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'Defunding the police': A consideration of the implications for the police role in mental health work

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Abstract

This paper examines the role of the police in mental health work. It explores whether the calls to 'defund the police' can be the basis for fundamental reforms of mental health services and the police role. The paper outlines the roots of the calls to '*defund the police*' situating the perspective in the wider Black Lives Matter movement (BLM). The wider BLM movement seeks to overturn long standing racial and social injustices, including the disproportionate use of force against black citizens and racial biases within the Criminal Justice System. It goes further in that BLM calls for a shift in funding from policing towards an investment in welfare and community services. These calls are captured in the phrase 'defund the police'. These calls have highlighted the police role in mental health, particularly, the police response to citizens in mental health crisis. The paper examines the police role in mental health work, highlighting the historic impact of policies of deinstitutionalisation and more recently austerity and welfare retrenchment. In calling for this policy shift, campaigners have highlighted the need to significant investment in mental health services. The police role in mental health services increased because of the failings of community care (Cummins, 2020a). Police officers have increasingly become first responders in mental health crises. The paper, focusing on England and Wales, uses '*defund the police*' perspective as a lens to examine long standing areas of concern. Police involvement in mental health emergencies is inevitably stigmatizing. There are also concerns from the police. This is an area of police demand that has grown of austerity and the wider retrenchment in public services. Police officers often feel that they lack the skills and knowledge required to undertake their role in mental health work. In addition, there is frustration generated by poor interprofessional working. Police officers on an organizational and individual level feel that they are often left '*picking up the pieces*'. There is a

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wide recognition that mental health services are failing to provide appropriate responses to those in crisis (Wessley, 2018). As well as being an issue of human rights and social justice, these failures place vulnerable people at increased risk. All aspects of police work involve contact with people experiencing mental health problems. People with mental health problems are first and foremost human beings who should be treated with dignity and respect. They are also citizens, family members, carers and work colleagues. Having acknowledged that core value perspective, if we accept that police officers will be involved in mental health work, we should seek to limit their role as far as is possible. The paper concludes that it is likely that there will be always be some form of police involvement in mental health–related work. However, there is a need to limit this as far as possible.

Keywords
Policing, mental health, community care, defund the police

'Defund the police'

Calls to 'defund the police' are part of the response to the death of George Floyd. Floyd died whilst being arrested by the police in Minneapolis in May 2020. Following his death, there were demonstrations in the USA and across the world in protest against police brutality and racial injustice. The protests were linked to the broader social movement Black Lives Matter (BLM). BLM began in the summer of 2013. It was a radical community-based response to the acquittal of George Zimmerman. Zimmerman had shot 17 year old Trayvon Martin in Florida 2012. The case highlighted the issue of racial profiling as well as Florida's '*stand your ground laws*'. The gay founders of *Black Lives Matters,* Patrisse Khan-Cullers, Opal Tometi and Alicia Garza, based the movement on a broader intersectional analysis that focuses on gender and sexual freedom alongside attacking racial injustice (Green, 2019). The expansion of the use of mobile phones and social media has exposed police brutality and racist conduct of officers. Citizens are now able to challenge law enforcement narratives, which seek to blame the conduct of the deceased, by posting clips of the events on social media. This does not prevent media attempts to portray the victims as offenders, whose own behaviour rather than that of the police was the cause of the fatality. These events are not new but the wider political reaction is. There is a significant literature that documents the role of racism in the development of the US penal state (Alexander, 2012; Drucker, 2011; Wacquant, 2002). '*Defund the police*' calls originated in the USA and there is a danger in simply reading across from the USA to other countries including the UK. It is vital that the historical, political, economic and social factors that have created the current situation are acknowledged. However, there are some parallels between the situation in the USA and UK. The Lammy (2017) review highlighted the continued overrepresentation of people from BAME backgrounds in the criminal justice system in England and Wales. The increased use of imprisonment and the wider involvement of police as the first response to a whole

range of social issues has been a significant feature of neoliberal welfare and social policy (Cummins, 2021). Vitale (2017) argues that the outcome is that frontline has become increasingly involved in responding to issues that are generated by the fundamental structural inequalities and welfare retrenchment.

