, comprehend their meaning, anticipate the outcome and respond accordingly (Wright and McGlen 2012).

Unfortunately, the revised guidance offers nothing dramatically new. Bittner (1967: 286) outlined a number of techniques which police officers could use during encounters with persons suffering from mental disorders in the 1960s. He observed that 'it is extremely rare that officers encounter a patient who is too passive or too withdrawn for interaction of some sort. Most can be drawn into an exchange' (ibid). The policeman, he argued, 'should try to establish and maintain the pretense of a normal conversational situation' wherein all of the patients remarks, allegations or complaints should be treated in a matter-of-fact manner. Police officers should 'not attempt to suppress or eliminate the absurd and bizarre but rather leave them aside while concentrating verbal exchanges on the ordinary aspect of things' (ibid). Furthermore, officers should not challenge statements or give any hint that they doubt the veracity of the story, but should instead 'turn to practical advice and reassure the person that the police can ensure their safety' (ibid: 288, 289). The encounter should thus transition from a 'dangerous phase to a phase of relative safety and normalcy' (ibid). The officers can subsequently use their technical communication system and transportation facilities to locate 'caretakers' for the 'patient' or return the person 'to circumstances in which they are sheltered' (ibid). He referred to this process as 'psychiatric first aid' (ibid: 286). Stone (1995) later argued that a police officer who cannot deliver a form of psychiatric first aid is akin to an officer attending an accident and being unable to deliver basic emergency assistance.

Unfortunately, Bittner's advice appears to have remained largely within the academic realm, which suggests that police officers may pay little more than lip service to the College's guidance. It is submitted that if wholesale changes are to be realised, the sensibilities and practices of rank-and-file police officers need to be 're-shaped' more thoroughly (Wood and Watson 2017: 289). First and foremost, the mechanisms for police accountability should ensure that each and every police officer is held responsible for the legality and probity of their own actions. The ancient common law principle of 'operational independence' holds that police officers are expected to execute the original, individual and legal office of constable faithfully, as public servants not as employees or servants of a perverse or prejudicial organisational culture (Marshall 1965; Walsh 1998). Police officers can lawfully reject the directions of commanding officers where such instructions do not meet the requisite legal standard and eschew any attempt by a political entity to force them to carry out unlawful deeds. In fact, they can be held individually accountable for a failure to do so. Although police officers are often told by Police and Crime Commissioners (PCCs) and government ministers that 'their only task is to cut crime', they have an 'operational responsibility' to be accountable to the public they serve (Punch and James 2017; Patten 1999).

When constables are dealing with a mental health-related situation, they must be cognisant of the need to take all relevant information and intelligence into consideration when they are making key decisions, even if it requires the exertion of additional effort. Not only is this a central component of the NDM but it is well established in legal jurisprudence that the

exercise of police discretion must meet a number of key criteria. Walsh (1998: 330-4) notes that the landmark *Wednesbury Test* formulated at common-law requires police officers to call their attention to matters which they are bound to consider and to exclude from their considerations matters which are irrelevant or inappropriate for the making of an impartial and rational decision. Failure to do so may render any subsequent action unlawful. This does not mean that their decision-making needs to be perfect. The Mental Health Act 1983 does not require police officers to be perfectly precise in their decision-making. It only requires that they make a judgement call about whether the person 'appears' to be suffering from a mental disorder and to be in immediate need of care and control. To make such a judgement call, a constable needs only to make a reasonable or practicable effort to call to their attention all relevant matters, information and intelligence which is available to them.

By going through this intrinsically intellectual decision-making or reasoning process, police officers can become more alive to the particularities and subtleties of the circumstances and the consequences which different courses of action might produce (Waddington et al 2013). Placing a premium on individual needs, emotions and the means by which they reach justiciable outcomes also means that the officer is actively practicing 'police ethics' (Neyroud and Beckley 2001). Ethics, because they connote the investigation of what is moral and the right way of acting, should naturally lead to more compassionate police practices, but they all too often represent what the police 'say they should do', not what they actually do in practice (Souryal 2015). Normalised behaviour which is common to the civilian, such as rudeness, indifference or impatience, falls short of the ethics expected of the policeman and has no place in mental health-related encounters. Instead, 'morality', which involves the daily application of ethical principles, should form an integral part of the police officer's 'vocation' and 'public service' (Weber 1918).

