

Policing, Crime and Mental Illness in England and Wales: Insights from the Literature

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Abstract

Mental illness pervades most societies, but it is only recently that its impact and effects upon individuals has slowly been recognised in England and Wales. When people suffering from this illness become involved with various public agencies, the way they are dealt with appears inconsistent and on occasions ends in tragedy. One agency that is constantly in contact with people who suffer mental health illness is the police service. Some high profile cases have clearly illustrated misunderstandings and the fact that the police are not generally equipped to deal with such individuals. This article considers a brief history and theoretical backcloth to police understanding and framing of mental illness in England and Wales, and explores the National Liaison and Diversion Model as an alternative to traditional police understanding and response. The article suggests that only by understanding the historical context, and literature, surrounding mental illness, can improvements be made in the criminal justice system as a whole and within the police service in particular.

Keywords: police, mental illness, criminal justice, diversion model

1. Introduction

Much Madness is divinest Sense
To a discerning Eye
Much Sense-the starkest Madness
'Tis the Majority
In this, as all, prevail
Assent-and you are sane
Demur-you're straightway dangerous
And handled with a Chain

From *Life* by Emily Dickinson in Appignanesi (2008)

The eloquence and simplicity of Emily Dickinson's outlook on the philosophical, political and sociological interactions of mental illness was published in 1890 and flowed from her personal experiences and emotional reactions but they held little sway in an age where science was now captivating the imagination of the influential. The chains of social control mechanisms evident via labelling, restrictive controls, exclusion or detention have a long history, periodically reinforced within our cultural responses in legislation. For policing this has meant attempting to provide a response to mental illness from within a mainly punitive framework.

2. Historical View

Since the Vagrancy Acts of 1714 and 1744, the "furiously mad and dangerous" were allowed to be restrained and detained (Vaughan & Badger, 1995; Thomas, 2016). Bentham's Utilitarianism concepts of "the greatest happiness to the greatest number" have remained from his grand project. They defined social parameters of conformity and deviance via constructs of morality and ultimately criminal and health legislation (Harrison, 1995). Walker (1968) speaks of long conflicts between judicial expediency and Utilitarianism. Heard (1997) illustrates the chief necessity of universal human rights is to provide a counter to societies and governments driven to surrender individual or minority rights in favour of the collective. Human rights are particularly susceptible to

suppression via cultural relativism and utilitarian concepts that assert limited or inadequate, social resources provide a justification in their allocation in terms of utilitarian calculations. Individual human rights are thus compromised or even denied when balanced against the claim of society as a whole. Even life itself, can be subjected to the promotion of the greatest good of society.

Wilson (2007) suggests Utilitarianism implemented across class divides depends upon the brutal reality that pleasing everybody is impossible and the secret of a stable society is to marginalise and enfeeble those minorities left miserable. Bentham's "panopticon" approach reflects the state's contention that the immediate benefit of the "greater" community is served by maintaining a governmental eye directed towards unruly, dissident or deviant minorities.

Lombroso (1889, 1911) in an age of Darwin's "Ascent" initiated a contextualisation of deviance within the confines of the evolutionary process, with science being called upon to identify bio-genealogical markers of criminality and insanity apparent in human appearance. Thus a "medical gaze" became focussed upon an over-arching theme of human degeneracy, afflicting those without socially desirable mental or moral qualities and thus rendering them abnormalities (Jalava, 2015). Emerging psycho-social views provided some counter view where social conflict or estrangement of community groups could initiate a reactive or even volatile response of anger fuelled by desperate hopelessness (James, 1890). Beccalossi (2014) notes that Lombroso moved from biological determinism in earlier works to a more environmental and sociological orientated position.

Merton's theory (1954) of anomie and strain recognised social barriers limit opportunities to achieving high cultural expectations of success and progressive achievement. Those ill-equipped to conform to social messages leading to rewards are more likely to engage in antisocial or illegal behaviours. For them, goals can only be attempted through deviant behaviour and so effectively and collectively become labelled and stigmatised as misfits, miscreants, degenerates, mentally ill or unemployable (Merton, 1954; Murphy & Robinson, 2008). Allport (1979) identified the social contexts of perceived prejudicial injustice felt by "out groups". Cohen (1955) speaks of youths hitting back against an exclusionary capitalist system and subsequently achieving the label of delinquency. Lea and Young (1984) note social groups adopting the most damaging values of selfish capitalist, acquisitive, aggression. Whilst more recently, Merari (2014) links the most extreme reactions, displayed in suicide bombers driven by altruistic loyalty to their sub-cultural groups.

