**‘This isn’t just a case of taking someone to the hospital’: Police approaches and management of situations involving persons with mental ill health in the custody suite and beyond**

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**Introduction**

One of the many, unforeseen, consequences of the policy to close long-stay hospitals has been a shift in the role of criminal justice agencies, which have had to deal with increasing numbers of people experiencing mental health problems (Cummins, 2012). As well as being responsible for the detection, investigation and prevention of crime, policing now involves responding to a much broader set of social problems. Indeed, it has been reported that mental health is the ‘core business of policing’ (Adebowale, 2013:6). With a third of people in police custody estimated to have some form of mental health problem (Leese and Russell, 2017) and mental health estimated to be a factor in 20-40% of police time, it has been described as ‘a number one issue’ for frontline officers (House of Commons Home Affairs Committee 2015:8). Growing recognition of the police’s involvement with those who are vulnerable and mentally ill has also led to increasing scrutiny of the risks involved with detaining vulnerable people in police custody (Adebowale, 2013; Angiolini, 2017; Department of Health and Home Office, 2014a, 2014b; Independent Advisory Panel on Deaths in Custody, 2015). While the Police and Crime Act (PCA) 2017 now places restrictions on the use of police cells as ‘places of safety’ for those detained under mental health legislation, it is important to remember that the police must still process, as well as care for, those they arrest or otherwise attend to on the frontline with mental health problems.

In this chapter, our initial focus will be on how people with possible mental health problems are processed and cared for in police custody, the protections available to them and the key challenges involved with their detention. First, we attend to the processes involved for those people that are detained following arrest by exploring the relevant provisions under Police and Criminal Evidence Act (PACE) 1984 along with consideration of liaison and diversion (L&D) services and Appropriate Adults (AA). Secondly, we attend to those people who find themselves in police custody after being detained under mental health legislation. It is at this juncture that we acknowledge concerns about the role of the police and the extent to which they have become the first point of contact for those experiencing a mental health crisis (Her Majesty’s Inspectorate of Constabulary (HMIC), 2017; Her Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), 2018). Drawing on data from an empirical study utilising Knowledge Exchange Groups (KEGs) and semi-structured interviews with police officers and other related practitioners, we identify the additional issues and challenges faced by police officers when approaching and managing incidents of mental health beyond the custody suite. As resources diminish in health and social care, we find that the police are increasingly called to situations that require care-taking skills but very rarely require the need for law enforcement.

**Mental health and vulnerability in police custody: Detention following arrest**

Many people detained in police custody following arrest have some form of vulnerability, including mental health problems (HMIC, 2015). Small-scale prevalence studies have revealed that between one-third and a half of detainees may be experiencing mental health problems. For example, Payne-James et al. (2010) found that 46% of detainees in their sample had a reported mental health problem. It is for this reason that the police have a legal obligation to care for, as well as process, those they arrest that are identified later as having mental health problems. In addition, officers working in police custody have a duty to ensure that those they arrest who present with a mental health issue are diverted from the criminal justice system at the earliest opportunity as well as ensuring justice is exercised for those identified as vulnerable.

Under Section 3 Health and Safety at Work Act 1974, the police have a statutory responsibility to ensure that detainees have appropriate access to timely and effective healthcare while in custody. In accordance with PACE Code C, the custody officer must make sure that appropriate medical attention is given as soon as practicable to any detainee who:

* Appears to be physically ill or injured
* Appears to be, they suspect, or have been told may be, experiencing mental ill health
* Appears to have a drug or alcohol dependence
* Appears to need medical attention
* Requests a medical examination

Custody officers must therefore, seek medical assessment (or treatment) for any person whom they suspect may be mentally disordered or otherwise mentally vulnerable, and consider the need for medical attention for those suffering the effects of alcohol or drugs. As part of this assessment, decisions will be made about a person’s fitness to be detained and interviewed (Kennedy, Green and Payne-James, 2017). However, research suggests that the number of people in custody under the influence of alcohol or drugs, along with limited police training (Cummins, 2016) adds to the problems involved with identifying and managing detainees with mental disorder in custody (Noga et al., 2015).

