***Deaths after police contact involving people with mental health issues***

This chapter examines mental health and policing by focusing on deaths after police contact in the US and UK. It considers how the policing of people with mental health issues leads to them being disproportionately more likely to die after police contact than almost any other group in society. The chapter begins by examining the circumstances that have led to police in the US and UK becoming the *de facto* emergency response to persons experiencing mental health crises. It discusses the differing organisational dynamics and policies that shape police responses to mental health crises in the US and UK. It considers how innovative programmes such as Crisis Intervention Teams in the US, and Street Triage in the UK might enable police to have fewer lethal outcomes with citizens. The chapter further examines issues such as the disproportionate use of police force on people with mental health issues; and the relative lack of training for officers about mental health conditions.

***Introduction***

This chapter examines the factors that lead to people with mental health issues (PMHIs) dying after contact with police in the United States (US), England and Wales. Such deaths are often portrayed as individual cases - the tragic results of vulnerable people coming into contact with law enforcement officers (in the US, see Hirschfield and Simon, 2010; in the UK, see Baker, 2018). The chapter argues that the factors that lead to cases of death after police contact (DAPC)[[1]](#footnote-1) are largely structural and result from systemic issues affecting the provision of public services in both countries - they should not be considered as individual cases or ‘tragedies’. To some extent, society gets the type of policing it demands, but this could also be said to be true about the provision of mental healthcare (Bradley, 2009; Adebowale, 2013). The issue of DAPC represents a meeting of both issues, and it is perhaps for this reason that these deaths can often be seen as contested, as they represent a nexus in the complex interplay between care and control; service and force, and the outcomes they produce for vulnerable people in society.

In the US, the lack of data on DAPC has been outlined by a variety of academic authors (see, for example Katz, 2015; Klinger *et al.* 2015; Dunham and Petersen, 2017; Zimring, 2017) and also by the Director of the FBI (Davis and Lowery 2015). In late 2015, he acknowledged that federal authorities could not accurately count these deaths, and that the Guardian Media Group and their website ‘The Counted’ represented the most accurate counting mechanism. The Counted calculated that cases of DAPC in the US numbered 1146 in 2015, and 1083 in 2016 (The Counted 2015; 2016). Approximately three citizens per day die after contact with police in the US. Because of the lack of data, it is not possible to precisely quantify the number of deaths that involve PMHIs, but numerous authors have asserted that PMHIs are disproportionately more likely to die than people who do not have mental health issues (see, for example Lamont-Hill, 2016; Mulvey and White, 2014; Zimring 2017). Most of these deaths result from fatal shootings, whilst in England and Wales the deaths occur either as a result of physical force being used, or as a result of neglect (see, for example Angiolini, 2017). In England and Wales a significant amount of official data on DAPC is collated. In the year 2017-2018 a total of 283 people died after police contact, a rise from the number of 241 recorded in the previous year (IOPC, 2018). In the period 2004-18, a total of 2265 people died after police contact, an average of 161 per year (IPCC 2016, IOPC 2018). Three people per week die after police contact in England and Wales (Baker, 2016a; IOPC, 2018). It is beyond doubt that in England and Wales you are disproportionately more likely to die after police contact if you are mentally unwell (see IPCC, 2016; Angiolini, 2017; IOPC, 2018).

We argue that these deaths often occur due to an absence of appropriate healthcare provision that leads police to become a de facto service left to deal with PMHIs. The ambiguity of the policing role partly enables this situation to exist, and persist. Police are both an agency of enforcement and care. When interacting with PMHIs they may be both within the same interaction, thus underlining the ambiguity of their role. This is no mere academic distinction – it can make the difference between preserving life, or extinguishing it. One factor influencing these outcomes is a police tendency to use force disproportionately on PMHIs, often due to misperceptions based on social stereotyping and stigmas associated with PMHIs. A lack of training, clear policies, and resources can lead police to use force in an attempt to ‘do something’ in encounters with PMHIs, as doing nothing is rarely an option.

The chapter considers how improved training and policies might enable police to better interact with PMHIs. It moves on to examine how multi-agency working with healthcare agencies might enable a more appropriate service to PMHIs, and how this approach effectively attempts to ameliorate the police response to PMHIs. It assesses how initiatives such as Crisis Intervention Training (CIT) in the US and street triage (in England and Wales) might represent a more effective approach to what is, after all, a healthcare issue. The chapter argues that the provision of appropriate mental healthcare is marked by inconsistency and variability, and that this can lead to fatal outcomes in encounters with police. It concludes that the issue of DAPC and mental healthcare provision is marked by continuity and change in both countries and considers implications for future policy and practice. We begin by examining how police became a de facto mental healthcare agency.

