Chapter 8
Law Enforcement and Mental Health: The Missing Middle

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Introduction

Over the last 30 years there has been increasing global recognition of the high prevalence of mental health conditions and the impacts this can have on individuals, communities and economies. Stigma, public attitudes, economic constraints, service availability and public policy all impact on the level of mental health treatment available within societies and, in turn, on people's inclinations and ability to access services. One group that is beginning to receive more attention have been termed the 'missing middle'; people who have mild to moderate levels of mental health need who commonly fall between the gaps of health services delivery. This is a group in need of more help and support than they can readily access in the community, but their level of need does not routinely or consistently reach the threshold of going to hospital.

This chapter starts by considering what mental distress is and how it can manifest, then explores the associations between social determinants of health and the experience of distress. Next the chapter navigates how, why and to what extent the police find themselves involved in responding to people in mental distress, focussing on the interface with the emergency department (ED). Finally, the chapter examines the challenges experienced by people navigating this space and questions whether, in light of the significant downfalls of the current health responses, a different service response if required to better meet the needs of this missing middle. A lived

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experience reflection is provided at specific junctures of the chapter to bring to life some of the challenges experienced when interfacing with our health and justice system when experiencing mental distress.

What Is Mental Distress?

There are various ways of measuring the prevalence of mental illness across populations. Estimated rates reported include that 1 in 4 people will experience a mental health condition at any one time, around 1 in 8 people will actually receive mental health treatment at any one time (at least in economically developed countries), and as many as 1 in 2 people will experience mental illness at some point in their lives. While the majority of people will access mental health-related treatment through planned primary care pathways, such as their local General Practitioner, others will experience a significant mental health crisis or a level of distress that can lead them to need to access services in an unplanned way.

Broadly speaking, it can be argued that there are three main 'groups' of people who experience mental distress. There are those who access/receive specialist mental healthcare or treatment, those who receive support from primary care services, and those who fall somewhere in between; in this chapter we refer to the latter group as the 'missing middle'. Attempts to quantify the size and scale of these groups is actually not a straightforward task. What we do know, however, is that mental distress varies in severity and duration; and further that only somewhere between a third and a half of those eligible to receive mental health-related supports do so in any given year (AIHW, 2020, p. 5).

Distress has been defined as 'a state of emotional suffering associated with stressors and demands that are difficult to cope with in daily life'; individuals may have symptoms of distress in relation to 'everyday life struggles', 'feeling inferior to others', or 'losing a grip on life' (Arvidsdotter et al., 2016). Conversely, people can feel that their 'whole world is caving in' (Geraghty et al., 2016), with acute psychological distress directly associated with a perceived helplessness to cope with serious life stressors. However, symptoms of psychological distress may also occur independently of stressful life events.

Symptoms of distress are also highly variable, and their causes are unique and complex; frequently they stem from significant life events and social causes such as failed relationships, unemployment, perceived lack of mobility, work and family conflicts (Horwitz 2007). Psychological distress may persist, with worsening symptoms that may become enduring and clinically significant, sometimes to the extent that they interfere with activities of daily living. Some individuals are pre-disposed to being more vulnerable, and less resilient to life events in adulthood, contributing to the distress they experience (Masten, 2011).

For some, the experience of mental distress is a one off or short-term occurrence, although the severity of distress can still vary; others will experience more than one, and often several episodes of distress over a prolonged period of time. How people

find themselves accessing crisis services is also highly variable; some may self-refer, or health or emergency services may be alerted by a friend/family member or a concerned member of the public. These referral routes may all indicate a different service response and need. There is increasing acknowledgement that frequent presentation to the ED is associated with both socioeconomic disadvantage and a significant burden of disease (Kahan et al., 2016). While presentation at an ED can lead to psychiatric referral and then admission to mental health services, for the vast majority this is not an available pathway with high admission thresholds precluding many from receiving this service response. There can be very good reasons to try to keep people out of acute psychiatric care, with admissions doing more harm than good (e.g. VLA, 2020). However, for many who present to the ED in mental distress, there may not be a timely or appropriate support available.

