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ARE SOUTH WALES POLICE EXPERIENCING AN INCREASE IN MENTAL HEALTH RELATED INCIDENTS, AND IF SO, IS IT THEIR RESPONSIBILITY?

MA Dissertation: Criminal Justice and Policing

Abstract

With an increase of mental health related incidents being reported to the police, are they the most appropriate service provider...or are the police's powers being used and abused?

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed  (candidate)

Date 10/03/2021

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used the extent and nature of the correction is clearly marked in a footnote(s). Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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STATEMENT 2

I hereby give consent for my thesis, if accepted, to be available for deposit in the University's digital repository.

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Table of contents

Chapter.1 Literature Review.....	p5
1. Introduction.....	p5
1.1. Defining Mental Health	p6
1.2. Increase in Mental Health	p8
1.2.1. Mental Health in Wales	p11
1.3. Policing Powers and Mental Health.....	p13
1.4. Policing role as interventionists.....	p15
1.4.1 Police Demand	p15
1.4.2 Police Recourses	p17
1.4.3 Planning for the Future	p19
1.5. Conclusion	p20
Chapter.2 Methodology.....	p21
2. Introduction.....	p21
2.1. Research Strategies	p22
2.2. Data Analysis	p24
2.3. Limitations	p24
2.4. Reliability and Validity	p25
Chapter.3 Results and Analysis.....	p26
3. Data Analysis	p26
3.1. Results: Questionnaires	p28
3.1.1. Results: Secondary Data	p56
3.2. Discussion	p62
3.2.1. Aim1: Have South Wales Police experienced and increase in mental health incidents?	p62
3.2.2. Aim2: Training	p63
3.2.3. Aim3: Impact of mental health incidents	p64
Chapter.4 Recommendations	p65
4. Recommendations.....	p65
4.1. Recommendations for future research	p68
Chapter.5 Conclusion	p69
5. Conclusion	p69
Chapter.6 Bibliography	p71

List of Figures

<u>Figure I</u>	Dimensions of mental well-being	P6
<u>Figure II</u>	NHS digital mental health survey 2014 graph	P9
<u>Figure III</u>	APMS prevalence of common mental health problems by sex	P10
<u>Figure IV</u>	NHS Digital -proportion of people displaying mental health symptoms	P10
<u>Figure V</u>	NHS funding and budget	p11
<u>Figure VI</u>	Total country expenditure on mental healthcare	p12
<u>Figure VII</u>	Number of section 136 detentions by police force area 2014-2015 to 2018-2019ff	p16
<u>Figure VIII</u>	Total Mental Health Occurrences (including administrative occurrences) per month for each year, from 2015-2020	P59
<u>Figure IX</u>	UK feelings of loneliness and hopelessness	p61

Chapter 1. Literature Review

1. Introduction

This study is aimed to focus on both the rise in mental health related calls/incidents reported to South Wales Police, and whether the police are the most appropriate public service to deal with mental ill-health related incidents. It has been perceived that mental health illnesses have increased within communities, however the influx in those suffering with mental health may be linked to the deinstitutionalisation.

Over the past three decades mental health services in the UK have undergone radical transformations. Due to 'growing emphasis on human rights as well as advances in social science and philosophy critiquing psychiatry and the boundaries of what constitutes mental illness' (Murray *et al*, 2015, p1) deinstitutionalisation was introduced which saw the closure of a large proportion of psychiatric hospitals and those suffering with mental illnesses were re-introduced back into community settings.

As a result of deinstitutionalisation, the police are becoming more exposed to people who are suffering with, and are in, mental health crisis as its their blue lights which are first on scene in emergencies. According to Lamb *et al* (2002, p1266), the police act as gatekeepers, assessing and decide whether the person whom they have encounter should be referred to mental health services or enter the criminal justice system. However, are the police the most appropriate service to be assessing mentally ill people? Afterall professional roles within the mental health field require a minimum of five years, with further years of training in a chosen specialist field, yet officers are required to assess and decide whether a person has mental capacity from a law-and-order perspective. Inspector Brown stresses that, 'the police should not be relied upon to be a de facto health care provider', or should the police's 24/7 availability be utilised to assist and work with health services to help those in mental distress get the help they require? This literature review aims to assess and evaluate these thought provoking questions.

1.1. Defining Mental Health

Before discussing the impact and increase, if any, that mental health is having on the police force, it is imperative to evaluate how mental health is defined within a policing environment compared to a medical one. Mental illnesses are complex issues, evaluating definitions shows whether the condition is fully understood as well as giving justification for any actions taken.

The World Health Organization (2018) defines mental health as, '*a state of well-being in which an individual realises his or her own abilities, can cope with normal stresses of life, can work productively and is able to make a contribution to his or her community*'. A person's mental health is therefore just as important as physical health. Mental health encompasses 'psychological, emotional and social well-being' which therefore 'impact how we feel, think and behave' (Xiong, 2018, p1), thus is portrayed in figure 1. Poor mental health can lead to mental disorders forming. The WHO (2017) continue to define mental disorders as, 'generally characterized by a combination of abnormal thoughts, perceptions, emotions, behaviours and relationships with others', and include a range of illnesses including, depression, dementia, autism, bipolar, schizophrenia and other psychoses. The Mental Health Act 1983 gives guidance to those suffering mental ill-health in relation to their rights in terms of treatment and assessments both medically and within the judicial systems. The Mental health Act 1983 defines mental disorder as, '*any disorder or disability of mind*' (Mind, 2018, p8) which includes 'any mental health problem normally diagnosed in psychiatry *and* learning disabilities, if the disability makes you act in a way which may seem abnormally aggressive or seriously irresponsible' (Mind, 2018, p8).

Figure. 1

Figure 1: Dimensions of mental well-being



Source: All Wales Mental Health Promotion Network, 2009

The UK criminal justice service is made up of many different institutions, the three major ones being, the prison service, the police and the crown prosecution service. Focusing on policing alone the UK is made up of 43 forces. Each year the HMICFRS publishes its PEELS report which assesses each force on their effectiveness, efficiency and legitimacy and scores them accordingly. Subsequently in the 2017 PEELS report the HMICFRS identified that police forces across the UK were using different definitions for mental ill-health, resulting in inconsistencies between forces when dealing with someone who suffered with mental ill-health. As well as inconsistencies in police forces actions there was also missed opportunities to identify vulnerable people suffering with mental health problems because the different definitions used across forces. Following the 2017 PEELS report, the HMICFRS published a second report specifically focusing on policing mental health. In the report the HMICFRS (2018) recommended a new national definition should be determined in order to ensure consistency in recognising, understanding and dealing with demand of incidents which involve mental ill-health.

The College of Policing have therefore created a nationally agreed definition of what constitutes as a mental health related police incident which is, *'any police incident thought to relate to someone mental health where their vulnerability is at the centre of the incident or where the police have had to do something additionally or differently because of it'* (2016). The College of Policing also recognises that mental ill-health is a broad term which refers to mental disorders, illnesses and needs as defined withing the Mental Health Act 1983. Under the Police and Criminal Evidence Act 1984 (PACE) Code C the police have also defined mentally vulnerable as those who, *'because of their mental state or capacity, may not understand the meaning or importance of what is said to them'* (College of Policing, 2016), which can also include mental distressed, formally diagnosed or not, experienced by an individual during contact with the police.

People suffering with a mental disorder should now, in theory, be treated the same regardless of which police force area they are under as all forces now share the same definition. As officers work with members of their communities, naturally they will encounter people suffering mental disorders. A national definition, therefore, should allow officers to identify and deal with mental health incidents in a positive and efficient manner. However,

the HMI CFRS (2018) voiced their concerns that the police are now 'working beyond their duty' and are questioning whether 'the police should be involved in responding to mental health problems to the degree that they are'.

1.2 Increase in Mental Health

Mental health can affect anyone, it does not discriminate on age, race, gender or social backgrounds, and can be just as debilitating as physical disabilities. Alike humans, mental health is a complex matter therefore, there is not one single cause in people developing a mental disorder. Poor mental health is usually more prevalent within certain groups including, offenders, homeless people and poor living conditions (Swansea Gov, 2017), however, 'mental health problems can also develop from difficult life events, such as moving home, losing your job or the death of someone special' (Swansea Gov, 2017, p20). The World Health Organisation states that, 'two of the most common mental health conditions, depression and anxiety, cost the global economy US\$ 1 trillion each year - Despite these figures, the global median of government health expenditure that goes to mental health is less than 2%'.

In the UK mental health illnesses are, 'the single largest cause of disability...contributing up to 22.8% of the total burden' (Department of Health, 2011) which is nearly 7% more than cancer and over 6% higher than cardiovascular disease. Mental illnesses can affect people's lives in many ways, it can affect a person's relationship with friends and family, their ability to participate in the community and their ability to function and perform daily tasks in work, school, and daily life.

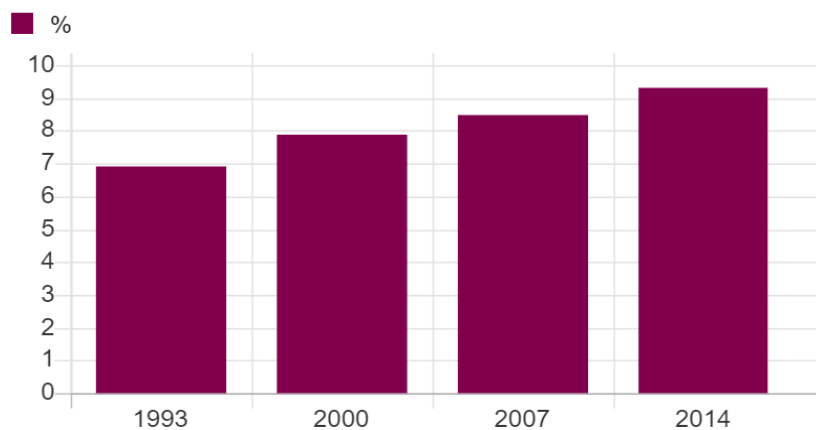
The most recent and reliable survey, conducted by Adult Psychiatric Morbidity Survey (APMS) in 2014, published in 2016, found 'every week, one in six adults experiences symptoms of common mental health problems...and one in five adults has considered taking their own life' (Mental Health Foundation, 2016a). Brown and Trigg (2018) continue to explain that in England alone 'at any one time, a sixth of the population aged 16-64 have a mental health problem', currently the UK population stands at over 66million meaning currently 11 million people are suffering with some form of mental disorder. A report by Mental Health Foundation (2016, p14) further suggests that 'a fifth of men and a third of

women have had diagnoses confirmed by professionals' as well as a third of the population, who have not formally been diagnosed, feel they have a mental health disorder.

Figure II shows the continuous increase of severe mental health disorders. The steady increase may be caused by the increase in women diagnosed with mental health illnesses. As per figures III and IV, the number of women suffering with a common mental health illness is higher than that of men, and within all age ranges, there are more women displaying symptoms of mental disorders than men. It is unclear why there are more women suffering with mental ill-health, some theories suggest the rise in social media has placed more pressure on women to look and feel a certain way, as well as hormonal changes including pregnancy, income inequality and low social status. Although women are more likely to suffer with mental disorders, they are also more likely to seek treatment. Men on the other hand are more likely to commit suicide, Brown and Triggles (2018) report that men make up three-quarters of the number of suicides each year. To put figures in perspective the Mental Health Foundation (2016a) state figures from the Office of National Statistics recorded 6,122 suicides in the UK in 2014, of those deaths 75.6% were male and 24.4% female, which corresponds to one death every two hours.

Figure. II

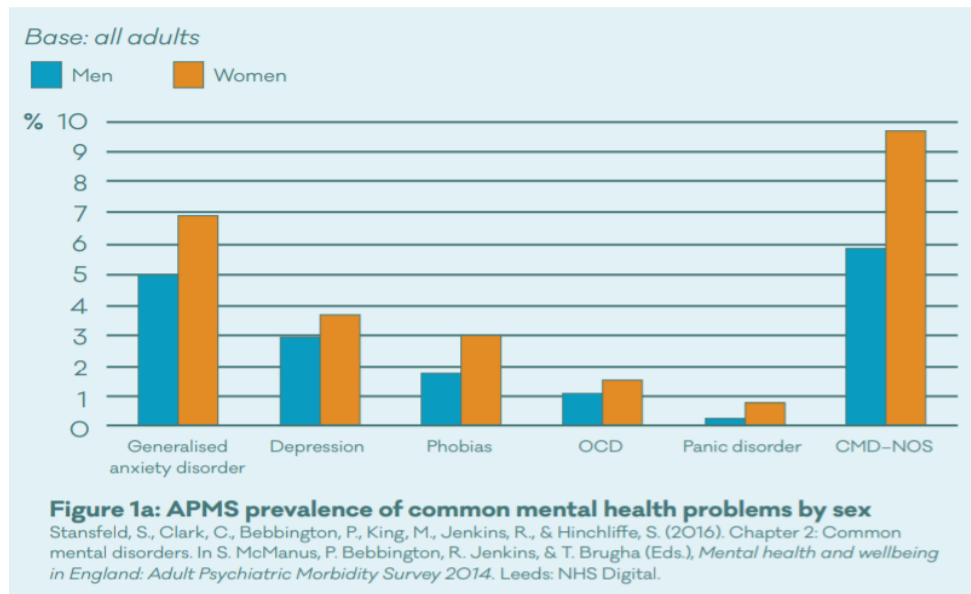
Proportion of people with severe symptoms of common mental disorders in the past week*



NHS Digital, Mental Health & Wellbeing in England, Adult Psychiatric Morbidity Survey 2014 *Percentages scored in the highest category for overall neurotic symptoms **BBC**

(Brown and Triggles, 2018)

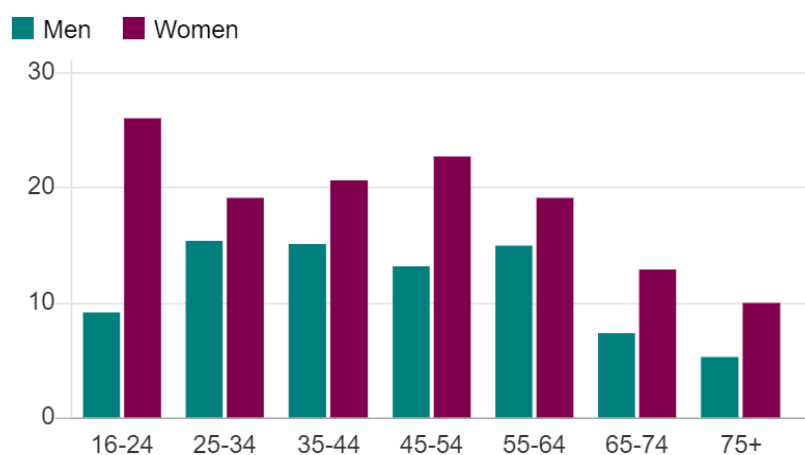
Figure. III



(Mental Health Foundation, 2016a, p15)

Figure. IV

Proportion with symptoms in the past week



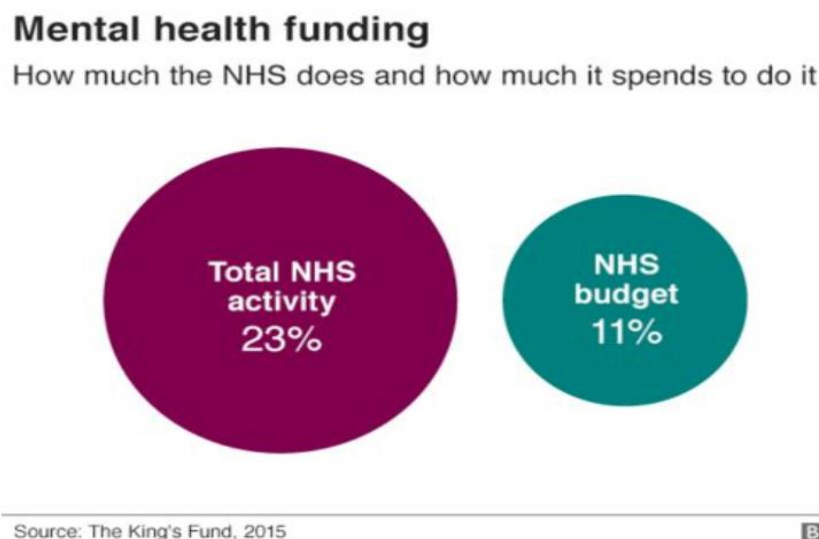
Source: NHS Digital, Mental Health & Wellbeing in England, Adult Psychiatric Morbidity Survey 2014

BBC

(Brown and Trigg, 2018)

According to a report by the Department of Health (2011, p3) the overall costs of mental illnesses annually, for England alone, was calculated at approximately £105.2 billion in 2013. This figure included 'direct costs of services, lost productivity at work and reduced quality of life' and was more than that estimated for the whole of the UK. Figure V shows that 23% of the NHS activities are spent dealing with incidents that centre around a form of mental health issue whereas only 11% of funding is allocated to the issue. Brown and Triggles (2018) describe mental health in England as 'the poor cousin compared to the spending on physical ailments.'