***Deinstitutionalisation***

From the 1960’s mental health care in both countries underwent radical change, moving away from a hospital-based model of care to a community-based model (Ruiz and Miller, 2004). This was driven by a number of factors: a drive to reduce public spending; social and moral concerns about conditions in asylums; human rights violations and the introduction of effective psychotropic drugs (Whitaker, 2002; Novella, 2008; Markowitz, 2011; Taylor-Salisbury *et al*, 2016). However, the shift in care provision was insufficiently supported by state funding. This led to considerable inconsistencies in provision meaning that even where community mental healthcare services do exist, they are often unable to cope with demand.

The inconsistency of resources allocated to healthcare can be illustrated by budget allocations in both countries. In the US budget of 2019, there were cuts to the previous budget of $17.9 billion (or 21%) for the Department of Health and Human Services, which includes mental healthcare provision (Mental Health America, 2018). The situation is similar for the National Health Service (NHS) in England, where in 2016 mental health issues accounted for 23% of its demand, but less than 11% of its total budget (NHS, 2016). Mental health services have consistently been underfunded in both countries since the era of deinstitutionalisation (for the US see Perkins *et al.* 1999, for England and Wales see Bradley 2009). The relative lack of resources given to mental health services might be seen to mirror societal views about the relative importance of mental healthcare in comparison to physical healthcare. There is widespread consensus that stigma and stereotyping are still manifest in both countries on the issue of mental health, and this appears to be reflected in the variable provision of appropriate healthcare, and also of appropriate policing (Morabito *et al.* 2012; Adebowale 2013).

With inadequate community care and support services for PMHI, the number of mental health crises in the community increased (Lancaster, 2016). In the absence of alternative emergency services it has increasingly become the duty of police to respond to crisis calls involving PMHI, forcing them into the role of a de facto mental health service (Morabito, 2012; Bonfine, 2014). As a result, interactions with PMHI are now considered core police business in both countries (President’s Task Force on Policing [PTF] 2015; College of Policing [CP], 2017). For example, in 2015, the New York Police Department (NYPD) estimated that it responded to 145,000 calls relating to mental health issues, rising to 157,000 in 2016 (NYPD, 2017). Similarly, in 2016-2017 the largest force in England - the Metropolitan Police - dealt with over 115,000 mental health crisis calls (College of Policing, 2015). Evidently, calls involving PMHI’s generate a significant amount of work for police within major cities in both countries (PTF, 2015; Angiolini, 2017). However, it is worth noting that these statistics provide only a snapshot of the issue as there are no reliable national statistics for the number of PMHI who come into contact with the police in either country (Kent and Gunasekaran, 2010). One might argue that the lack of data on this issue reflects the relative value that society and governments place on mental healthcare and PMHIs – gathering data about an issue is typically a precursor to doing something about it.

***The ambiguity of the police role***

The police occupy a striking diversity of roles. These include: order maintenance, peace keeping, crime prevention, public reassurance and crime control (Reiner, 2010; Gaines and Kappeler, 2015). Police react to a complex number of issues that occur in a variety of contexts. Reactivity is a key part of their role and to a large extent, what the public expect from them (Crank 2016, Reiner 2010). Officers have a duty to preserve a citizen’s life, but also – in certain circumstances - the authority to extinguish it (Baker 2016a; Zimring 2017). This raises the issue highlighted by Reiner (2013, p. 165) as to whether police officers might be better termed ‘peace officers’. One view from the US (Shane, 2013, p. 69) is that they might be better conceived of as ‘safety officers’. The way society, the state, and the police themselves view their role has an effect on whether police act as enforcement officers or ‘safety’ officers, thus directly impacting the issue of DAPC.

Police are increasingly expected to be both a force and a service; to provide law enforcement and healthcare provision - sometimes both within the same encounter (Reiner, 2010; Gaines and Kappeler, 2011; Her Majesty’s Inspectorate of Constabulary [HMIC], 2015). The contrasting roles of police as a force or service is a prominent theme throughout policing literature; whether police approach PMHI with a “warrior” mind-set based on law enforcement or one based on guardianship (Balko, 2014; PTF, 2015). The former implies a force-based approach where police view citizens through a lens of criminal justice enforcement; the latter implies a more welfare-based approach whereby individuals are viewed through a lens that prioritises their safety and well-being (Wood *et al*. 2011; Shane, 2013). The role of discretion is key to understanding how police approach incidents and individuals, and to a great extent dictates how police act in incidents involving PMHI (Tyler and Jackson, 2014).