If mental health needs have been identified, it is at this point of the process that diversion from the criminal justice system may take place and detainees may be provided with access to L&D services. While diverting people with mental health needs away from the criminal justice system into the care of health and social services has been a policy aim for some time (Department of Health and Home Office, 1992; Home Office, 1990; 1995) a renewed emphasis on the provision of L&D schemes has emerged following the Bradley report (Department of Health, 2009). This has led to the implementation of schemes such as ‘street triage’ where police officers and mental health nurses work together to identify people with mental health needs (Horspool et al., 2016). When working effectively, these services present opportunities for people with mental health problems to be identified and assessed as early as possible. Following screening and assessment, individuals may be given access to appropriate services including mental health, social care and/or substance misuse treatment. Consistent with the recommendations made in the Bradley review (Department of Health, 2009), information from these assessments may then be shared with appropriate agencies so that informed decisions can be made on issues of diversion, charging, case management and sentencing.

In addition to the opportunity to refer individuals to L&D schemes, a person identified as particularly vulnerable – juveniles (aged 10–16), adults with mental health problems and adults with learning difficulties – should be accompanied by an AA during police interrogation (as well as other procedures including fingerprint identification and searches). An AA can be: a relative, guardian or other person responsible for their care and custody; someone experienced with mentally disordered or mentally vulnerable people but who is not a police officer or employed by the police; or, failing these, some other responsible adult aged 18 or over who is not a police officer or employed by the police (PACE Code C, para. 1.7 (b)).

Despite this provision, the use of AAs with vulnerable adults with mental health problems is suspected to be low (Cummins, 2011). A recent review by the National Appropriate Adult Network (NAAN, 2015) expresses concern about the inadequate identification of suspects’ vulnerabilities and their need for an AA. Indeed, NAAN (2015) estimates that while 11% of adults in police custody require the support of an AA, only 1-2% of suspects are supported by an AA during police interview. Identification of mental health problems is important because if they are not identified, no application for an AA will be made. In addition to concerns about inadequate police practices for identifying mental health needs, concerns have been expressed about the limited availability of AAs (NAAN, 2015). This can lead to significant delays in accessing AAs, which can create procedural difficulties because of the limited time suspects can be held, while also causing unnecessary stress to detainees, which may increase their vulnerability while in custody (NAAN, 2015). There is also concern about the ‘variable quality’ of AAs (NAAN, 2015) and that their role is ambiguous (Cummins, 2011; Pierpoint, 2008). Indeed, Cummins (2011:308) suggests that the role can be contradictory and confusing on the basis that an AA is ‘not quite an advocate, not quite a referee’. While Cummins (2011) generally advocates the protections that AAs afford to vulnerable detainees he also reminds us that one potential counter argument and negative aspect of their role is that they may undermine the autonomy of the person they are trying to support. One way this can happen is if the AA insists on legal representation attending the station after the detainee has already waived their right to legal support. To address these issues, calls have been made for the role of AAs to be both extended and clarified (Pierpoint, 2011).

Unfortunately, the evidence suggests that the majority of people in police custody who are entitled to the support of an AA are not getting it. Given research has found disproportionately high levels of false confessions among people with mental illness (Redlich, 2004), it is essential that any mental health difficulties are identified if the interviewing process is to be fair and just (Gudjonsson, 2010). The lack of AA provision raises concerns regarding the rights of the detainee being properly met but may also represent a missed opportunity to encourage proper assessment and diversion to appropriate services. This ‘undermines their welfare, inhibits the exercise of their legal rights, risks miscarriages of justice and lengthens custody times potentially increasing the risk of self-harm’ (NAAN, 2015:4).