The accountability and transparency of mental health policing

Since the exercise of police discretion allows police officers to unilaterally decide the ends of justice and dispose of mental health-related cases on the street, diluting the full potential of the criminal law and usurping the role of the rule-orientated judiciary, strong checks and balances are needed (Reiss and Bordua 1967; Wilson 1968). Once a police officer has considered the merits of a particular case, weighed up the options and exercised their discretion to deal with the incident, one of the parties involved, whether the victim or aggressor, is likely to feel aggrieved, embarrassed or humiliated by the decision (Goldsmith 1991; Waddington 1999). The decision may be considered to be the most appropriate by the police officer but 'the fact that policemen are required to deal with matters involving subtle human conflicts and profound legal and moral questions, without being allowed to give the subtleties and profundities anywhere near the consideration they deserve, invests their activities with the character of crudeness' (Bittner 1990: 9). Quick or aggressive decisions and actions which are taken on the basis of conflicting or inaccurate information and normally without the full facts of the case are often 'doomed' to be unjust and offensive to at least one of the parties involved (ibid). Moreover, the emotional anxiety of the police officer, allied to the perceived need to resolve situations quickly and authoritatively, may also impinge upon their ability to think objectively and act with a reasonable degree of impartiality, particularly in dangerous situations (Skolnick 1977). Police managers might expect police officers to be judicious and skillful in the performance of their work but it would be 'foolish' to expect that they will remain 'error-free' (Bittner 1970: 5; 1990: 9).

Police managers and supervisors are primarily responsible for shaping the police officer's 'sense of permission' of what is possible and appropriate and 'perception of reality and purpose', but if a complaint is not forthcoming it is largely up to the police officer to individually report upon the nature and outcome of each encounter (Van Maanen 1983: 276; Chan 1996). Unfortunately, police officers' decisions and actions are not always brought to their supervisors' attention, which can render the internal hierarchical regime largely incapable of monitoring and swiftly addressing the erroneous or prejudiced exercise of discretion (Skolnick 1966; Wilson 1968; Skogan 2008). The exercise of police discretion has thus been identified as an area of 'low visibility' from a managerial perspective (ibid). Wilson (1968) famously observed that police forces have the special property that discretion actually increases as one moves down the hierarchy due to the unpredictable nature of police work and the difficulties of administrative supervision. Despite this, little effort has been made to establish a national police system for collating and analysing the outcomes of mental health-related encounters in England and Wales, whether through self-reporting or civilian feedback. A more intensive usage of Body Worn Cameras (BWCs) in the future may help to enhance the quality of oversight and transparency, rendering the exercise of police discretion more visible, but the problems of police leadership, management and training go deeper (Ariel et al 2017).

Even in areas where accountability and transparency are more easily attainable, 'low visibility' persists. When an individual is transported to the police custody suite, a custody officer should make a record of any use of force and carry out a risk assessment in order to assess the extent of an individual's mental disorder (HMIC 2015). The custody officer should consult with specialised mental health services whenever appropriate and act independently to ensure procedural fairness, accountability and transparency (PACE Code C). However, HMIC (2015) recently published a major report on the welfare of vulnerable people in police custody which indicated that the custody risk assessment did not accurately identify mental health needs in many cases. Custody officers reportedly relied heavily on individuals disclosing their vulnerabilities themselves when asked a series of mechanistic questions from a mental health screening questionnaire, despite the fact that people in mental distress can find it difficult to communicate their needs (ibid: 84-6; 115-20). Communication difficulties can hinder their ability to understand what they are being asked and cause them to adopt a state of passiveness during the custodial process (Jones and Mason 2002). Police officers and staff were reportedly 'highly dependent on their own personal experience and judgments when identifying and responding to vulnerable people' (HMIC 2015: 116-20).

HMIC (2015) also found that custody officers were not always using the relevant databases to gather information which could inform the assessment process. Nor were custody officers always aware of the existence of specialist teams, even within the police organisation, resulting in 'limited links' between response officers, custody officers and specialist mental health teams (HMIC 2015: 118-20). The 'strong reliance on detainees self-reporting' resulted in a 'high proportion' of risks remaining unidentified (HMIC 2015: 84-6; McGilloway and Donnelly 2004; McKinnon and Grubin 2013). The Inspectorate reported that it was 'not always clear from the record why a person had been detained' or whether appropriate support had been provided (HMIC 2015: 116-20). In some cases, the basic welfare needs of detainees 'seemed to be overlooked' (ibid). The risk assessment questionnaire, in particular, appeared to be little more than a superficial 'exercise in compliance' rather than a genuine effort to meet the needs of vulnerable persons (ibid: 84-6). Similar issues reportedly affected the 'Pre-Release Risk Assessments' (PRRAs). PRRAs should assess whether an individual is fit to be released, whether they can get home safely and any referrals or action required. However,

HMIC (2015: 104-9) found little evidence of continuing support for vulnerable people who leave custody and reported that the assessments often contained incomplete sections and missing information. It even warned that if one of the 43 territorial police forces in England and Wales refused or failed to act in cases of mental health crises, it could result in over a thousand cases of 'severe harm with a strong possibility of death' per year, mainly due to the risk of suicide and self-harm (HMIC 2015: 51; Linsley et al 2007).