3. A Modern View

Today science provides neurological evidence of real-time biological reactions to episodes of marginalisation, adding weight to the scientific belief that "there is a lifelong need for social connection and a corresponding sense of distress when social connections are broken" (Eisenberger & Lieberman, 2004). Social context is further confirmed as a major contributor in moulding community attitudes and influencing individual behaviour (Richard et al., 2003). Yet the medicalised individual model of mental illness continues to prevail in policy, practice and health management, despite long term challenges from professionals and service users. They challenge the heavy dependency on medication to rectify problems deemed to originate within the individual. The language of disability, labelling and stigmatising, "difference from normality" perpetuates substantial obstacles to socialisation and inclusivity. The social model's approach is to identify and remove inherent barriers predominant within society, not the individual, but it does not provide a "fit all" framework of analysis. It has however, muted medical model dominance and permitted varied concepts of "recovery" which continue to evolve (Beresford, Nettle, & Hall, 2010).

Swartz and Bhattacharya (2017) contextualises media fuelled public concern over the risk of violence associated with serious mental illness; if mental illness in the U.S. was miraculously cured, violent attacks would be reduced by approximately 4% with 96% of attacks continuing (Hiday et al., 1999). Contrasting those figures, a systematic review of nine studies on the risk of the seriously mentally ill being criminally victimised, reported a risk ranging between 2.3 to 140 times higher than the general population (Maniglio, 2009). Notwithstanding those figures, the bio-psycho-social model, accepted within academic and institutional contexts over the past few decades represent an holistic approach to recovery concepts (Alonso, 2004). These models are evolving which places violence within the multifaceted framework of mental health problems so as to establish and better comprehend factors of causation. Issues such as gender, genes, brain chemical imbalance, cognitive and verbal skills, self concept, minority status, social deprivation and fragmentation, role models and peers groups militate towards violent behaviour but, which can be addressed by therapeutic interventions (Steinert & Whittington, 2013).

Foucault in *Discipline and Punish* (1991) previously conflated reactions to crime and madness as representing the state's exercise of power via its professional's "disciplinary gaze". Certain individuals became classified and controlled either in prison or asylum regimes. The continued failures of asylums and prisons to turn out model citizens belie their rehabilitative purpose, but illustrate their role in quarantining the deviant poor. Vagabonds, criminals and "deranged" minds supplanted the leper's place of social exclusion. Ritualistic, highly public state interventions moved from the bodies of prisoners and patients to what he perceived to be an omnipresent form of social control exerted upon the mind.

Academic lawyer Seddon (2007) has investigated transformations in the management of the mentally vulnerable who become imprisoned, concluding they are viewed increasingly as a source of risk requiring containment rather than the rapetuc responses. Developments in the fields of psychiatry and criminology have emerged from conflicting professional interpretations of common behaviours. As a consequence prisons have always confined considerable numbers of the mentally ill, originating from flawed community mental healthcare. Peay (2014) points out that potential injustices of incarceration used to manage all forms of social deviance stem from flouting widely held public moral values concerning our social requirement to display care and compassion for the sick and disabled and where appropriate to support recovery. Rose (2000) describes liberal control strategies via routes of exclusion for the social non-compliant. For those considered a low risk, controlling "treatment" will be offered with the aim of achieving ethical reform through surveillance. For those considered a high risk, where reform and "re-insertion" is considered not viable, then quarantining occurs. Hudson (2002) too has noted, the political focus within criminal justice on both sides of the Atlantic is upon the management of risk.

The media, academia and clinical practice have maintained persistent focus upon people with mental illness or personality disorder, concerned whether their behaviour is more likely to be a risk to public safety. Simon (2007) has coined the term, "Governing through Crime", reflecting the drive towards mass incarceration. A form of "statecraft" creates political and civil structures where the perceived danger of being a victim of crime has been utilised to impact the opinions, choices and behaviours of citizens. Law and order becomes politicised through high profile criminal cases to enhance government legitimacy by using populist reactions to undermine the perceived authority of experts, judges and liberal courts. Human and financial costs of mass incarceration to the individual, community and state have been ignored. Boyd and Kerr (2016) document this process by subjecting the reporting of "Vancouver's mental health crisis" to a critical analysis. Negative discourse emanating from public police reports succeeded in shifting resources away from the preventative and supportive responses within health, community and peer-run organisations towards a reactive response of increased policing budgets.

