Policing and models of Mental Health Triage.

Abstract

In his recent report, Lord Adebowale (2013) described mental health issues as "*core police business*". The recent retrenchment in mental health and wider public services mean that the demands on the police in this area are likely to increase. Mental health triage is a concept that has been adapted from general and mental health nursing for use in a policing context. The overall aim of triage is to ensure more effective health outcomes and the more effective use of resources. This article examines the current policy and practice in this area. It then goes on to explore the models of mental health triage that have been developed to try and improve working between mental health services and the police.

Keywords: mental health, policing, triage

Introduction

The interaction between the Criminal Justice System (CJS) and mental health systems continues to be an area of policy concern. At the time of writing, the Home Office is carrying out a review of sections 135 and 136 of the Mental Health Act (1983), the Commons Home Affairs Select Committee is undertaking an Inquiry into this area - written evidence was published 14.5.2014 and the College of Policing is also carrying out a review of the field. The police have a key role in a range of scenarios that address mental health issues. These include dealing with individuals, who are experiencing acute mental distress, supporting colleagues in community mental health services and responding to incidents within mental health units. This area can be used to examine one of the wider questions policing research and policy - *what is the role of the police, are they fundamentally a force or a service and what links the huge range of tasks that modern police officers are called upon to perform*? As Cummins et al (2014) highlight the media and popular culture representation of policing with its emphasis on the solution of violent crimes is far removed from the reality of day to day work. As Bittner (1967) argued policing involves much more than the detection of crime and the apprehending of offenders. In fact, tackling crime does not constitute the majority of police work. In Bittner's (1970) famous phrase a police officer could be seen as "*Florence Nightingale in pursuit of Willie Sutton"* - Sutton was a famous bank robber. In his work, Bittner argued that the unifying factor in the bewildering range of police tasks from investigating serious crime to directing

traffic was that they all potentially required the legitimate use of force. The police are a representation of Weber's definition of the State as the entity which has a *"monopoly of the legitimate use of physical force"*

Police involvement in mental health work has to be viewed as 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. However, as Husted et al. (1995) suggest it is not an area that is often valued that highly within police work. This is vital work. It does not fit with aspects of *"cop culture"* that Reiner (2000) identifies. For example, there is often not an immediate response in terms of action that can be taken.   It is an area that does create particular challenges for police services (Carey, 2001, Lurigio and Watson 2010). These challenges are both individual and organisational. Police officers do not receive a great deal of training in this area (Cummins and Jones 2010). In addition, there is well-documented frustration amongst the police about the short comings in community - based mental health services and the potential impact that these have on their own role. Despite this background, at the time of writing, there is some cause for cautious optimism that there is finally a commitment to tackle these difficulties. Pilot schemes have been announced that will see mental health nurses being based in police custody suites to assist officers. This paper will explore models of mental health triage and their potential impact.

The role of the police in modern mental health services

Lord Adebowale (2013) concludes that for the police mental illness is "core business". His report was commissioned following a number of deaths in custody. A recurring feature of these awful events is that the person suffered from a history of mental illness (IPCC: 2011). Lord Adebowale's analysis shows that the Metropolitan Police dealt with over 60,000 mental health related incidents in 2012. This is an average of 160 incidents a day. One of the problems here is that mental health and illness are terms that cover such a wide range of human experiences. In a survey carried out amongst officers, they categorised the nature of these "daily or regular" contacts as follows: victims (39%), witnesses (23%) and suspects (48%). In their responses, two-thirds of officers indicated that they encountered unusual behaviour caused by alcohol or street drugs. The report also highlighted an area that is often overlooked in the policing and mental illness debate - the fact that people with mental health problems are at increased risk of being victims of crime. These risks appear to be significantly increased for violent offences. The report concluded that victims, who had a mental problem,

generally felt that the service provided by the police fell below an acceptable level. The report confirmed the findings of the Sainsbury Centre (2008) investigation which indicated that fifteen per cent of police work was related to mental health issues.