The extent to which the consultation with a mental health specialist will replace, inform or even improve the risk assessment process is unclear. There is no statutory requirement for the mental health specialist to engage directly with the vulnerable individual in every case. Instead it is likely that they will rely to a degree on the perspectives and observations of the officers involved. Moreover, there is no guarantee that mental health specialists will be more thorough than the custody officer. Police forces traditionally employed police surgeons, Forensic Medical Examiners (FMEs) and on-call doctors to check and treat the health of detainees (Laing 1995; Riordan et al 2000). However, a shortage of psychiatric training, expertise and experience has affected the ability of some medical practitioners to diagnose whether a detainee was even fit to be detained and interviewed, culminating in numerous miscarriages of justice on the basis of improperly and unconstitutionally obtained confessions (Savage et al 1997). The more recent employment of mental health experts within police custody suites as part of the Liaison and Diversion (L&D) scheme has done little to allay these doubts. The mental health specialists, who receive referrals from the custody officer so that they can conduct an initial screening and commence the treatment process, are often outsourced from private healthcare providers on confidential contracts (HAC 2015; HMIC 2015). The confidential nature of their employment can make it difficult to evaluate the competency, qualifications and experience of the embedded staff (Skinns 2011; Paterson and Best 2016). The disjointed nature of the endeavour is reflected in the fact that some police forces will employ mental health professionals within the custody suite for set times during the day, some will wait for nurses or doctors to arrive within a 90-minute period, while other forces rely on a combination of co-located mental health professionals and dedicated mental health support lines which police officers can call. As Skinns et al (2017) have observed, the opening up of the 'backstage' nature of the custody suite, where police officers traditionally '… felt free from legal and formal organizational rules…', to civilian 'outsiders', can foster greater accountability and transparency but the contractual nature of the work can also serve to make the system more opaque and unaccountable. HMIC (2015) has reported that delays continue to be commonplace; requests for assistance are not always responded to; healthcare teams are not always available around the clock; and systems for recording and sharing information are incomplete and prone to error. Ninety percent of participants in a study by Koskela et al (2016) reported a negative experience in police custody, which included: a perceived lack of acknowledgment, empathy and respect; the loss of power, liberty and control; and perceptions of disinterest, disbelief, blame and punishment for having mental health problems.

The wider hierarchical police organisation has done little to reform poor practices. Detailed records should be made in every instance involving the use of force for the purposes of 'management information', but HMIC (2015) has found that the collection and analysis of information concerning the use of force was under-developed across all of the forces it inspected. It found 'no evidence … of any analysis of trends that might enable police forces to understand how far officers' use of force was proportionate and safe…' (HMIC 2015: 118-20). Moreover, it did not find 'any evidence' that the use of force was monitored by vulnerability which could '…provide assurances to forces and the public that force was not

being applied in a discriminatory way' (ibid). Police forces '… did not know with any certainty what type of restraint had been used, how often and in what circumstances' (ibid: 94-6). They were not even able to confirm from their records whether or not tasers had been used in custody in the previous 12 months (ibid: 94-6). Little evidence was found of management review or analysis of the use of force and 'senior managers could not demonstrate that the use of force had been safe and proportionate' (ibid 110-2). It concluded that neither the police nor the public could 'be confident that the use of force was always necessary' (ibid: 118-20).

The absence of complete records means that there is no meaningful way of quantifying the demands on police time or the scale, nature and range of welfare needs within police custody. HMIC (2015: 110-2) found that chief officers had 'no oversight' and little awareness of how people with mental disorders were being treated in custody, culminating in a 'clear gap' between the policies described by senior officers and practices on the ground. The lack of systematic monitoring and the collection and review of data means that police forces do not know the level of demand and are therefore unable to plan appropriately or provide assurances that custody provision is safe, lawful or adequate (ibid). The quality of outcomes, any shortfalls in provision and the scale of police abuses remain largely unknown. HMIC (2015: 95) has, for example, stated that the use of force on vulnerable detainees is likely to be far higher than the instances recorded by police forces. Partly in response to this, the Minister for Policing and the Fire Service informed parliament in March 2017 that a new data collection system was being rolled-out to record key information about every serious use of force, including the type of equipment used, location and the ethnicity and age of the individual (Lewis 2017). He admitted that 'for the first time, these data will allow meaningful comparison across the range of techniques and tactics used by the police, and this should in time directly influence and strengthen police training, and operation decisions around the most appropriate tactics and equipment available where needed … it will allow scrutiny of why force is being used' (ibid).