Political use of moral panic concerning socially constructed forms of deviance conflates disease with crimes requiring "medical" interventions. Hence terms such as the "psychology of defiance" examines boundary pushing juvenile behaviour which then becomes pathologised. This feeds into the "solidarity of prejudice", pitted against perceived threats to the status quo, often during times of change, as seen in China's struggle with western liberal influences upon its young (Bakken, 2014). Cummins (2012) has used Simon's "Governing through Crime" to contextualise mental health policies and the consequences of deinstitutionalisation. Policy discussions and responses shared a deep-seated conviction that the problems in mental health services lay in legislative frameworks rather than in the administration, organisation and delivery of mental health services. He highlights the contradictory affect legislative action had. Whilst legal rights for the mentally ill increased it still did not produce full citizenship. Failings in community care and media coverage of high profile cases shaped public opinion where, "something has to be done" and produced a culture framed in terms of Cohen's (1972) "moral panic" focussed upon the management of audit and risk associated with the mentally ill, who are depicted as "folk devils". Cummins calls upon Wacquant's (2007) contention that neoliberal attacks upon the welfare state serve to "criminalise poverty" and relegates the poor to marginalised status with the "mad" included in the new milieu of urban poverty.

Jones (1972) presents a Whig progression of humanitarian reactions against abuse within the asylums of the late eighteenth and early nineteenth centuries. The 1845 Lunatics Act represents part of the greater process of social revolution, progressing to the "Enlightenment". This view that the succession from savagery and ignorance, towards medical science and institutional humanitarianism was due to emerging rational and scientific principles, driven by good will and moral intent, has been subjected to considerable challenge. Berridge (1990) believes consensual progression does not fully provide explanations for medicines involvement in the rise of state hospitals and asylums, but sees the Enlightenment and medicine engineering a new era of secular control involving the recruitment of the "medical police". Concerns for bodily fulfilment rather than suffering and pain justified control of social morals via medical interventionism through public hygiene.

Stone (1983) challenges Foucault's allegation that medicine has played a part in state social control. He believes Foucault has promoted a pessimistic conspiratorial model, which has initiated doctors and psychiatrist in taking up the concept and reacting against "the great confinement". This has given rise to a large body of international, multi-disciplinary thought which rejects any moral humanitarian intentions behind the care of the mad, or validity of the medical approach. Together with revisionist ideas from psychiatrists such as R.D. Laing that schizophrenia is not a disease has initiated a process where thousands of psychiatric patients were inappropriately discharged, unsupported onto the streets. Stone contends Foucault's limited structuralist assertions of dominance and control prevents consideration of fine cultural distinctions evident within different societies. Thompson (1981) supports that view by suggesting socialisation includes elements of restraint and control, in that it is,

...a neutral concept concerned with the objective needs of society, to guide, restrain and control its members to generally observe accepted conventions in thought and behaviour.

(Thompson, 1981, p. 191)

The UK Department of Health (1998) concedes however that the period of deinstitutionalisation was insufficiently supported by an adequate array of community services and resources which increased demand upon policing and the criminal justice system. Singleton et al. (1998) suggest diversion from custody is an aspiration rather than a successful policy (Cummins, 2007). Failure to meet the needs of those with mental illness within the community has therefore resulted in the criminalising of mental illness (Aboleda-Florez & Holley, 2008; Chaimovitz, 2012). Boyd and Kerr (2016) highlight the negative impacts of indistinct or merged mental health and criminal justice policy, seen not only in Canada but also in other western countries. The consequences of intentional intensified enforcement is often inadequately understood or ignored, both by the vocal public making vociferous calls for action, and the politicians who are keen to satisfy their constituents. This often initiates harmful social consequences (Drucker, 2013).

Distinctions between crime and illness focus upon perceptions of personal responsibility. A criminal is deemed responsible whilst the sick are not, determinations ultimately made with moral judgements just a pinprick below the surface (Zola, 1972). The Offender Health Research Network (2012) reports that some studies have shown that a number of mental illnesses such as schizophrenia, affective disorders and personality disorders, are linked to offending, but as yet, no causal relationships have been established. There is however, a body of literature which focuses on moderating factors such as gender (e.g., Maden, 1996; Monahan et al., 2001; Watzke et al., 2006), ethnicity (e.g., Hawkins et al., 2000; Sampson et al., 2005) and personality traits (e.g., Krueger et al., 1994; Nestor, 2002).