Defund the police has been caricatured by the Right as a movement which seeks to disband the police entirely. As in any social movement, there is a range of opinion. However, the US focus of *defund the police* is not to disband the police, it is rather to question the police role, the increased militarisation of policing (Harcourt, 2018) and argue that the huge sums of money spent on law enforcement could be diverted to social programmes. Vitale (2017) argued that policing has increasingly taken on a role in responding to the problems of modern urban poverty and the impact the neglect of educational, mental health and other services. Vitale (2017) argues that the police are poorly trained and ill-equipped to perform these '*social work roles*'. This combined with what has been termed the '*warrior*' mindset of modern urban policing inevitably leads to conflict on both an individual and societal level. This leads to the excessive use of force and the escalation of essentially minor incidents. George Floyd died after he was arrested on the suspicion of use a counterfeit dollar bill. In April 2021, a former police officer, Derek Chauvin was convicted on three counts for the murder of George Floyd. There was a sense of relief at the verdict. This was partly due to the rarity of such an event but also the potential impact of a not guilty. This was a highly unusual case in that the murder of Floyd had been filmed by a member of the public. The extent of the change that needs to take place is demonstrated by the expansion in police budgets. The US police budgets have increased in a period where crimes have been falling. Since the 1970s, spending on police has nearly tripled, reaching US$114.5 billion in 2017 (Bliss, 2020). This spending has been focused on equipment that has further militarized policing (Vitale, 2017).

There are huge significant cultural, social and organizational differences between policing in the USA and the UK. The most significant is that frontline British police officers are not routinely armed. This is of particular importance when examining the role of the police in responding to individuals in mental health crisis. There is a significant research literature that highlights that in jurisdictions where the police are routinely armed; then, the police response to an individual in mental health crisis can lead to a fatality. This is the case, for example, in the USA (Baker and Pillinger, 2019 Campbell et al., 2019; Sherman, 2020) and Australia (Thomas, 2020). Shapiro et al. (2015) note that several policing and mental health initiatives have followed fatalities following police contacts with individuals experiencing a mental health crisis. These are hugely significant issues. It is not the totality of police involvement in mental health work. Wood et al. (2017) concluded that the majority of calls do not involve violence or reach a threshold where compulsory admission to hospital would be required. They concluded that the majority of calls into what they term the '*gray zone*' of police work.

Policing and mental health

This section examines the police role in mental health work. The themes that are outlined here including the increased police involvement in mental health and the broader welfare

role of policing apply across jurisdictions. Punch (1977) described the police as the '*secret social service'*. This phrase captures the way that policing is a role that entails much more than apprehending offenders. The policing role has always involved a much broader welfare and public safety remit. The majority of modern policing is concerned with these issues. Police mental health work has to be placed in this context. It is important to emphasise that police officers will encounter people with mental health problems in all areas of their work. They will be colleagues, fellow professionals, victims of crime and so on. The focus on mental health emergency interventions can, on occasions, obscure this fundamental point. Police involvement in mental health work is part of their role in wider community safety and the protection of vulnerable people. Wolff (2005) argues that the police have always had what might be termed a '*quasi social work*' role.

Section 136 MHA

Section 136 MHA is discussed here because it is an emergency police power that allows the police to detain an individual experiencing a mental health crisis. Section 136 MHA is the law in England and Wales, similar legislation exists in Scotland and Northern Ireland. As the law currently stands, the police are the only professionals who have such powers. A radical approach to '*defund the police'* would have to address the gap that the abolition of section 136 MHA would create. In addition, section 136 MHA has become something of a measure of the extent of police involvement in mental health work. Section 136 MHA authorises any police officer to remove someone who appears to be mentally disordered, from a public place to a *'place of safety'*. The *'place of safety'* is usually a hospital or can in certain circumstances be a police cell. It is generally used in situations where a person is considered to be putting themselves or possibly others at immediate serious risk. There is no need for a formal medical diagnosis so the application of section 136 MHA is dependent on a number of factors including the experience and skills of the officer, the information they may have and the nature of the incident. The place of safety should normally be a hospital-based setting. Most mental health trusts have created specially designated areas – section 136 suites – where the formal assessments can take place. A person detained under section 136 MHA is then formally assessed by a psychiatrist and an Approved Mental Health Professional.