Although such practices are long overdue, it is still not clear whether and to what extent the new recording practices will investigate the nature of mental health-related encounters more specifically. It is submitted that a far more extensive system should be developed to capture the range, nature and outcomes of mental health-related encounters so that police training and operational and strategic decision-making can be appropriately informed. Ironically, the employment of mental health specialists within police custody suites may actively encourage police managers to rely on the contracted specialists to collate relevant data and spot problems rather than instigate much needed organisational reforms. Rather than acting as 'civic educators' and transformative leaders, police managers may remain unaware, acquiescent or participants in the unhealthy police attitudes which are shaping police practices on the ground (Bayley 1995). It is abundantly clear that the recent changes do not go far enough and that a root-and-branch reform of police attitudes and the prevailing culture around mental health policing is needed.

The future of mental health policing

The attitudes and actions of police officers are not singularly responsible for the present condition of the mental health function of public policing (Marshall 2016). The efforts of police officers can be frustrated by inadequate services provided by members of the National Health Service (NHS), local authorities, mental health agencies and even police forces' own call-handlers. Police staff call-handlers, who receive and 'triage' calls for assistance, do not

always access all available databases to check whether 'warning markers' are held on a person's known mental disorders (HMIC 2015). Quick checks for whether a person has a propensity to use violence are reportedly prioritised over mental health concerns, leaving police officers bereft of crucial information at key times (ibid). Services provided by local authorities and the NHS are also frequently inadequate. Once referrals are made to s.136 suites, some local authority areas have too few suites to meet the needs of the local population; while some have too few staff members allocated to suites or rely upon staff who are temporarily seconded from other wards and are under 'constant pressure' to return to their 'normal' duties (CQC 2014; HMIC 2015). The lack of round-the-clock services in some force areas is particularly problematic (HAC 2015). Staffing shortages are reportedly so severe in places that mental health crisis teams have advised people who call for help that '…the only route to health intervention would be through calling the police' because police custody is considered by some to be a legitimate substitute for mental health care (HMIC 2015: 57, 113-5).

At NHS hospitals, waiting times for a mental health assessment can be severely problematic, averaging between four and eight hours nationally (HAC 2015). The average waiting time can extend to nine and a half hours if officers request an assessment to be conducted at a police cell (HMIC 2015: 98-103). Some of the most common reasons for delay include the unavailability of Authorised Mental Health Practitioners and the erroneous perception of some healthcare professionals that if a person is detained in custody, they are in 'a safe place' (Bradley 2009). A growing body of evidence also suggests that delays are occasionally caused by nurses, doctors and mental health professionals who are reluctant to attend police-related admissions because they fear the possibility of encountering a violent incident (Stirling et al 2001; Royal College of Psychiatrists 2007; de Tribolet-Hardy et al 2015). Furthermore, an 'anti-police sentiment' has been identified amongst some healthcare professionals, who object to police officers bringing individuals to hospitals out of inertia rather than experimenting with more creative and proportionate solutions (Bean et al 1991). Faced with inadequate support services, some police officers have 'unwillingly' charged vulnerable persons for public order or criminal offences in the hope that a magistrate may provide a 'gateway' to much needed psychiatric treatment, a phenomenon referred to as a 'mercy booking' (Teplin 1984; HMIC 2015).

Left to bear the brunt of these social problems due to a degree of societal and political neglect, vulnerable people have been described as 'police property' due to their frequent interactions with the police and subjugation to coercive police powers on a routine basis (Reiner 2010: 25). Conducted largely out of the public eye, good police work in this area has remained, by and large, a 'secret social service', shorn of the recognition and esteem that it deserves (Punch 1979: 102). Legal safeguards of 'necessity', 'proportionality', 'shortest possible time' and 'exceptional circumstances' have been rendered largely meaningless where there are no suitable services available to support police officers. However, the lack of esteem associated with this area of police work and the shortage of support services do not represent valid reasons for a police officer, or the wider policing organisation, to neglect a core policing function. Mental health needs may be largely misunderstood by the general public, leaving vulnerable people blighted by inequality, injustice and discrimination because of their inferior status and power, but police officers should remember their legal and operational responsibility to provide them with an ethical policing service.