As police are increasingly responsible for dealing with highly vulnerable individuals there is growing official discourse in both countries for their role to be re-imagined (see for example PTF, 2015; Angiolini, 2017). Policies and protocols are beginning to reflect their role as mental health interventionists; but incongruencies between policy and practice remain. For example, the PTF (2015, p. 1) states that “law enforcement culture should embrace a guardian rather than a warrior mind-set”, yet numerous writers have highlighted that policing in the US has become more aggressive in the 21st century (Balko, 2014; Crank, 2016). This is also apparent in the increasing numbers of deaths following restraint and/or medical neglect in England and Wales despite a growing official discourse that increasingly claims to respect the right to life of citizens (Angiolini, 2017; IOPC, 2018).

The increasing use of force could be attributable to officers adopting a “warrior” mind-set, and being more likely to take an aggressive approach when confronting an individual in crisis (Angiolini, 2017; Rossler and Terrill, 2017). Conversely, officers with a “guardian” mind-set are more likely to focus on de-escalation, prioritising the protection of individuals, their safety and well-being (Bonfine *et al*. 2014; Chappell and O’Brien, 2014). In the absence of specific mental health policy and training, an officer’s capacity to deal appropriately with PMHI is questionable. This also highlights that police, who are to some degree trained to adopt a warrior mind-set for the pursuit of law enforcement, are not necessarily best placed or best trained to deal with what is, essentially, a healthcare issue (Bradley 2009; Angiolini, 2017). Traditional law enforcement methods are viewed as being unsuitable for securing safe and effective resolution of crisis calls involving PMHIs (Wood *et al*. 2011). This in turn underlines the need for officers in both countries to receive specific mental health training to enable them to fulfil their role as “guardians” rather than acting as “warriors” in the performance of their innumerable duties (Angiolini, 2015; PTF, 2015).

***Deaths after police contact: vulnerable groups and the use of force***

Cases of DAPC highlight a number of issues that encapsulate concerns about policing modern societies (Adebowale, 2013; Mulvey and White, 2014). Deaths disproportionately affect people from marginalised groups in society: persons of colour, PMHIs, or people with dependency issues are disproportionately more likely to die after police contact than other groups in society (in the UK, see Baker 2016a; Angiolini, 2017, in the US see Klinger *at al*. 2015; Kahn *et al*. 2017). Any combination of these issues can occur in relation to a death, which is sometimes known as intersectionality (Mulvey and White, 2014; House of Commons Home Affairs Select Committee [HAC], 2015). International policing literature indicates that PMHIs are disproportionately more likely to die after police contact in the US, UK, Australia, and Canada (see, respectively Mulvey and White, 2014; Razack, 2015; Baker, 2016a; Australian Institute of Criminology, 2013). This, then, is a common issue in the English-speaking world, it is not particular to a specific country, and this underlines the systemic and structural factors that are apparent in such deaths.

These deaths occur at the intersection of a number of charged issues in policing, challenging their legitimacy to police society in a consensual manner: the tensions involved in police being both an enforcement agency and an agency of care; the use of force; and the disproportionate number of deaths from marginalised groups within society. In both countries, these issues are exacerbated by the apparent inability of police and regulators to learn lessons that prevent future deaths (in England and Wales see Baker, 2016a; Angiolini, 2017; in the US see Hanafi *et al*. 2008; Katz, 2015). In the US this is further compounded by a lack of federal data on DAPC that leads authors to question the legitimacy of both governmental and policing agencies (see, for example Klinger *at al.* 2015; Dunham and Petersen, 2017).

When called to incidents, police officers are essentially situational problem solvers (Morabito, 2007; Reiner, 2010). They are able to exercise considerable discretionary decision-making, deciding in the moment how best to respond to ensure a rapid and effective resolution of encounters whilst attempting to protect the safety of all involved. Policing therefore requires simple and immediate solutions to complex problems. Police are able to manufacture such solutions because, if required, they have the legitimate authority to use coercive power (Bittner, 1975). When responding to calls involving PMHI officers may be faced with an individual behaving erratically, and in some cases under the influence of substances and/or in possession of a weapon. Limited time to assess the situation, inadequate mental health training and lack of officer confidence in dealing with PMHI could lead to rushed evaluations and the use of inappropriate techniques (Ruiz and Miller, 2004).

There is also a risk that police may not understand certain situational contingencies and respond to PMHI based on stereotypical views, tending to view PMHIs as unpredictable, dangerous and violent (Ruiz and Miller, 2004; Chappell and O’Brien, 2014). When officers are confronted by a situation, event, or citizen they are unable to categorise or recognise, they may feel unsure or threatened, and use force as a first, rather than last resort to secure a rapid resolution to the situation (Morabito, 2007; Tyler and Jackson, 2014; Rossler & Terrill, 2017). In both countries the law permits the use of force by police officers but only when deemed necessary, and not as a default to secure compliance (National Institute of Justice, 2016; Angiolini, 2017).