The policy of deinstitutionalisation -i.e. the closure of the large asylums and their replacement by community based mental health services - has been followed across Europe and North America (Cummins, 2011). The failure to develop adequate community mental health services and the impact on individuals is well documented (Moon, 2000, Kelly, 2005 and Wolff, 2005). One impact of these failings has been for the police and CJS to become de facto providers of mental health care (Lamb et al 2002). This is the case across a number of jurisdictions. Wood et al (2011, 6) show US police have become "front-line workers who often come into contact with persons with mental illness and must respond to their needs with whatever tools lie at hand (emphasis added)" This is reflected in the Australian context. Godfreson et al (2011) concluded that responding to mental health related incidents was a significant part of the working week for most officers. It is an area that police officers feel unprepared for by the current training (Cummins and Jones, 2010). The IPCC role in investigations of serious incidents and deaths in custody means that officers can feel very exposed. The impact on individual officers who are involved in such cases is not to be underestimated. This is a reflection of wider organizational cultures. As Pollitt and Bouckaert (2011) suggests the audit culture with an emphasis on risk and risk management that the new style of public management produces, can also lead to risk adverse practice.

Bittner (1967) notes that policing requires the exercise of considerable discretion and individual judgment. Arrest and custody should be viewed as being at one end of a continuum. In Teplin's (1984) seminal study of policing and mental illness, she 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 would ensure that the person was given food and shelter -even if it was in custody. Morabito (2007) argues that police decision making is more complex than is allowed for in these situations. She argues that police decision making is shaped by a number of variables. These are termed "horizons of context". This model provides a tool for the analysis of the decisions that officers make. In Morabito's model, there are three variable contexts. The scenic context refers to the range of the community resources that are available including the range of voluntary and statutory mental health services, access to training for officers and the working relationships between agencies. The

discretion that officers can exercise is clearly limited by the range of services available. If community services are limited, then custody becomes regrettably a more likely outcome.

As well as the community resources, Morabito (2007) outlines two other "horizons of context", which she terms temporal and manipulative. In this model, temporal refers to the individual and manipulative to the actual incident. There will be some incidents -for example in the rare cases when a violent crime has been committed -where the police for evidential and public protection reasons will have little alternative but to take the person into custody. At the other end of the scale, a very experienced officer dealing with a minor incident involving an individual they know well, will have much greater scope to exercise discretion. The scope will increase in areas where there are greater community mental health resources. As Morabito concludes there is a tendency to oversimplify the decision making processes that police officers use in these complex and demanding situations. The local service, social and environmental contexts are thus vitally important.

The Mental Health Act (MHA 1983) outlines specific powers for police officers in the area of mental health. The most significant of these is section 136 (MHA) which allows for an officer to take a person, who is in a public place and appears to be mentally disordered to a place of safety. If someone is detained under section 136 MHA, they must be assessed by a psychiatrist and an Approved Mental Health Professional. The MHA Code of Practice emphasises that the place of safety should be a health facility. It has been recognised that a busy and stretched A+E department is not an ideal environment for a patient who is experiencing acute mental distress. As a result, trusts have established dedicated section 136 MHA suites where these assessments can be carried out.

 In exceptional circumstances, a police cell can be used as a place of safety.
A joint review led by HM Inspectorate of Constabulary (2013) found that the use of police cells was a common practice. The most common reasons given for the use of the police cell was that fact that the person was drunk, violent or had a history of violence or there was inadequate health-based provision. As the report notes, the person who is detained under sect ion 136 (MHA) and taken to a police cell is essentially treated like any other person in custody. They are searched and go through exactly the same booking in processes as someone who has been arrested for an assault. There are no specialist facilities within custody suites. Generally, there are very limited services to assist the police in ensuring that distressed

individuals remain safe and receive access to mental health care. As Cummins' (2007 and 2008) studies

of the work of custody sergeants shows the management of section 136 MHA is a source of considerable frustration for the police.

The case of MS v. UK which was decided in the European Court of Human Rights (ECHR) in 2012, demonstrates illustrates the potential difficulties that can arise. MS was detained under section 136 MHA following an assault on a relative. When he was assessed at the police station, it was decided that he needed to be transferred to psychiatric care. There then followed a series of delays and arguments between mental health services as to which unit would be the most appropriate to meet MS's mental health needs. This argument went on for so long that the seventy-two hour limit of section 136 (MHA) was passed. MS was still in police custody and this has a dramatic impact on his mental state. For example, as a result of paranoid delusional ideas, he refused food. The ECHR held that the treatment of MS constituted a breach of article 3 which prohibits inhumane and degrading

treatment. This is clearly an unusual case but it illustrates the potential issues that

arise. The judgement made it clear that the initial decision to detain MS under mental health legislation was valid and justified. It is clear that the police cannot hope to tackle the root causes of these problems in isolation. In January 2014, 10 pilot sites were announced where mental health nurses are to be allocated to police custody suites to assist in the assessment of detained persons suffering acute mental distress.