Police cells can be used as a '*place of safety*'. Cells should only be used in *'exceptional circumstances'*. Hampson (2011) argues that in practice exceptional means that the patient is *'too disturbed to be managed elsewhere'*. The use of police cells not only criminalises the mentally ill – the experience, however well the police respond – is bound to be a custodial rather than therapeutic one. In addition, police cells are simply not designed for this purpose. A cell is a bare concrete space with a mattress and a steel toilet. Police custody is a pressurised, busy and often chaotic environment. There is clearly the potential for this to have a negative impact on an individual's mental health. Police officers are called upon to manage very difficult situations such as self-harm or attempted suicide often with little training or support. These issues are not new. There has been significant progress made in reducing the use of police cells for detention under section 136 MHA. Her Majesty's Inspectorate of Constabulary (HMIC)'s 2013 study *A Criminal Use of*

Police Cells examined cases where a cell had been used as a place of safety. The most common reason for a police cell being used was that the person was drunk and/or violent or had a history of violence. HMIC (2013) review notes the process is essentially the same as being arrested. From a service user perspective, the experience was a custodial not a therapeutic one. Service users felt that they had been criminalised, dehumanised and their dignity and human rights abused (Riley et al., 2011) The Angiolini (2017) review reported a fall in the use of police cells as places of safety.

In 2017, significant changes section I36 MHA were introduced. *Length of the section:* Under the original legislation, a person could be held under section 136 for *up to 72 hours.* Local arrangements and protocols where in place to try and ensure that no individual was detained under section 136 MHA for such a long period. However, it was not unheard of – particularly, if there were delays in finding a hospital bed when it was decided an individual should be admitted to hospital. The reduction to 24 hours meant that England and Wales legislation was brought into line with similar powers in Scotland. A duty to consult was introduced to support and improve police decision making in mental health emergency situations. Before using the section 136 powers, a police officer is now required by new section 136(1C) to consult a specified health professional. The consultation allows a police officer to receive relevant mental health information and advice. The changes to legislation make the detention of a juvenile in a police cell under section 136 MHA unlawful in any circumstances.

A police station can now only be used as a place of safety for adults if

1. the behaviour of the person poses an imminent risk of serious injury or death to themselves or another person;
2. because of that risk, no other place of safety in the relevant police area can reasonably be expected to detain them, and.
3. so far as reasonably practicable, a health care professional will be present at the police station and available to them

(The Mental Health Act 1983 (Places of Safety) Regulations 2017). An officer of at least the rank of inspector must authorise the use of a police station in such circumstances.

Policing and the response to citizens in mental health crisis

Modern policing role has seen officers become involved in an increasingly diverse range of tasks. These tasks are additional to the traditional function of the maintenance of law and order and the apprehension of offenders. The period of austerity in the UK has seen police forces struggling to meet demand (Walley and Adams, 2019). Reduced police numbers have been a key factor here. However, there are other challenges including police changes in the nature of offences, such as the rise in digital crime, the increase in sexual offences and population changes. These combine to impact on the police role and demand on resources in complex ways (Laufs et al., 2020). Policing is clearly not the only area of the public sector that has been subject to retrenchment. However, retrenchment in other

areas such as social work, community provision and mental health services has a direct impact on the role of the police in mental health work.

One of the most complex and challenging areas is police involvement in mental health work. There has been an increased policy focus on the role of police officers in responding to citizens who are experiencing a mental health crisis. Since the Bradley Review (Dept of Department of Health, 2009), there has been a series of formal considerations of policing and mental health work. These include Lord Adebowale's (2013) inquiry into the issues in the Metropolitan Police Service (MPS) in London, Her Majesty's Inspectorate of Constabulary (HMIC) (2015) review of the use of police cells in cases where people have been detained under the Mental Health Act and the Angiolini Review (2017) of deaths and serious incidents in police custody. There have been two House of Commons inquiries by the Home Affairs Select Committee (2015, 2018) that have considered these issues. The most recent report by Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) (2018) *'Policing and Mental Health; Picking up the pieces'* captures the frustration that senior police managers and individual officer feel about the current police role in mental health work. Police officers often act as first responders, in situations where people are experiencing severe mental health episodes. If family, carers or members of the public are concerned that an individual's extreme or unpredictable behaviour posing a danger to themselves and members of the public then they are likely to make a 999 call to the police. There have been a range of initiatives such as mental health triage to try and tackle these issues. Closer working between the police and mental health agencies can help to ensure that individuals receive timely and appropriate mental health interventions in emergency situations (Rogers and Wintle, 2019). However, the broader context of retrenchment in mental health and wider community services cannot be ignored. Austerity has had double impact on mental health. It has increased social and other pressures that are the determinants of mental health but also reduced the services to support those in most need (Cummins, 2018a).