Although force is considered a possible solution to incidents involving PMHI, the use of it is by no means a safe alternative, as it has been linked to a number of deaths (Angiolini, 2017). For example, Bartlett (2016) notes, that in cases of DAPC in England and Wales between 2010-13, where restraint was a factor, approximately half involved PMHI (also see IPCC, 2016; IOPC, 2018). A number of official reports also reveal that restraint related deaths are disproportionately more likely to affect people from Black and Minority Ethnic (BAME) groups and/or PMHI (IPCC, 2016; Angiolini, 2017), thus underlining the relevance of intersectionality to the issue of DAPC.

It is well established in policing literature that officers are more likely to use force on PMHI due to a lack of training leading to stereotypical assumptions and misperceptions about how PMHI might react in encounters with police, viewing them as more violent than citizens without mental illness (Ruiz and Miller, 2004; Morabito, 2007; Morabito *et al.* 2012; IPCC, 2016; Angiolini, 2017; College of Policing, 2017; Kahn *et al.* 2017; Rossler & Terrill, 2017). Police use of force can exacerbate the distress of PMHI, who are unlikely to understand why they are under arrest or being restrained (Wood *et al*. 2011). This is a vicious cycle as the use of force could lead to increased fear and resistance by PMHI resulting in officers using more force to gain control of the encounter thus leading to the potential for increased harm to the citizen (Lamb *et al*, 2002; Mulvey and White, 2014). The capacity of police to use force leads Lamont-Hill (2016) to conclude that the police role in mental health crisis can actually make the vulnerable more unsafe. Adopting a more aggressive approach raises questions about the police commitment and capacity to provide a duty of care to the most vulnerable and marginalised groups in society (Abebowale, 2013; Mulvey & White, 2014; Angiolini, 2017). With heightened awareness of the number of cases of DAPC involving PMHI and the use of force, an increasing number of policy documents have outlined the need for officers to prioritise de-escalating incidents using appropriate techniques and the need for police to provide a duty of care for PMHI (Adebowale, 2013; HMIC, 2013 and 2015; PTF, 2015; IPCC, 2016; Anglioni, 2017).

The apparent failure of police and regulators to reduce the number of PMHIs dying after police contact has led to increased governmental focus on this issue in terms of how to prevent future deaths (PTF, 2015; Angiolini 2017). More than half of those who died in or following police custody in England and Wales had mental health issues (IOPC 2018). As has been noted previously, the lack of US national data on DAPC means that the number and nature of these deaths remains uncertain at the time of writing. The governmental and regulatory response to these deaths has principally centred on how to better train police, and how to produce clearer policies that might improve the police response to PMHIs (see Wood *et al.* 2011). The former seeks to improve officers’ understanding of the conditions a PMHI might have, and thus enable them to better interact with citizens who may be undergoing a mental health crisis, leading to a safer outcome for the citizen (Coleman and Cotton, 2014; Bartlett, 2016). The latter aims to better regulate police practice by clearly setting out parameters on how to respond to PMHIs in an attempt to both manage the police response and limit the discretionary power of officers (in the UK see Angiolini, 2017; in the US see PTF, 2015).

***Police training and policies***

The ambiguous police role and concomitant reliance on discretion combined with the vulnerabilities of PMHIs leads numerous authors to identify the fundamental relevance of police being trained appropriately on issues relating to mental health and interactions with PMHIs (Hails and Borum, 2003; Morabito, 2007). In both countries the provision of training and policies on how police deal with PMHI is variable (in the US see PTF, 2015; in England and Wales see HAC, 2015). This is largely due to two key drivers - the organisational structure of policing in practice, and available resources. These are principally characterised by the spatially fragmented nature of policing agencies and their heterogenous organisation in terms of officer numbers and resources. This is particularly acute in the US with 18000 police forces, of which fewer than 100 have more than 900 officers (PTF, 2015). While some agencies might have clear and established policies and training for officers on PMHIs, others might have none (see Wood *et al.* 2011, Coleman and Cotton, 2014, Watson *et al.* 2014). Organisations that do have clear and established policies and training might be using quite different models based on available resources and knowledge, sometimes in forces that are geographically adjacent (Dupont and Cochrane 2000; Coleman and Cotton, 2014).

