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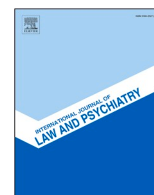

Policing psychiatric illness: An organisational paradox for Health & Law

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ABSTRACT

This conceptual article examines the organisational crisis in England's National Health Service in light of the recently launched model of policing called *Right Care Right Person* introduced to reduce police hours spent dealing with mental health crisis calls. It is a move that has come with concerns for health services because these newly created gaps alongside the existing ones pose challenges around funding and timescales in implementing the new model. It is a curious case of organisational paradox that diverting mentally ill persons into health services and 'decriminalising' those whose health conditions bring them to the attention of the justice system, has raised concerns in the health sector about access to adequate mental health services unless an arm of the justice system is involved. Given the similarities in health and legal systems in the Anglo-Western world, this English model has international implications about organisational paradoxes in health systems.

1. Whose role is it to manage mental illness?

It is a question that has been as illusive as the nature of this type of illness itself. How to best deal with those suffering from severe mental disorders is an issue that has swung between extremes, as Scull (1990) would put it, ranging from the 'economics of compassion' of the optimistic Victorians in their quest of moral treatment, to the pessimistic realisation that the needs of those curable vary significantly from those of the chronically incurable who continue to pose challenges in mental health care. The responsibility to care for those afflicted by madness had long shifted from those with religious power to those with medical and psychiatric power: from trephined skulls dating back to 5000 BCE designed to expel evil spirits, to the naturalistic and Hippocratic medicine that saw illness as an imbalance of bodily 'humors', to the early introduction of behavioural disturbances with Aretaeus's clinical terms of mania and melancholia, to faults in cognition and rationality characteristic of modern institutional psychiatry (Porter, 2003). But it was the Victorians who set the tone in matters of national responsibility in providing humane care for those with mental ailments. Following recommendations by the House of Commons Select Committee to establish county asylums, the 1800s saw the passing the *Wynn's Act 1808* and the *Shaftesbury Act 1845* to establish rural asylums for therapeutic purposes. These were institutions that arose from a complex negotiation of interests in Georgian and early Victorian England of mixed consumer economy sought by both families and the state (Porter, 2003: 99) and revealing of an administrative grid designed not solely to treat but police this population's undesirable behaviour. This grid has relied on antecedent grids for sense-making (Foucault, 2005, p. xxi) within an 'epistemological field' of knowledge possibilities (xxiii).

However, a monumental shift came when more liberal attitudes in mental health care policy sought to eradicate the deteriorating conditions of the over-crowded and coercive asylums, further aided by the establishment of the National Health Service (NHS) in 1948, the rise of psychoactive drugs in the 1950s (Killaspy, 2006), and the expansion of social welfare programmes and transfer of state budgets (Scull, 1990) which led the way for treatment in outpatient and community settings. These ideological shifts ushered in rights-based legalism, establishing the *Mental Health Act 1959* and later its 1983 version to limit involuntary treatment and detention. It is this process of deinstitutionalization and the detrimental outcomes in housing, access to care and recovery associated with it that brought police into the business of mental health management because symptoms that were once hidden were now public. The welfare cutbacks of the 1980s and austerity measures in 2010 exacerbated the burdens on police who were eventually using police cells to detain the mentally ill when health-based places of safety were scarce leading some detentions, though rare, to end with deaths in custody (Hannan et al., 2010); a landscape which led to the 2014 Mental Health Crisis Care Concordat. The Concordat is a national agreement signed between 27 services who manage crisis care and support in health, policing, social care and housing, designed to deliver adequate and timely support before reaching crisis and maintain recovery.