Figure. V



(Brown and Triggles, 2018)

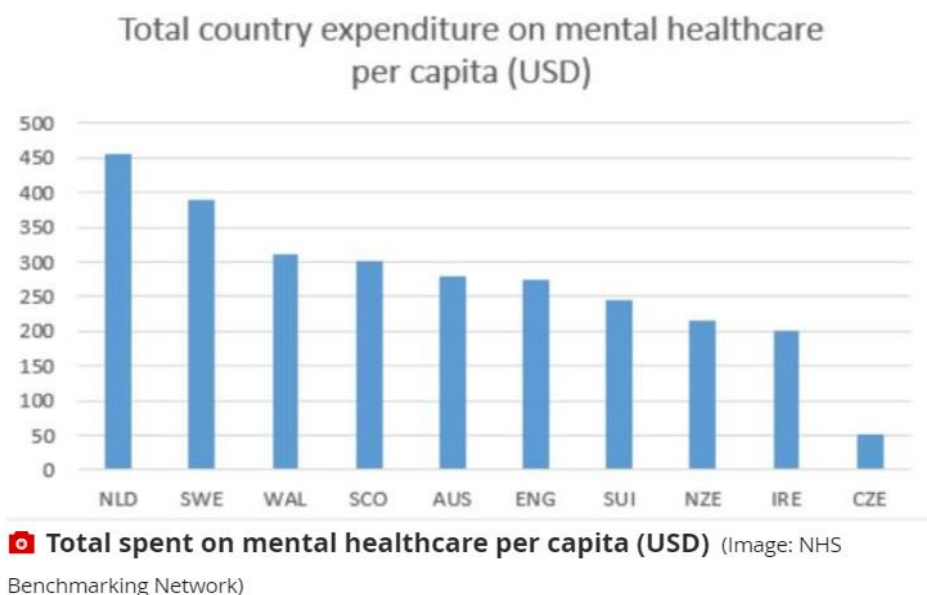
1.2.1 Mental Health in Wales

Results by the Mental Health Foundation (2016b) found a small increase in people receiving treatment for their mental health in Wales, from 11.7% in 2014 to 13% in 2015. Although this may appear as an exceedingly small increase, the quality of data may in fact underestimate figures as it only acknowledges those who have formally been diagnosed and treated by a professional. Based on data from 2012, a strategy for mental health and wellbeing in Wales states, '1 in 4 adults experiences mental health problems or illness at some point during their lifetime with 1 in 6 of us experiencing symptoms at any one time' (Swansea Gov, 2017, p21).

It is estimated that the overall cost of mental health problems for Wales is £7.2 billion a year with approximately £600 million invested into mental health services a year (Mental Health

Foundation, 2016b). However, a report published by Plaid Cymru highlighted concerns that although the Welsh NHS is spending most of its budget on Mental Health service there is little evidence measuring its success (Johnson, 2019). Figure VI illustrates findings from Plaid Cymru's report, which shows Wales having the highest expenditure on mental health services within the UK at just over \$300 per person, working out as 11% of its overall health expenditure (Smith 2019).

Figure. VI



(Smith, 2019)

Despite Wales ensuring enough funding the report also looked at workforce, occupation of beds, and community mental health contact and discovered Wales ranked the lowest or one of the lowest in each category. According to Smith (2019) in comparison to the other countries in the report Wales had 'fewer mental health inpatient beds, a smaller number of specialist consultants and reduced mental health contacts in the community'. These findings have left Mair Elliott, chairwoman of mental health charity Hafal, express her opinion that the services are not fit for purpose, broken and need of reform. Overall, the report by Plaid Cymru identified the need for, 'high quality data on outcomes rather than inputs, as we cannot assume that inputs are a good proxy for successful treatments' (Johnson, 2019, p5)

1.3. Policing Powers and Mental Health

People suffering with mental ill-health may encounter the police for reasons including, being a witness, a victim, a suspect or subject (subject referring to any report made regarding a specific person which is not of a criminal manner, e.g., report of concern or missing person report). The findings of the annual PEELS report 2007 found overall 'police approach to people with mental health problems is generally supportive, considerate and compassionate' (HMICFRS, 2018, p3), however, the degree of which police are used in, and responding to, people suffering with a mental crisis has become a major concern.

The Police and Criminal Evidence Act (PACE) 1984 and The Mental Health Act 1983 (which was further revised in 2007) are the two main pieces of legislation which represent policing powers surrounding those who may be suffering with a mental health illness and/or crisis. Under the Mental Health Act 1983 police officers can detain a mentally ill person under section 135 or section 136. Both sections allow officers to detain a mentally unwell person for health and safety reasons not only for the person themselves but for others around and can be executed without the persons consent thus to ensure the person is admitted to hospital for treatment (Welsh Government, 2019, p1). Under section 135 police must obtain a warrant and can then, 'enter a person's home to take a person (or keep them at) a place of safety so that a mental health assessment can be done' (Welsh Government, 2019). A section 136 on the other hand does not need a warrant and allows officers 'to take them from a public place to a place of safety for up to 72 hours' (Chappell, 2012, p45). A place of safety is defined by the College of Policing (2016) as:

- *residential accommodation provided by a local social services authority under Part I of the Care Act 2014 or Part IV of the Social Services and Well-being (Wales) Act 2014*
- *a hospital (as defined by this act)*
- *a police station*
- *an independent hospital or care home for people who are mentally disordered*
- *any other suitable place*

Previously a place of safety included hospitals, police stations or *'anywhere else temporarily willing to receive the person'* (Schwarze, 2019). However medical facilities like A&E took advantage of the loosely defined *temporarily willing* statement and began to turn mentally ill patients away resulting in the majority of people suffering with mental health being detained at police custody. After the definition was revised, police custody was identified as not being an appropriate place of safety and now, *'little more than two per cent of the 28,000 people detained under 136 go to a criminal justice setting'* (Schwarze, 2019).

Chappell (2012, p45) explains under PACE 1984, *'police can arrest someone considered to be in need of police intervention and where the person is suspected of having a mental illness and needs to be controlled and taken to a safe place'* which is predominately done through the use of section 135 or 136. Those detained under the Mental Health Act must be assessed as soon as possible by a professional. Once assessed, as stated in paragraph 3.16 under code C of PACE 1984, *'a detainee must be immediately discharged from detention if a registered medical practitioner, having examined them, concluded they are not mentally disordered withing the meaning of the Act'* (Home Office, 2018, p18).

In general, the polices' main roles and responsibilities are to prevent and investigate crime, as such the College of Policing (2016) state,

when there is no reason to suspect that a crime has been, or is likely to be committed, responses to the needs of people with mental ill health and vulnerabilities should be provided by appropriately commissioned health and social care services.

In addition to crime the police are also called upon in emergencies to protect life and property from harm. Under article 2 of the Human Rights Act 1998 the police have a duty to protect life, and therefore if officers identify someone in mental distress or have mental health problems, they should respond appropriately to prevent suicide or any other harm thus saving a life(s) (AMHP, 2013). Along with their 24/7 availability, and responsibilities to protect life, the police are by default, having to attend incidents which are primarily concerning a person's mental health even though doubts have been cast on whether the police are the most appropriate service and trained sufficiently to respond.

1.4. Police role as interventionists

According to Wood and Watson (2016) since the times of deinstitutionalization there has been need for officers to, 're-imagine themselves as *guardians* rather than *warriors* in the performance of their innumerable duties'. Due to officers encountering mentally vulnerable people more often Wood and Watson (2016) suggest policing practices, attitudes and mindsets should shift toward health and welfare-orientated conduct 'during routine order maintenance and crime control activities.' However, should police have to change their practices as a result of incidental health role or does this present cause for reform within the health care environment?

The HMICFRS assesses and scores each UK police force in their annual PEELS report. The report scores police forces from outstanding, good, requires improvements or inadequate, in three categories: effectiveness, efficiency and legitimacy. Within these categories core areas of police work such as police demand, working with others and police recourses are discussed which can lend as a good source to evaluate police input with mental health related incidents. In 2017 the HMICFRS graded South Wales Police overall 'good' in understanding demands, use of recourses and planning for the future.

1.4.1 Police Demand

In the 2017 PEELS report South Wales Police was praised on its ability to use external, internal, historical, and shared information from other services to understand and deal with its demand effectively and efficiently. Within the police control room, the report highlighted that staff 'work well with ambulance service staff to identify and appropriately deal with those callers who have mental health problems and those who are repeat callers to both agencies' (HMICFRS, 2017, p12). Although staff can identify callers in mental health crisis officers are still being deployed to those incidents which is costing Welsh police around £1.2 million a year plus a loss in recourses as officers, on average, deal with mental health patients between 10-12 hours before a medical professional is able to assess them (Fischer, 2019).

The number of detentions under section 136 of the Mental Health Act 1983 has increased in Wales with numbers raising from 1,955 in 2017/18 to 2,256 in 2018/19 (National Assembly

Wales, 2019), which is a 15% increase. Figure VII below shows the number of detentions under section 136 by police force area, overall, three of the four Welsh forces have all experienced an increase with South Wales police force experiencing the second largest increase. The National Police Chiefs Council state,

Policing is currently experiencing unprecedented levels of mental health related demand, which continues on an upward trajectory. The police service has become the 'de facto' agency and the first point of contact for many persons suffering with mental ill health. (National Assembly Wales, 2019 p13)

ACC Jonathan Drake also added that due to the round the clock availability the police are called in any and most instance. Drake continued to explain that 98% of incidents that don't result in detention under the Mental Health Act involve a health and welfare concern and feels that at present the police, 'are involved in too many issues that are purely health concerns, or may be linked to social care, as opposed to fitting that definition of an immediate risk to themselves or others' (National Assembly Wales, 2019 p13).

Figure. VII

Number of section 136 detentions by police force area: 2014-15 to 2018-19

	2014-15	2015-16	2016-17	2017-18	2018-19
Dyfed-Powys	197	226	270	239	270
Gwent	310	266	287	237	278
North Wales	466	323	589	680	795
South Wales	749	710	679	799	913
Total	1,722	1,525	1,825	1,955	2,256

(Sources: 2014-15 National Police Chiefs' Council, 2015-16 National Police Chiefs' Council, 2016-17 Home Office statistics, 2017-18 Home Office statistics, 2018-19 Home Office statistics)

(National Assembly Wales, 2019 p14)

1.4.2. Police Recourses

In 2016 South Wales Police took part in implementing the Mental Health Concordat as part of the Welsh Government strategy in mental health and wellbeing. The Mental Health Crisis Care Concordat was established in 2014 and saw 27 national organisations within policing, health, social care and local government backgrounds, come together in a multiagency approach to deal with people in mental health crisis and ensure they get the help they are required (Crisis Care Concordat, 2014). The concordant recognised police custody as an inappropriate environment for people in mental health crisis and has therefore helped reduce the number of police cells used and instead ensured people are receiving correct help, support and treatment for their mental distress. Despite this the HMICFRS (2018) recognises that people continue to use the police for medical and health incidents which is unsustainable in the long-term future of policing.

To combat the overarching consensus that police are being deployed too often to incidents of a medical or health concerning nature, all welsh police forces have established mental health triage teams which involve specialist mental health trained staff being situated within control rooms (Fischer, 2019). The purpose of mental health triage teams are, 'to bring police and mental health practitioners together to jointly asses a mental health incident' (National Assembly Wales, 2019 p15) thus reducing detentions under section 136 and the use of police custody as a safe space. Mental health triage teams are also able to access medical notes held on an individual enabling them to share useful information with officers. Important information shared may include, whether the person is known to mental health services, officer safety notes, and previous incidents whereby the persons experienced a mental health crisis. Thus, helping officers to ensure a person receives the most appropriate help, which at times may include no police deployment as officers may scare or make the experience worse for a person in distress. Although the triage teams have been mainly successful within Welsh police control rooms a report by the Welsh Assembly (2019) found an inconsistency in funding for the triage teams across the Welsh police forces. South Wales Police has one of the biggest budgets out of the four Welsh police forces, their triage team was funded entirely by the police which in the future does not appear sustainable. As a result, pressure has been put on

the Welsh Government to fund the project moving forward which is estimated to cost around £2.5 million (National Assembly Wales, 2019)

Due to the continuous increase in demand Chief Constable Matt Jukes worries that without a budget increase in the future there is no certainty that all services currently being offered can continue to operate. In response to Jukes the Welsh Government have stated there will be a £1million investment to help improve out of hours mental health crisis care which will be used in various initiatives like crisis support, street triage and liaison services (Rees, 2019) although in this statement the money does not appear to be going directly to the police but is funding crucial initiatives which will work alongside officers with the hope to alleviate pressure off them.

Research conducted by MOPAC found that officers are apprehensive when having to attend a mental health related incident. The report indicated officers feared making the wrong decision which may result in the incident escalating and getting worse adding to the fear of any legal ramifications of their actions (Hobson *et al*, 2015). South Wales Police along with twenty other forces have invested in mental health related training via the College of the Policing, however the HMICFRS (2018) found training to be inconsistent as some forces are investing more than others along with challenges like allocating training time for officers. The college of Policing gives access to online e-learning packages which can be easily accessed at any time however, the HMICFRS (2018) suggests forces should not rely solely on e-learning but should seek to expand training through face-to-face seminars that are instructor-led which will allow more complex issues to be explained in detail and promote discussion amongst officers and staff.

1.4.3. Planning for the future

Areas of improvements suggested by the HMICFRS (2017 p26) PEELS report included better processes and governance to 'understand and realise the benefits of collaborative work, and how they affect the force's ability to meet current and likely future demand efficiently'. South Wales Police acknowledged this in their 2018-21 police and crime plan, stating their aim 'is to work with partners to ensure that people get the response they need, when they need it...' (South Wales Police, 2018, p2). Through identifying the importance of working collaboratively with other agencies like the ambulance service, mental health practitioners, social services and local government South Wales Police have been able to react more proactively to incidents which may not necessarily need police involvements. By signposting people to the correct agencies and/or sharing information South Wales Police can remain efficient and effective and that message has continued to be at the forefront of their planning for the future in their 2019/23 report which acknowledges that, 'our work with partners is fundamental to people getting the response they need, when they need it' (South Wales Police, 2019).