As there is no federal oversight body for policing in the US, there is no facility to enforce policies, or best practice; albeit one might argue that the International Association of Chiefs of Police (IACP) and the National Institute for Justice (NIJ) are able to promulgate policy documents exhorting best practice. Consequently, the police response to PMHIs in the US is to a great extent determined by geography (Wood *et al.* 2011). In England and Wales, the problems are similar, but less pronounced with 43 police forces. Each force has a similar hierarchical structure, but is largely driven by local imperatives (see Reiner, 2010). As in the US, there is no national body to enforce national standards, but the CP publishes guidance on best practice and the IOPC and HMIC encourage police forces to use this practice and also learn lessons from previous errors in practice (see HMIC 2015; IPCC 2016). It should be noted, though, that neither the CP, HMIC or IOPC can sanction police, or enforce recommendations made in relation to inquiries or investigations (Baker, 2016a). In this sense, the US mirrors England and Wales – there is no national body capable of enforcing recommended policy or training.

When encountering PMHI in England and Wales, the standard procedure is for police to refer individuals to crisis resolution home treatment teams for assessment and referral to support services (Onyett *et al.* 2006). However, the structure of these teams and the services they provide vary according to locality and, in most cases, they are inadequately staffed or only have funding to operate during restricted hours. Outside of these hours, when the majority of incidents occur, police have little choice but to transport a PMHI to alternative places of safety (HMIC 2013; HAC, 2015). Section 136 of the Mental Health Act 1983 enables officers to detain PMHIs if they believe them to be ‘suffering a mental disorder and to be in immediate need of care and control’. In such a case, the PMHI should then be taken to a ‘place of safety’ which is broadly defined as being any healthcare or custodial facility (Mental Health Act, 1983). Whilst police custody is intended to be used as a place of safety only in ‘exceptional circumstances’ (HMIC 2013), research demonstrates it is commonly used due to lack of alternate provision (see, for example Adebowale, 2013; Angiolini 2017). The stressful environment of police custody can serve to increase anxiety, fear and further exacerbate PMHI’s mental state, in some cases leading to DAPC (Apakama, 2012; Angiolini, 2017).

In the US, officers encountering PMHI use discretion to make decisions based on a broad palette of available options. Officers can resolve a situation informally, make an arrest or utilise other formal approaches such as wellness checks, psychiatric hospitalisation or police initiated trans-jurisdictional transportation (see Wood *et al.* 2011). These options have variable efficacy for resolving incidents with PMHI and tend to lead to PMHIs becoming stuck in a revolving door between community living and a criminal justice system ill-prepared to meet their needs (Johnson, 2011; Watson *et al.* 2014). A key issue in both countries is officers use of discretion to make decisions about how to deal with the person in front of them (Morabito *et al*. 2012; Bartlett, 2016). It can affect whether force is used, whether back up is summoned, and whether de-escalation is attempted. In the absence of clear policies, training, or alternative provision, officers unsurprisingly resort to using discretion, as doing nothing is rarely an option.

Even with specialised training there is evidence in the US to suggest that officers feel ill-equipped to deal with calls involving PMHI (Watson and Fulambarker, 2001; Wells and Schafer, 2006). Ruiz and Miller’s (2004) research into police training on PMHIs found that only 47% of officers felt confident responding to crisis calls involving PMHI, whereas 49% said they felt uneasy, worried or threatened by such encounters. Research in England and Wales suggests that despite officers being expected to deal appropriately with PMHIs, they receive little or no training for their role as “street corner psychiatrists”, leaving them lacking the specialised skills and knowledge to effectively manage such encounters (Bradley 2009; Adebowale 2013). Cummins and Jones (2010) found certain groups within police culture viewed PMHIs as not ‘real’ police work, whilst Docking et al. (2008, p. 12) found some officers believed PMHIs to be a ‘waste of police time.’

Following a number of high-profile cases in which PMHIs were seriously injured or killed by police in the US (Dupont and Cochrane, 2000; Ruiz and Miller, 2004), interactions between police and PMHIs came under increasing public scrutiny (Wood *et al*. 2011). In response, police departments across the US implemented various training programmes and alternate strategies to improve officer responses to calls involving PMHIs (Coleman and Cotton, 2014; Watson *et al.* 2014). In England and Wales, there is a wealth of governmental data on DAPC, and a number of significant policy reviews setting out key issues that might lead to lessons being learned more effectively to prevent future deaths (see, for example HMIC, 2015; IPCC, 2016; Angiolini, 2017). This, though, has not resulted in a reduction in the number of deaths (see IOPC, 2018). More knowledge and data about this issue in England and Wales has not yet led to improved outcomes. As in the US, the focus of government, police, regulators and advocacy groups has shifted to responses that go beyond purely the police response to PMHIs and have begun to consider multi-agency responses as the key way to minimise force in encounters with PMHI.