NAAN (2015) highlight that the absence of a statutory duty on any agency to ensure vulnerable adults have access to an AA means that there is patchy provision across the country. For example, under s38 of the Crime and Disorder Act 1998 local authorities are legally required to ensure that an AA be provided for all children via their Youth Offending Team (YOT) yet there is no such statutory duty on any agency to provide an AA for vulnerable adults with learning difficulties or mental health problems. NAAN (2015) therefore recommends that statutory responsibility for AA services for vulnerable adults is given to local authorities to ensure provision of an AA when requested by police and to create parity with children’s services. In August 2018 the Association of Police and Crime Commissioners (APCC) (2018) also wrote to the Policing Minister calling for this statutory duty to be introduced. In the absence of a statutory duty Cummins (2015) argues that it is not possible to effectively tackle the serious issues identified in the provision of AAs.

**Mental health and vulnerability in police custody: Police custody as a ‘place of safety’**

In addition to being detained as a consequence of arrest, some people have historically found themselves in police custody following detention under mental health legislation. Under the Mental Health Act 1983 (as amended by the MHA 2007 and PCA 2017), a police officer may remove a person who appears to be having a mental health crisis and is in need of immediate care and control, to a ‘place of safety’. Under s135 of the MHA 1983, with a warrant, police officers have the power to enter *private* premises and remove a person to a place of safety, while under s136 of the MHA 1983, the police also have the power to remove a person from a *public* place to a place of safety.

Following changes under the PCA 2017, police stations can no longer be used for those under the age of 18 in any circumstances while the detention of people aged 18 or over in police custody can now only take place in very limited circumstances. If police custody is to be used as a place of safety it must now be done in accordance with the MHA 1983 (Places of Safety) Regulations 2017, which sets out a number of conditions that must be met and safeguards that should be in place.

These changes came about because of a broad consensus and growing concerns that police custody is not an appropriate place for a person in mental health crisis (Home Office, 1990; Department of Health and Home Office, 1992, 2014a, 2104b; Royal College of Psychiatrists, 1997; Jones and Mason, 2002; Katsakou and Priebe, 2007; see also MS v UK 24527/08 [2012] ECHR 804). Indeed, Bradley identified that detention in police custody ‘has the effect of criminalising people for what is essentially a health need’ and ‘may exacerbate their mental state, and in the most tragic cases can lead to deaths in custody’ (Department of Health, 2009:45). However, in the absence of appropriate alternatives, police cells have historically become the de facto place of safety. Indeed, a review of the use of place of safety in 2008 found that twice as many people were being held in police custody as a place of safety than in a more appropriate, hospital environment (IPCC, 2008).

Recent Home Office data for the year ending March 2018 reveals while the use of police custody to detain people under s135 and s136 has fallen, the use of s135 and s136 powers has been increasing with a 5% increase recorded between March 2016 and 2017 (Home Office, 2018). In 85% of cases a person detained under s136 was taken to a health-based place of safety (HBPOS) and a further 12% were taken to Accident and Emergency as a place of safety. This means that in 2017-18 only 2% (n=471) of people were taken to a police station as a place of safety, down from 4% (n=1,029) in the previous year. While these data suggest that the PCA 2017 is having the desired effect and that there has been a significant reduction in the use of police custody as a place of safety, further analysis of the data for those taken to a police station, reveals ongoing problems with the availability of mental health services. Indeed, 40% of those who were taken to a police station as a place of safety were taken there because local HBPOS had no capacity, and in a further 10% of cases because the HBPOS refused admission. The remaining 50% were taken to police custody because of concerns about violence (27%), following arrest for a substantive offence (12%) or for ‘some other reason’ (11%) (Home Office, 2018).

These figures remind us that the police are still likely to come across, and have to manage, those in mental health crisis. Moreover, they reflect long-standing and ongoing problems with the provision of mental health and social care services. Since the closure of the asylums, investment in mental health provision has fallen dramatically. The King’s Fund (2017) reports that between 1987/88 and 2016/17, the number of overnight mental health beds fell by 72 per cent. The most dramatic effects have taken place during the recent period of austerity where, since 2011, approximately 40% of mental health trusts have experienced year on year budget cuts (Gilburt, 2015). The provision of mental healthcare has now reached such a state of severity that the police are being used to fill the gaps that other agencies cannot (HMIC, 2017). This shift has had a profound effect on the work of police officers, who are having to play an increasingly important role in responding to people who are experiencing difficulties with their mental health. Often, the police are the very first point of contact for those in crisis and research suggests that the level of contact between the police and those with mental illness continues to increase (Morgan and Paterson, 2017). At the time of writing, the HMICFRS (2018) reports that the Metropolitan Police Service receives a call about a mental health concern every four minutes and sends an officer to respond every 12 minutes.