A number of factors have combined to increase concern about the role of the police. These include demands on police resources but also more fundamental questions about whether it is appropriate for police officers to take on the role (Marsden et al., 2020). The response has been initiatives such as street triage or liaison and diversion schemes. There is a wide variety of local initiatives and models of street triage and other schemes. They all share the aim of improving joint working and ensuring that individuals in crisis receive appropriate, timely access to mental health care. The models in England and Wales include, for example, ones where between mental health professionals, paramedics and police officers, are co-located in a dedicated response vehicle. Such teams would attend incidents where there is an immediate threat to life, that is, someone threatening to self-harm or commit suicide. The street triage team might also respond in situations where a family member or carer has expressed concern for someone's immediate safety. There are other models, for example, placing mental health professionals in police control rooms so that they can give advice to officers on how to respond to such calls.

The traditional response model of policing does not, in the mental health field, meet the organisational needs of the police. In addition, there is significant evidence that police encounters with people in mental health crisis carry the potential for harsher treatment of

individuals even the use of lethal force. As a result, police forces across the world have developed new models. These models have been developed as a result of national and local circumstances – often in response to a critical incident or a fatality. The most well-established of these models are to be found in the USA and Canada. Lamb et al. (2002) identify three possible models of police response:

1. specialist trained officers;
2. joint police and mental health teams;
3. phone triage or a system that allows officers to access relevant health information and records.

The best known of these models is the Crisis Intervention Team (CIT) based in Memphis (Compton et al., 2008). This model was established in 1988 following an incident when the Memphis Police shot dead a man who was suffering from a psychotic illness. CIT officers deal with mental health emergencies but also act in a consultancy role to fellow officers. In the context of policing, mental health triage has come to be used as a short-hand for a number of models of joint services with mental health staff and policing. These models combine some element of assessment with a recognition that individuals need to access the most appropriate services in a timely fashion. In addition, these models of service provision seek to improve officers' confidence in their decision making in the context of mental health.

The overarching aims of all these models, whatever their configuration is to ensure that individuals are safe, members of the public are safe and that those in crisis receive appropriate mental health care as soon as possible. The aim is to limit police involvement. This is driven by the recognition that the police cannot and should not be providers of mental health care but also by a drive to reduce the organisational demands on the police. These aims are largely recognised as laudable. However, Williams et al. (2020) question whether policy in this area is sufficiently clear as to what problems are being addressed and the role of the police should be. This perspective is based on a concern that recent policies such as street triage have had an unintended consequence. Police are more, not, less involved in mental health work. McDaniel (2019) argues that the result is a crisis of legitimacy in police mental health work. Officers are not adequately prepared for this work. There is a danger that decision making and the exercise of police discretion are not based on sound professional knowledge and practice. The outcome is poor provision of treatment of people with mental health problems (McDaniel, 2019).

Rogers and Wintle (2019) conclude that the increased police involvement in mental health work is the result of deinstitutionalisation, the failure to develop robust community mental health services and more recently welfare retrenchment policies. These trends can be recognised across Europe countries, Australia and New Zealand and North America (Cummins, 2020b). They are trends that can be identified across the last 40 years. The concerns about the current police role in this area can be traced back to the long term failings of community care. Bittner's (1967; 1970) hugely influential work had highlighted that police beat officers were increasingly responding those experiencing mental health difficulties. Teplin (1984) used the term '*mercy booking*' to describe the situation

where the police arrest an individual because they felt that this would ensure that a vulnerable person was given food and shelter even if it was in custody. Teplin's work is now nearly 40 years old, more recent scholarship such as Morabito (2014) has emphasized that policing of vulnerable populations is more complex and that contrary to popular myth arrest is not the first police response. The contemporary focus on mental health and policing can be traced back to the period of community care (Cummins, 2020b). The failings of this area led to a series of inquiries. The focus of these inquiries was on mental psychiatric services and mental social work. In the media coverage, in particular, the police role was marginalized. However, the role of the police was highlighted in several community care inquiries in the 1990s – most notably the Ritchie Inquiry (1994) into the care and treatment of Christopher Clunis. Clunis murdered Jonathan Zito at a tube station in 1992. Clunis had contact with the police and a range of other agencies following a series of compulsory admissions under the Mental Health Act.