The use of section 136 MHA is a very important area. It raises very important civil liberty issues as well as wider ones about the treatment of people experiencing mental health problems. As Latham (1997) points out it allows for an individual to detain someone. Unlike sections 5(2) and 5(4) of the MHA the person with the power has no medical training and no medical evidence is required for the power to be enacted. In fact, the purpose of detention under section 136 is for   psychiatric assessment. However, it is important to bear in mind that this is just one area of mental health work, in which, police officers are potentially involved. There is a danger that debates about the working of section 136 overshadow the whole debate in this field.

Models of policing and mental health triage approaches

This section will explore the concept of mental health triage and the differing approaches or models of service provision that have been developed to improve interprofessional working in this field. Until relatively recently, the focus of offender mental health provision has been on prisons rather than earlier in the CJS process. Triage is a well-established concept within general nursing and medicine. In this process, an early assessment allows for individuals at accident and emergency so that they can be treated speedily in the most appropriate setting. This process allows for the more efficient allocation of medical resources. It is also suggested that triage provides for more effective patient outcomes (Fitzgerald et al 2010). Accident and Emergency can be a key point of contact for those experiencing acute mental distress. Clarke et al's 2009 study explored service-users' views of Emergency Departments. The first thing to acknowledge that A +E is a far from ideal environment for those experiencing acute distress. The noise, distress of other patients, the possibility of long delays, lack of amenities and staffing difficulties are all factors that contribute to this. As Clarke et al (2009) argue mental health crises do not fit into the standard pattern of assessment and treatment at A+E. This is not to deny that there are complex interactions between social and other environmental factors in all forms of illness. However, in this context, mental illness is different. A mental health crisis may well be triggered by one recent event, for example a bereavement which might be easily identified. However, the underlying causes are more complex, likely to be deeply en-grained and not immediately responsive to treatment in the same way as psychical illness. The service-users in Clarke et al's (2009) study clearly felt that the emergency system did not meet their needs but they often "*had nowhere else to go*". Other factors that were highlighted were the impact of waiting times and what is termed "*diagnostic overshadowing*" - i.e. the idea that any or all symptoms were put down to mental illness. As Rosenhan (1973) noted in his famous study, one of the most profound impacts of a diagnosis of mental illness is that all other behaviours become interpreted through that prism.

The psychical environment makes A +E a far from ideal environment for the assessment and treatment of mental illness. In addition, as Kirby and Keon (2004) mental health can be an area where even experienced general nursing staff lack confidence. This is despite the fact

those between five and ten per cent of presentation at A+ E relate to mental health issues. Mental health issues can be more difficult to assess, particularly in the patient is not well-known. Background information that would help this process is often difficult or not possible to obtain. Spandler (1999) showed that service-users felt that unsympathetic at best or hostile at worst attitudes were not uncommon amongst nursing staff at A+E. As McDonough et al (2004) note the shift to community services has meant that the number of mental health presentations at emergency departments have been increasing. In this context, the need for mental health triage becomes even greater. Sands (2004) makes it clear that because mental health issues are, generally more difficult to assess and can be masked by factors such as alcohol and drug misuse triage is a longer and more complex process. As a result of these difficulties, models of mental triage have been developed. Clarke et al (2009) outline one such model where cases are assessed on a scale from emergency -patient is violent, aggressive and suicidal to non-urgent where the patient has long-standing mental health issues and is not acutely unwell.

As outlined above, mental health triage is a difficult practice, organisational and logistical issue for specialist services. The pressures outlined above that impact on assessment are mirrored or replicated in community settings. As Seddon (2007) argues there is something of an unrealistic view that the mental health and criminal justice systems can ever be two completely distinct entities. The boundaries between the two are "porous" (Lurigio: 2011) As Cummins (2013) has argued the pressure on community mental health services makes these boundaries more confused. 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 systems share the same aims as triage in that they 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 are trying to improve officers' confidence in decision making in these situations. They also support the recently developed National Decision Making Model (http://www.nationaldecisionmodel.co.uk/) for police officers.