Against this backdrop, the following section draws on data collected from three KEGs and twelve one-to-one interviews with police officers and other related practitioners from one UK police force area to explore some of the issues and challenges confronted by police officers when approaching and managing incidents involving mental ill health.

**The empirical study: Purpose, design and method**

The qualitative study was conducted in the Midlands, UK, and was designed specifically to identify issues, obstacles and concerns relating to how the police approach and manage situations involving persons with mental ill health. The first phase of the study involved the implementation of a KEG consisting of 30 frontline staff and strategic partners who work within the context of policing and mental health. During this phase of the research, three groups were formed consisting of ten participants each. Each group was asked to identify a key area of concern or issue related to their role. One member of the group was then asked to present their issue to other members while the research team, actively listened and guided the case presenter. Other members of the group were also given an opportunity to ask questions. After questions had been answered and the issue or area of concern clarified, other members of the group were asked in turn to provide ideas that may help address the issue or area of concern identified. This process was then repeated for each member of the KEG. The KEG met three times during the year 2016/17 identifying ongoing issues as they arose. The second phase of the project comprised 12 in-depth interviews with participants from the KEG. The participants of the study were recruited through existing contacts within the police service and, thereafter, through snowball sampling. The semi-structured interviews permitted us to explore, in more depth, the issues that were raised during the KEGs. All of the KEGs and interviews were recorded, transcribed, and axial encoding was conducted to organise the raw data into ideas, themes and phenomena as they arose (Strauss and Corbin 1997). The second phase of data analysis consisted of a discussion between the research team whereby prevalent themes were identified and compared. Following this phase of cross-checking, final themes were derived from the dataset.

Consistent with the objectives of the chapter we focus our discussions on three, interlinking, themes. We begin by reporting on practitioners’ observations of the impacts of *austerity and the displacement of mental health and social care services*. The discussion of this theme helps set the context for the next two themes: *taking responsibility and ‘holding the fort’* and *filling the gaps in service provision: ‘this isn’t just a case of taking someone to hospital’.*

**Austerity and the displacement of mental health and social care services**

Many of our participants expressed humanitarian concerns for the people who were requesting help and support and although resources were not always referred to, the narratives of practitioners often moved to the inevitable conclusion that mental health and social care services are suffering from dire under-funding. Although the CQC (2018) found no evidence that the police are using mental health legislation to detain people who do not meet the criteria for mental health services, observations made by many of the practitioners in this study revealed that changing admission criteria in mental health services was impacting on the support received by those in need:

“Because the public sector is being tightened, where someone might fit the criteria for more [mental health] support a year or two years ago they don’t fit that criteria now so they are not getting the support they need, and if they’ve not got family around them then that person can become quite isolated” (Kevin[[1]](#endnote-1), police officer).

In the absence of care previously received, practitioners reported that those in need of care were more likely to reach out to emergency services:

“I would say there are issues. Resources without any question ... when you think how many acute inpatient beds we used to have and how many we have got now ... so we have got more people being supported within the community ... people don't disappear, what we do is move it into somewhere else and I think that's what we are seeing. I’m sure the police will say that what they deal with now is more health and social welfare than crime” (Janet, mental health practitioner).