Police officers should make every effort to learn the policies of their own organisation and those of partnering agencies, attend voluntary mental health awareness training and strive to

act ethically during every encounter. Police managers, in turn, need to develop clear oversight of the nature of mental health policing. Strategic planning, training and direction and control should be informed by systematic data collection and analysis of all manner of encounters between police officers and people who appear to be suffering from mental disorders. Rather than using banal labels such as 'non-crime' or 'social' to group together different types of social tasks, the policing organisation needs to develop a much clearer understanding of the nature of mental health policing on the ground. Long-standing theories, such as 'problem-oriented policing' (Goldstein 1990), 'intelligence-led policing' (Ratcliffe 2008), and 'community-oriented policing' (Manning 1977), should be applied to this area more systematically. 'Problem-oriented policing' is attractive as it encourages police forces to be more proactive in addressing the underlying causes and problems associated with mental health-related encounters. Police managers could, for example, gather and analyse data for the purposes of determining whether and to what extent incidents are concentrated in certain locations, such as group homes or homeless shelters, and how the management of these locations might be improved. 'Intelligence-led policing', in turn, encourages the analysis of data with a view to identifying and managing chronic and transient persons, who may move regularly between force areas. Finally, the ethos of 'community-oriented policing' indicates that the maltreatment of people with mental disorders raises issues of 'policing by consent', police legitimacy, procedural justice, human rights and 'the public good' (Loader and Walker 2007; Punch and James 2017). Police managers could, for example, arrange regular seminars with mental health charities and people who have been detained under s.136 so that police officers at every rank can better appreciate the 'lived experiences' of police interactions and the prejudices associated with mental illness (HAC 2015: 33-7). More broadly, the content of the 'police and crime plans' for various force areas would suggest that PCCs, who should guide strategic decision-making and the exercise of police discretion in key areas, are not engaging in longitudinal and extensive grass-roots consultation with individuals who are affected by poor police practice (McDaniel 2017).

From an accountability and transparency perspective, HMIC should consider widening the focus of its annual inspections to ensure that a basic standard of policing is being delivered across all manner of mental health-related encounters, not just in thematic areas such as domestic violence. Regular and thorough inspections are likely to be more effective than relying on the external police complaints mechanisms, such as the IPCC, to shape police practices since people with mental disorders are often unlikely to complain out of fear of being disbelieved, discredited or blamed for taking up police time (Koskela et al 2016). Furthermore, within academia, there is a palpable need for more targeted research and investigation. The current literature on mental health, as a distinct policy area, makes little or no attempt to analyse the strengths and weaknesses of policing approaches. Mental health texts occasionally contain distinct chapters on police powers but the discussion is generally limited to a banal restatement of legal powers and regulations listed in the Mental Health Act 1983 and the associated guidance; or only a tangential mention is made of 'the police' as an ambiguous participant in multi-agency partnerships. A small number of policing scholars have commendably engaged in empirical research in England and Wales, but the extant literature on the mental health dimension of public policing as a distinct subject remains haphazard, disjointed and under-developed. This is partly attributable to a lack of acute funding by policy and funding bodies (Wood and Watson 2017). Van Dijk and Crofts (2017) have observed that research funding tends to flow more readily in the health domain to medical research based on clinical trials than to policing and public health studies, largely because it is not yet properly appreciated as a distinct policy and research area. The mental health dimension of public policing continues to be 'the least developed in the offender

pathway', remaining in the periphery of policing studies and police science (Bradley 2009: 34). In the absence of targeted research and robust investigations into the present condition of mental health and policing, a litany of inter-related problems remain largely untreated.

Conclusion

If major reforms are not introduced, there is little to prevent ongoing delays 'at every stage in the process' and 'inconsistency of practices and procedures across the full range of custody operations' (HMIC 2015: 116-8). Decision-making by police officers, custody officers and police leaders may continue to be 'neither well-informed nor protective' in many cases, resulting in 'some very poor treatment of vulnerable people' and some entirely unnecessary detentions in police custody (ibid). Treatment may continue to be defined by procedural and clinical decision-making which is neither timely nor adequate. In the absence of greater understanding and appreciation of the constituent issues, government ministers and PCCs may continue to pressurise police forces to reduce the use of police custody as a 'place of safety' and laud major reductions as an indicator of success, even though police custody can potentially offer better quality care and referral pathways in some cases (Payne-James et al 2010; Morris 2016). To urgently address these issues, a new philosophy of 'treatment-led' policing should be carefully constructed by the policing organisation so that police officers are encouraged to exercise their discretion in more suitable ways, in spite of their limited resources. An ethos of accountability, transparency and ethics needs to inform and permeate the mental health function of public policing.