But after years of a triage scheme designed to achieve one of the aims

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of the Concordat – by co-locating mental health nurses in police stations for a collaborative approach –English police have now decided to retreat so Health deals with the matter independently because attending to crisis calls falls outside the scope of policing whilst unnecessarily consuming resources. This is not however an English issue nor a novel frustration; the difficulties and, frankly, burdens of policing psychiatric illness without the requisite specialist training consuming a significant portion of police time has been documented internationally in the English-speaking world: in New Zealand (Dew & Badger, 1999) and Australia (Fry et al., 2002) police spend 8–10 % of their time responding to crisis calls which aligns with an American systematic review (Livingston, 2016), though other Australian scholars (Godfredson et al., 2011) estimate up to 20 %; interactions that have created another 'patient pathway' (Thomas & Forrester-Jones, 2019) to accessing care.

It is within this historical context that the next sections explore the policing question followed by the nature of organizational paradox in the health system in light of its core mission aims in providing care. This conceptual article thus seeks to initiate dialogue about whose responsibility it is to treat or manage mental disorders by providing a novel theoretical framework in exploring this historically contested issue: is it self-evident that the NHS is the institution of choice? If so, why has it so far been a most challenging task requiring assistance from an arm of the justice system? In doing so, it employs organizational paradox theory as a useful framework of analysis because beyond describing conflicts and contradictions in an organization's aims and mission statements, the theory offers solutions by positioning paradoxes as opportunities for creativity that can usher in organizational behavioural change for practical management of core structural aims at tension with one another.

2. Policing mental illness in England

In England, section 136 of the *Mental Health Act* (1983) allows police to detain anyone who appears to be mentally ill and move them to a place of safety. Following a tenuous political landscape surrounding deaths in custody and the use of police cells in the absence of psychiatric beds has reduced detention from a previous 72 h to 24, pursuant to s81 of the Policing and Crime Act (2017). Since the 2000s, there have been significant increases in the numbers of detentions under s136; and though the causes may be disputed – some argue welfare cutbacks in the 80s and austerity measures in 2010 (Loughran, 2018), others are sceptical given the Blair government's investment in mental health in 2001 (Cresswell, 2020a) – limited resources have meant that police have had to bear a significant amount of responsibility in matters of mental health management. These interactions are not initiated by police themselves; whilst they have powers to detain anyone with an 'appearance' of mental disorder, in practice it is members of the public, the sufferer or their family, or health services that call police to deal with a mental health crisis (Wondemaghen, 2021). These are detentions that aim to deal with the 'mental' aspect of the illness rather than 'criminalize' the symptoms – as has often been presumed within the 'criminalization hypothesis' framework.

Importantly yet have been the liability concerns for police should fatal incidents occur (Wondemaghen, 2021) so they had to respond to every call and resort to s136 detentions. The available data on s136 shows that police risk aversion following threats of self-harm is the strongest factor when deciding to detain under s136, but also a route to care for many in an inadvertent 'patient pathway' that provides acute access (Thomas & Forrester-Jones, 2019). This is especially significant when incidents happen out of hours and the required services are unavailable for advice. So, it is not just risk aversion but a humanitarian approach toward suicide prevention that guides police practice (Bendelow et al., 2019).

In Britain, there is a general positive mental health attitude aimed at tackling the clinical and 'mental' aspect of the issue with attempts to 'decriminalize' by way of deploying a 'mental' framework rather than a criminal one that resorts to arrest (Cresswell, 2020b). While three decades ago police may have predominantly dealt with aggressive behaviours, they now also focus on self-harming or suicidal behaviour. In this regard, the national street triage scheme has helped deliver positive outcomes in providing acute care to those in need and reducing unnecessary detentions through police and health partnership[2]. Further, service users have generally had a positive experience when sectioned by police for treatment purposes (Bendelow et al., 2019). Britain has seen various efforts aimed at avoiding punitive interactions for those who may have previously experienced policing as a 'criminalizing' experience: the 2011 independent inquiry into acute care by the national mental health charity Mind; the signing of the 2014 Crisis Care Concordat by 27 national bodies; the 2015 Home Office inquiry into the number of mentally disordered persons in police cells instead of hospitals; the Department of Health's £15 million funding to improve interventions and access to care; the Care Quality Commission's recommendations which led to a rise in health-based places of safety so as to avoid detentions in police cells when applying s136; and the street triage police partnerships with health thereafter demonstrate the efforts to improve the provision of mental health care to those who need it most. Further, in 2016 the College of Policing published the Authorized Professional Practice with updates in light of findings from the Independent Police Complaints Commission and Coroner's Inquests, so that police can have consistent national guidance when identifying vulnerable populations in liaison with health services. In addition, the Metropolitan Police Commissioner's request of an independent inquiry on mental health and policing in 2013, demonstrates transparency and accountability which led to Lord Adebowale's (2013) recommendations that mental health needs to be reflected in all policy and operating procedures because it is 'core police business'.