Janet’s observation that ‘people don’t disappear’ and that they simply get ‘moved’ implies a ‘displacement’ of mental health and social care provision. In the same way that crime may be displaced as a consequence of crime prevention methods (Hesseling, 1994) so too might mental health and social care provision, particularly in the context of austerity where there have been year on year budget cuts and dramatic cuts in the availability of mental health beds. As Janet observes, this may have impacted on the role of emergency services that are now expected to respond to mental health and social care issues at an increasing rate. From a straightforward legal and organisational perspective, the role of the police is to maintain law and order, protect the public and their property, detect, investigate and prevent crime. Yet, growing empirical evidence suggests that this role has now been extended to include ‘citizen protection, public reassurance and safeguarding’ (Charman, 2018:6) as John, a police officer, explains:

“the days of coming in and locking up criminals and burglars and robbers every day, the percentage of that work is decreasing. It is now about safeguarding, it is about safeguarding of vulnerabilities, probably our biggest challenge at the moment” (John, police officer).

**Taking responsibility and ‘holding the fort’**

Dominating the discussions in both the KEGs and interviews were police officers’ frustrations with the increasing expectation placed upon them to respond to people with low severity mental health, i.e. those people who may not be in crisis but might be regarded as vulnerable in the absence of appropriate support services and networks. Consistent with the findings of the HMICFRS (2018) report, a large proportion of 999 calls to the police are no longer emergencies and instead what the emergency services call ‘frequent callers’: a group of people with chronic, often multiple conditions, mental health issues, high levels of anxiety, lack of confidence in managing their own problems, and people feeling socially isolated that may be seeking attention. Police officers expressed concerns about the increasing volume of calls being received by people who are known to mental health services but are not experiencing crisis:

“We obviously have people who ring off on a daily basis, who suffer very low-level mental health issues” (Jim, police officer).

This situation led to feelings of deep frustration. Ill equipped to predict the risks posed by those people they attend to - especially where a mental health issue becomes apparent- police officers often stepped in as a minder until other health and social care services were able to respond:

“We're the ones that get called to it because it's instant, but actually all we do is get there and hold the fort until other people whose response times are not anything like what ours would be, ours would probably be 10 or 20 minutes an hour at most, can get there” (Mark, police officer).

“I have been to jobs where an individual, certainly in the city when I was a sergeant and as a PC where people just want someone to talk to for 8 hours, they can't be assessed because they are drunk. Eventually they will sober up and then we will go, or someone will come and say here's an appointment for next week and we've used two officers for the best part of an entire shift. Sitting with someone because we hold the risk” (Gary, Inspector).

Whilst Lord Justice Slade, in the case of Alexandra v Oxford [1993]4 All ER 328, held that police should not be held liable for failure to respond to an emergency call, the police do have a duty of care to ensure that they do not act in a manner that makes things worse when they arrive at a scene (Rigby v Chief Constable of Northamptonshire [1985] 1 WLR 1242). This duty of care is clearly evident in Mark’s and Gary’s expressions above, which reveal their feelings of responsibility towards the people they attend to.

**Filling the gaps in service provision: ‘This isn’t just a case of taking someone to hospital’**

Whilst section 136 of the MHA 2007 has become a fundamental tool for police officers when managing situations involving persons with mental ill health (Turner et al., 1992), in recent years police officers have had to draw on tools and resources that have often been developed through the course of their policing careers. As police officers are increasingly expected to respond to the demand caused by a shortage in mental health provision, their role has become much more than simply ‘taking someone to the hospital’:

“There are people who don't want to be locked up on a warrant and will really fight. I remember one guy, not only did he have mental health problems but also had brittle bones so they positioned themselves behind the door like because they knew that if we if we were to put the door through we would have broken their legs.  It's extremely challenging but this isn't just a case of taking someone to hospital. We have to think about how we are going to get into the house, how we are going to get them out of the house safely because the sight of two police officers with Tasers dragging some frail lady or carrying someone out is never good, it's not good for anybody. It can involve quite a number of so many different agencies” (Bill, police officer).

Bill’s observation that the role of the police officer isn’t simply about ‘taking someone to hospital’ is captured in Mark’s following description of his day to day encounters:

“You try and interact with the person don't you? You ask them to talk you through why they’re feeling like this. It might be that they’ve been on the phone to us saying that they need some help or they might have been on to the crisis team or the community mental health team, saying that they’re struggling and going to take a an overdose. We then get a phone call and we turn up. So we've got a little bit of background and they're quite happy to open the door to us and we’re thinking have you taken anything? Do I need to think about an ambulance? If I can get you an ambulance then maybe I can get you referred at the hospital? But if they are like no, no I haven't taken anything then you've got a situation in the property, which way do you go on that? Sometimes it can take hours” (Mark, police officer).