Bibliography

Ariel, B. et al (2017) 'Contagious Accountability', *Criminal Justice and Behaviour*, 44(2), 293-316.

Banton, M. (1964) *The Policeman in the Community*. Tavistock Publications. London.

Bayley, D. (1994) *Police for the Future*. Oxford University Press.

Bayley, D. (1995) 'Getting Serious about Police Brutality' in Stenning, P. ed. *Accountability for Criminal Justice*. University of Toronto Press.

Bayley, D. and Bittner, E. (1984) 'Learning the skills of Policing', *Journal of Law and Contemporary Problems,* 47, 35 – 50.

Bean, P. et al (1991) *Out of Harm's Way*. Mind Publications. London.

Bittner, E. (1967a) 'Police discretion in emergency apprehension of mentally ill persons', *Social Problems,* 14, 278–292.

Bittner, E. (1967b) 'The Police on Skid-Row: A Study of Peace Keeping', *American Sociological Review,* 32(5), 699 – 715.

Bittner, E. (1970) *The Functions of the Police in Modern Society*. Centre for Studies of Crime and Delinquency. Maryland.

Bittner, E. (1974) 'Florence Nightingale in Pursuit of Willie Sutton' in Newburn T. (ed), *Policing: Key Readings*. Routledge.

Bittner, E. (1990) *Aspects of Police Work*. Northeastern University Press.

Blair, I. (2016) 'The police can't continue to pick up the pieces of Britain's mental health cuts', *The Guardian*, 25 October 2016, accessed at: https://www.theguardian.com/commentisfree/2016/oct/25/police-britain-mental-health-cuts-crisis

Bradley, K. (2009) 'Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. Department of Health. London.

Campbell, D. (2016) 'Ban use of police cells for people in mental health crisis, MPs told', *The Guardian,* 16 November 2016, accessed at: https://www.theguardian.com/society/2016/nov/16/ban-police-cells-mental-health-crisis

Care Quality Commission (CQC) (2014) 'A Safer Place To Be'. Independent Publication.

Chan, J. (1996) 'Changing Police Culture' *British Journal of Criminology,* 36(1), 109

Chiswick, D. (1992) 'Reed Report on Mentally Disordered Offenders', *British Medical Journal,* 305(12), 1449.

Clifford, K. (2010) 'The thin blue line of mental health in Australia', *Police Practice and Research,* 11(4), 355-370.

Cohen, S. (1972) *Folk Devils and Moral Panics*. McGibbon and Kee.

College of Policing (2016a) 'Authorised Professional Practice: Mental Health'. Revised October 2016.

College of Policing (2016b) 'Authorised Professional Practice: Control, Restraint and Searches'. Revised December 2016.

Compton, M.T. et al (2011) 'Use of force preferences and perceived effectiveness of actions among crisis intervention team (CIT) police officers and non-CIT officers in an escalating psychiatric crisis involving a subject with schizophrenia', *Schizophrenia Bulletin,* 37(4), 737–745.

Crawford, A., Lewis S. & Traynor, P. (2012) *Research Findings: Anti-social Behaviour Interventions with Young People*. University of Leeds.

Cummins, I. (2012) 'Policing and Mental Illness in England and Wales post-Bradley', *Policing,* 6(4), 365-376.

Cummins, I (2013) 'Policing and Mental Illness in the era of deinstutionalisation and mass incarceration: A UK Perspective', *International Journal of Criminology and Sociological Theory*, 6(4), 92-104.

Cummins, I. and Edmondson, D. (2016) 'Policing and street triage', *The Journal of Adult Protection*, 18(1), 40-52.

De Tribolet-Hardy, F., Kesic, D. and Thomas, S. (2015) 'Police management of mental health crisis situations in the community: status quo, current gaps and future directions', *Policing and Society*, 25(3), 294-307.

Dodd, V, (2016) 'Police say they are becoming emergency mental health services', *The Guardian*, 9 October 2016, accessed at: https://www.theguardian.com/uk-news/2016/oct/09/police-forces-mental-health-section-136

Dyer, W., Steer M. and Biddle P. (2015) 'Mental Health Street Triage', *Policing,* 9(4), 377-387.

Emsley, C. (1996) *The English police: a political and social history*. London. Longman.

Goldsmith, A. (1991) 'External Review and Self-Regulation' in Goldsmith A. (ed) *Complaints Against the Police*. Clarendon Press.

Goldstein, H. (1990) *Problem-oriented Policing*. Temple University Press.

HMIC (2015) The welfare of vulnerable people in police custody. London: Her Majesty's Inspectorate of Constabulary.