Despite these strides, health services have been relying on police to fill the gaps they themselves cannot. Indeed, as a Joint ACPO/NPIA/DH Guidance (2010), it is police who are often the gateway to the necessary healthcare for many with mental health needs demonstrating the health sector's nature and quality of needs in mental health management. It demonstrates the responsibility of contemporary policing to both keep the public safe from harm and to ensure vulnerable populations with mental disorders are able to access care. It also demonstrates the failure of ministers and successive governments to deal with this issue in a meaningful way by addressing the root causes; as London Metropolitan Commissioner Rowley (2023) recently put it in an ultimatum to health leaders, "it is important to stress the urgency" of this crisis and a need for a new way forward because "we are not setting officers to succeed". For police, discretion in law enforcement matters for specific crimes is a simpler endeavour than interactions with vulnerable population groups in public spaces and after years of frustration and risk aversion, they have now chosen to retreat by adopting a new model of policing: Right Care – Right Person.

3. Right Care, Right Person: Decriminalization

The tasking nature of this matter on police has meant that, for some time, they have been considering a new way forward that removes police from purely health-related crises calls so they may carry out their law enforcement duties more effectively. This new model is called Right Care, Right Person and it is designed to end police responses to crises calls and welfare-checks, so that "people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs" (Home Office, Department of Health, and Social Care, National Police Chiefs' Council, Association of Police and Crime Commissioners, NHS England, 2023). It is essentially 'a decriminalization move' for mentally ill persons by virtue of reducing or removing the risk of contact with members of the justice system, making the term 'criminalization' in the British context a misnomer that is jurisdictionally unfit.

Now in effect nationally, this model was first trialled for three years

by Humberside police. It began in 2019 and based solely on police self-evaluation, the average number of police deployments per month is reported to have decreased by 508, reducing attendance to mental health incidents from 78 % to 31 % between January 2019 and October 20 (College of Policing, 2023). How the model will continue to unfold is set out in the The National Partnership Agreement (Home Office, Department of Health, and Social Care, National Police Chiefs' Council, Association of Police and Crime Commissioners, NHS England, 2023).

Whilst police have expressed legitimate concerns, their withdrawal already underway is to be handled with care because without the right support and management in the NHS to fill both existing and new gaps, the conditions of many service users are likely to deteriorate especially given the persistent pressures on the NHS and mental health services after years of austerity (Care Quality Commission, 2022) now further exacerbated by the Covid pandemic. As Dr. Lade Smith CBE, President of the Royal College of Psychiatrists (2023) put it, there is concern around workforce resourcing and additional funding not least the timescales for 'planning and preparation' in partnership with police. Given the current needs of mental health and social care, the question of 'additional' funding really means new sources of funding for newly formed gaps in care following police retreat, not a rerouting from existing, burdened services.