We know that people who experience mental distress may present to the ED for emergency treatment and support, or also as a point of access to other service pathways (Minshall et al., 2020). Evidence gleaned from research studies internationally also indicates that a small number of people account for a disproportionate number of emergency presentations (Wise-Harris et al., 2017); many of these presentations represent the 'missing middle'. While this group are heterogeneous, they commonly perceive and/or experience significant stigmatising attitudes and behaviours, as well as structural discrimination from the very health services they are seeking help and support from (Perry et al., 2020). This next section explores factors related to why some people can and do lead more complex lives, why they experience more distress and why they may be perceived as additionally vulnerable by the various agencies they come in contact with.

Multiple Disadvantage and the Social Determinants of Health

Within recent decades, the role of social inequalities and their detrimental effect on health outcomes has grown in increasing prominence. Strong relationships have been demonstrated between poverty and health inequalities, with the conditions that people grow, live and work known as the social determinants of health (e.g. Marmot & Wilkinson, 2000).

Studies of early life adversity and its impact on later adulthood have been well documented. In a landmark study, Felitti et al. (1998) reported that four or more adverse childhood experiences (ACEs) were reported to be linked to 4- to 12-fold increases in alcohol misuse, drug abuse, depression and suicide attempts. Multiple studies published since have confirmed the relationship between ACEs and a wide range of negative health outcomes in adulthood (Hughes et al., 2017). In short, these studies suggest that neglect, sexual, physical and emotional abuse in childhood are related to an increase in depression, anxiety, drug use, suicidal behaviour and attempts in adulthood. Robust international evidence also adds that adulthood mental distress is exacerbated by the extent and types of childhood adversity experienced.

Poorer socioeconomic status and inequality have been found to at least partially explain poorer health outcomes, with around 15–20% of the association of poor health risks in adulthood for those with high numbers of ACEs being explained by (poor) socioeconomic circumstances in adulthood. The three ACEs of domestic violence, parental divorce, and living with someone once incarcerated, are almost entirely explained by socioeconomic circumstances (Font & Maguire-Jack, 2016). However, ACEs characterised as physical, emotional and sexual abuse have been reported to be associated with many adult health risks not adequately explained by socioeconomic status alone. Cohort studies, tracking people prospectively over time, have found ACEs associated with lower educational attainment, and higher risk of depression, substance use and use of tobacco; while those with four or more ACEs reported 2.4 times more diagnoses of depression, and 3.1 times more substance-use that persisted, after taking into account the effects of various family and socioeconomic factors (Houtepen et al., 2020). A recent systematic review and meta-analysis of 37 published studies confirmed that having multiple ACEs was a major risk factor for many adverse health outcomes, noting that the strongest associations were for problematic drug use, interpersonal and self-directed violence (Hughes et al., 2017); sexual risk-taking, mental ill-health and problematic alcohol use also featured prominently.

Many susceptible individuals with multiple ACEs, living in disadvantaged communities, exposed to social inequality, can face particularly challenging circumstances that make them more likely to be exposed to our health and justice systems. This necessitates a public health approach to health and justice, with attention paid to prevention of harm, and addressing the panoply of complex social issues present in people's lives. Cumulatively, what we now know is that the people who frequently present to EDs, and those who have ongoing unmet healthcare needs due to a lack of access to these services are, on the whole, the same people from the same communities as those who become justice involved (Crofts & Thomas, 2018). The next section considers how, and in what contexts, people who experience mental distress come into contact with the police and how the nature and extent of these encounters can lead to potentially very different health and/or justice pathways.

The Role of the Police in Responding to Mental Health-Related Incidents

It has long been recognised that the police are pivotal in determining the health and criminal justice trajectories of people they come into contact with (Lamb et al., 2002); in this way, some have described the police as providing the 'gateway to appropriate care' (Adebowale, 2013, p. 6). In recent years, there has been increased recognition that mental health should be considered core business for the police (Thomas & Watson, 2017). At the same time, policing services report that the demands being placed on them in responding to mental health calls are at an

'intolerable' level (HMICFRS, 2018, p. 3). A good part of the reason that the police remain centrally involved in responding to mental health-related situations is that it is their legal obligation to respond to calls for assistance and provide services 24 h a day, 7 days a week. Because of this, they are often the first and, more often than not, the only community response available (Lamb et al., 2002).