Contentious issues centering on societal management care and support for mentally disordered offenders will continue to be debated. Laing (1999) summarises current philosophies: In the "Liberal Approach", legal professionals protect the right of the mentally disordered to be judged responsible and proportionately punished for misdeeds. Through this framework society has an obligation to treat the disorder and rehabilitate the offender. The "Treatment Approach" however, places greater emphasis upon not subjecting the mentally disordered offender to the counter productive effects of punitive sanctions and custody. More prominence is given to treatments centred upon the humanity and dignity of the offender and where due cognisance is paid to the consequences mental illness has in gradation of responsibility. These professional outlooks from law and healthcare seem to create a central position of middle ground social acceptance.

The psychological mechanisms contributory or causal to crime and desistance are diverse. Laub and Sampson (2003) dismiss determinism and the predictability of childhood factors, contending that offenders cannot be precisely grouped into distinct categories, of unique routes and aetiology of offending. Instead, "the full life course matters, especially post-childhood, adolescence, and adult experiences". Desistance may be achieved through multiple pathways, but criminal behaviour occurs in the individual when there is a lack of social control, structured routine activities or human agency. When these factors are present desistance is more likely to occur. Employment is exemplified as providing "a meaningful change in routine activities" or one of significant "turning points" or positive life-course events which may include marriage, military service, reform school or community change. These events play a key role, particularly when combined with personal agency and historical context which facilitate a breaking from the past so as to become an active participant in deciding to desist from crime.

A symbolic-interactionist theory was provided by Giordano, Cernkovich and Rudolph (2002) and later by Giodano Schroeder and Cernkovich (2007). Attempts to integrate and augment Laub and Sampson's social control notions, were made to provide a more comprehensive model of understanding to changes in life direction

than either viewpoint used in isolation. Ideas were developed around the importance of individual cognitive processes and “agentic moves”. Consistent with Laub and Sampson, it was found that respondents whose lives included traditional elements of social capital and control were less involved in crime. Both male and female respondents reported: extreme poverty, poor educational achievement, dysfunctional family history, “bad” companions, marginal and shifting housing arrangements, repeated contacts with criminal justice and mental health services, and an array of treatments. Personal emotions are given a social character which creates interactions with cognitive processes, influencing long-term patterns of criminal involvement. These Neo-Meadian frameworks contrasts desistance theories reliant upon the influences of social control and expands the view of an emotional self, thriving independently of the major roles typically emphasised in the sociological studies of the “life course”.

Goffman (1963) examined the variety of coping strategies adopted by stigmatized people, i.e., those that do not have full social acceptance. They are constantly striving to adjust their social identities, due to their physical, character or group identities, to deal with social rejection and the complex images of themselves they project to others. Relevant in this particular regard, Goffman includes any inference of a record of, dishonesty, mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicidal attempts, or radical political behaviour.

Identity’s relationship with offending has been considered and examined by a number of recent studies. They establish a beneficial component of progression towards desistance is the creating of a therapeutic environment, where the possibility of a more positive self-identity, free from criminal behaviour could be achieved (Stevens, 2012; King, 2013; Breen, 2014). Paternoster et al. (2016) has built upon these previous studies of desistance in alignment with Goffman’s stigmatised identities to consider their significance in an individual’s ability to desist criminal behaviour. Using survival time information from a sample of serious drug troubled offenders, released from prison and monitored for almost twenty years, the study did little to contradict previous theoretical models emphasising pro-social factors or emotional outlooks which brought significant understanding into pathways of desistance. It did however established that the offender finding a “good” self-identity and making positive intentional actions to seek help in changing behaviour were positively related to extended desistance from crime.

Strong political rhetoric in the United Kingdom during the 1990s had reinforced social incentives and deterrents which proposed the axiom “prison works”. It brought greater punitive mechanisms; new prisons, new criminal offences, new police powers and longer minimum term sentences. The three year trend of declining prison population was quickly overturned with a 25% increase in two years (Leacock & Sparks, 2002). It reflected too, widespread popular and political focus centred upon retributive punishment, having little regard to social inequalities responsible for “out group” schisms which contribute towards a proposed social model, whether in terms of criminality (Taylor et al., 1973; Hall et al., 1978; Lea & Young, 1984; Young, 1999; Scraton, 1990) or illness (Parsons, 1951; Whitehead, 1992).