Given the lack of an independent evaluation of Right Care – Right Person not just on policing but also on the impact of this shift on the health sector and the service user in the Humberside region where it was first trialled, the newly formed gaps as police withdraw will need to be filled in primary care, community mental health services, ambulance and security staff lest the deinstitutionalization mistake is repeated again. Closure of psychiatric institutions for community services following shifts in mental health care policy in the 1960s is a good case study of a well-intentioned and legitimate idea that was launched without adequate resourcing and staffing leading to, on balance, more harm than good for many service users; indeed, it is failure in social care and policy following deinstitutionalization, be it lack of funding, staff, and restrictive high threshold criteria for admission that have led police to enter this equation and deal with symptoms that were once contained in remote asylums under professional psychiatry. This time, there can be no gaps in adequate support for those with health vulnerabilities and it is unclear how a model trialled in a small regional city will translate as a national model, including bigger metropolitan settings such as London with the London Metropolitan Police announcing they will no longer respond to crises calls and welfare checks from 1st of September 2023. Importantly, the Humberside model was based on liaison with various members of the health providers and their model was launched with support from Health over a year (though that too required a deadline to inspire urgency) – a crucial aspect lacking in places like London where the Commissioner's ultimatum only gave less than 4 months to launch Right Care, Right Person, highlighting the longstanding tensions between these two institutions and their competing aims: 'to provide care' versus 'to enforce the law'.

4. The organizational paradox of the British National Health Service

Whilst both institutions – health and criminal justice – present individually legitimate concerns and stances, when they are considered together these present an organizational paradox about the nature of modern mental health care. For the purposes of the issues explored in this article, organizational paradox refers to contradictions within a statement (Murnighan & Conlon, 1991), contradictions in organizational practices (Eisenhardt & Westcott, 1988) and unintended consequences (Sitkin & Bies, 1993) stemming from the national health service's tensions about its identity and duty. Drawing from psychology, philosophy, and organization studies, Lewis (2000) develops three elements of a paradox that move beyond descriptors to serve as a theoretical framework of analysis that identifies:

(1) how tensions develop from polarized cognitive or social constructions,
(2) how actors' defensive mechanisms lead to reinforcing cycles and,
(3) how actors can develop management strategies with greater cognitive and behavioural complexity.

Firstly, paradoxical tensions develop through mixed messages and system contradictions that are eventually reflected in the goals, resource demands, and divisions of labour (Putnam, 1986, p. 161). In its first of its seven guiding principles underpinned by its core values, the British National Health Services says in its The NHS Constitution for England (2023) that it "is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard". In its fourth principle it claims that "patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment" which, where police are involved, current practice has been devoid of patient consultation of any kind; police have not needed to consult any mentally distressed person when sectioning under s136. And whilst its fifth principle acknowledges that it works across local and public sector organizations to "provide and deliver improvements in health and wellbeing", nothing in its values and mission statements suggests that the national health provider, at its inception, had police forces in mind as key stakeholders to help improve or deliver health and well-being, least of all diagnose or treat. However, the following statement from the Royal College of Psychiatrists (2023) President is telling of the contradictions within the statement but also within the organizational practice in mental health service delivery in modern Britain such that the health provider cannot deliver health care without assistance by an arm of the justice system:

> It should not be taken as a green light for a unilateral discontinuation of police presence in mental health emergencies. Such a withdrawal poses a real danger to patients. The needs of people in crisis must be at the forefront of any action taken by all services and requires a fine balance of both policing and mental health services. We expect all policing, across all regions, to continue providing their vital services, as certain mental health emergencies, when people are in acute crisis, will always need a systems-wide approach. The fact is that there are certain legal powers only held by the police such as the power to convey a person in crisis from a public place to a place of safety, and so mental health is always going to be police business and they will always be needed in some form.

Notwithstanding the assumption that Health cannot acquire those legal powers, these sentiments, echoed by other senior leaders in mental health care, highlight another aspect of paradoxes: the cognitively polarized and contradictory nature of these tensions that manifest in resource demands and complex divisions of labour. Dr Sarah Hughes, Chief Executive of one of the most prominent mental health charities Mind (2023), is of the view that:

> The way this decision has been framed is deeply worrying and sends completely the wrong message…It is simply impossible to take a million hours of support out of the system without replacing it with investment and mental health services are not resourced to step up overnight…It would also be dangerous for forces to step back while local communities and health systems work out how to respond.