In their report South Wales Police (2019 p2) explain one of their priorities is to, 'work to protect the most vulnerable ...understanding cause and taking prompt positive action...'. In order to meet this aim regarding those vulnerable due to mental distress South Wales Police (2019, P13) published the following three objectives:

1. *Working with partners to improve communication between the police and those with mental health needs or learning difficulties and promoting the Keep Safe Cymru card*
2. *Working to support safe, friendly non-custodial places of safety for those experiencing crisis or at risk of being detained under Section 136 or 135 of the Mental Health Act*
3. *Employing mental health professionals in the Public Service Centre*

All three objectives show an ongoing concern for, and effort to identify, help and support those suffering with mental health issues and show a promising future for those in need as well as support for officers.

1.5 Conclusion

In a survey conducted by HMICFRS 2% of respondents 'felt it was the police's responsibility to respond to mental health-related calls' while '70% felt it was the main responsibility of the health services' (HMICFRS, 2018, p15). Instead, the public felt incidents like violent crimes, terrorism and child sexual exploitation should be prioritised by police forces rather than mental health and wellbeing concerns. Zoe Billingham, HM Inspector of Constabulary "There will always be situations where someone in crisis needs a rapid response from the emergency services. But too often, our public services are failing to work together to prevent the crisis in the first place ... Blue lights should not have to flash for someone to get the help they need in time." (HMICFRS, 2018, p4)

Inspector Michael Brown says, 'being subject to the criminal justice system stigmatises, criminalises and often frightens vulnerable persons' (Schwarze, 2019) thus prompting discussions around the role both police and health services should play in managing mentally vulnerable individuals. Police should not be relied upon to fill the void left by an inadequate health service because of their 24/7 availability. As stated in the Bradley Report, 'It has become increasingly apparent that when people with mental health problems in the community are in crisis, neither the police nor the mental health services alone can serve them effectively and it is essential that the two systems work closely together' (AMHP, 2013, p1

Chapter2. Methodology

2.1. Introduction

To answer the question, 'are South Wales Police experiencing an increase in mental health related incidents', this research will adopt a mixed research method approach. Research methods usually consist of a deductive and inductive approach. Deductive research is rooted in quantitative data as a *'hypothesis is derived from existing theory and the empirical world is then explored, and data collected in order to test the truth or falsity of the hypothesis'* (O'Reilly, 2009, p104). An inductive approach contrary to the deductive way, is rooted in qualitative data. O'Reilly (2009, p104) says *'an inductive approach is where the researcher begins with as few preconceptions as possible, allowing theory to emerge from the data.'* However, I have chosen a mixed method approach, this approach enables the researcher to combine *'elements of qualitative and quantitative research approaches for the broad purpose of breadth and depth of understanding corroboration'* (Schoonenboom and Johnson, 2017). A mixed method approach will be beneficial for this research as it allows new primary data to be collected which will add to and strengthen any secondary literature that is already published, thus contributing to the overall results and conclusion.

Due to deinstitutionalization mental health instantly became more visible within communities. Mental health was, and at times for some people still is, a social taboo with little understanding surrounding the subject a negative stigma quickly formed. O'Hara (2009, p1) reported in a survey of 2,000 respondents *'people are more reluctant to reveal they have a mental illness than to come out as gay'*. However, Borinstein (1992) explains that *'other societal changes have contributed to greater public awareness of mental health issues'*, thus resulting in the matter becoming *'demystified'*.

In 2013 Mind mental health charity teamed up with victim support to publish a report 'At risk yet dismissed'. The report found that people suffering with a mental health illness were,

- *three times more likely to be a victim of crime,*
- *five times more likely to be a victim of assault*
- *more likely to be a repeat victim and experience different types of crime*

(Pettitt *et al*, 2013)

As mental illnesses have become more visible in communities, and those suffering with mental health being recognised as some of the most vulnerable to crime. Therefore, to ensure those most vulnerable suffering with mental illnesses are both recognised and supported correctly has become a key priority for police forces. South Wales Police now record any incidents which relate to or derive from a mental health illness/crisis. This research is important to identify, if any, the demand, and challenges police face from mental health crisis. As a result of this, the research will also highlight the lack of support from other emergency services, like the ambulance service, who could be more adequately trained to deal with these complex issues.

2.2. Research strategies

Yin (2003, cited in Saunders *et al*, 2009, p141) explains that research strategies '*can be used for exploratory, descriptive and explanatory research*'. Research strategies are specific to the research approach, Saunders *et al* (2009, p141) continues to add that the chosen strategy '*will be guided by your research questions(s) and objectives, the extent of existing knowledge*' and other contributing factors. Research strategies although initially appear to belong to either a deductive or inductive approach, they can also be used in combination, as previously discussed a mixed method approach is to be followed and therefore a combination of strategies will be utilised.

My research will combine both surveys and case study strategy as it considers both qualitative and quantitative data as well as the '*ability to generate answers to the question "why?" as well as the "what?" and "how?"*' (Saunders *et al*, 2007, p139). According to Robson (2002, p178, cited in Saunders *et al*, 2007 p139) case study research is a strategy relating to '*research which involved an empirical investigation of a particular contemporary phenomenon...using multiple sources evident*'. Within this research I will be investigating whether there is in fact an increase of mental health related incidents, thus being the empirical part, and proving whether this is accurate or not represents the specific contemporary phenomenon which South Wales Police report to be experiencing. I aim to collect numerical data produced by South Wales Police which displays the number of incidents and contacts made by South Wales Police which primary concern involves mental

health issues over several years. I will also utilise any reports, news articles and documents that support the completion of this research question. The use of a case study research strategy is likely to require triangulation of multiple data sources. *'triangulation refers to the use of different data collection techniques within one study'* (Saunders *et al*, 2007, p139) thus is required to ensure a full and clear conclusion can be determined. This research will consider both primary and secondary data, collected by means of questionnaire as well as literature like reports, newspaper articles and organizational records which are already published.

A survey strategy consists of two main elements, Jhangiani *et al* (2015) explains these elements as firstly, *'variables of interest are measured using self-reports...in essence, survey researchers ask their participants to report directly on their own thoughts, feelings and behaviours'*. I have designed a questionnaire which I will send to those employed by South Wales Police. Within my questionnaire I aim to discover whether the respondents think that there has been an increase in mental health related incidents and if so do they feel they are adequately trained or have enough support to deal with the incident or is intervention required from other services. The second element explained by Jhangiani *et al* (2015) is that *'considerable attention is paid to the issue of sampling...survey researchers have a strong preference for a large random sample because they provide the most accurate estimates.'* I aim to distribute questionnaires to police officers, control room staff and mental health staff, all of which work for South Wales Police specifically. By doing so this not only allows a large sample group but also provides various opinions within different roles thus enabling a more accurate estimate to the question.

2.3. Data Analysis

The overall aim and purpose of conducting any research is to achieve a deeper understanding and insight of a specific topic by means of collecting data. However, in order to achieve an accurate insight, the data which has been collected must be analysed correctly. Bhati (2018 p1) suggests, '*we look at data to find meaning in it...the first instinct is to find patterns, connections and relationships*' within the data that has been collected.

After distributing and collecting responses from my questionnaire, I will transfer the data into pie charts. Pie charts allow a researcher to clearly visualize a large amount of data by displaying it in comparative segments. Hurley (2017) suggests that although pie charts easily display large disparities as well as emphasize data when there are less options for respondents to choose from. However, Hurley (2017) continues to explain that pie charts are not favoured for data which displays trend over time or is saturated with numerous different responses. In order to ensure the best analysis, there will be limited choices to each answer which will also be relevant to the current time, not over a period, which will display a clear representation of each answer.

2.4. Limitations

The main limitation I will face during this research will be restrictions imposed by the government due to the global Coronavirus pandemic. In order to overcome the restrictions, I have designed an electronic questionnaire which I aim to distribute online, via email and South Wales Police intranet. This will allow me to collect data safely and store securely.

There are also limitations within my chosen research strategies. When conducting surveys, a large sample group is best in order to collect enough data to concur a valid conclusion. Saunders *et al* (2007, p139) notes how a survey strategy, 'although the research is undertaken in context, the ability to explore and understand this context is limited by the number of variables for which data can be collected'. To overcome this, I have made my questionnaires open to police officers, control room staff and mental health staff of South Wales Police, thus with the hope to attain as many participants as possible.

2.5. Reliability and Validity

'Reliability and validity are ways of demonstrating and communicating the rigour of research process and the trustworthiness of research findings' (Roberts and Priest, 2006). When conducting quantitative research considering the reliability and validity of the chosen research method used is important to ensure consistency.

The main statistics in relation to the number of incidents handled by South Wales Police which circumstances derived from mental health will be taken from data collected and published by the organization, and therefore will be valid. Roberts and Priest (2006) define validity as, *'the closeness of what we believe we are measuring to what we intend to measure'*. My literature review supports the belief that mental health illnesses and those experiencing a mental health crisis have been increasing, which in its turn have been affecting public services like the police as it places a more complex demand on the service. As a result, the data collected from South Wales Police should therefore mimic the increase identified in the literature review, thus making it valid.

Reliability on the other hand, *'describes how far a particular test, procedure or tool, such as a questionnaire, will produce similar results in different circumstances'* (Roberts and Priest, 2006). My questionnaires will be distributed to various roles, within South Wales Police, that encounter mental health related incidents. The responses from the questionnaires should therefore produce a similar result of the numerical data published by the organization as well as the research collected within the literature review.

Chapter3. Results

3. Data analysis

The overall aim of this research is to discover whether South Wales Police officers and control room staff are experiencing a rise in mental health related incidents and if so, are they adequately equipped and trained to deal with the complexity of the issues. In order to fulfil the aim several objectives were agreed which will assist in answering the research. In this chapter empirical research findings will be presented; this includes both qualitative and quantitative forms of data. Data collected from survey results and empirical results done by the employer will be analysed and summarised individually with the aim to provide support in the overall findings of this dissertation.

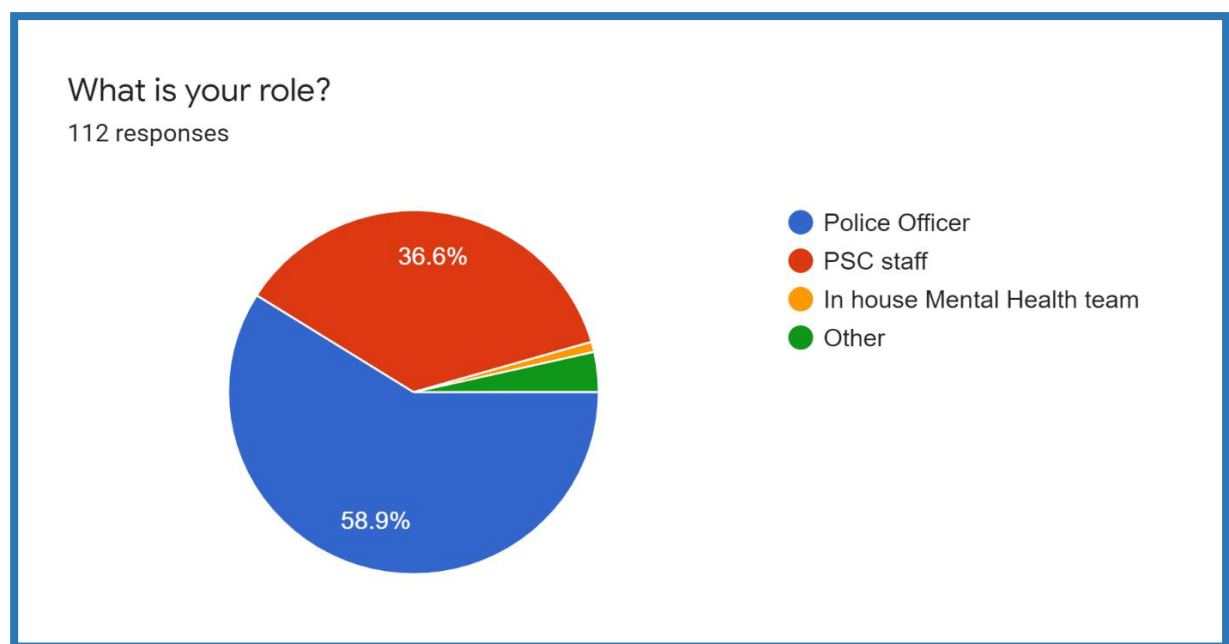
The first set of results, 4.1, feature questions and answers collected from questionnaires. Questionnaire were a chosen method of research for a couple of reasons. Firstly, they can be shared, completed and returned electronically and as a result this ensured all data was stored securely. Secondly by sharing electronically the method did not require any face-to-face contact with people, although this usually is not a specific requirement, it was incredibly useful under current climate with regards to government restrictions imposed due to the ongoing global pandemic that is Coronavirus. The data collected is displayed in both table and pie chart form. All data has been converted into a table format to reflect and condense the questionnaires into one easy table, each table has then been transferred into a pie chart. A Pie chart was better suited for this research as it clearly displays the data visually with each answer being shown as parts of a whole whereas line graphs would be better suited to show changes over a time period (Slater and James 2014).

The second part of results, 4.1.1, is secondary quantitative data which has been collected and shared by South Wales Police for the purpose of this research. South Wales Police, after being instructed to do so by the Home Office, have been identifying all incidents which are mental health related. In order to submit relevant figures to the Home Office each incident created, before being finalised, has its own qualifiers which need to be verified. In simple terms qualifiers are boxes which must be ticked, these gather data in regard to notifiable offences or areas of interest to the Home Office, the police force, and other agencies for data collecting and auditing purposes.

Qualifiers include, youth related, alcohol, drugs and prejudices. The mental health qualifier should be endorsed when an incident involves a person who has or appears to be suffering from a mental disorder or mental impairment including learning difficulties. For example, if someone has reported ongoing anti-social behaviour from a group of youths in an area then a qualifier for 'ant-social behaviour' would be chosen whereas an incident which saw someone stabbed would be endorsed by the 'weapons used' qualifier. Incidents which primarily concern themselves with someone's mental health, illness, or crisis, thus meaning the incident has happened as a result of someone's mental health, not that they have reported something and happen to be diagnosed with depression, would meet the criteria for the mental health qualifier to be chosen.

3.1 Results: Questionnaires

Question.1 - <i>What is your role?</i>	
Answer/choice	Number of responses
Police Officer	66
PSC staff (control room operators)	41
Other	4
In house Mental Health Team	1



Both a convenient and stratified random sampling technique was used when choosing participants to take part in the questionnaire. Convenience, also referred to as opportunistic sampling, is a sampling method that uses participants that are easily accessible to the researcher, although this method is usually criticized for its generalisability it is in fact this characteristic that was essential for this research question (Mathers *et al*, 2009). Generalisability '*is the extent to which the findings of a study can be applicable to other settings, it is also known as external validity*' (Shantikymar, 2018), thus meaning the data may be valid in one setting but not in another. The research question is specific to South Wales Police force's officers and control room operators therefore choosing people who work those

roles within South Wales Police was required thus ensuring external validity. As I work within South Wales Police all participants were easily accessible.