Loong et al. (2016) noted from the mid. 1990s that Canada and the USA saw a marked rise in the number of defendants with mental illness entering the criminal justice process. Some areas saw increases in excess of ten percent per year. The response was to provide dedicated mental health courts. This addresses the specific requirements of defendants who do not meet “insanity criteria” but whose mental illness was a significant contributory factor to their criminal conduct. Processes involve screening, assessment, and negotiation between diversion and criminal justice staff to avoid inappropriate or counter-productive prosecutions. The outcomes have reflected additional emerging data from North America and Europe, suggesting these responses are beneficial in reducing recidivism.

Of course, as contacts with people identified as experiencing mental health issues increase, those involved in policing need more than ever specialised training which focuses upon effective interventions and communication skills (Cummins, 2007, 2016; Adebawale, 2013). Loucks (2013) established partnerships between mental health professionals and law enforcement can lead to improved relationships and treatment of individuals with mental illness. Furthermore officer training which includes both instructive and interactive elements are beneficial in enhancing understanding and knowledge of mental illness, its effects upon individuals and the broader community.

The UK Government via Home Office guidance (1990, 1995) clarified the mentally disordered should never be remanded to prison just to receive medical treatment or assessment. It also reminded courts of their powers to divert those whose mental illness had initiated minor offences, towards specialist services in health and social services with a view to improving health outcomes. Data collected during 1993 in England and Wales, however,

identified piecemeal development and a lack of nationally strategy of agreed guidelines (Dyer, 2011). Welsh Government (2001) reminded health boards and relevant agencies that,

...effective local agreements need to exist between police, probation, health and social services to provide flexible arrangements for the urgent assessment of offenders with mental health problems...

(Welsh Govt, 2001)

The Reed Report (1992) had emphasised the importance of “alternative provision” for assessment of mental health needs (OHRN, 2011). Despite this, the contention that people with mental illness have been inappropriately detained in prison has received wide academic support (Gunn, Maden, & Swinton, 1991; Reed, 1992; Durcan, 2008; Singleton, Meltzer, & Gatward, 1998).

4. Police and Mental Illness

Clearly mental health presents a regular challenge in a police officer’s core workload (Adebowale, 2013). The psychologically vulnerable or those suffering from mental illness can give unreliable testimony including false confessions (Gudjonsson, 2010). Mentally vulnerable people in custody often report they did not understand what was happening to them or why, they felt alone, did not know who to turn to for support and were uncertain about what to say or do (Hyun et al., 2014). In addition more than 33% who died in police custody in 2013/14, and 66% of people who took their lives within two days of being released, had mental health concerns (Home Affairs Committee, 2015).

Gudjonsson et al. (1993) had found the police were very good at identifying the most disabled and vulnerable suspects but not so for those suspects however, falling outside that criteria. Irving and McKenzie’s (1989) recognised the difficulties custody officers faced soon after the implementation of PACE and had suggested, if the diagnostic ability of the police could not be improved, the role of medical and social work staff should have greater priority.

Research into the low identification rates of the mentally vulnerable/disordered by custody staff is suggested to be the consequences of; a lack of systematic and effective screening, inadequate training for police, a disregard of self-reporting, an overdependence on the importance of visual behaviour, such as anxiety and stress used then in comparison with other people detained, the affects of alcohol or drugs masking identification and detainees actively attempting to conceal their condition (Hodgson, 1997; Jacobson, 2008; Young et al., 2013).

Noga et al. (2016) has established that despite the mentally ill being in daily contact with the UK police, officers have underdeveloped links with mental health and social care services. Police officers are provided with little or no training in the identification and management of mental illness, making them highly dependent on the support of partner agencies (Adebowale, 2013; Borum, Deane, Steadman, Morrissey, & Williams Deane, 1998; Cummings & Jones, 2010; Mind & Victim Support, 2013). This has potentially significant consequences for the safety of both officers and vulnerable detainees (Adebowale, 2013; Krameddine, Demarco, Hassel, & Silverstone, 2013). Despite this dependency on outside services, Noga et al. (2016) highlighted gaps in provision created by organisational silo working resulting in a distinct lack of support from appropriately experienced partner agencies. Consequently problems in identifying and also appropriately managing the mentally ill in police custody hindered the efficacy of partnerships outcomes.