Despite this, the true extent of mental health-related calls that the police respond to remains difficult to ascertain (McGeough & Foster, 2018); international research estimates, based on official records or frontline officer estimates, suggests that this part of their role consumes somewhere to up to 20% of police time (Thomas & Kesic, 2020). The actual figure is likely to be much higher. The fundamental question about whether police should be involved at all in mental health-related matters remains moot here; police contacts-based statistics clearly demonstrate the significant role policing services have had, and continue to have, in responding to mental health-related calls. However, it is well-established that the police statistics do not adequately capture contemporary police functions and tasks (Davis et al., 2015). For example, a significant area of police work is said to involve conducting 'welfare checks' on people in the community; these checks require police to locate a person to make sure they are safe (e.g. Department of Health and Human Services [DHHS], 2016, p. 15) and can be requested in response to a wide range of concerns that community members (or health workers) may have about the personal safety of an individual. While, anecdotally speaking, police suggest that this forms a significant part of their role, there has been very little written about it, nor attempts to quantify or otherwise measure the extent of this type of policing work. Piecing together the available anecdotal evidence and commentary, it suggests that a significant proportion of this involves responding to situations where the person is experiencing mental distress and presenting as a risk to their own safety.

What does appear clear is that, due to the complex, multidimensional and intergenerational histories and presenting challenges of people who experience mental distress, no one service is adequately equipped to respond (van Dijk et al., 2019). Indeed, for some time now, many agree that both the policing and emergency mental health system need to work in partnership to adequately respond to people experiencing a mental health crisis (Lamb et al., 2002). One area of particular (vexed) focus has been on the nature and extent of their role in transporting people to the ED. It is now generally accepted that the police should only be used as a means of transportation for a person experiencing a mental health crisis as a last resort, when all other options have been considered and ruled out. This stance is based on basic principles of basic dignity and human rights (Boscarato et al., 2015). What is especially worrying, in this respect therefore, are (now dated) estimates that suggest that up to 30% of mental health presentations to EDs are the result of police referral (Lee et al., 2008); either with police escorting an ambulance, or directly transporting the person when an ambulance isn't available or where safety issues preclude an alternative response. An Australian study (Short et al., 2014) found that despite the last resort mantra, once police were involved, they were most commonly the ones used to transport the person for further assessment. Another Australian-based study reported a substantial increase in the proportion of mental health-related

presentations brought in by police, comparing rates recorded in 2003 to those in 2013 (Alarcon Manchego et al., 2015).

There is also a connected resourcing issue here with limited numbers of ambulances being available, coupled with high demand in densely populated areas. Those patients assessed as being in serious critical need are prioritised, which can lead to long wait times in accessing supports for people experiencing mental distress. Furthermore, there is also evidence that people living in more regional and rural areas are also more likely to transported to ED by police due to a lack of availability of ambulances (VLA, 2020). While this may simply be a pragmatic decision, aimed at getting the person to care and treatment, it also, in part, criminalises mental distress.

While people are not always transported to an ED for assessment and can find themselves being taken directly to a psychiatric service or into police custody (Short et al., 2014), one of the more practical challenges reported by police has been the wait time at ED and substantial knock-on effect of having less police resources to respond to subsequent incidents. Some jurisdictions have developed agreements between police and health services so that there are no delays in handover by police to health at the ED (Steadman et al., 2001), but this is uncommon. Most jurisdictions require police to remain with the person in the ED until they have been assessed by ED staff; indeed, their release from police custody and formal handover to ED staff needs to be based on the mutual agreement of the police and health staff present that there are 'no significant safety risks or concerns for themselves or others' (DHHS, 2016, p. 11). Essentially, the person remains in police custody until the ED staff accept the custody of that person. A perennial problem reported by police in these matters is that the low priority given to these cases in the triage process leading to protracted delays for police at the ED precluding them from responding to further calls for assistance. However, from an ED clinician perspective, the high rates of intoxication found among those brought in by the police impedes thorough assessment of wellbeing and risk (Zisman & O'Brien, 2015); nursing staff also commonly report being concerned about the person absconding and committing another act of self-harm, as well as feeling uneasy around people who could be violent, aggressive or unstable (Doyle et al., 2007).