Stratified sampling *'is a way of ensuring that particular strata or categories of individuals are represented in the sampling process'* (Mathers *et al*, 2009). As shown above there are four categories of individuals thus being police officers, control room staff, mental health team and other. When devising the questionnaire, the option for 'other' was included for any other person who works for South Wales Police that may wish to contribute, this may include any supervisors, PCSO's and other roles who are public facing and come into contact with mental health related incidents.

Although the questionnaire has provided a large group of participants, a larger sample group ensures reliability in results, as the bigger the sample the more accurate results will appear. However there appears to be a disproportion within the groups of participants, as although a large group of officers and PSC staff have completed the questionnaire only 1 person from the mental health team has engaged.

Question.2 – *In your own words, define Mental Health.* (112 responses)

A condition that has a potential detrimental effect on a person's mental wellbeing and their ability to make objective or rational decisions.
Complex & unbiased. Mental health can be affected by daily issues , trauma , general well-being and can affect anyone at any point at many times.
An umbrella of different illnesses relating to your mind.
Psychological well being
How people think and act in relation to their emotional, psychological and physical well being
Emotional/cognitive wellbeing.
Your brain fitness
Your state of mind
A condition where it affects someone's psychological and emotional wellbeing . It can be contributed by anything including but not exclusive pressure, stress, injury, chronic illness.
When someone is struggling mentally with any situation
Emotional or mental distress or disturbance
Crisis to underlying gloom
A person who is not in the right frame of mind
It's the health of your mind . People who suffer with their mental health are prone to anxiety, depression, self-harm/suicidal thoughts and other illnesses.
Hygiene of the mind
A condition of a persons' state of mind
Someone's state of wellbeing and they feel unable to express normal stresses of life mental stability and feeling comfortable with your current situation. chemically balanced
How well a persons' mental wellbeing is, there are many conditions within this bracket.
The well-being of your mind
A pandemic
Disorder of the mind
An illness which does not define the person themselves
People through no physical disabilities struggle to cope in certain situations
When a person struggles and is unable to maintain rational thinking , sometimes just on occasions. I think it's very difficult to define such a massive word/s
Someone's mental state that effects their decisions on a da-to-day basis
A mental disorder which impacts someone's day to day life
The wellbeing of the mind and how it impacts on your life.
Everyone has mental health, some just need an extra bit of help managing and controlling it, be it counselling, medication , amongst others. Different events will affect peoples' MH differently. It can be affected by various things such as age (Alzheimer's), drink or drug induced, experiences and so on.
Being able to live life with balance , without any emotion in particular taking hold of your life.

Mental health is a health of the mind. It can be affected by a chemical imbalance
Mental wellbeing
A particular frame of mind, whether that be in the positive or negative
is psychological well-being and how we are coping with stress, grief, emotions etc
The capability for the mind to deal with everyday tasks and dramas.
Wellbeing of my mind
The way you feel when you're happy and sad and everything in between
A persons' emotional well-being
People suffering a mental episode, diagnosed or not
Your mindset and emotions that can differ depending on circumstances and situations. These can be good or bad feels. It is also your perception and how you evaluate the world / other people.
Any disorder or disability of the mind including brain injury. It can also be a state of wellness or illness.
There is good mental health and bad mental health, bad mental health is where a person struggles with themselves, there's a wide variety of mentally health
Our state of mind, and how that can impact our daily lives.
Crippling depression
Affects a person's ability to think and act rationally. Makes people more sensitive and emotional to situations which impacts on day-to-day life.
A state of well-being
Strain on policing
Mental health is a vast spectrum of issues relating to the mind, mainly effecting well-being and mind related issues
Healthy mind, managing your own mental wellness.
Illness that affects a persons' day to day.
Anything from stress to psychosis. Can be situational and temporary to ongoing medical conditions.
Mental health is the ability to deal with thoughts and feelings that are linked to the wellness of the mind.
Contentment
Looking after your mind
Mental well-being
vulnerability in relation to a person's state of mind through injury or illness
Depression, anxiety, anything that affects a person managing daily functions and tasks!
A state of which you perceive your own mental well-being.
Anything that affects the way you feel, and impacts on your well being
Any deviation from the accepted 'norm' whether temporary or permanent
ABNORMALITY OF THE MIND
The state of ones mind
Such a broad term- someone who is struggling with emotions/anxiety/depression
A person who does not have the capacity to take care of themselves whilst not under the influence of drink or drugs

From policing perspective its poor mental health, we deal with. Someone experiencing mental crisis.
When your mind takes control of your thoughts and you're not able to control where these thoughts go or what they lead to.
A person's psychological and emotional well being
Something that affects your mental wellbeing
The balance of your brain
The condition of the human mind based on emotional feelings
Mental Health is an illness like any other illness in that it needs to be treated and if untreated it can worsen.
Your state of wellbeing, whether good or bad
Mental health is the wellbeing of a person's psychological and emotional health.
Psychological and emotional well being
Broad term used to describe someone who struggles or does not/cannot cope. A chemical imbalance in the brain
A sense of wellbeing in your own mind
State of mind
Mental health is very hard to define as it effects all different people in all different ways, but effectively is how people deal with situations in their life and how situation/incident during their childhood or extreme trauma.
Your mental well-being. How you feel emotionally over physically.
The way a person thinks and acts dependent upon their experiences in life.
Illness which affects mind and can affect how you deal with everyday situations/information
A disability that comes in many forms, whether visible or not, often the result of a traumatic experience or upbringing.
Someone suffering with how they feel and how to cope with negative thoughts
Someone who struggles with daily tasks
The wellbeing of a person through their emotional and cognitive states, which can be affected by any number of situational incidents affecting those states either positively or negatively.
Everyone has 'Mental Health', sometimes it's in a good state, however the majority of people in their lifetime will experience a period where it declines. This sometimes becomes complex and in need of a helping hand from medication and or specialised MH workers.
Mental health is our emotional and psychological wellbeing. It can alter how we act, think and feel. It also affects how we handle situations including stress and our ability to make informed choices.
Somebody that cannot cope or deal with themselves due to not feeling right, experiences or the overwhelming thing which is called life. Unable to rationalise or put things in perspective, loss of inhibitions and life in general.
How healthy your mind is
Mental health is your thoughts and feelings which then lead on to impact your behaviour.

A disconnect with the world around you
Fair
The well-being of emotions
How you are feeling.
When someone is not functioning properly mentally
Balancing the health of the mind against life!
Someone who has faced things in life and has difficulties dealing with them.
Your state of mind and emotional well-being
When an individual is suffering an impairment to the psychological processing due to a lapse in their mental health.
Poor mental health is where an individual is vulnerable as they are unable to make effective decisions in context due to an abnormality of mind (temp or permanent)
OTHER (8)

Above is a table including all the answers given by participants of the questionnaire in relation to question two. Different colours highlight key words and phrases that indicate a theme which has been identified within the answers, this form of analysis is known as coding. The following table displays and explains the coding themes identified.

Colour	Coding meaning/ theme
Pink	Positive perspective of mental health
Yellow	Negative perspective of mental health
Green	Inability to make decisions / effects daily life
Blue	Understanding the need for support/treatment
Red	Causes and diagnosis's

Question two, as well as question eleven featured later, are both open ended questions this was purposely included in order to allow the participants to have more freedom when answering. As seen above the use of open-ended questions allow an unlimited range of answers however these answers can be difficult to summarize, as a result a coding method is a common technique adopted when analysing data.

'Coding is a way of indexing or categorising the text in order to establish a framework of thematic ideas' (Gibbs 2008, p39). Corbin and Strauss (2008 cited in James and Slater, 2014, p190) explain two ways of coding qualitative data, one of which being open coding. Open coding method refers to *'when researchers read the entire body of data without preconceived*

ideas as to what they will find, coding items of interest as they go', which differs to selective coding which sees researchers highlights findings that agree or disagree with the overall research question. An open coding method is therefore displayed in the above question as its answer has no bearing in the overall research question or previous literature, however it was important to ask to attain a deeper understanding of how the workforce perceive mental health. Identifying staffs understanding of mental health could highlight whether a stigma is present within the workforce and ultimately *'lead to a deeper understanding of the interrelatedness among the variables associated with the issue'* (James and Slater, 2014, p190).

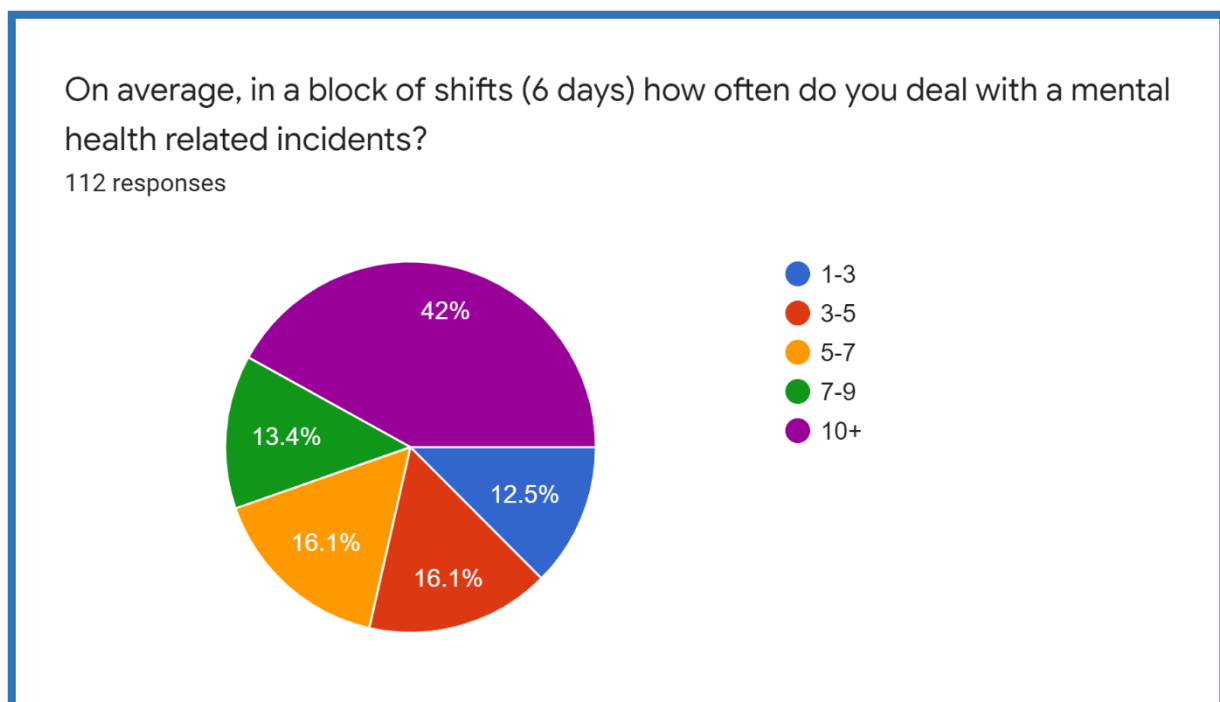
The main theme recognised within question 2 is one of a negative perspective. Negative explanations are used 42 times out of the 112, which accounts for 37.5% of the answers. Responses which included phrases like 'illness' being used ten times, 'state' sixteen times, 'condition' six times and 'disability' twice, reflect officer opinion is that it is not a police priority. As the results portray a common theme of negativity toward mental health, this may suggest a negative and possible discriminatory stigma of mental health within the force. According to the Mental Health Foundation (2015, p1), *'stigma and discrimination can worsen someone mental health problems, and delay or impede their getting help and treatments, and their recover'*, subsequently it's imperative for those working within the police force to have a full understanding and ability to recognise those suffering with their mental health.

The most used word, which appears thirty times, is 'well-being'. Well-being is a broad concept which covers an array of meanings, it can include how a person may feel, how they cope with daily life and what feels possibly to them (Mind UK 2015). According to the Oxford English Dictionary, well-being is defined as *'the state of being comfortable, health, or happy'* (Then Mental Health Foundation, 2015, p1) additionally, The Mental Health Foundation (2015, p1) expand upon this definition emphasising that well-being should only refer to moment-to-moment happiness but instead *'can be understood as how people feel and how they function, both on a personal and a social level, and how they evaluate their lives as a whole'*. Terminology like 'wellbeing', 'fitness', 'hygiene', and 'stability' of the mind account for 36% of the answers provided which is only a 1.5% difference, thus, shows an equal divide in responses.

A fourth of participants, 25%, explain the assumption that mental health can affect the ability to make informed choices, to manage day to day life and cope in different situations. This statement is in fact true as Nemeroff et al (2014) explains, *'a commonality of patients with major psychiatric disorders is their propensity to make poor decisions, which is intimately related to poor real-life outcomes'*. Although a quarter of participants recognised that mental health could affect someone, only 5% mention the need for support and medication with only 2 participants mentioning the term 'vulnerable'. A second report by Mind UK and Victim support (2013, p4) stated that *'people with mental health problems are more likely to be victims of crimes than others...up to 90 percent of prisoners and two fifths of those on community sentences have mental health problems'*, officers, operators and other members of the police force should be able to identify vulnerabilities. The initial report published by Mind UK and Victim support, *'At risk, yet dismissed'* (Pettitt et al, 2013), identified discrepancies in how police as well as other agencies handled reports made by someone who identified as having a mental health problem. Common discrepancies included lack of empathy, not being believed and as a result being told they were an unreliable source, lack of or poor communications from the police, and police failing to take appropriate, and in some cases immediate, action in the incidents which were being reported to them. Overall, those who had mental health problems felt their negative experiences with officers and police staff was due to *'attitudes of prejudice or being misinformed about mental health'* (Pettitt et al, 2013). As a result of this report several recommendations were made, and several police forces have taken action to implement various strategies and plans to ensure help and support for people who are affected by their mental health. Initiatives include investment in further training, partnership working between police and mental health services, and appropriate adult schemes to name a few. South Wales Police have invested in further training as well as appointing mental health liaison officers and working in partnership with mental health staff in their control room.

Finally, 10% of responses listed or mentioned mental health conditions or illnesses, these including stress, depression, and anxiety. Although the question does not specifically ask about mental disorders/conditions it is presumed that most participants would have come into contact with victims/witnesses who are diagnosed with mental health. It is encouraging to see that participants are aware of common illnesses and symptoms.