***Multi-agency working in the US***

In light of inadequate service provision, concerns about the criminalisation of mental illness, and rising numbers of DAPC involving PMHIs, police face a potential legitimacy crisis. In order to avert this they have recognised the need to be seen to be working more proactively with vulnerable groups in society (PTF 2015; Angiolini, 2017). Efforts by police to build trust and foster better relationships with the public and particularly PMHI can be seen in the various initiatives that attempt to provide a more guardian-based approach to dealing with PMHIs. Such initiatives include the provision of mental health training for officers, improved access to community mental health facilities, and the implementation of alternative community treatments (Cummins & Jones, 2010; Kent & Gunasekaran, 2010; Lancaster, 2016).

In addition, multi-agency initiatives are increasingly being implemented in both countries to improve provision for PMHI. For example, in the US forces use CITs, whilst in England and Wales, Liaison and Diversion (LD) schemes and street triage are becoming more common. These initiatives emphasise a care-based, rather than an enforcement-based response to handling encounters involving PMHI. CITs aim to foster effective working partnerships between police, local mental healthcare providers, PMHIs and their families. They aim to de-escalate crises, and facilitate referrals to the mental health system in an attempt to reduce the number of PMHIs involved in the criminal justice system (Bonfine *et al.* 2014). The Memphis model, established in 1988, is the most widely implemented model of CIT training. Its purpose is to address the issues underlying the call and provide a care-based response to PMHIs rather than incapacitating the individual or resorting to arrest (Thompson and Borum, 2006). Self-selected officers and call dispatchers receive 40 hours intensive specialised training in identifying mental illness, de-escalation and crisis intervention techniques (Dupont and Cochran, 2000). These officers then serve as front-line responders who are better able to support PMHI and divert them from the judicial system to appropriate mental healthcare services.

Whilst CIT originated as a specific model (see, for example Hanafi *et al.* 2008) it tends to be used in the US as a catch-all term encompassing police responses to mental health crises (such as mobile crisis teams, for example), and also to officers who have undertaken mental health training (see PTF, 2015). This ‘police response’ model is widely supported by advocates for PMHI, mental health policy makers and CIT trained officers (Wood *et al*. 2011; Morabito *et al.* 2012; Bonfine *et al.* 2014). It is considered a ‘best-practice model’ for police and has been deployed in law enforcement agencies worldwide (Watson and Fulambarker, 2012; Coleman and Cotton, 2014; Watson *et al.* 2014). However, research findings relating to its efficacy are mixed (Wood *et al.* 2011; Bonfine *et al*. 2014) and the model has not been evaluated sufficiently to be considered an ‘evidence-based practice’ (Watson and Fulambarker, 2012).

There is evidence to suggest CIT training improves officer self-efficacy and confidence in their ability to respond to calls involving PMHI; increases officer knowledge about PMHIs; reduces the use of force and arrest; increases referrals to psychiatric services; and reduces the risk of injury to both officers and PMHI (Wells and Schafer, 2006; Johnson, 2011; Morabito *et al.* 2012; Chappell and O’Brien, 2014). Conversely there is also evidence to suggest that even after officers undergo CIT training, PMHI are more likely to be arrested; officers are more likely to use force (although PMHI are not at increased risk of injury); and that there is increased risk of officer injury during incidents involving PMHI (Rossler and Terrill, 2017).

Whilst CIT might be viewed as a positive development in terms of alternative responses, this does not necessarily translate into widespread practice on the ground in US policing. The number of CIT trained officers varies significantly across jurisdictions with uptake heavily dependent on officer self-referral (Wood *et al.* 2011). Indeed, Morabito *et al.* (2012) found that within four districts of the Chicago Police Department, the percentage of CIT trained officers varied from 4% to 15%. The Memphis model CIT guidelines suggest 15-25% of police personnel should be trained, including officers, call takers and dispatchers (Thompson and Borum, 2006). In 2016, the IACP suggested that 20% of officers should be trained in this programme (Thomas and Watson, 2017), whilst the PTF (2015, p.56) states that all officers should undergo CIT training and refresher training. Yet with more than 18000 police forces (PTF, 2015), it seems clear that organisational factors should not be underestimated when assessing the viability and effectiveness of models in practice, thus underlining the structural impediments affecting the appropriate delivery of care to PMHIs in the US.