Picking up the pieces: Current debates about the police role in mental health

In the UK context, the issue of the police role in mental health–related work has been rising steadily up the policy agenda. These issues have been brought into sharper focus by the impact of austerity. There are two key themes that can be identified in the current debates about the police role. The first is a fundamental questioning of whether the police should have a role in mental health related work. The second is a concern that police are being asked to take on an increasing role in mental health related work – a role that they are not trained for or have the resources to fulfil. In October 2018, the House of Commons Home Affairs Committee published a report '*Policing for the Future'*. Dee Collins, Chief Constable of West Yorkshire Police, in giving evidence stated that '*83% of my time in terms of delivering services is not about crime'*. It includes a focus on issues relating to vulnerable people – including people with mental health problems. Chief Constable Collins identified three areas: *mental health work, missing people (particularly missing children) and multi-agency child protection work.* The inquiry concluded that

'A prominent theme emerging throughout this inquiry was the increasing volume of police work arising from identifying and managing various forms of vulnerability, including safeguarding vulnerable adults who cross their path, being first-on-scene during a mental health crisis, undertaking child protection work on a multi-agency basis, and dealing with repeat missing person incidents, including looked-after children'.

Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) (2018) *Picking up the Pieces* report focuses on a range of issues that were similarly highlighted by the House of Commons report. From its title onwards, the main thrust of the report is clear: the police are called upon to respond to too many people experiencing mental health crisis. This is not considered an appropriate use of police resources. The report repeats the concern that officers have not been adequately trained to support people in the midst of a mental health crisis. It may also put people who are experiencing a crisis at greater risk – they may not receive appropriate treatment or the mental health concerns may not be identified by officers Police officers have a range of transferable skills that

might equip them for to respond in these situations. Frontline officers should have good communications but also be able to de-escalate situations. This is not quite the same as feeling properly trained and supported to respond. Police officers report that they find contacts with people with mental health problems a difficult area of work. Police officers regarded work as time consuming and often unpredictable. This remains the case despite an increase focus on training for officers in this area (Thomas and Watson, 2017). The report also raises the ethical question of whether police involvement serves, by accident rather than design, to criminalise or potentially criminalise people who are experiencing a mental health crisis. The final area that the report highlights is the need for a more co-ordinated and systematic approach to the training of police officers.

There are many areas of police work that, whilst not involving psychiatric or specialist services are, in fact, related to broader mental health issues. For example, Chief Constable Collins identified '*missing persons*' as one of the key areas driving increased demands on the police. Such calls are often mental health–related (Parr and Stevenson, 2013). The question of getting a clear and consistent picture of police demand that is related to mental health is a difficult one. It is important to note that, the focus in this area has been emergency work. There is another area in terms of people with mental health problems as victims of crime and the police' response to them that needs to examined in more depth. Edmondson and Author (2014) noted that *'mental health'* was a flexible term covering a wide range of situations. It was often used rather crudely. Some calls were badged as mental health where it was not clear what the exact nature or the relevance of the mental concern was. Having acknowledged some of the data collection difficulties, in 2008, the Sainsbury Centre suggested that 15–20% of police work was mental health–related. In 2013, Lord Adebowale, having carried out an inquiry in the MPS in London, described mental health work as *core police business.*

The demand pressures produced by austerity alongside the reduction in the numbers have occurred at the same time as a general concern and uneasiness with police involvement in mental health (Cummins, 2018a). The result has been to question whether mental health work is police work at all. In 2013, as the fall in police numbers was being keenly felt, the then Home Secretary, Theresa May told the police that their role *'was to cut crime no more no less'*. In 2016, the former Met Commissioner, Sir Ian Blair suggested that responding to vulnerable people in crisis was preventing the police fulfilling its core function of ensuring community safety. In 2017, Sir Tom Winsor stated the police had become the service of first not last resort for people in crisis. The HMICFRS found that based on reports, data obtained from 22 forces on three per cent of all calls were flagged as mental health. There were 318,000 incidents around two-thirds of these calls were related to a *'concern for safety'* for an individual. This covers a potentially broad area but it is not generally an immediate emergency. About 10 per cent of these concerns for safety calls came from other agencies. The peak time for calls to police for support with mental health–related incidents is 3 p.m.–6 p.m., Monday to Friday. This possibly reflects that community mental health and other agencies are less likely to be available. This is not to suggest that there will never be calls where it is appropriate to call the police. The current structure and delivery of services makes this impossible in England and Wales. The concern from a police perspective is that officers are being asked to undertake,

which is more appropriate for staff from social welfare agencies. Mental health issues are complex and often the police are being asked to respond to situations as emergencies, which are actually the result of long-term complex issues that cannot be resolved quickly. The report, for example, highlights that the five most frequent callers to the MPS made over 8,600 calls in 2017 – an average of roughly 4.5 calls each every day.