Question.3 -	<i>On average, in a block of shifts (6 days) how often do you deal with a mental health related incident?</i>
Answer/choice	Number of responses
1-3	14
3-5	18
5-7	18
7-9	15
10+	47

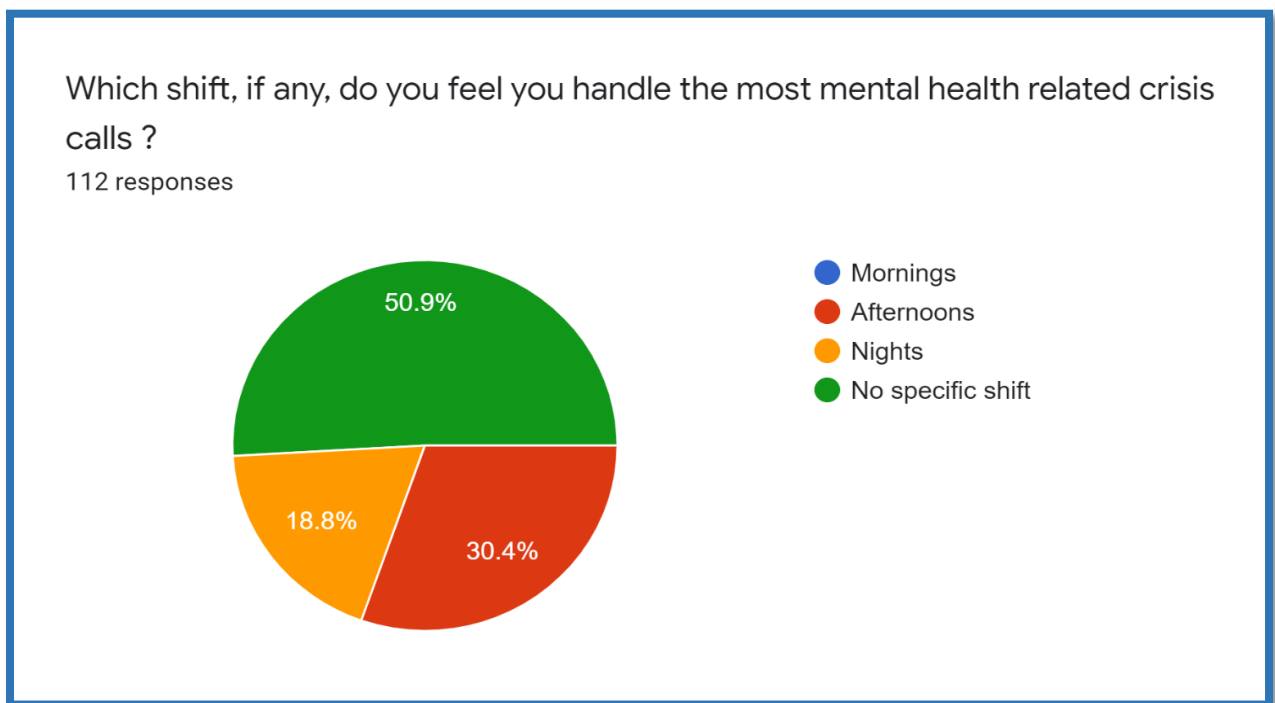


42% of participants claim to deal with a mental health relate incident ten or more times in a block of shifts, followed by 5-7 and 3-5 times, with the least amount of responses, 12.5%, choosing 1-3 times. An inquiry into policing mental health reported, *'it is generally acknowledged that policing individuals with mental health problems takes up a considerable amount of police time'* (Sainsbury Centre for Mental Health, 2008 cited in Police Foundation, 2017, p1), and is estimated to take anywhere between 15% and 30% of officer's time.

Since 2010 austerity measures have had major impacts on all public services including the police and care services. Cuts to police budgets resulted in staffing cuts as forces across England and Wales experienced a loss of 20,000 officers (Dearden, 2018), likewise, care

services have experienced a '*significant reduction in the availability of mental health nurses*' (Dearden, 2018). With less officers to attend and investigate incidents forces have had to prioritise the most serious crimes and incidents. A mental health related incident, whereby people are in immediate danger, would rightly be dealt with as an emergency or priority by the police. According to Dearden (2018), GPs and social service teams are '*transferring their risk and shunting their demands by calling police to conduct safety checks outside their office hours*'. Knowing that the police operate 24/7, and that they must prioritise mental health calls due to the unknown risk factors associated, many feel that care services are taking advantage of the police which can be supported by question 3 of the questionnaire as participants feel they regularly attend mental health calls throughout their block of shifts.

Question.4 -	<i>Which shift, if any, do you feel you handle the most mental health related crisis calls?</i>
Answer/choice	Number of responses
Mornings	0
Afternoons	24
Nights	21
No specific shift	57



It is interesting to see a split in the above response for question three, as half feel that there is no specific shift, however 30% feel that afternoon shifts are busiest with mental health related calls followed by nearly 20% choosing night shift, and no one choosing morning shift.

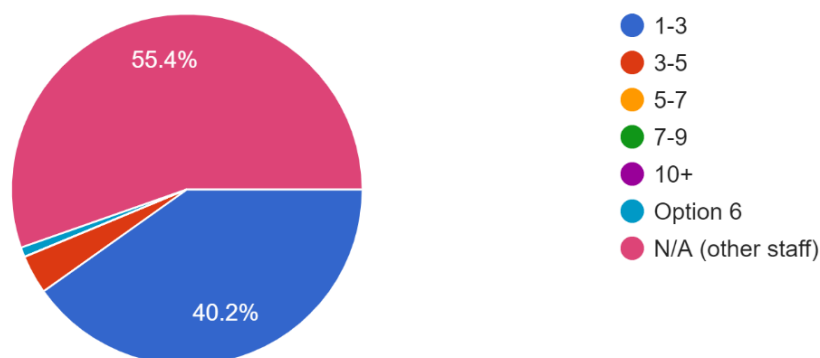
According to a report by the mental health foundation, *'impairments to sleep quantity and quality are associated with a range of mental health problems'*, this is caused by the circadian rhythm. Circadian rhythm refers to a person's sleep-wake cycle, an internal 24-hour rhythm commonly known as 'biological clock'. A persons' sleep and ability to function depends on their circadian rhythm and therefore an irregular rhythm *'can result in a number of health problems, including mood disorders such as depression, anxiety, bipolar disorder, and seasonal affective disorder'* (Epstein and Hassan, 2020). The fact that nearly half of

participants chose afternoon and night shifts as being the most common shift to deal with a mental health related incident may therefore actually be true as it corresponds with theories that a person's body clock effects their mental health. Schimelpfening (2020) explains '*a person may have more energy and better mood earlier in the day, with symptoms of depression becoming worse at night*', as a result there may be more pressure on police to respond to those suffering with their mental health later in the day/ night-time, especially as most GP's, social workers, mental health staff work 9am-5pm office hours. South Wales Police Chief Constable Matt Jukes says, '*despite not being the most appropriate service to support those suffering a mental health crisis, the force was often plugging the gap because it ran 24.7*' (Rees, 2019).

Question.5 -	<i>As a police officer, on average, in a block of shifts (6 days) how many times do you use section 136?</i>
Answer/choice	Number of responses
1-3	45
3-5	4
5-7	0
7-9	0
10+	0
N/A	63

As a police officer, on average, in a block of shifts (6 days) how many times do you use section 136?

112 responses



According to Durcan (2014, p4) the use of a section 136 under the Mental Health Act 1983, 'allows a police officer to remove a person from a public place...that person must appear to the police officer to be suffering from a mental disorder and to be in immediate need of care or control'. Section 136, unlike section 135, allows the officers themselves can make their own assessment of the person and decide whether they require a mental health assessment and support or whether they need to be detained/ arrested.

Almost all of officers who have responded, 40%, said that they would use a section 136 1-3 times within a block of shifts with the remaining 4% saying they use it 3-5 times. This is as

expected since the Welsh Government and partners published their mental health crisis care concordat. The concordat was created to promote partnership working to help those who are suffering with their mental health and have contacted the police, and as a result may be subject to the police detaining them under a section 135 or 136 (Welsh gov *et al*, 2015). The overall aim of the concordat is to ensure all services and partners within the agreement *'intervene early, if possible, to reduce the likelihood of people presenting a risk of harm to themselves or others because of a mental health condition deteriorating to such a crisis point'* (Welsh gov *et al*, 2015) with the aim to reduce the use of powers of detention under section 135 and 136 of the Mental Health Act 1983. Since the implementation of the concordat, the Police and Crime Commissioner South Wales (2019) explained that, upon attending incidents whereby officers feel a person maybe experiencing a mental health crisis, they should contact the relevant crisis team withing the local health board to seek advice prior to any decisions re detaining the person under the Mental Health Act. As a result of seeking advice the force should benefit *'in not only providing an alternative to using S136 but will reduce time spent escorting S136 detainees and provide a better service to those in crisis'* (Police and Crime Commissioner South Wales, 2019, p18). By speaking with mental health proffesional prior to using section 136 or 135 officers may be able to find better support for the person in need which would confirm the responses of the questionnaire.

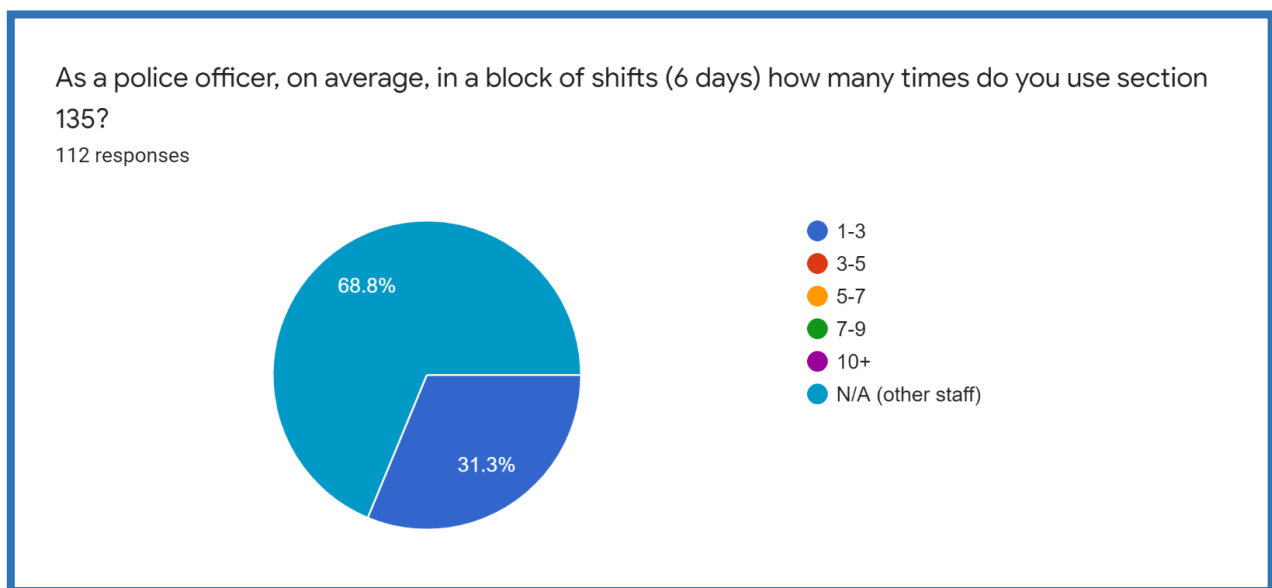
The concordant along with recommendations by the HMICFR inspection saw South Wales Police establish an in house mental health triage team who work alongside control room staff to assist in any incidents which incolve someone in crisis. *'Since the initiation of the triage there has been a 21% overall reduction of S136 use across the force'* (Broome and Davies, 2020, p7) from 2018 to 2019 with December 2019 experiencing the gratest difference of 51% decrease compared to its previous year figures. Each basic comman unit (BCU) also experienced an overall decrease with the Western BCU achieving the biggest decrease of 36% followed by Northen BCU with 8% decrease and Eastern BCU with 4% decrease in 2019 (Broome and Davies, 2020). However the triage team haven't only reduced the use of S136, thus freeing up more time for officers, but have also experienced *an 'estimated £231,743 opportunity cost reduction in 2019 for activity within police, the NHS, ambulance service and local authorities'* (Broome and Davies, 2020, p7) within the Western, Northen and Eastern BCU. Overall the *'total conservatively estimated opportunity cost savings from reduced S136*

use (£220,3033) across South Wales covers just over two thirds of the annual service costs for triage (£321,000)' (Broome and Davies, 2020, p7). Yet the overall figure may actually be 3 times grater than that reported as the estimate savings are based on the detention taking 3-4 hours, however the Independent Police Complaints Commisions believe the detention to take an average of nine hours (Broome and Davies, 2020).

According to the Department of Health and Home Office (2014, p5) *'The majority of S136 detentions are made outside of normal business hours when some services are not always available'*, thus also explaining why the use of detentions under a section 136 is not used often. The Concordant also stated that section 136 should only be used as a last resort, even during non office hours emergency care providers should be available to access services thus avoiding the use of detention under section 136.

As you can see from the above pie chart there is an error made with the choices of answers. 'Option 6' has been added in error however it was chosen by one participant. The person who chose option 6 left feedback stating that there should be a preference of 0 usage of 136 and 135 as they would usually seek guidance form the in-house mental health team before detaining someone under either section.

Question.6 -	<i>As a police officer, on average, in a block of shifts (6 days) how many times do you use section 135?</i>
Answer/choice	Number of responses
1-3	35
3-5	0
5-7	0
7-9	0
10+	0
N/A	77



A section 135 is made up of two sections but ultimately refers to the use of a warrant to enter a private property to remove a person suffering a mental disorder. Durcan (2014, p4) explains section 135, part one,

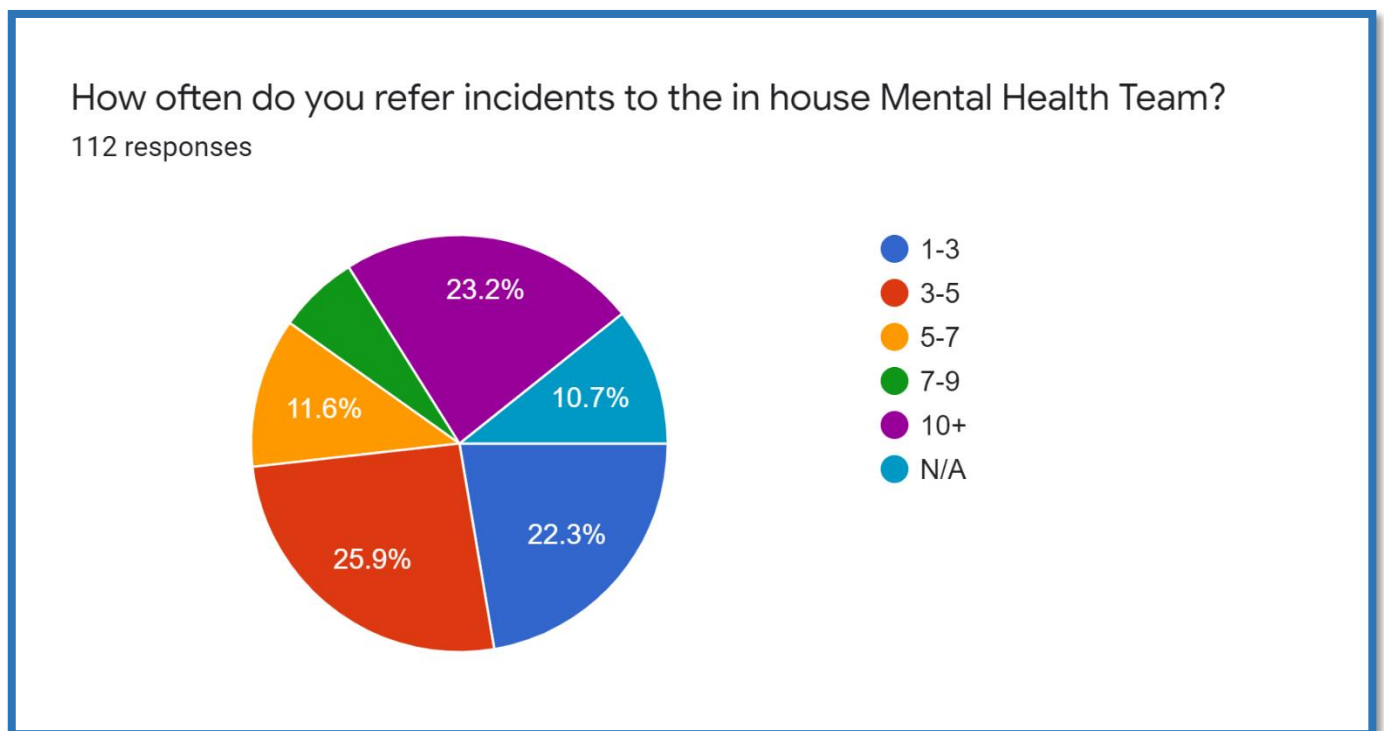
allows a magistrate to issue a warrant to the police allowing entry (by force if necessary) to a private place...to remove a person who an approved mental health practitioner (AMHP) has reasonable ground for suspecting is suffering from a mental disorder and not capable of caring for themselves, or is being mistreated/neglected or is not able to be controlled.