Lamb et al (2002) identify possible models of police response. The models can be divided into three very broad types: *specialist police offices response, specialist mental health professional response or some form of joint team.* It should be noted that

these models are essentially developed to respond to mental health crises that occur when officers are on patrol or called to an incident. The first is the selection and training of designated specialist officers. The first and probably best known of these schemes is the Crisis Intervention Team 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. The CIT officers deal with mental health emergencies but also act in a consultancy role to fellow officers. To become a CIT officer, personnel have to undergo intensive mental health awareness work as well as training in de-escalation techniques. The second approach is to have a joint mental health and police team that is on-call to respond to identified mental health emergencies. For example, both West Midlands and Leicestershire have established pilot projects using a patrol car with a mental health nurse in addition to police staff. In the US, there are examples of specialist mental health teams that have been established to respond crises. The final model that Lamb et al (2002) identify is a *"phone triage"* approach where mental health professionals are available to offer advice or information to patrol officers.

The CIT is a well-established model. In addition to the training of officers, one of the cornerstones of CIT is the fact that there is an agreement that the local hospital will accept all CIT referrals. Franz and Borum (2011) analysis suggests that this model continues to have a positive impact. The authors calculated that the "prevented arrest" rate over a five year period in an urban county in Florida where the CIT model was introduced. One of the difficulties in this area is the collection of the data before CIT was developed. However, in the period analysed there were 1539 calls that led to 52 arrests -an arrest rate of 3%. The study estimated 342 arrests in such incidents in the previous five years before the introduction of CIT. Thus 290 arrests were prevented. Even allowing for a cautionary approach -for example- in some circumstances an arrest might be simply unavoidable-this shows the potential of such models. As Watson et al (2008) note two key factors in the success of the CIT model are the increased police confidence in dealing with these situations and the no *"refusal policy"* that is established with the local mental health units.

Hails and Borum (2003) carried out a review of eighty-four law enforcement agencies. They examined not only the amount of training provided to officers but also the use of specialist teams for responding to mental health incidents. They found wide variations in the levels of

training provided – the median was six and half hours for basic recruits and an hour for in-service training. As the study notes, the training for basic recruits was also used to address the issues of substance misuse and learning disabilities. The study also examined the organisational responses to these issues. A total of 27 agencies provided relevant information. 11 agencies they had access to mental health professionals "in house" that could assist officers. Hails and Borum classify this as a "*police- based specialised mental health response model".* 9 followed the model of having specially trained officers – a model the authors' term *"police-based specialised police response model".* The final seven responses indicated that the police were able to contact a mobile mental health crisis team – a model classified as "*mental health based specialised mental health response model".* The study concluded that programmes such as the CIT model had the greatest potential to reduce the use of lethal force and arrests. The authors also argue that this model requires little organisational change to be developed and operate effectively.

Reuland et al (2009) argue either a joint team or specialist mental health support both approaches have produced promising results in terms of both health care and more effective use of police resources. There is an organisational cultural issue that needs to be addressed here as the usual measures of police outcomes such as response times or arrest rates cannot be neatly applied to this issue, which is essentially a public health one. An example of the joint approach is Car 87 in Vancouver. In the ten years to 2002, Canadian police fatally wounded eleven seriously mentally ill people. This scheme is part of the response. The project is a jointly funded between the police and local mental health services. In addition to a joint response it provides a phone triage service (www.vancouver.ca/police).

In England and Wales, the Cleveland Street Triage team was established in 2012. This is also a jointly health and police funded project that ensures that a mental health nurses are available to carry out assessment when police are called to an incident. The scheme has a broader remit as assessments also take place if there is a substance misuse problem or the individual has a learning disability. In the first year of the scheme, there were 371 assessments. Only 12 (3.2%) resulted in section 136 assessments. Drug or alcohol related problems were the main presenting issue in 129 cases. 205 individuals were regarded as not having any "*significant mental disorder*". 134 (36.1%) were known to the local trust. This scheme highlights a number

of key issues. The majority of these cases may well not be "psychiatric emergencies" in a clinical sense but they are representations of long-standing often deeply entrenched problems. This is not to down play their significance, it is rather highlights the need for a range of professional responses. For example, the issues of mental health and substance misuse are often inter-related. It is clearly important to consider the use of section 136. Obviously, the use of such restrictive powers has to be avoided if at all possible. The MH Code of Practice is clear on this point. The use of police powers can also be seen to add to the stigma attached to mental illness. However, there is a possibility that the focus on the use of section 136 dominates discussions in this area. In particular, there is the danger that the use of section 136 is only seen as appropriate when the person is subsequently detained under section 2 or 3 MHA 1983. This is a very reductive measure. Any triage system will not remove the need for the use of such powers.