Frontline officers' views

Alongside the push back against an increased role for the police in mental health work from senior managers, who have questioned demand and the appropriateness of police interventions, there is frustration from officers on the beat. This is part of a wider police organisational culture. Loftus (2008) highlighted that there have been shifts in the management culture, particularly in the areas of equality and diversity. However, organisations do not have one culture. It is important to examine the views of police officers in all ranks. Management might see the issue in terms of resources, Lane (2019) carried out a study of posts by police officers on an online forum, to examine attitudes. The research identified two distinct themes. The first was that mental health incidents as wasting police time that could be more effectively spent fighting crime (Lane, 2019). The other theme that Lane (2019) identified was one that associated mental health problems with violence. Loader (2013) argues that the police have a key role in defining the nature and extent of social problems. In the context of policing and mental health, there is a strong narrative which sees the police being drawn into this realm because of the failings of other agencies.

The narrative framing of police mental health work Frederick's et al (2018)'s study highlighted that the increased police role in mental health work was framed in a narrative of deinstitutionalisation. Whilst this has a historical significance, it obscures the impact of austerity (Cummins, 2018b). This narrative also constructs the issue in terms of it being an organisational issue. This obscures the experiences of service users – potentially positive and negative – when police are involved. For example, whilst Riley et al. (2011) study of service user' experience of being detained under section 136 MHA emphasised that the damaging custodial aspects of it, it was recognised that police officers responded in a compassionate way to those in distress, showing concern for individual's safety.

Discussion

There is a police concern at both an organisational and individual level that the police are becoming the de facto of mental health emergency care. Following on from this, individual officers feel that '*this is not part of the job',* (Lurigio and Watson, 2010). Senior managers see the increased demands on police time and resources as unsustainable. The solution so far has been to develop of new models of working such as street triage. These models still involve police officers, so there are concerns that they will continue to stigmatise people with mental health problems. In addition, there is the possibility that these models, rather than solving the problem will draw the police further into the mental health field. Alongside these organisational issues, there is a wider concern that police are

plastering over the deep cracks in community mental health services. This is a fundamental issue of ethics and human rights. The original aim of community care was to replace the asylum system with well-funded community mental health services based on fundamental values of dignity and recognition. There is a wider recognition that the police cannot take on the role of mental health professionals. Wood et al. (2011)'s review of trends in the UK, Canada and the USA concludes that the same issues arise across the countries: a reduction in the number of mental health beds and limited community mental health services has led to a greater role for the police. This is not a role that the police have sought. These officers receive little specific mental health training. Police officers, particularly in urban areas deal with incidents that relate in some way or another to mental illness on almost daily basis. It is likely that the police will always be 'first responders' to many incidents.

The calls to '*defund the police'* have been largely based in the USA and the focus has been on reducing the budgets for riot gear. Alongside this, there have been calls for the budgets of a range of welfare services to be increased. The question that then arises is, is it possible to create a mental health system that does not involve the police or grant them emergency powers akin to section 136 MHA? Government funding never works in a straightforward fashion. The reductions in budget A rarely lead to an increase in Budget B. However, if the funding and broader role of the police is to be considered and re-evaluated, then mental health work has to be part of this. It is clear that there needs to be greater investment in a range of mental health service. The focus on police involvement in emergency and crisis work should not obscure this. The current debates have been focused on minimising police involvement or making the response more effective. This includes the more effective use of police resources. However, the broader aim is to ensure that in emergency situations in particular, individuals receive appropriate care as soon as possible in a way that ensures their dignity and wider human rights are respected.

Conclusion

The role of the police in mental health work has come under greater examination. These concerns developed in the first wave of deinstitutionalisation from the 1960s onwards. They have been present ever since but have been heightened by the double impact of austerity policies. The double effect of the reduction in social and welfare spending has been to increase the demands on mental health services at a time when resources have been cut. In the UK, the police, unusually under a conservative government have not been immune to these reductions in spending. The increase in demand creates a situation where the police feel that they are '*picking up the pieces'* – plastering over the gaps in mental health community services. Police officers have skills that are applicable in mental health emergencies but they cannot or be expected to take on the roles of mental health professionals. These trends can be observed across North America, Europe and Australia and New Zealand. While there is a recognition that police involvement in mental health is, at the moment, unavoidable and something of a necessary evil, there are calls for a root and branch. In the mental health sphere, the calls to '*defund the police'*, if we take this to mean reduce police involvement, are in a sense largely supported by the police. *Defunding the*

police would become part of a wider social investment that seeks to reinvigorate the progressive values that were at the heart of community care.

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