It should also be noted that the quality and intensity of training also varies significantly between jurisdictions as forces have adapted the Memphis model to meet the needs and resources available in their area (Coleman and Cotton 2014). Hails and Borum (2003) note that training on PMHI in many forces occurs with more generic training that focuses on other vulnerable populations, and that local mental health services generally have limited or no input into developing training content and delivery. Finally, only one third of CIT programmes have formal agreements with local specialised crisis response centres and although some have informal arrangements that work well, there are some jurisdictions that are unable to engage collaboratively with local community psychiatric services (Wells and Schafer, 2006). CITs should not therefore be viewed as a one-size fits all approach, a panacea for policing PMHIs, or as a model which can actually be put into practice given the organisational contingencies of policing in the US. The CIT model has, though, been adapted by police forces in a number of countries including England and Wales to inform the development of similar schemes such as Liaison and Diversion (LD) schemes and street triage.

***Multi-agency working in England and Wales***

LD services aim to identify vulnerabilities in individuals as early as possible when they come into contact with the criminal justice system and provide appropriate support, whether supporting them through the earliest stages of the criminal justice pathway or referring them to more appropriate health and social care services (James, 2000). Essentially, LD schemes seek to reduce the likelihood that PMHI will reach crisis (Kane and Evans, 2018). Although LD programmes are governed by a standard service specification (NHS England, 2018), services have developed in a variety of forms, developing a local structure with delivery tailored to local need (HAC, 2015). Despite regional variation, the effectiveness of the initiative is predicated on a dedicated LD team to deliver and co-ordinate a responsive service. The service is linked to, and supported by an extended network of professionals in various mental healthcare agencies. Although LD programmes are seen to have a positive impact in reducing the use of Section 136 of the Mental Health Act (1983) to detain PMHIs, facilitating information sharing and fostering effective multi-agency working (James, 2000) their success is limited by regional variations in implementation, with only 63% coverage in England (Kane and Evans, 2018).

Street triage is another strategy whereby mental health professionals support police on calls involving PMHI to ensure people are not unnecessarily detained and receive timely and appropriate needs based support and care (Cummins and Edmondson, 2016; Kane and Evans, 2018). Unlike the LD programme there is no specific model for street triage and schemes tend to vary locally according to need and resources available (NHS England, 2018; Horspool *et al*. 2016). Some areas (for example, Cleveland, Leicestershire and Dorset) use variations of telephone-based support from mental health professionals; whereas the West Midlands deploys officers with mental health professionals in ambulances; and other areas (for example, the Metropolitan police) do not use street triage at all (HAC, 2015). There is a variety of street triage provision, but none of it is 24/7. Evaluation of the services available indicate that the use of Section 136 of the Mental Health Act (1983) has decreased between 30-50% in areas where street triage is deployed, similar to findings on LD schemes (HAC, 2015). These schemes also demonstrate enhanced collaboration and communication between police and mental health services (Cummins and Edmondson, 2016; Kane and Evans, 2018).

Although LD schemes and street triage provide solutions for a number of issues that arise from police involvement in mental health crisis, they have the potential to create additional problems for police, mental health services and service users (Horspool *et al*. 2016). Sourcing street triage staff from existing mental health teams may cause problems for existing mental health services as there are fewer staff available to deliver other aspects of the mental health service. Furthermore, in many areas street triage is staffed by an officer from the regular shift and losing an officer from the shift at a busy time could compromise their ability to respond to other emergency calls.

Although multi-agency schemes in both countries may be regarded as progressive, they also have significant drawbacks. There is no legal obligation to implement these initiatives, it is left to individual forces to decide if they take action, and the nature of this action varies according to local need, resources and available funding (Horspool *et al.* 2016). In addition, the organisational contingencies that determine the operational reality of emergency service provision in both countries means that any attempt to implement models or policies will run up against the obstacle of how they might be put into practice due to situational contingencies. Similarly, it is unclear how the use of multi-agency approaches in a more systematic and planned manner might be achieved, or by what measure, or by which regulator their use might be evaluated. Ultimately, these initiatives aim to ameliorate aspects of the police response to PMHIs rather than re-imagine how appropriate healthcare might be delivered for vulnerable individuals in crisis.