HAC (2015) Policing and Mental Health. House of Commons Home Affairs Committee Eleventh Report of Session 2014-15, HC 202.

Horspool, K. et al (2016) 'Implementing Street Triage', *BMC Psychiatry,* 16(313), 1-11.

IPCC (2016) Police use of force. London: Independent Police Complaints Commission.

Jones, S. and Mason, T. (2002) 'Quality of treatment following police detention of mentally disordered offenders', *Journal of Psychiatric and Mental Health Nursing,* 9(1), 73-80.

Kane, E. et al (2017) 'Effectiveness of current policing-related mental health interventions in England and Wales and Crisis Intervention Teams as a future potential model: a systematic review', *Systematic Reviews,* (6), 1-7.

Koskela, S., Pettitt, B. and Drenna, V. (2016) 'The experiences of people with mental health problems who are victims of crime with the police in England: A qualitative study', *British Journal of Criminology*, 56, 1014–1033.

Laing, J.M. (1995) 'The mentally disordered suspect at the police station' *Criminal Law Review,* 371-381.

Lamb, H.R., Weinberger, L.E., and DeCuir, W.J. (2002) 'The police and mental health' *Psychiatric services*, 53(10), 1266–1271.

Lewis, B. (2017) Parliamentary Debates: Minister for Policing and the Fire Service, 2 March 2017, Vol 622, Column 17WS. House of Commons. Hansard.

Linsley, K., Johnson, N. and Martin, J. (2007) 'Police contact within 3 months of suicide and associated health service contact', *The British Journal of Psychiatry,* 190 (2), 170-171.

Loader, I. and Walker, N. (2007) *Civilizing Security*. Cambridge University Press.

Lustgarten L. (1986), *The Governance of Police*. London Sweet and Maxwell.

Manning, P.K. (1977) *Police Work*. MIT Press.

Marshall, A. (2016) Public Bill Committee: Chief Constable College of Policing, 15 March 2016, Column 77. House of Commons. Hansard.

Marshall, G. (1965) *Police and Government: The Status and Accountability of the English Constable*. Methuen. London.

Martin, T. and Thomas, S. (2015) 'Police officers' views of their encounters with people with personality disorder', *Journal of Psychiatric and Mental Health Nursing*, 22, 125–132.

McDaniel, J.L.M. (2017) 'Rethinking the law and politics of democratic police accountability', *The Police Journal: Theory, Practice and Principles*, DOI 10.1177/0032258X16685107.

McGilloway, S. and Donnelly, M. (2004) 'Mental illness in the UK criminal justice system: A police liaison scheme for Mentally Disordered Offenders in Belfast', *Journal of Mental Health*, 13(3), 263–275.

McKinnon, I. and Grubin, D. (2013) 'Health Screening of People in Police Custody - Evaluation of current police screening procedures in London, UK', *European Journal of Public Health*, 23(3), 399-405.

Morris, S. (2016) 'Police raise concerns after letting vulnerable patient sleep in patrol car', *The Guardian*, 2 September 2016, accessed at: https://www.theguardian.com/society/2016/sep/02/wiltshire-police-hospital-bed-mental-health

Muir, W.K. (1977) *Police: Streetcorner Politicians*. University of Chicago Press.

Murphy, G.E. et al (1971) 'The role of the police in suicide prevention', *Life-Threatening Behavior*, 1, 96– 105.

Neyroud, P. and Beckley, A. (2001) *Policing ethics and human rights.* Willan.

Paterson, C. and Best, D. (2016), 'Policing Vulnerability through building community connections', *Policing*, 10 (2), 150-157.

Patten, L. (1999) 'A New Beginning: Policing in Northern Ireland', Report of the Independent Commission on Policing for Northern Ireland.

Payne-James, J. et al (2010) 'Healthcare issues of detainees in police custody in London', *Journal of Forensic and Legal Medicine*, 17 (1), 11-17.

Peay, J. (2010) *Mental health and crime*. London. Routledge.

Punch, M. (1979) 'The secret social service' in Holdaway S. (ed), *The British police*, London. Arnold.

Punch, M. and James, S. (2017) 'Researching law enforcement and public health', *Policing and Society*, 27(3), 251-260.

Punch, M. and Naylor, T. (1973) 'The police: a social service', *New society*, 24 (554), 358– 361.

Quinn, B. et al (2016) 'Mental health crisis takes huge and increasing share of police time', *The Guardian*, 27 January 2016, accessed at: https://www.theguardian.com/uk-news/2016/jan/27/mental-health-crisis-huge-increasing-share-police-time-40

Ratcliffe, J. (2008) *Intelligence-led Policing*. Willan.