Considerable research has centred upon the implementation and efficacy of Code C of the 1984 Police and Criminal Evidence Act (Bean & Nemitz, 1994; Bradley, 2009; Brown, Ellis, & Larcombe, 1992; Bucke & Brown, 1997; Gudjonsson et al., 1993; Irving & McKenzie, 1989; Medford, Gudjonsson, & Pearse, 2003; NAAN, 2015; Palmer & Hart, 1996; Phillips & Brown, 1998). The Codes of Practice document the role and use of an “Appropriate Adult” (AA) to support the welfare and legal rights of the detained mentally disordered/vulnerable detainee (Code C: Home Office, 2014). Unfortunately the decisions regarding whether the codes should apply are often made by custody officers with access to limited knowledge of identifying the “mentally disordered” or “mentally vulnerable” and officers have voiced their concern over their lack of formal training (Cummins, 2007).

The role of the AA and its dependency upon quasi clinical judgements entering upon mental disorder/vulnerability, is an issue of considerable concern, due to its potential impact upon the legal outcomes (Pierpoint, 2011). The high complexity of mental health needs within the prison population spoken of earlier, suggests there is a similarly high proportion of needs amongst those arrested by the police. There is a consensus that people with mental health problems have increased contact with the police yet there does not appear to be any substantial diversion from the criminal justice system at this early stage and this runs concomitantly with an

additional theme concerning the relatively limited involvement of the AA through the custody process (Cummins, 2016).

The National Appropriate Adult Network reported only a planned 50% of coverage of England and Wales in 2015 for organised AA schemes and that many mentally vulnerable people are being detained or interviewed without the support of an AA (NAAN, 2015). This vagueness and obscurity of custody suite judgements permits interpretations to align themselves with police cultural aims and objectives so as to subsume PACE safeguards. At present this appears to receive little attention from the courts. The law and our responses permits crime control by convicting offenders efficiently and this remit currently appears to be assigned a higher significance by the courts than the safeguarding of vulnerable suspects via due process entitlements (Dehaghani, 2016).

5. A New Model

The National Leadership and Innovation Agency for Healthcare and Public Health Wales (2011) established that 50% of the Health Boards did not have an overall strategy to facilitate operational planning, management or the delivery of criminal justice liaison and diversion services. It further reported a general situation where some areas had “more comprehensive and integrated services in place than others”, also highlighting some services were too dependent upon the personal dedication of individual practitioners or small teams operating in virtual isolation, reflecting similar findings made earlier by Bradley (2009).

The Welsh Government (2013) recognises that most who come into contact with criminal justice mechanisms originate from the very disadvantaged communities that generate poor physical and mental health. Prison population expansion in the last ten years coincides with significant increases in the proportion of inmates experiencing mental illness, substance misuse or learning difficulties, to a point where 9 out of 10 prisoners in Wales experience these problems. Also a disproportionately high numbers of Welsh prisoners originate from black and ethnic minority communities. The Youth Justice Board (2015) in a study conducted upon a group of children and young people who were prolific offenders, reported 57% had contact or referrals to mental health services. Whilst support to this vulnerable group is sustained within section 38(4) of the Crime and Disorder Act 1998 which requires local authorities to ensure provision of an AA to children and young persons detained or questioned by police, it does not extend to mentally disordered/vulnerable adults in similar circumstances.

Within the process of rehabilitation, maintaining bonds with family and friends are considered to be most significant towards success (Farrell, 2004; McNeill et al., 2012; Sampson & Laum, 1993). Unfortunately a barrier to this in Wales is insufficient national custodial accommodation. Of the 4,679 people imprisoned in 2014 from home address in Wales, over 2000 were serving their sentence in England, some categories of prisoner, such as women or young adults have no such accommodation in Wales (UK Parliamentary Papers 2015). A Prison and Probation Ombudsman Report (2016) records a suicide rate in UK prisons at over 11 times greater than the general population. Furthermore, 70% of those who died in prison from self-inflicted means, evidence existed of mental health needs. It was also determined that almost half of these individuals had these needs “flagged” on entry to the prison. The Harris Review (2015) examined 101 self-inflicted deaths of detained children and young adults in a previous seven year period. It concluded more must be done to address the needs of troubled children and young adults. Diversion away from the criminal justice system to health and social care and other alternatives can be better at directly addressing the needs of young offenders. This indirectly, better serves the victims of crime and society as a whole. Figures today reveal the highest number of prison suicides since records began with understaffed prison mental health teams struggling to help prisoners in desperate need (Taylor, 2017).