Part two of the section 135 again includes a warrant being executed in order to '*re-detain someone who is liable to be detained or already absent without leave*' (College of Policing, 2016).

There is a clear and definite answer with regards to the use of section 135, thus being, for those who use it (31%), only 1-3 times in a block of shifts. This figure is particularly low yet is expected as a result of the concordant. A review by The Department of Health and The Home Office (2014) stated that little literature was found with regards to the use of section 135 and this may be due to fewer detentions in comparison to a section 136 or because it is deemed less controversial. The Department of Health and The Home Office (2014, p9) believe a s135 to be less controversial as it '*entails obtaining a warrant and so have the additional safeguards of involving an approved mental health professional (AMHP) in making the warrant application, and a magistrate in granting it*'. As the section 136 depends on officers opinions in the moment it attracts more criticism than the s135, ethical arguments in relation to human rights cause more publicity in the use of a s136, thus also suggesting why there is limited information re s135.

As a s135 is pre planned by way of a warrant being obtained it is usually executed during day time hours. As previously noted participants of the questionnaire felt that most mental health related incidents happen in the afternoons/night times which would be out of officer hours. Therefore it can be assumed a s136 would more likely be used at these times, thence justifying the s135 being used less.

Question.7 -	<i>How often do you refer incidents to the in-house Mental Health Team?</i>
Answer/choice	Number of responses
1-3	25
3-5	29
5-7	13
7-9	7
10+	26
N/A	12



Front line officers reported that incidents which predominately involve a person in mental health crisis *'is the most significant demand on their time, with significant delays when seeking a decision on individuals conveyed to mental health facilities'* (Gov Wales 2018, p2). In their 2017-2018 annual impact report, South Wales Police and Crime Commissioner explained their vision to establish a team of mental health professionals who will be located within the public service centre (control room). The pilot aimed to support officers as well as control room operators who are the first point of contact with people who are experiencing a mental health

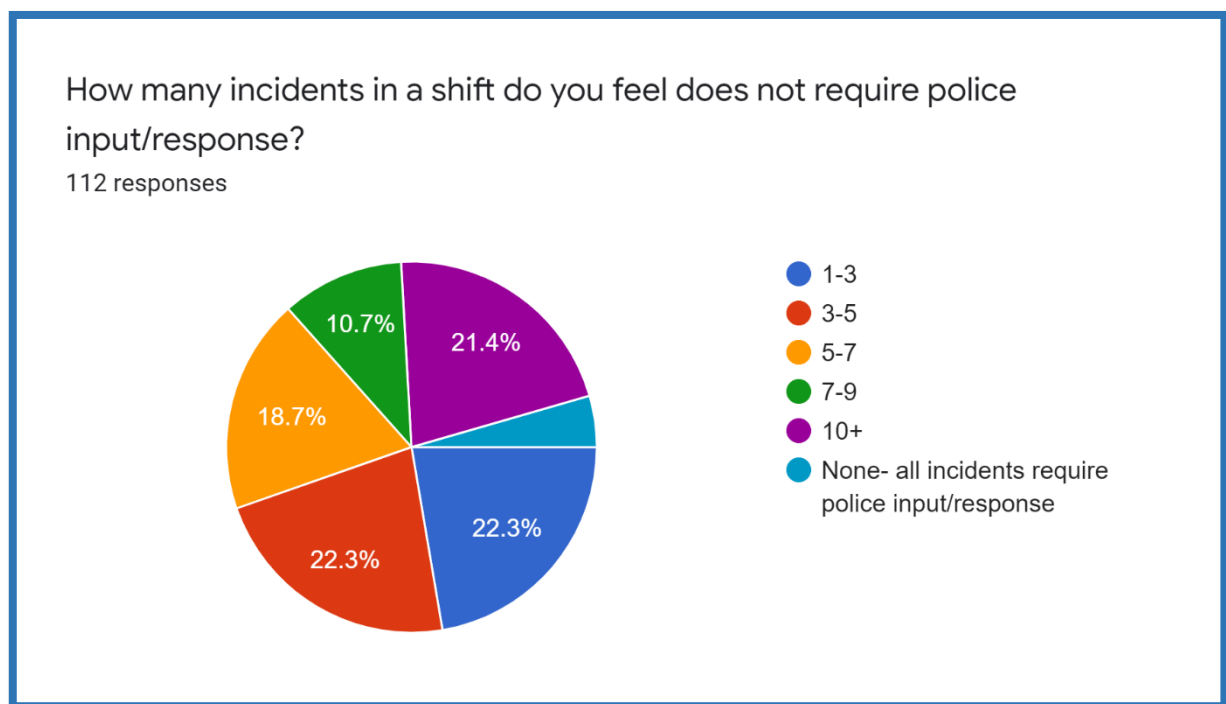
crisis. Triage teams or street triage services are now operating and are available in 42 of the 43 forces in England and Wales (HMICFRS, 2018).

The results reflect that the triage service is regularly used however the number of times incidents are tagged to them do vary but are consistent within each option. An initial evaluation of the mental health triage team pilot scheme emphasised that the team had *'bridged an information-sharing gap between police and health, allowing specialist MH Nurses access to health data that could inform police decision making and support individuals in MH crisis and distress'* (Broome and Davies, 2020, p4). As a result of officers and control room staff utilising the triage service the force reported an 86% decrease in repeat callers, *'indicating that the service is appropriately supporting individuals with mental health concerns at the first point of contact.'* (Police and Crime Commissioner South Wales, 2019 p17). Overall Broome and Davies (2020, p9) note that the triage team,

provides control and front line staff with educational and learning opportunities in the alternative management of mental health incidents, including services or strategies that service users might access to address their concerns/needs.

Prior to the Caronavirus outbreak the HMICFR had conducted an inspection into police control rooms and reviewed the management of call handling. In their findings they stated that it was good practice to have a mental health practitioner working within the control room as it, *'makes a difference to understanding and dealing with vulnerability and effectively managing demand such as repeat callers with mental health problems'* (HMICFR, 2020, p16). This is reaccussring feedback form the HMICFR which should give the force more confidence going forward to tagg more incidents and work closly with the triage team.

Question.8 -	<i>How many MH incidents in a shift do you feel does not require police input/response?</i>
Answer/choice	Number of responses
1-3	25
3-5	25
5-7	21
7-9	12
10+	24
None – all incidents require police input/response	5



The majority concensus is that most mental health related incidents do not require police input at all, whether it be 1-3 or 10 and more incidents per shift, the majority response is clear. Only 5 out of 112 responses chose that all mental health related incidents require police response/input. This concensus demonstrated the forces perception that mental health is not the polices' responsibility. A report conducted by the HMICFRS supports that opinion as, 70% of the public thought that the NHS is responsible for people suffering with their mental health compared to 2% who thought the police are responsible.

There is an assumption that police staff do not consider mental health incidents as being 'real' police work. Through all the literature gathered I was unable to find any research specifically in relation to the impact non-crime demand like mental health incidents is having on South Wales Police staff. However, Gloucestershire Police force found,

indisputable evidence that people with mental health conditions are stigmatised by society...such stigmatisation has the potential to infiltrate public sector establishments which can in turn impact on the quality of service received by people with mental health presentations (Martin-Burrows and Taylor, 2020, p22).

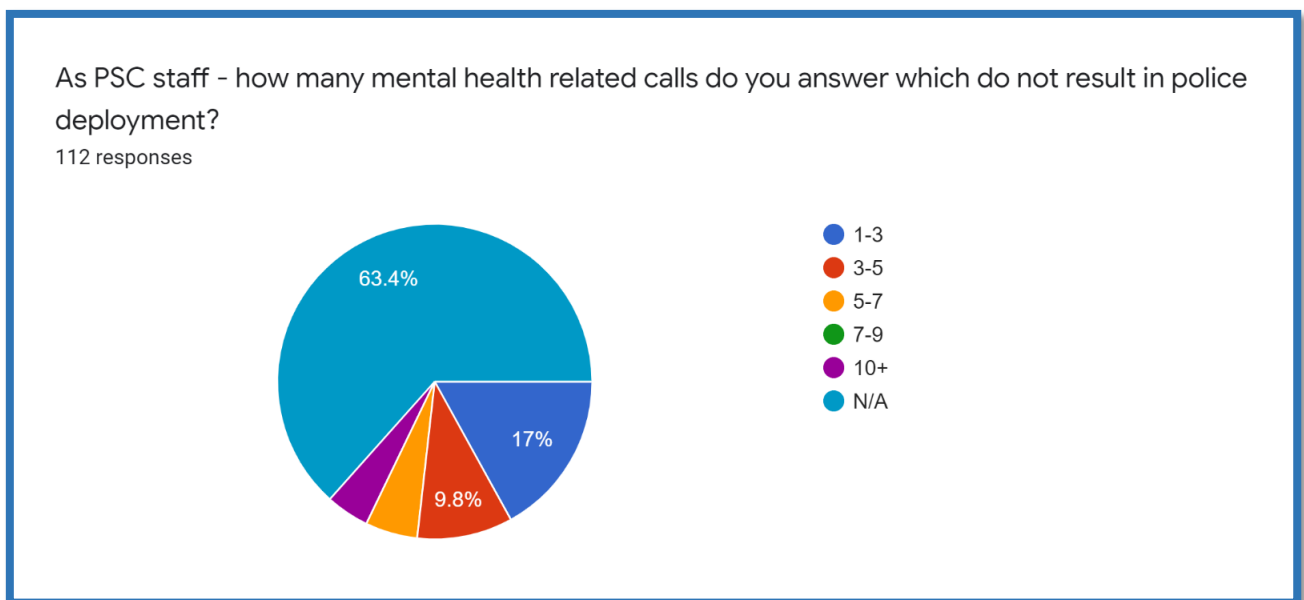
As over 90% of responses expressed the opinion that police are not required to attend mental health related incidents it can be argued that a prejudice has manifested causing a workplace stigma toward mental health. After conducting research, I understand that asking this question specific would have provided exclusive and invaluable research which would have assisted in forming a reliable conclusion.

On the other hand, according to Zoe Billingham, HM Inspector of Constabulary,

Police officers naturally want to respond and do their best to support vulnerable people when they ask for help. And we found that police officers respond to those with mental health problems with care and compassion (HMICFRS, 2018).

Billingham continued to explain that police forces are being overstretched and are overwhelmed all at the expense of a broken mental health system which is affecting how officers respond to incidents. Ergo, it may be argued that there is not a prejudice associated with mental health but perhaps a stigma surrounding health care, or the lack of. Headlines suggest the increase in mental health incidents, and lack of health care availability, is putting more pressure on police, thus making them resent and stigmatise the health care service as not being sufficient.

Question.9 -	<i>As PSC staff - how many mental health related calls do you answer which do not result in police deployment?</i>
Answer/choice	Number of responses
1-3	19
3-5	11
5-7	6
7-9	0
10+	5
N/A	71

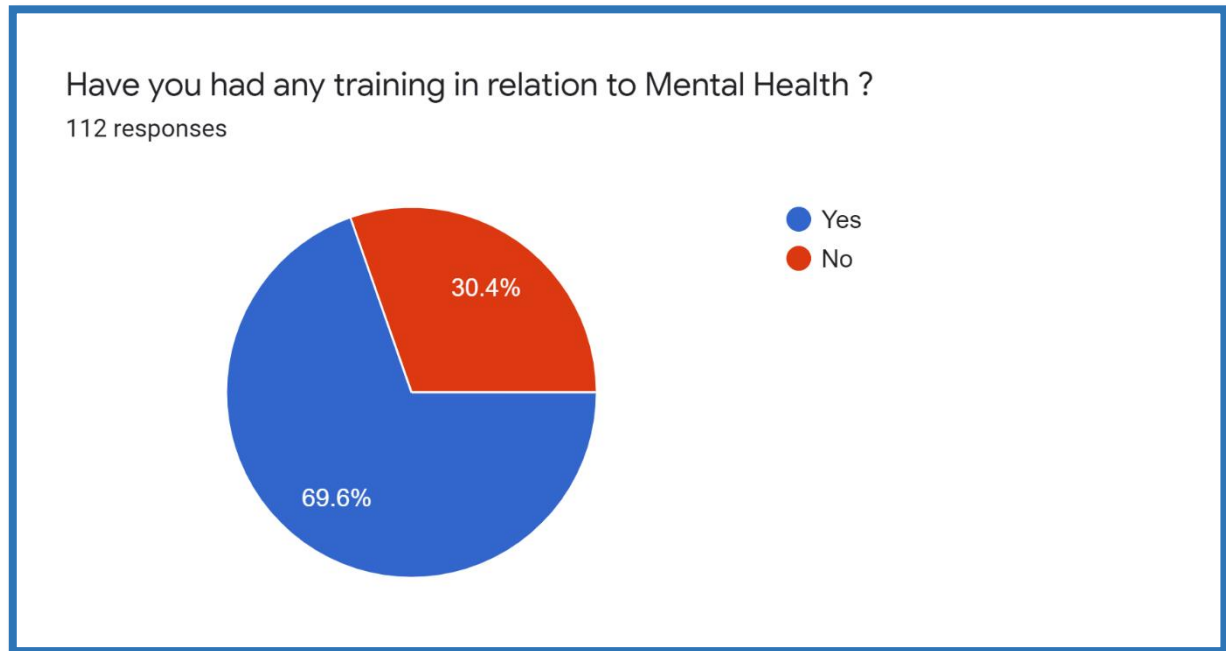


'On average, 34% of contacts with input from the Mental Health Triage team result in no further action required – reducing the deployment of ambulances and reducing demand for crisis care' as well as police involvement (Police and Crime Commissioner South Wales, 2019 p17). There is little literature to suggest that mental health triage teams are assisting in reducing police deployment, instead they are reducing the number of detentions made

In terms of reducing demand on officers the triage team have not had much of an influence, instead they have assisted in reducing the number of detentions made by officers. Officers still must attend incidents in which someone in crisis may cause harm to themselves or others, once in attendance and the risk assessed, officers can then pass updates to the triage team for appropriate advice. This allows the person in crisis to receive the best and most

appropriate support instead of being placed in a police cell or detained under a section 136 of the Mental Health Act, however it does not appear to be reducing the police workload as officers are still having to attend the calls.

Question.10 -	<i>Have you had any training in relation to Mental Health?</i>
Answer/choice	Number of responses
Yes	78
No	34



According to Government Wales (2018, p1) *'It is estimated that approximately 70% to 80% of calls now relate to non-crime issues including vulnerable people and mental health'*, this is an astonishing figure considering the police's main purpose is to maintain law and order. It is assuring to see that almost 70% of participants have received training in relation to mental health. However there appears to be an inconsistency in the delivery of training as 30% answered no to having received training. This is concerning as previous data suggests an increase in mental health related incidents and a subsequent increase in contact with police suggests that a everyone should receive the same training of adequate level to ensure a consistent and professional approach.