Conclusion

Beresford (2013) outlines the current pressures that mental health services face. The economic climate and current government policies have two affects. The first is that services have to try and provide services with reduced funding. The second is that the need for services increases (Cummins: 2013). NHS England and Monitor the health service regulator have recently proposed a twenty per cent cut to mental health funding on top of the cuts of the past four years. In a recent joint letter to the Guardian (11.3.2014), a number of bodies, including the Royal College of Psychiatrists outline the possible devastating outcomes Mental health is chronically underfunded. It accounts for 28% of the disease burden, but gets just 13% of the NHS budget. Mental health services are straining at the seams and these new cuts will mean support is slashed in response to instructions from NHS England. This decision will cost much more in the long term as it will drive up admissions to A&E and the number of people reaching crisis and needing expensive hospital care.

Mental health and policing is moving up the policy agenda. This is a welcome development. The debates in this area need to include a consideration of possible reform of section 136

MHA including ways of ensuring that police cells are not routinely used as places of safety. However, there is a danger that the focus on section 136 will push to the margins the wider role that police officers potentially have in this field. Lord Adebowale concluded mental health is *core police business*. We take this to mean that dealing with individuals experiencing mental distress is a key feature of the working week of most police officers. The models of triage that have been examined here have developed in response to local organisational, demographic and other factors – for the example a response to a tragic incident or the commitment of individuals. It would be foolish to try to be very prescriptive in developing models of triage. However, all these schemes have two key features – the improved training for officers and improved liaison with mental health services. These elements are vital whatever the nature of the mental health crisis or incident that is being addressed.

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References

Adebowale, Lord 2013. Independent Commission on Mental Health and Policing Report

Beresford P. 2013. https://theconversation.com/mental-health-is-in-no-fit-state-whateverthe-

politicians-say-15743

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

Bittner E. 1967(b) The Police on skid row: A Study of peace keeping. *American Sociological Review* 32(5) 699-715

Bittner, E (1970) Functions of the Police in Modern Society Washington DC NIMH

Bradley K. 2009. The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. London: DoH.

Carey S. J. 2001. Police officers' knowledge of and attitudes to mental illness in southwest Scotland. Scottish Medical Journal 46: 41-42.

Compton, M, Bahora M, Watson, A and Oliva, J (2008) A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs Journal of American Academy of Psychiatry and the Law 36:1:47-5

Cummins I. 2007. '" Boats against the Current: Vulnerable adults in police custody". Journal of Adult Protection 9(1):15-24.

Cummins I. 2008. "A Place of Safety: self-harming behaviour in police custody". Journal of Adult Protection 10(1):36-47.

Cummins I. and Jones S. 2010. "Blue Remembered Skills: Mental Health Awareness Training for Police Officers". Journal of Adult Protection 12 (3):14-19.

Cummins I. 2010. "Mental health services in the age of neo-liberalism". Social Work and Social Policy in Transition 1 (2):55-74

Cummins I. 2012 "Policing and Mental Illness Post Bradley". Policing: A Journal of Policy and Practice 6(4):365-376.

Cummins I. 2012 "Mental Health and Custody: A follow on study". Journal of Adult Protection 14(2): 73-81.

Cummins I. 2013. "Policing and Mental Illness in the era of deinstutionalisation and mass incarceration: A UK Perspective". International Journal of Criminology and Sociological Theory.

6(4):92-104

FitzGerald, G Jelinek, G Scott, D and Gerdtz, M (2010) Emergency department triage revisited Emergency Medicine Journal 27:86-92

Franz, S and Borum, R (2010) 'Crisis Intervention Teams may prevent arrests of people with mental illnesses', Police Practice and Research, 1-8

Godfredson J., Thomas S., Ogloff J. and Luebbers S. 2011. "Police perceptions of their encounters with individuals experiencing mental illness: A Victorian survey".
Australian & New Zealand Journal of Criminology 44: 180 -195.