Pakes and Winstone (2006, 2009) produced literature reviews for the Home Office and identified that, screening, assessment, facilitating access to mental health support, information exchange, multi-agency work, liaison, data collection and analysis were all key requirements of effective service delivery, to those experiencing mental health problems within the criminal justice system. The literature to date on efficacy identifies that liaison and diversion schemes are associated with improvements in some mental health conditions (Joseph & Potter, 1993; Rowlands et al., 1996). Such schemes have also created new pathways that increase the number of people referred to mental health services (James & Harlow, 2000; Kingham & Corfe, 2005; Pakes & Winstone, 2009). There is some evidence these schemes created longer periods in desistance from crime (Haines et al., 2012). Durcan et al. (2014) has stated that clear evidence of benefit that liaison and diversion schemes bring is unavailable, but that the evidence to date justifies further research and service development.

From 2015, NHS England implemented a National Liaison and Diversion Model which created some minimum standards, such as a required data set and a defined list of permitted referral agencies (NHS England, 2014). This will no doubt permit, in the future, a level playing field for some form of critical assessment. The Welsh

Government however, has not imposed a similar model, citing its rationale as, "...‘a one size fits’ all approach would not meet local need", but then acknowledges, "the need to address the current disparity in provision between and within areas" (*Criminal Justice Liaison Services in Wales, Policy Implementation Guidance*, 2013). Presently however, whilst there are some local innovative practices, understanding of the service, availability of provision and collaboration was variable. Future service improvements have been assured as part of the Welsh Government's current delivery plan, *Together for Mental Health* (Prison Reform Trust, 2016).

Law enforcement officers themselves are exposed to high occupational stress (Bonifacio, 1992). The risk of threats and assault are five times the average (Health and Safety Executive, 2014). They have a higher risk of suicide associated with suicidal ideation, dealing with disturbing or traumatic incidents, organisational stress, alcohol abuse, shift work and relationship problems (Chae & Boyle, 2013). Police Officers are more likely to suppress problems and less likely to seek help (Alexander & Wells, 1991). Incidence of Post-traumatic stress disorder and depression rise with career length (Regher et al., 2013).

Karaffa and Koch (2016) document the attitudes of stigma and pluralistic ignorance within police culture which inhibit openness about police officer mental health with implications for the entire organisation. In the United Kingdom a survey of over eleven thousand police officers and staff identified many who are concerned about the consequences of stigma attached to any personal disclosures of psychological injuries or mental illness. Whilst dealing with traumatic incidents is seen as part of the job, officers feel staff aftercare is poor and the awareness of issues associated with stress, anxiety, depression and other mental health conditions is limited. Furthermore, whilst psychological issues account for almost a half of injuries, there is a belief that these are treated differently to physical injuries and are associated with a sense of stigma, making officers reluctant to report their injuries or mental health issues (Fielding et al., 2016).

Police officers also incur the most stress from interactions with their supervisors and official procedures within their organization (Adams & Buck, 2010; Crank & Caldero, 1991). While officers anticipate and deal with many of the challenges, dangers and abuse from the public more readily many contextualise the treatment at the hands of internal management as unsupportive, unjust or punitive (Shane, 2012). When considering how mental illness relates to criminal justice mechanisms we should not view police and public encounters in terms of actors and neutral reactors. Clearly occupational police culture can create considerable personal psychological stressors. In recent Police Federation surveys concepts of officer welfare are not discussed in terms of mental health, but rather in terms of morale and dissatisfaction. Just under half of respondents listed management treatment as being instrumental in their low morale but over eighty percent saw "how the police as a whole are treated" as being significant (Police Federation, 2016).

Johnson (2013) believes hierarchical structures within police organizations hinder officers from challenging management without suffering career repercussions. This provides the embodiment of the displaced aggression model. It is reasonable to suppose, officers may displace that aggression onto less empowered members of the public with less fear of repercussion [that will also include those experiencing mental distress or disorder which may stray into offending behaviour]. In these circumstances officers in their application of the law are more likely to arrest for minor offences. Thus internal cultural management issues not only affects officer morale, mental health, and employment turn over but may indirectly affect the impartiality of decision making surrounding criminal justice or health pathways out of offending concerning the more vulnerable within our communities.

The National Liaison and Diversion Model commissioned by NHS England in 2014, is tasked to provide, a twenty-four hour, seven days a week, age appropriate service for anyone over the age of criminal responsibility, at all points within the adult and youth justice pathway not just limited to police custody and courts. It covers a range of health issues and vulnerabilities. As well as diverting individuals, where appropriate, from criminal justice systems into health, social or other supportive services, it focuses on delivering efficiencies in criminal justice systems and reducing offending behaviours (NHS England, 2014).