Question 11. - If yes to the above please list/explain any training (78 responses)

Training days with an input on the MHA
Force training days
Minimal training for the job we do not us
Asist course
Training days / input from mental health team
1-day mental health course
I have taken courses outside of work to understand mental health more we have had an in out one training day but nothing that would be useful in dealing, also attending a suicide intervention course
MH tactical advisor from previous police force
Assist course training, initial start of job training
We've had one mental health input from the in-house MH team, on a training day lasting approx 1 hour.
MH training which the force has given us.
guest speakers from mental health team
1 training day years ago explaining the use of s136 and s135. Was by no means in depth.
General training as a student officer
Training day off s136
Suicide prevention and other inputs on PSC training days
Training days
Various inputs from mental health professionals.
Force training day refreshing the s135 and s136 legislation
Dealing with a mental health crisis.
No specific training but do get guest speakers on training days
Nothing specific, just general training as part of our initial training
Mental Heath First Aid
Believe it was a 1 day course by LDS.
MH first aid: via police federation
Training when initially started but nothing specifically remembered
Basic training, nothing of any use
We had a small input from the in-house mental health team to discuss their role.
When I came into post as force advisor on mental health the force sent me on a course with Dave Sheppard an expert in mental health
Training days, ppn input however not alot
In house training day session
Training days about responding to crisis and dealing with MH
Mental health awareness and powers and procedures
Ncalt packages and training days on Acute behavioural issues
Very basic input in initial training. NCALT after that.
Ncalt
Mental health team input

A day input mainly to do with legislation
Training on the different sections and how to deal with mental health (1 day input)
Vulnerability Training, Blur Light Training for staff, Mental Health training around use of section 136
CPD INPUT ON MENTAL CAPACITY ACT
One training day explaining the 136/135 procedure when the new amendments came into the act, and an ncalt package.
MH awareness, information through bob
Mental health input from LDS day training
Have had some training days regarding mental health. I personally have had counselling for mental health having dealt with a few incidents in work that I needed a bit of support with. As well as things happening in my personal life at the same time.
Input from the mental health team and NCALT
Mental health awareness
Training provided through SWP on training days however the training has not been helpful
Force training days input etc
Had an input on a training day
First aid training with mental health awareness. Training on how childhood experiences effect a person's mental health (Adverse childhood experiences)
Cannot recall but several
Very brief 1 hour input during initial training
Training on MHA specially S136 and S135 which is scenario based.
Basic mental health NCALT packages.
No in-house training. My previous job was a senior manager with adults who suffered mental health, so I draw on that experience.
In Force mental health training on a number of occasions over the years.
Mental health awareness training, PoISA course inputs regarding Missing people and Mental Health.
Input from PSC MH team, input into MH legislation, own learning and discussion with force MHLO
Generic NCALT,
ASSIST
I had half a day training when I joined 6 years ago.
Mental health input in training day
Trim, stride
Lots of mental health training from previous jobs - most importantly ASSIST suicide prevention
In house Mental Health awareness training.
Identifying MH v's intox but not much else!
Very brief input from mental health team members on a couple of training days
Just general awareness during initial learning on the police officer recruitment training.
Negotiator, frontline cop
Mental health awareness, learning disabilities/vulnerable adults/ how to deal with a mental health inc where 135 and 136 is used. Done on NCALT system, and training days when a response officer.
Limited training in how to recognise and deal with someone with mental health in my opinion.
Only a brief introduction to the legislation. Not specifically MH training

Two-day mental health input in 2019
Suicide training
Two days ASSITS training which refers to suicide prevention
Nothing specific only basic mental health definitions and illnesses as per training
NCALT training re different disabilities and vulnerabilities
Assist course

The following table displays and explains the coding themes used for question 11 of the questionnaire.

Colour	Coding meaning/ theme
Pink	Third party input
Green	ASSIT suicide prevention course
Blue	In house training
Red	Minimal training/ not adequate

South Wales Police (2018, p1) state that they are, '*committed to providing professional responses to all mental health related calls.... the force has made significant investment in training in this area*', as well as investing into specific training the force also state they employ a mental health strategic leader as well as four mental health liaison officers. South Wales Police continue to expand upon the aims and objectives of their two-day mental health training which includes, an overview of mental health conditions, knowledge of appropriate communication skills to use with a person who may be suffering a mental health crisis and an understanding of their role and responsibilities when attending incidents that involve persons' experiencing suicidal thoughts, including the use of sections 13 and 136. (South Wales Police, 2018). It is by no surprise that 58% of responses state they have attended training days and/or completed mandatory NCALT (online training packages) specific to mental health.

It is however disappointing and surprising to see 32% of participants have not had a good experience or feel the training is not adequate for their role. Some responses which stated this include, 'Limited training in how to recognise and deal with someone with mental health in my opinion', 'Very basic input' and 'the training has not been helpful'. This may explain the opposing opinions in participants when defining mental health. Yet, with the largest proportion of participants claiming to be in contact with a mental health related

incidents ten or more times during their block of shifts, perhaps the force should look to change or expand on the training they currently provide.

22% indicate training from other internal departments, mainly the in-house mental health team. Although having input from the mental health team themselves should provide valuable insight there is no further explanation into what the training covered, how in depth it was or if it was adequate in assisting their role, however one response does mention the training to be brief.

Only 9 responses stated they had received ASSIST training. ASSIST is an acronym for Applied Suicide Intervention Skills Training. This initiative has recently been rolled out within the police control room as it is the operators who are the first point of contact for every incident and often find themselves speaking with those in mental health crisis and suffering with suicidal ideations. The ASSIST course is available for anyone over the age of 16, which aims to provide participants with the understanding and knowledge to recognise when someone is experiencing suicidal thoughts and the ability to then support them, ensure their immediate safety, and create a plan for future safety. Given the nature of control room operators role the ASSIST training would be an essential skill, yet only one of the forty-one PSC responses claimed to have attended the training. This low figure may be because the ASSIST course is not mandatory and is in fact voluntary to all staff.

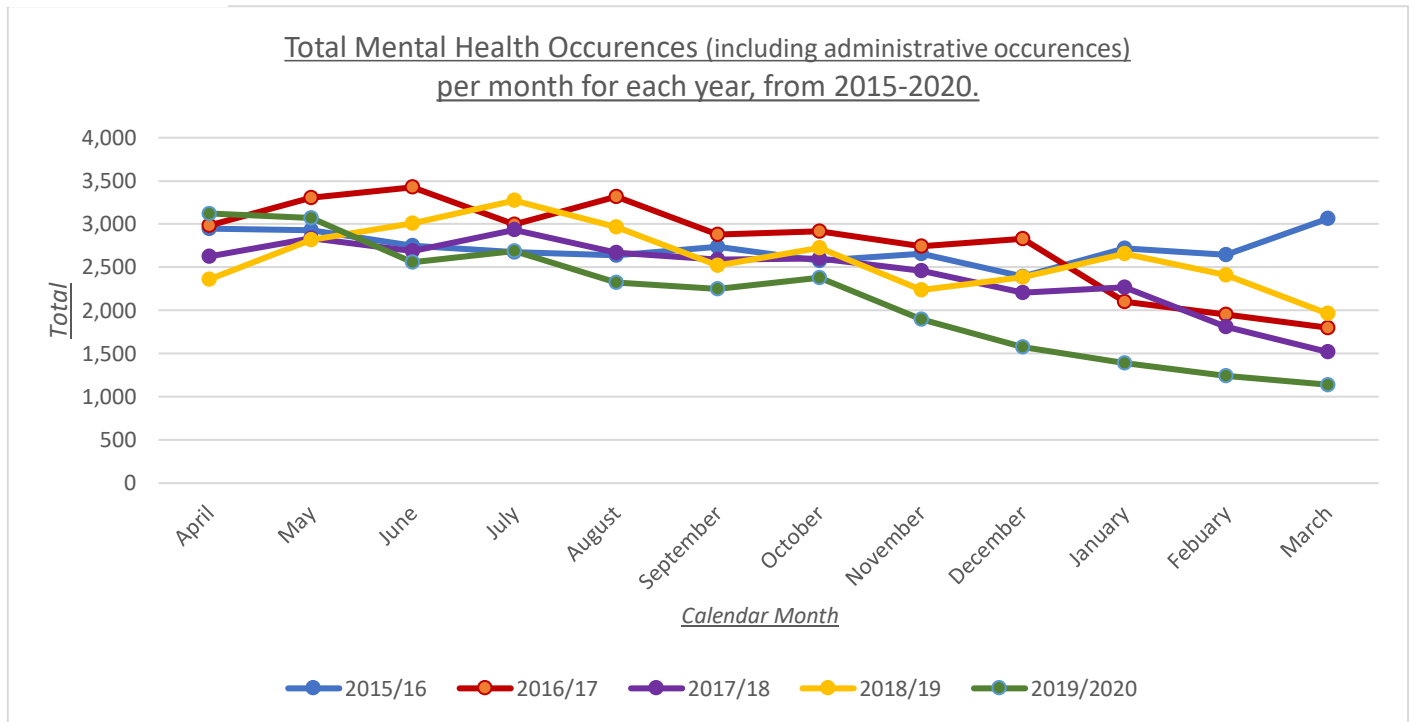
3.1.1. Results: Secondary Data

2015-16															2014-15 to 2015-16 CHANGE	
Including Administrative Occurrences																
BCU	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Year End Total	Average	2014-15 to 2015-16 CHANGE	Percentage change
Northern	610	650	656	589	624	699	581	623	564	689	656	760	7,701	642	1,293	20.2%
Eastern	888	839	805	816	810	773	809	853	708	859	736	874	9,770	814	1,327	15.7%
Central	584	569	532	503	521	504	449	459	449	462	532	593	6,157	513	218	3.7%
Western	859	863	745	761	678	757	731	719	670	703	718	832	9,036	753	838	10.2%
OUT	9	6	11	5	4	7	4	1	2	3		4	56	5	17	43.6%
Total	2,950	2,927	2,749	2,674	2,637	2,740	2,574	2,655	2,393	2,716	2,642	3,063	32,720	2,727	3,693	12.7%
															Comparison	
2016-17															2015-16 to 2016-17 CHANGE	
Including Administrative Occurrences																
BCU	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Year End Total	Average	2015-16 to 2016-17 CHANGE	Percentage change
Northern	754	874	886	760	777	733	752	703	773	500	471	416	8,399	700	698	9.1%
Eastern	873	979	1018	895	968	797	822	769	743	610	525	484	9,483	790	-287	-2.9%
Central	579	591	608	548	640	538	556	497	570	433	410	423	6,393	533	236	3.8%
Western	771	859	910	790	927	803	784	773	737	560	540	474	8,928	744	-108	-1.2%
OUT	5	3	4	5	3	7	5	4	4	1	5	3	49	4	-7	-12.5%
Total	2,982	3,306	3,426	2,998	3,315	2,878	2,919	2,746	2,827	2,104	1,951	1,800	33,252	2,771	532	1.6%
															Comparison	

2017-18															2016-17 to 2017-18 CHANGE	
Including Administrative Occurrences																
BCU	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Year End Total	Average	2016-17 to 2017-18 CHANGE	Percentage change
Northern	620	648	651	688	731	675	632	573	596	577	430	341	7,162	597	-1,237	-14.7%
Eastern	712	734	709	823	732	730	744	722	608	665	509	420	8,108	676	-1,375	-14.5%
Central	564	673	587	576	522	512	551	534	426	418	392	342	6,097	508	-296	-4.6%
Western	726	777	731	842	680	663	669	628	574	599	480	414	7,783	649	-1,145	-12.8%
OUT	4	1	8	3	5	10	3	3	2	7	1	2	49	4	0	0.0%
Total	2,626	2,833	2,686	2,932	2,670	2,590	2,599	2,460	2,206	2,266	1,812	1,519	29,199	2,433	-4,053	-12.2%
2018-19															Comparison	
Including Administrative Occurrences															2017-18 to 2018-19 CHANGE	
BCU	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Year End Total	Average	2017-18 to 2018-19 CHANGE	Percentage change
Northern	559	662	751	772	661	563	663	566	535	622	623	502	7479	623	317	4.4%
Eastern	718	832	849	964	918	760	852	664	759	843	742	576	9477	790	1,369	16.9%
Central	484	574	607	737	639	544	576	467	502	557	480	417	6584	549	487	8.0%
Western	597	748	805	799	745	651	632	541	589	636	563	468	7774	648	-9	-0.1%
OUT	2	3	4	5	4	5	5	3	7	5	3	8	54	5	5	10.2%
Total	2,360	2,819	3,016	3,277	2,967	2,523	2,728	2,241	2,392	2,663	2,411	1,971	31,368	2,614	2,169	7.4%
															Comparison	

2019-20															2018-19 to 2019-20 CHANGE	
Including Administrative Occurrences																
BCU	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Year End Total	Average	2018-19 to 2019-20 CHANGE	Percentage change
Northern	818	674	557	586	533	517	528	453	360	338	247	267	5,874	490	-1,605	-21.5%
Eastern	765	888	703	741	625	590	614	504	406	373	358	350	6,917	576	-2,560	-27.0%
Central	618	640	519	601	485	504	551	384	407	326	258	235	5,524	461	-1,060	-16.1%
Western	912	861	773	746	673	635	672	544	400	346	376	284	7,221	602	-553	-7.1%
OUT	10	9	9	11	5	5	11	11	5	5	6	4	91	8	37	68.5%
Total	3,123	3,072	2,561	2,685	2,321	2,251	2,376	1,896	1,578	1,388	1,245	1,140	25,636	2,136	-5,732	-18.3%
															Comparison	

Figure. VIII



According to Broome and Davies (2020) since 2012 South Wales Police experienced a continuous increase in the number of mental health related incidents, however for the purpose of this research figures from 2015 to the current year 2020 have been used. There are two main reasons as to why I have chosen to analyse data from 2015-2020; firstly, the mental health concordant was established in 2015 with the HMICFR also recommending that all forces who had not already introduced a triage team should carry out an analysis re the effectiveness of implementing such team. The second reason is because it allows an analysis over a five-year span to be considered.

The above graph displays the overall combined total of mental health occurrences for all Basic Command Units (BCU) over the course of a year. During 2015-2016 the amount of mental health occurrences remained at a steady level and experienced a small increase by the end of the year. There was an overall 12.7% change in the amount of mental health occurrences received by South Wales Police during 2015-16. This trend continued throughout

2016-2017 as figures maintained at an overall high compared to following years, decreasing drastically from December 2016 to March 2017. This may be due to the addition of the mental health triage team; staff were able to identify mental health related incidents more easily.

Although figures for 2017-2018 began slightly higher than the previous year the amount of mental health occurrences decreased steadily throughout the year resulting in a -12% decrease overall. Despite the decrease the figure remains the highest among Welsh forces, this may be due to the higher population density covered by South Wales, nonetheless South Wales Police are strategizing for the future, as they planned to, and recently have, reduced their basic command units from four to three, which align with the three University Health Boards. This change in BCUs comes following an analysis into the future of policing recognizing that demand will continue to increase over the next decade within South Wales as *'rising population and housing projections identify the need to re-evaluate how (our) operating model can best fit the needs of the communities of the future'* (Police and Crime Commissioner 2019, p14). South Wales Police plan to continue to work closely with not only their mental health triage team but each of the University Health Boards, local charities and others who specialise in complex issues like mental health and social issues to provide more appropriate options and early interventions.