This type of interaction illustrates the variety of challenges confronted by police officers in their everyday work. It shows the range of questions a police officer must consider in order to make informed decisions about possible actions to be taken. Importantly, however, this interaction also reflects a police officer acting within the confines of legislation. Being in a property with a person that is presenting with a mental health issue presented Mark with a quandary. He could not instigate a s136 under the MHA because he was in a private property (and would therefore need a warrant to exercise his powers under s135), yet neither could he leave the property until he was convinced the individual in question was safe.

Police officers also talked extensively about their role in safeguarding, particularly with regards to those people experiencing low severity mental ill health. In an effort to reduce the number of calls being processed in the control room one officer described how he had made regular arrangements to visit people who might be described as ‘frequent callers’:

“The control room, if they are able to might have a little chat with them on the phone and that's it they will go on their way again. I have got a couple on myself I go and try to see them a couple of times a week” (Aaron, police officer).

Additionally, Aaron offered various examples of the type of support he had provided to people with mental ill health, ranging from help with accommodation, utility bills, and cleaning:

“There is this particular person who calls in, has been one of our highest callers. Some of the agencies that were dealing with him were unable to get him rehoused and we had to step in a little bit. Some of our PCSOs [Police Community Support Officers] have gone in and helped him clean his flat, they have helped him with some bills, they have done things like that. He now knows that if he rings the police someone will go and speak to him and tell him what he needs to do. When it comes through the control room now it’s flagged that he has got mental health issues and it is myself that goes to see him and then I update the incident to notify when I am going to see him next, so if he calls they will say "OK Gary but Aaron is coming out to see you next Tuesday so you can wait till then" ... and that has actually reduced his calls quite dramatically, just by doing that and I've done him a flowchart as well … I've done the flow chart so that if he hears a bang in the day, don't do anything, if he hears a bang in the night he makes a note in his log … to be fair it's working quite well” (Aaron, police officer).

According to the discussions had during the KEGs, the situation described by Aaron is typical of a police officer’s day to day encounters with vulnerability. Consistent with research conducted in the United States, most of the interactions officers have with persons affected by mental illnesses do not involve major crimes or violence (Draine et al., 2002; Fisher et al., 2006) nor do they often meet the legal criteria of emergency apprehension (Bittner, 1967; Green, 1997; Teplin and Pruett, 1992). Rather, police encounter individuals who have fallen through the gaps in service provision due to a lack of service initiation or sustained engagement outside of crisis situations. Described by Wood et al. (2017) as the ‘grey zone’, these encounters occur where the problems at hand do not call for formal or legalistic interventions including arrest and emergency apprehension.

This changing nature of police work raises fundamental questions about police training and the decisions they make. As the following observations made by James and Gary illustrate, in addition to training on mental health legislation, police officers need to know what they can do to help the situation and who they can ask to assist them:

“For mental health s135 and s136 training, having looked at it, it was almost aimed at teaching you how to suck eggs. You know, recognising someone in the street that doesn't look very well.  Do I really need that?  Come on, I got this job for a reason not because we decided to walk in off the streets to the police station one day and said give us a job. We've got something about us, we've gone through a selection process, you think I really need 20 minutes looking at some pictures of somebody that doesn't look very well because that should be second nature, you shouldn't be teaching that, you should know it almost. I want to know what things I can do, what I need to do with them and who is going to help me and fundamentally what powers I've got. Once I have got all of those things in place no problem at all” (James, police officer).

“My biggest challenge will be who do I pass it to next if it's not an emergency, who do I pass it to and how long are they going to be? I would say that's probably it for both myself and the response officers because we are an emergency service and we are there to prevent injury to them and anyone else and once you've got that under control we are the experts, we can talk to someone, we can make some referrals, but really we need to make sure that that person is safe and get that help they need” (Gary, Inspector).