Hails, J and Borum, R (2003): Police Training and Specialized Approaches to Respond to People With Mental Illnesses Crime & Delinquency, Vol. 49 No. 1, 52-61

Her Majesty's Government (2014): Mental Health Crisis Concordat -Improving outcomes for people experiencing mental health crisis

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/ 36353_Mental_Health_Crisis_accessible.pdf) (last accessed 21.2.14)

Her Majesty's Inspector of Constabulary (HMIC) 2013. A Criminal Use of Police Cells? The use of police custody as a place of safety for people with mental health needs (www.hmic.gov.uk last accessed 24.2.14)

Kelly B. 2005. "Structural violence and schizophrenia". Social Science and Medicine 61: 721–730.

Kirby, M. J. & Keon, W. J. (2004). Mental Health, Mental Illness, and Addiction: Overview of Policies
and Programs in Canada. Interim report of the Standing Senate Committee
on Social Affairs, Science, and Technology, Ottawa, Canada;

Lurigio, A. (2011) People With Serious Mental Illness in the Criminal Justice System Causes, Consequences, and Correctives The Prison Journal vol. 91 no.3 (s) 66-86

Lurigio A. and Watson A.C. 2010. "The Police and people with mental illness: New Approaches to a longstanding problem". Journal of Police Crisis Negotiations 10 (1-2): 3-14.

McDonough, S Wynaden, D Finn, M McGowan, S, Chapman R and Hood, S (2004) Emergency department mental health triage consultancy service: an evaluation of the first year of the service Accident and Emergency Nursing 12, 31–38

Moon G. 2000. "Risk and protection: the discourse of confinement in contemporary mental health policy". Health & Place 6 (3): 239-250.

Morabito M. 2007. "Horizons of Context: Understanding the Police Decision to Arrest People With Mental Illness". Psychiatric Services ps.psychiatryonline.org 58 (12): 1582–1587.

Ogloff J., Warren L., Tye C., Blaher F., and Thomas S. 2011. "Psychiatric symptoms and histories among people detained in police cells". Social Psychiatry and Psychiatric Epidemiology 46:871–880.

National Decision Making Model http://www.nationaldecisionmodel.co.uk/

Ogloff J., Thomas S., Luebbers S., Baksheev G., Elliott I. Godfredson J.,Kesic D.,Short T., Martin T.,Warren L. ,Clough J., Mullen P.,Wilkins C., Dickinson A., Sargent L.,Perez E.,Ballek D.,Moore E. 2013. "Policing Services with Mentally Ill People: Developing Greater Understanding and Best Practice". Australian Psychologist 48 (1): 57–68.

Pollitt, C. & Bouckaert, G. (2011) Public management reform: a comparative analysis: New Public management, Governance and the Neo-Weberian State. Oxford: Oxford University Press.

Reuland, M., Schwarzfeld, M., & Draper, L. (2009). Law enforcement responses to people with mental illnesses: A guide to research-informed policy and practice. New York: Council of State Government's Justice Center

Rosenhan, D. (1973) : On Being Sane in Insane Places Science, New Series, Vol. 179, No. 4070, pp. 250-258

Sainsbury Centre for Mental Health (2008).
http://www.centreformentalhealth.org.uk/pdfs/briefing36_police_and_mental_health.pdf

Sands N. (2004) Mental health triage nursing: an Australian perspective Journal of Psychiatric and Mental Health Nursing 11 150–155

Seddon T. 2007. Punishment and Madness. Oxford: Routledge.

Spandler, H (1996) Who's who hurting who ? Young people, self-harm and suicide Manchester 42ND Street

Teplin L. 1984. "Criminalising mental disorder". American Psychologist. 39: 794–803.

Vancouver Police: Car 87 www.vancouver.ca/police

Wolff N. 2005. "Community reintegration of prisoners with mental illness: a social investment perspective". International Journal of Law and Psychiatry 28 (1):43–58.

Wood J., Swanson J, Burris, J.D. and Gilbert A. 2011. Police Interventions with Persons Affected by Mental Illnesses: A critical review of global thinking and practice. Rutgers University, New York : Center for Behavioral Health Services and Criminal Justice Research