Rawlings, P. (2011), 'Policing before the Police' in Newburn T. (ed), *Handbook of Policing* 2nd edn. Willan.

Reiner, R. (1985) *The Politics of the Police*. Whitsheaf Books.

Reiner, R. (2010) *The Politics of the Police*. 4th edn. Oxford University Press.

Reisig, M.D. et al (2004) 'Suspect disrespect toward the police', *Justice quarterly*, 21(2), 241–268.

Reiss, A. and Bordua, D. (1967) 'Environment and Organization: A Perspective on the Police' in Bordua D., *The Police: Six Sociological Essays*. John Wiley Publishers. New York.

Reuland, M. (2010) 'Tailoring the police response to people with mental illness to community characteristics in the USA', *Police Practice and Research*, 11(4), 315–329.

Riordan, S. et al (2000) 'Diversion at the point of arrest: mentally disordered people and contact with the police', *The Journal of Forensic Psychiatry,* 11(3), 683-690.

Royal College of Psychiatrists (2007) in Bowers, L. *et al* (2011) *Report from the conflict and containment reduction research programme.* King's College London.

Savage, S.P. et al (1997) 'Divided loyalties? —the police surgeon and criminal justice', *Policing and Society*, 7(2), 79-98.

Schulenberg, J. (2015) 'Police Decision-Making in the Gray Zone', *Criminal Justice and Behavior*, 43(4), 459–482.

Sims, A.C.P. and Symonds, R.L. (1975) 'Psychiatric Referrals from the Police', *The British Journal of Psychiatry*, 127(2): 171-178.

Skinns, L. (2011) *Police custody: governance, legitimacy and reform in the criminal justice process*. London. Routledge.

Skinns, L., Wooff, A. & Sprawson, A. (2017) 'Preliminary findings on police custody delivery in the twenty-first century: Is it 'good' enough?', *Policing and Society*, 27(4), 358-371.

Skogan, W. (2008) 'Why reforms fail' *Policing and Society,* 18(1), 23 – 34.

Skolnick, J. (1966) *Justice Without Trial: Law Enforcement in Democratic Society*. John Wiley and Sons. New York.

Skolnick, J. (1977) 'A sketch of the policeman's working personality' in Newburn, T. (2005), *Policing: Key Readings*. Routledge.

Smith, J.P. (1990) 'Police are best at community care of mentally ill people in England', *Journal of Advanced Nursing,* 15(10), 1117.

Souryal, S. (2015) *Ethics in Criminal Justice*. 6th edn. Anderson Publishing.

Stone, N. (1995) *A Companion Guide to Mentally Disordered Offenders*, Shaw and Sons UK.

Teplin, L. (1984) 'Criminalizing mental disorder: The comparative arrest rate of the mentally ill', *American Psychologist*, 39(7), 794–803.

Towl, G. and Crighton, D. (2012) 'Policing and Mental Health', *Evidence Based Mental Health*, 15 (4).

Treplin, L. and Pruett, N. (1992) 'Police as streetcorner psychiatrists. Managing the Mentally Ill', *International Journal of Law and Psychiatry*, 15(2).

Van Dijk, A. and Crofts, N. (2017) 'Law enforcement and public health as an emerging field', *Policing and Society*, 27(3), 261-275.

Van Maanen, J. (1983) 'The Boss' in Punch, M. (ed) *Control in the Police Organisation*. MIT Press.

Waddington, P.A.J. (1999) *Policing Citizens*. Routledge.

Waddington, P.A.J. et al (2013) *Professional Police Practice*. Oxford University Press.

Walsh, D.P.J. (1998) *The Irish Police: A legal and constitutional perspective*. Roundhall Sweet and Maxwell.

Watson, A. et al. (2004) 'Police Officers' Attitude Toward and Decisions About Persons with Mental Illness', *Psychiatric Services,* (55), 49-53.

Weber, M. (1918) 'Politics as a Vocation' in Weber et al (2012), *From Max Weber: essays in sociology*. Ulan Press.

Wilson, J.Q. (1968) *Varieties of Police Behaviour*. Harvard University Press.

Wood, J. & Watson, A. (2017) 'Improving police interventions during mental health-related encounters: past, present and future', *Policing and Society*, 27(3), 289-299.

Wood, J. et al (2011) *Police interventions with persons affected by mental illnesses: a critical review of global thinking and practice*. Center for Behavioral Health Services and Criminal Justice Research. Rutgers University.

Wright, K. and McGlen, I. (2012) 'Mental Health Emergencies: using a structured assessment framework', *Nursing Standard*, 27(7), 48-56.