The need to prevent harm when confronted by situations involving persons with mental ill health was consistent among the expressions of those attending the KEGs and those interviewed. In accordance with a police officer’s duty of care to ensure that they do not act in a manner that makes things worse, it was thought that if police officers were trained sufficiently enough to have the confidence and ability to deescalate a situation, the need for specialist secondary care services, which are associated with higher costs, may be avoided.

**Conclusion**

Throughout this chapter we have presented evidence supporting the view that police officers are frequently being called upon as ‘the service of first resort’ (HMIC, 2017:8; HMICFRS, 2018) and that demands on the police to support people with mental health needs are increasing (Office of the Police and Crime Commissioner for Staffordshire, 2013). Given the criticisms that have been levied at the police service for the ‘criminalisation of the mentally ill’ (Teplin, 1983; Department of Health, 2009), this situation is somewhat surprising. As Bean (1999:42) asks; ‘would any other occupational group take on the task? The answer is surely no’. Bean further questions if any health profession would offer a 24-hour service to deal with the potential dangerousness of people with mental health problems in the community. This responsibility of the police to pick up people with mental disorder coupled with concerns about the ‘policing of mental health’ reflects that the police are between a rock and a hard place when it comes to those presenting with mental health issues. As Bean (1999:42) observes: ‘keen though the Royal College may be to keep the police at arm’s length, it wants them nearby when the trouble starts’.

As resources diminish in areas of health and social care, the police are increasingly being called upon to respond to situations that not only require some level of competence in health or social work but also require the capacity to exercise non-negotiable force should compliance not be achieved through other means. This type of policing has been previously characterised by Bittner (1990) as “Florence Nightingale in Pursuit of Willie Sutton”. Bittner (1990) does not suggest that police are a substitute for nurses or social workers but, rather, they respond to situations requiring care-taking skills while also being attuned to the potential for danger (Sknolnick, 1966) and are ready to respond by invoking the law or using force. In reality though, police rarely need to follow through with formal action. As Banton (1964:127) puts it, ‘the most striking thing about patrol work is the high proportion of cases in which policemen do not enforce the law’. Bittner (1990:240) similarly remarked that ‘when one looks at what policemen actually do, one finds that criminal law enforcement is something that most of them do with the frequency located somewhere between virtually never and very rarely.

Others have observed the police to be performing a multitude of tasks that have been previously described as ‘dirty work’ (Muir, 1977; Wilson, 1968; Westley, 1970). Such tasks are often performed in the most deprived areas often characterised by high levels of poverty, low levels of employment, and other characteristics of social disorganization (Goldstein, 1977). In such contexts, Goldstein (1977:25) suggested that ‘the police most frequently care for those who cannot care for themselves: the destitute, inebriated, the addicted, the mentally ill, the senile, the alien, the physically disabled, and the very young’. With respect to mental illness, efforts to enhance the professionalism of police during encounters date as far back as the 1950s (Matthews and Rowland, 1954), but the ‘dirty work’ function of police did not receive much attention until the combined effects of mental health deinstitutionalisation (Slate et al., 2013), and criminal justice re-institutionalisation (Wood et al., 2011) have become apparent. Arguably, the second half of the 20th century brought with it an increased pressure on police to resolve encounters with a growing proportion of people in the community affected by mental illness.

Given that little has changed since Penrose (1939) suggested that the criminal justice system has been increasingly forced to take on the role of providing basic healthcare management it is perhaps time we take a 21st century look at the broader context of police interactions with persons affected by mental illnesses (Wood, et al. 2017). As we have revealed in this chapter, and sometimes out of necessity, the police have developed innovative ways to address mental health issues. For example, informal police encounters characterised by trust have helped to reduce the frequency of 999 callers. Yet we must acknowledge that, while mental health effects every area of policing, the police are not mental health professionals and should not be held solely responsible for those in mental health crisis (College of Policing, 2016).

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1. Pseudonyms are used to protect the anonymity of our participants. [↑](#endnote-ref-1)