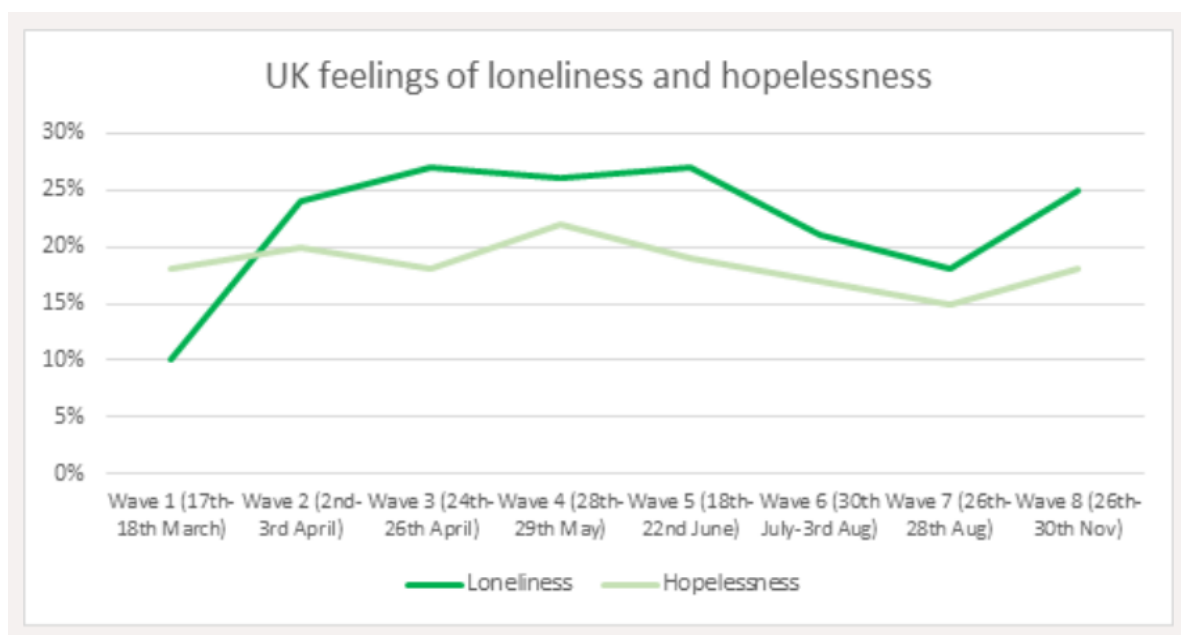
A multi-agency working approach, between the police force and other agencies, appears to have had a positive effect on the amount of mental health related occurrences as the initial figures in April and May 2018-2019 are lower than that the previous year and in fact are lower than the previous year's overall average. The rest of 2018-2019 figures appear quite turbulent as figures rise and fall with no real pattern, the highest peaking during summertime from June to August. Although the year appeared promising the overall annual percentage changed increased by 7.4%, which reflects over 2000 more incidents being tagged as being of a mental health related nature.

Finally, figures for April 2019 were at their all-time highest over the last five years, yet the year finished with its largest percentage decrease of 18.3% which amount to over 5700 less mental health occurrences being flagged. However overall, the year-end total occurrences in 2019-2020 was 25,636 which is only just over 7,000 less than the year-end total in 2015-2016.

Over a five-year period, mental health occurrences decreased by 21.6% which doesn't appear exceptional given there was an 18% decrease in 2019-2020 alone.

It will be interesting to see whether an increase has been experienced during 2020 as a result of Coronavirus pandemic. The Mental Health Foundation reported on the effects of Coronavirus on peoples' mental health, which can be seen in the below graph. Thus far results showed that the ongoing lockdowns, restrictions, and rapid growth of the virus saw an increase in people suffering with loneliness, hopelessness, anxiety, depression and other mental health problems. The feeling of loneliness and hopelessness increasing between March-April was anticipated and corresponds with the first lockdown in the UK. The downward trend from July onward is surprising considering the continuation of the pandemic, however people getting used to restrictions, having more information available to them regarding support, more awareness of the virus, as well as the change in seasons and more natural daylight having a positive effect on people's mental health. It is likely that police would have also experienced an increase in mental health occurrences during the pandemic because of face-to-face consultations being revoked and continued isolation in lockdown, effecting people's mental health.

Figure. IX



(The Mental Health Foundation, 2020,

3.2. Discussion

The discussion section of this research will briefly present the findings within the context of the three aims set out at the beginning of the project. This section will discuss and confer how the results, if any, support the overall aims and objectives, as well as identify if any data contradicts the literature, or gives reason to extend the knowledge base.

3.2.1 Aim1: Have South Wales Police experienced and increase in mental health incidents?

The initial aim of this research was to discover whether South Wales Police force are experiencing a rise in mental health related incidents. By comparing past and present statistics in the number of mental health related incidents provided by South Wales Police, overall a 21.6% decrease has occurred over five years. The year-end total number of mental health occurrences decreased by 7,084 from 32,720 in 2015-2016 to 25,636 in 2019-2020, although this does not appear to be substantial given the time frame the downward trend is promising for the future.

The media headlines portray a pressured police force and an absent care services, as police are forced to fill the gap and respond to people in mental health distress. From data collected from the questionnaires 42% of participants felt they dealt with a mental health related incident ten or more times in a normal block of shifts. Considering the polices' main purposes are to prevent and detect crime the group consensus, supported by news trends, is that police are frequently attending mental health related calls which may be better dealt by a medical professional. However, another policing purpose is to protect the public, some may argue that a person in crisis, albeit a mental health crisis, is in danger from themselves and may cause danger to others and as a result the police should attend. Either way, the addition of mental health triage teams within police control rooms or on the ground with officers, not only evidences the increase in demand for such service, but also shows that police forces have been forced to provide a service which was not required previously in order to meet demand as well as support and protect those in crisis. The mental health triage teams have supported

and shared knowledge with officers and PSC staff, resulting in fewer detentions and more people receiving the appropriate help. However, officers are still having to attend mental health related calls in the first instance which is not reducing their workload. If there is not a decrease in workload then are the triage service providing a worthwhile service to the force, or would the police benefit more from the government investing in early interventions to stop people reaching crisis point.

3.2.2 Aim2: Training

In the event that South Wales Police had in fact experienced an increase in mental health related incidents, this research intended to determine whether or not officers and operators alike are adequately trained. The questionnaire asked what mandatory training, if any, officers, and operator have been subject to in relation to mental health awareness and management.

70% of participants said they have had training in relation to mental health in comparison to 30% which said they had not. South Wales Police announced that they were investing in force wide training, specifically mental health related training. The force rolled out a two-day mental health training course which covered a large amount of information considering the abridged course. The training promised to provide brief information on various mental health conditions, communication skills, as well as what is expected from officers. However, there is no mention of training in being able to identify someone who is experiencing a mental health crisis. This surely would be of benefit as officers may mistake someone who is in crisis as being someone aggressive thus resulting in a delay in the person receiving appropriate support if any at all. Those who wish to train to become a mental health nurse or counsellor undertake a minimum three-year course which can be extended to five years pending on the field of choice, considering the police are expected to attend and support people experiencing mental health issues is a two-day course enough? Is the expectation asking too much of police officers with such minimal training, and allowing them to fail before they even get a chance to try?

Over a quarter of participants also stated that they did not feel adequately trained to deal with mental health specific incidents which is troubling considering the increase in incidents. However, the addition of a mental health triage team has assisted in bridging the gap between

information sharing, has given officers another option other than arresting, and some may say has given the officers confidence in knowing there is support available for them and the person they may be dealing with. It would be interesting to investigate how front-line workers like officers and control room staff value the mental health triage team who sit withing the control room, and whether they feel they are making a difference and worth the investment.

3.2.3. Aim3: Impact of mental health incidents

Finally, this research sought to find out whether the increase of mental health related incidents has an impact on staffs' perceptions and daily police business. Question eight was the most insightful with respect of discovering whether mental health incidents are having an impact on staff's perception. Nearly all participants thought that mental health incidents do not require any police input and/or attendance. Without specifically asking police staff to directly answer the question 'do you think mental health is *****?' then we can neither confirm nor reject the statement. As mentioned in question eight there is a clear argument for and against the argument.

However, with regards to daily business withing policing the answer is more apparent. Daily business is suffering, South Wales Police and all other forces alike are having to prioritise mental health incidents due to the risk associated, thus limiting their time to investigate crimes, and consequently attending less crimes.

Chapter4. Recommendations

4. Recommendations

- *Regularly review mental health training*

South Wales Police should regularly review their mental health training programmes, as data suggests that mental health training is neither enough nor consistent across the force. Ensuring the same mental health training is issues to all front-line workers is essential should the force wish to respond to mental health emergencies both professionally and efficiently. Coleman and Cotton (2010, p28) state that mental health awareness training for police officers is important, *'in order to promote non-stigmatizing front-line practice and an appropriate/proportionate response'* when engaging with members of the public who experience mental health problems. The force may wish to turn to *'the College of Policing learning standards, to establish whether they are giving their officers the right tools to understand and respond'* (HMICFRS, 201, p24) to people in crisis.

It may be beneficial to the force to ask staff members their opinions on what they feel they could learn and what may be beneficial to them. By asking staff for their input the force will benefit as all staff will be trained and equipped with the same skills force wide leaving no room for excuses. Gathering employee feedback and ideas is also advantageous as it shows the workplace values their opinions. Staff are more likely to be engaged and interested in what is being taught to them as they chose and contributed toward the training. Attaining feedback from participant will also produce an outcome measure of effectiveness for future training.

It may also be beneficial to speak with people who live with a mental illness as well as mental health professionals. This could bring opportunities for scenario-based training which is engaging and more impactful along with increasing empathy and promoting de-escalation strategies. Officers will only speak with people who have mental disorders when they are at crisis point, as a result it may be difficult for officers to treat each incident individually. However, by having input from someone who has a mental illness, who is not at crisis point, of clear mind, officers may then respond with more empathy instead of seeing these incidents

as a chore. If South Wales Police were to consider input from external parties then they would also need to be mindful that all content meets the College of Policing standards.

- Annual reviews of the Mental Health Triage team

Kirubarajan *et al* (2018) explains, triage models typically involve '*mental health professionals working in partnership with police officers, providing expertise through telephone service or an in-person mobile unit*'. Currently South Wales Police operate with a triage team in the control room, they can view and consult incidents which operators feel require their input and can call officers direct on scene to provide support and guidance when needed. Despite South Wales Police choosing a telephone-based triage team there is no information available regarding which triage models are more efficient, if any. There is also a lack of feedback from officers and their opinions on the triage models. A survey by Thames Valley Police identified the majority of officers (47%) preferred the in-person mobile unit response as they found it more proactive and helpful, in comparison to one person who preferred the telephone-based response and the reminder favouring (Kirubarajan *et al*, 2018). Adopting an in-person mobile unit may be a consideration for South Wales Police moving forward as Thames Valley Police show enthusiasm toward it.

Should South Wales Police wish to continue operating their triage service then more evidence is required to establish whether they are worth investing in, as mental health occurrences have not drastically changed from April 2015 – April 2020. Yet, multiple sources agree that the triage services have supported collaborative work thus enabling information to be shared and a better quality of service being delivered to people in crisis.

- Collaboratively policing mental health hot spots

According to Weisburd *et al* (2018, cited in Goldberg *et al*, 2020) '*people who live in places with high levels of crime and disorder are more likely to experience mental illness compared to those who do not live in these types of places*', because of this mentally ill people are more likely to encounter the police. Mentally ill people are also more vulnerable and more likely to become victims of crimes thus too increasing their chances of encountering the police.

South Wales Police could establish whether any geographical hot spots are prominent within their force area. If any hot spots are identified, then South Wales Police may benefit by teaming officers with mental health professionals to patrol and spend time within these locations with the aim to not only to educate and raise awareness of support that is available to them but also to build trust between the officers and the community. It would be recommended that the force trial a pilot scheme in one location initially to discover whether it has the desired effect.

4.1. Advice for future research

Policing and mental health individually are enormous subject fields, together the possibilities are endless and research extensive. The research undertaken has exposed several topics on which further research would be beneficial.

Firstly, there is a lack of robust comparative information identified within the research, and additional research focusing solely on the mental health triage teams would be beneficial. Further investigation of their effectiveness, thus identifying whether they are helping to alleviate as well as decreasing officers time spent dealing with mental health incidents would be valuable. It would also be interesting to compare the cost of running a triage service in comparison to the cost of allocating officers, as well as comparing the different types of triage services available to see whether, if any, are more efficient and effective for the police.

The literature review identified a common opinion that police forces are being used and abused to 'plug the gap' within the national health services. Furthermore, the research has highlighted a need for more mental health services and support. A study into reports made to the ambulance and their attendance to mental health related calls in comparison to police reports and attendance would provide surprising and eye-opening results and would be a valuable to expanding on the current research.

Finally, there has never been a more appropriate time to explore the potential strains associated with policing mental health than that of doing so during a global pandemic. As Coronavirus was new and continuously changing throughout the year, there is a clear gap and opportunity for further research into policing mental health during a stressful and uncertain time. Coronavirus has affected everyone and brought new challenges alight to all workplaces including the police, national health services, and the government. Future research should explore the governments capacity to address the psychological support needs for everyone, including front line professionals, and any future plans to ensure best practice when handling sensitive and complex mental health matters.

Chapter 5.

5. Conclusion

The police are often the first responders to many challenging and violent incidents. Those who suffer with their mental health are likely, when in crisis, to appear aggressive and unpredictable thus posing a danger to not only themselves but to others around them. As a result, the police are often the first on scene, it is therefore imperative that officers can identify when someone is experiencing a mental health crisis as opposed to someone who is not.

The introduction of mental health triage teams within many forces across England and Wales are not only proven extremely useful and supportive to both staff and patients but have highlighted the clear deficiencies within care services. The HMICFRS (2018) expressed their concerns with regards to the increasing pressure put on police forces, stating that their 24/7 availability is taken advantage of leaving a lot of responsibility on them in a complex situation which others are more trained and best suited to handle. The HMICFRS (2018, p3) concluded that,

...There is only so much the police can do to improve the overall picture. This is because, in our view, too many aspects of the broader mental health system are broken; the police are left to pick up the pieces. The fact that almost every police force now has its own mental health triage team indicates that there isn't nearly enough emphasis on early intervention and primary care to prevent the need for a crisis response.

The HMICFRS continues to explain that their report did not aim to point fingers and blame other services, however it recognised the importance and need for early intervention. Sir Thomas Winsor, HM Chief Inspector of Constabulary, said;

There will always be situations where someone in crisis needs a rapid response from the emergency services. But too often, our public services are failing to work together to prevent the crisis in the first place ... Blue lights should not have to flash for someone to get the help they need in time (HMICFRS, 2018, p3)

The overall situation currently evinces an overstretched and overwhelmed police force which is expected to not only prevent and detect crime but also triage mental health patients. The extra pressure is not only affecting the ability of officers to successfully complete daily business but can also affect officers mental and physical wellbeing. The evidence portrays a grim reality of the inadequacy of care services as those in crisis are not receiving the help they desperately need.

The current mental health models within many forces are a forlorn attempt to overcome the increasing demand of mental health related incidents. If the police continue to fill the void of mental health services, then the situation may never correct itself. Policing roles could expand and incorporate medical responsibilities however that would be requiring more training, more officers and overall, more funding which during uncertain and unprecedented times (with the UK leaving the European Union as well as an ongoing global pandemic) is unlikely. The eventuality of increasing mental health incidents may therefore forces policing to choose between its core duties thus leaving those in crisis with nowhere else to go.

With long waiting lists before being able to see a specialist and limited services available 24 hours a day, can those suffering with their mental health be blamed for calling on and using the police? In the end the message is simple, a radical re-evaluation of the mental health system is needed for it to be revolutionised. The increase in those being diagnosed with, suffering from, and feeling highlights that education, early interventions, counselling, mental health awareness and support is greatly needed. If that is not achieved, then can there be any future for policing.

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