But the decision to reconsider police involvement in crises calls is not a sudden one; it is a relationship that has been under scrutiny since the 1970s and 80s (Abramson, 1972; Teplin, 1984) characterising this relationship as a criminalizing act: the criminalization hypothesis asserted that police dealing with mentally distressed persons in a civil context where crime is not an issue makes mere contact with police 'criminalization'. It may even be argued that health services had since the 1980s to formulate a workable solution given the system failures following institutional closures in the 60s, not least the multiple reviews since to illuminate the inadequacy of any sector but health to deal with

mental distress. For example, in a 2017 report on deaths in police custody, Dame Elish Angiolini (Home Office, 2017) found that almost half of the deaths involved those suffering a mental health crisis because of the undue force and restraint methods. Indeed, the latest 2022/23 data from the Independent Office for Police Conduct (2023) shows that more than half of deaths in or following custody had mental health concerns (13/23) with 4 of them detained under s136, and 8 people taken ill or unwell in a police cell, 3 of whom died within the police cell. It is thus puzzling to see concerns now expressed by leaders in Health when the nature of this issue has been longstanding – which is telling of an identity crisis.

Secondly, paradoxical tensions lead to defensiveness that end up reinforcing negative cycles; that is, a response or policy designed to prevent threats that simultaneously prevents solutions to the threat in a reinforcing cycle perpetuating the initial tension. For example, rather than rethink existing contradictions in mental health care policy and practice, a defensive reaction holds on to practices of the past that have proven challenging and sometimes lethal thereby avoiding reflection on current developments, risks, and cognitive dissonance. Defensiveness (Lewis, 2000) toward a paradox leads to, amongst others, *regression* – a preference for practices of the past that may have previously shown some utility such as police assistance with crises calls, and *projection* – a scapegoating of another, in this case police withdrawal, for the dissonance about the latest developments in mental health care policy. Similar to the aforementioned concern by Dr. Hughes, the following from Danny Mortimer, deputy chief executive of NHS Confederation (2023), illustrates the second element of a paradox:

> Health leaders believe that it should be healthcare staff who primarily support mental health patients, not the police, and overall agree that this move is a sensible one for patients, the police and the NHS. However, while the police will still have a role to play, freeing up their time in this way will undoubtedly have some consequences for an NHS already struggling with capacity and resource, particularly ahead of what will be a seriously difficult winter.

It appears as though it is not so self-evident that this matter should only concern Health and that, in fact, how police prioritize to manage their time according to their institutional demands and aims will have dire consequences for Health. Crucially, this is an issue that only concerns a specific population group seeking access to health care rather than the general patient pool: mentally ill persons. In this regard, a health system that requires the justice system to provide care for a particular cohort of people within its legal duty is akin to admitting that mental health care necessarily involves 'deviance management'. If that is the future framing of this issue, then all behaviours in the realm of deviance will undoubtedly bring police into the equation, making it core police business indeed. It is a historically persistent issue that highlights the nature and quality of the administrative grid of practices that seem to not only be concerned with the therapeutic but also the policing aspect of this group.

Finally and importantly, paradoxes need not be characterized by contradictory tensions, defensiveness, and negative reinforcing cycles that keep tensions alive and, therefore, access to care services inadequate. Paradoxes can also be opportunities for progress and change beyond the reinforcing cycles serving as tools for creativity (Eisenhardt & Westcott, 1988) which is when a paradox is finally managed. There is thus an opportunity for positive transformation and examination of the organizational paradoxes at play provides a useful framework of understanding tensions in core institutional aims, dissonance that devolve into projection and regression, before moving beyond these to better self-management. The current developments in mental health care policy leave the NHS between the safety net of the familiar past, the old ways of doing business, and the uncertainty of a riskier future in light of austerity measures and post-Covid and inflation gaps in care now exacerbated by a retreating police service. In this case, paradox management will require immersion in the tensions and navigating through to better frameworks and solutions, rather than denial or avoidance (Lewis, 2000). That is, the only way forward for the NHS is to:

- reflect on the predicament of a health care organization requiring assistance from an institution of justice and law enforcement and the organizational cognitive dissonance therein.
- evaluate its social duty and purpose to patients and service users in line with its Constitutional principles because, as it stands currently, the Constitutions is not conceived with external stakeholders in mind.
- consider if in this particular instance, with this population group, deviance management is an additional issue to consider in patient health care – which will necessarily demand Constitutional amendments should an arm of the justice system needs to be deployed for 'deviance management'.
- invest in transparency to ensure a system of compliance with the aims of a clearly set out Constitution in practice.
- consider ethical standards in practice by setting parameters for external partners outside of the health sector with whom it may need to liaise.
- consider that it is likely that mental health care provision is solely a matter for the health system despite the complex nature of contemporary policing involving some assistance to Health in extreme circumstances.

5. Conclusion

It has increasingly become difficult to discern who should deal with mental health crises calls that are unrelated to criminal behaviour and therefore outside the scope of policing. The current developments in policing illustrate the challenging nature of how to best manage mental illness in a liberal society. The dominant discourses which are fundamentally polarized and differentially oriented illustrate not only the organizational paradoxes that entail caring for this particular population group but also their transhistorical qualities given the persistent dilemma of who should be in charge in matters of one's mental health care. However, this may be the most opportune time for the health sector to engage in paradox management for better insight into organizational identity in order to deliver adequate care.

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Declaration of competing interest

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References

Abramson, M. F. (1972). The criminalization of mentally disordered behaviour: Possible side effect of a new commitment law. *Hospital and Community Psychiatry, 23*(4), 101–107.

Adebowale, V. (2013). Independent commission on mental health and policing report. http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_05_13_report.pdf.

Bendelow, G., Warrington, C. A., Jones, A. M., et al. (2019). Police detentions of 'mentally disordered persons': A multi-method investigation of section 136 use in Sussex. *Medicine, Science, and the Law, 59*, 95–103.

Care Quality Commission. (2022). Monitoring the mental health act in 2021 to 2022. https://www.cqc.org.uk/publications/monitoring-mental-health-act/2021-2022.

College of Policing. (2016). Mental illness and vulnerability: Authorised Police Practice. https://www.college.police.uk/app/mental-health/mental-vulnerability-and-illness.

College of Policing. (2023). Right care right person – Humberside police. https://www.college.police.uk/support-forces/practices/smarter-practice/right-care-right-person-humberside-police.

Cresswell, M. (2020a). Rise in the use of section 136 of the Mental Health Act 1983 in England and Wales: A viewpoint on Loughran (2018). *Medicine, Science and the Law, 60*(2), 140–146.

Cresswell, M. (2020b). Self-harm and moral codes in emergency departments in England. *Social Theory and Health, 18*, 257–269.

Dew, K., & Badger, S. (1999). Police perceptions of the mental health services and the mentally ill. *The New Zealand Medical Journal, 112*(1081), 36–38.

Eisenhardt, K. M., & Westcott, B. J. (1988). Paradoxical de- mands and the creation of excellence: The case of just- in-time manufacturing. In R. E. Quinn, & K. S. Cameron (Eds.), *Paradox and transformation: Toward a theory of change in organization and management* (pp. 169–194). Cambridge, MA: Ballinger.

Foucault, M. (2005). *The order of things*. Routledge (first published 1989).

Fry, A. J., O'Riordan, D. P., & Geanellos, R. (2002). Social control agents or front-line carers for people with mental health problems: Police and mental health services in Sydney, Australia. *Health & Social Care in the Community, 10*(4), 277–286.

Godfredson, J. W., Thomas, S. D., Ogloff, J. R., & Luebbers, S. (2011). Police perceptions of their encounters with individuals experiencing mental illness: A Victorian survey. *Australian & New Zealand Journal of Criminology, 44*(2), 180–195.

Hannan, M., Hearnden, I., Grace, K., et al. (2010). *Deaths in or following police custody. An examination of the cases 1998/99–2008/09*. London: Independent Police Complaints Commission.