Evaluation of the model's efficacy (Rand, 2016) faces significant challenges due to a lack of quantitative data for comparisons with a suitable counterfactual. The quantitative data however, does give insight into the extent and range of perceived needs and the qualitative findings provide a considerable evidence base which demonstrates liaison and diversion methodology in relation to the barriers and spurs to implementation. A total of 22,502 adult and 3,636 youth cases were documented in the year prior to 2015. There were mental health needs identified in 10,636 adults. Of the youth cases 1039 had previous contact with mental health services. In adult cases 67% of all disposals were via non court measures, 17% received a court community sentence, 1% a hospital order and only 15% a custodial sentence. Both data sets suffered with a high degree of missing data, so much so, that in the

youth set no meaningful extrapolation could be produced. It seems that disposal information must be retrieved manually from the CPS or courts. The evaluation reflects the conclusions of Durcan et al. (2014) which noted the lack of definitive evidence of benefit, but what evidence exists justifies further service development.

6. Discussion

Today the traditional revolving door of adversarial criminal courts are gradually giving way to “solution focused” courts that recognize psychosocial challenges, such as addiction, mental illness and social care needs, accommodation and unemployment all militate towards offending behaviour. New principles of “therapeutic jurisprudence” utilise legal systems to incentivise offenders to actively engage with social agencies as a means of addressing the causes of their offending (McKenna et al., 2017). Whilst these services remain piecemeal, the Care Quality Commission (2015) reports (in England) people experiencing mental health crisis coming into contact with the police are having a more positive response than from many of the specialist mental health services. In a number of areas triage schemes operate where mental health nurses accompany officers to the incidents believed to involve people in need of mental health support. Initial results are positive with pilots appearing to show a substantial reduction in inappropriate arrests.

Frevel and Rogers (2016) note that available funding streams for community initiatives have contributed to significant attention in England & Wales to the evaluation of successful Community Safety Partnerships, on the basis that it evidences effective crime preventative measures. Whilst initially evaluations tend to lack an empirical and scientific approach, later methods have become more rigorous, providing robust evidence of “good practice” suitable for dissemination. They point to research by Newburn and Souhami (2005), where empirical evidence of cautioning within youth diversion schemes suggests it is of benefit in reducing repeat offending. Importantly however, Frevel and Rogers (2015) raise concerns over legitimacy and accountability, questioning, whose interests are regarded and whether the range of partners help to expand or diminish legitimacy? Who steers the process and is accountable for the results of interagency policing, finally considering whether supplying security as a commodity in the community increases social inequalities?

Recently, the Prime Minister in the UK, Rt. Hon. Teresa May on the 9th January 2017, spoke of an historic opportunity to right a wrong, and give people deserving of compassion and support the attention and treatment they deserve. Elaborating on the estimated costs of mental illness to the UK (£105 billion, equating to the entire NHS spend) there was focus on the need for earlier interventions and highlighting children with behavioural disorders being 4 times more likely to be drug dependent, 6 times more likely to die before the age of 30, and 20 times more likely to end up in prison. There was a clear undertaking that mental health problems are to be tackled via more focus on general social issues, not in hospitals but via schools, employment and within communities, including plans to reduce the suicide rate by targeting those most at risk, including those in contact with the criminal justice system (UK Govt., 2017).

Returning to Bentham’s general principle of utility in our codes of law, if people are deterred by punishment from causing future pain, then punishment is justified. The moral defence of pain inflicted by punishment is justified only if it is outweighed by the pains of the actions it deters. Utilitarianism is a consequentialist ethic which looks towards actual and possible future states of affairs to validate active responses, but not in any way towards retribution for past actions (Harrison, 1995). Vic Gatrell (1996) contends barbarity’s moderation within Britain’s criminal justice system owed very little to state humanitarianism, but was due in part to the revulsion by polite society of the ugliness of justice that subtly served their interests. Emsley (2005) too suggest law reforms were to secure wider popular acceptance and support for the legitimacy of law and order.

Utilitarianism’s emergence coincided with the move away from exemplary public deterrents including public execution in recognition it did not serve utility. That paved the way for more professionalised preventative measures, including the conception of modern-day policing. As our broader understandings of mental health’s association with crime and policing continue, it is hoped that further realisation regarding the “starkest of madness” in over-dependence on counter-productive punitive deterrence receives wider acceptance and initiates more constructive outcomes.

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