***Continuity and change***

This chapter has established that the issue of DAPC in relation to PMHIs is common to English speaking jurisdictions. It is characterised by structural and systemic factors that influence the delivery of public services in both countries. That these deaths disproportionally affect PMHIs is an issue of real concern, not least because of the increased prevalence of PMHIs in society in the 21st century. We should not be surprised that an agency focused on law enforcement finds it problematic to provide healthcare to vulnerable people in our societies. The structural factors that affect officers’ capacity to deal with PMHI include a lack of training, a lack of clear policies, a lack of resources and interconnectivity with healthcare agencies. In the US this is compounded by the geographically fragmented organisational distribution of forces. The structural nature of these issues is a key reason why this issue continues to bedevil the provision of care by police to PMHIs. Structural conditions, by their very nature, are difficult to address within large organisations. That is not to say that pockets and areas of good practice do not exist, but this is cold comfort to the loved ones of people who die after police contact in what might be termed a ‘postcode lottery’ (see Wood *et al.* 2011). The use of CITs in some US cities from the 1980s was an innovative and progressive response to a healthcare issue, but the application of this method across the US has been patchy, at best. The adoption of LD and street triage schemes in England and Wales largely mirror CIT delivery as they are applied differently by different forces, and in some forces not applied at all. Thus, whilst there is evidence of change in policing practices, structural and systemic factors present obstacles to change being consistent or long-lived. One might say that ‘street triage’ is a neat metaphor for a public service approach to PMHIs – a quick fix that aims to avert immediate crisis but does not tackle the underlying structural symptoms that stymie a more holistic and appropriate response to PMHIs. It is perhaps unsurprising that the police, acting principally as a reactive law-enforcement agency, have formulated such a response in the absence of any other initiative from healthcare providers.

One change that has become apparent in England and Wales is the increasing focus on this issue from government and policy makers. A significant driver of the increased focus has come from Article 2 of the European Convention on Human Rights (see Baker, 2016b). This has placed an obligation on the government to ensure that necessary preventive measures should be demonstrably in place to reduce the number of deaths after interactions with state agents. One by-product of this development has been to prompt a reconsideration of the role of public services in relation to PMHIs. The wide-ranging Angiolini (2017) review into cases of DAPC is the most recent example of this in England and Wales. In addition to recommending changes to policy and training, and to improving multi-agency working and communication, Dame Angiolini (2017, p.37) emphatically states: ‘Effective training is crucial but a transformation in culture away from physical intervention as the default position to one of de-escalation will require strong leadership and recognition of the wider skills set required of our police officers in the 21st century.’ Given the problems noted above with regards to implementing structural change, it is uncertain how, when, or if, this transformation might occur.

Police continue to be a de facto service for PMHIs largely due to the absence of other agencies. This is another structural issue that has not been addressed and is apparently becoming more of a problem in both countries as budgets shrink. In England and Wales, this is exacerbated by austerity which has consistently reduced police budgets year on year since 2010. Police are now operating with 16% fewer officers in 2018 compared to 2009 (National Audit Office, 2018); at the same time mental health services have been cut, with the number of acute psychiatric beds reduced by 38% in the period 1998-2012 (College of Policing, 2017).

People with mental health issues dying after police contact should not be viewed purely as a ‘police’ issue. Contact occurs typically due to a failure of healthcare provision. Healthcare provision is lacking due to governmental priorities that lead to insufficient funds being allocated to enable appropriate mental healthcare for those who require it. These same priorities could be said to mirror social norms and values and how these in turn affect societal views of what healthcare is or might be. The focus on physical healthcare as a priority when compared to mental healthcare is a clear manifestation of this. Stigma and stereotyping continue to remain central to societal perceptions of mental health issues. The most obvious way to reduce the number of deaths after police contact is to reduce the number of contacts vulnerable individuals have with the police.

In order to effect change on the issue of DAPC, we need to look beyond the police response to PMHIs; to continue focusing on these deaths as a ‘police issue’ is myopic. Police do not work in a vacuum, they are reflective of society. They are funded by governments and work collaboratively with other public services. For change to occur, there needs to be both a political will to fund mental healthcare commensurate with the funding of physical healthcare; and a political will to demand a change in police cultures that prioritise safety over enforcement, and care over control. These demands represent significant challenges to the systems and structures that currently comprise public service delivery in both countries. There are tentative signs that this is being picked up in policy reports in England and Wales, but this chapter has demonstrated that the formulation of improved policy does not necessarily equate to changes in practice when it comes to policing society. The issue of DAPC in relation to PMHIs is clearly marked by a gap between rhetoric and reality, and policy and practice. Whilst structural issues clearly have a significant impact on the ability of the police to respond to PMHIs, a more relevant issue might be to consider why we still consider it appropriate that a law enforcement agency is best placed to respond to healthcare emergencies.

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1. The term ‘death after police contact’ is used in England and Wales by the Independent Office for Police Conduct (IOPC). Due to the lack of official data and lack of definitional criteria on this issue in the US, the authors have used the IOPC’s term which broadly denotes any citizen who dies after being in contact with police in a place which is public, private, or custodial (IOPC 2018). The IOPC is the principal police regulator in England and Wales, taking over from the Independent Police Complaints Commission (IPCC) in January 2018. [↑](#footnote-ref-1)