Home Office. (2017). Deaths and serious incidents in police custody. https://www.gov.uk/government/publications/deaths-and-serious-incidents-in-police-custody.

Home Office, Department of Health & Social Care, National Police Chiefs' Council, Association of Police and Crime Commissioners, NHS England. (2023). National partnership agreement: right care, right person (RCRP). https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person/national-partnership-agreement-right-care-right-person-rcrp.

Independent Office for Police Conduct. (2023). Deaths during or following police contact Statistics for England and Wales 2022/23. https://www.policeconduct.gov.uk/sites/default/files/documents/Annual-deaths-statistics-report-England-and-Wales-2022-23_0.pdf.

Introduction of Right Care, Right Person model (2023). Metropolitan Police: https://www.met.police.uk/notices/met/introduction-right-care-right-person-model/#:~:text=In%20a%20letter%20sent%20to,setting%20officers%20up%20to%20succeed.

Joint ACPO/NPIA/DH Guidance. (2010). Responding to people with mental ill-health or learning disabilities. https://dl.icdst.org/pdfs/files2/fde37a33030246a574ed34d5351de2a9.pdf.

Killaspy, H. (2006). From the asylum to community care: learning from experience. *British Medical Bulletin, 79*(1), 245–258.

Lewis, M. W. (2000). Exploring paradox: Toward a more comprehensive guide. *Academy of Management Review, 25*(4), 760–776.

Livingston, J. D. (2016). Contact between police and people with mental disorders: A review of rates. *Psychiatric Services, 67*(8), 850–857.

Loughran, M. (2018). Detention under section 136: Why is it increasing? *Medicine, Science and the Law, 58*(4), 268–274.

Mind. (2023). Mind reacts to UK Government announcement of Right Care, Right Person approach. https://www.mind.org.uk/news-campaigns/news/mind-reacts-to-uk-government-announcement-of-right-care-right-person-approach/.

Murnighan, J. K., & Conlon, D. E. (1991). The dynamics of intense work groups: A study of British string quartets. *Administrative Science Quarterly, 36*, 165–186.

NHS Confederation. (2023). *NHS Confederation responds to met police update on the adoption of the right care*. Right Person Approach. https://www.nhsconfed.org/news/nhs-confederation-responds-met-police-update-adoption-right-care-right-person-approach.

Policing and Crime Act. (2017). www.legislation.gov.uk/ukpga/2017/3/contents/enacted.

Porter, R. (2003). *Madness: A brief history*. OUP Oxford.

Putnam, L. L. (1986). Contradictions and paradoxes in organizations. In L. Thayer (Ed.), *Organization communications: Emerging perspectives* (pp. 151–167). Norwood, NJ: Ablex Publishing.

Royal College of Psychiatrists. (2023). RCPsych responds to the national partnership agreement between the government, police and health and social care services. https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2023/07/26/rcpsych-responds-to-the-national-partnership-agreement-between-the-government-police-and-health-and-social-care-services.

Scull, A. (1990). Deinstitutionalization: Cycles of despair. *The Journal of Mind and Behavior*, 301–311.

Sitkin, S., & Bies, R. J. (1993). The legalistic organization: Definitions, dimensions, and dilemmas. *Organization Science, 4*, 345–351.

Teplin, L. (1984). Criminalizing mental disorder: The comparative arrest rates of the mentally ill. *American Psychologist, 29*, 794–803.

The NHS Constitution for England. (2023). Department of Health and Social Care. https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#:~:text=The%20NHS%20belongs%20to%20the,the%20end%20of%20our%20lives.

Thomas, A., & Forrester-Jones, R. (2019). Understanding the changing patterns of behaviour leading to increased detentions by the police under section 136 of the Mental Health Act 1983. *Policing: J Policy Pract, 13*, 134–146.

Wondemaghen, M. (2021). Policing mental illness: Police use of section 136–perspectives from police and mental-health nurses. *Medicine, Science, and the Law, 61*(4), 266–274.