In a number of jurisdictions, there is a four-hour limit imposed or aspired to; reports from Scotland and Australia suggest that the majority of those referred to the ED by police are seen within 2 h (McGeough & Foster, 2018; Short et al., 2014); the Scottish report notes that the target is for 95% of ED patients to be either admitted, transferred or discharged in 4 h. International reviews have frequently commented on the need to expedite the transfer of care. The Iacobucci Report (2014, p. 12) noted wait times in Toronto, Canada of up to 8 h, and speaks of the lengthy procedures as being 'an obstacle to efficient care for people in crisis, and symptomatic of the uncoordinated relationship between the police and the mental health system' (p. 101).

> In distress I was always scared of what would happen. Sometimes I would drink in the hope that it would dampen the distress. But then either I would make a drunken call or a member of the public would be so concerned about me they would call. The police would take me to

> ED. I would be told I wouldn't be assessed until I was sober. I was never aggressive towards staff, but the police would remain until i was assessed, which could be hours later.

Another significant frustration reported by police relates to the threshold for admission to public mental health services; this threshold being so high as to exclude the vast majority of those who present to services in need of assistance. While some jurisdictions have developed an 'accept all' policy for police referrals (Steadman et al., 2001), this is certainly not the norm. The Short et al. (2014) study noted that one in five mental health transfers was deemed inappropriate for admission, while statistics from a Scottish Government report (McGeough & Foster, 2018) reported that as many as 61% of police referrals to the ED for mental health assessment were allowed to go home. Related Australian-based research reported people being told they were 'not sick enough' or 'not in crisis' so could not access services (Olasoji et al., 2017, p. 407).

A substantial proportion of people referred to in the McGeough & Foster report had self-harm or suicide-related concerns, which resonates with earlier findings internationally that reported 'situational crises' as a common precursor to ED presentations (Meadows et al., 1994). Other research has found that people who have substance-use related disorders (Tran et al., 2020) and those attracting a personality disorder label, particularly borderline personality (Martin & Thomas, 2015) are frequent presenters to ED services. As noted by Iacobucci (2014), while hospitals should seek to connect the person with appropriate community services when they don't meet admission thresholds, their efforts may not be sufficiently robust, or the person may refuse. Iacobucci notes that this means that police 'may encounter the person in the community after a few days – or even after only a few hours, once again in need of help' (p. 84–85). A longstanding concern reported here is that these groups do not routinely access voluntary services (McNiel et al., 1991; Burgess et al., 2009), and receive little or otherwise sub-optimal care and support from community services.

> I frequently found myself in distress. The more I presented in crisis, the harder it seemed to be able to access help. I found myself turned away from EDs, I was told by psychiatric wards they would not admit me again. On one occasion I was outside and crying. I'd been trying to cut myself, but only managed some superficial scratches. I remember the police officer talking to me, saying let's go to hospital where i could get help. It must have been late afternoon, by early evening I had been sent home. That's when I really hurt myself. It was the same officers that had attended earlier in the day.

A recent UK-based HMICFRS report (2018, p. 3) went as far as to say that the mental health system was broken. While this report recognises that the failure of health services to adequately respond to levels of mental health need in the community has directly contributed to ongoing tensions between police, health, justice and welfare services (Thomas & Watson, 2017), it has also paved the way for the development of some innovative partnerships. These partnerships acknowledge that, due to the breadth of the presenting needs of a population, any response needs to span multiple disciplines and agencies (Christmas & Srivastava, 2019) in a 'joined-up' fashion (van Dijk et al., 2019). Such sentiments for a shared, common, agenda involving multi-agency commitment require a sustained significant investment in time and energy.

The Impact of Gaps in the System and Human Responses to People's Experiences of Being Kept Safe

> Many times I was picked up in crisis, accessed ED or was admitted to hospital I always felt alone, fighting for support, judged. There was no planning. It felt like a roundabout, each crisis we all just went around again looking for something that just was not there.

As already mentioned, compelling international evidence indicates that most people who are brought into the ED by the police are not viewed as time critical. This represents a double-edged sword. From a service-based partnerships perspective, as noted by Iacobucci (2014), the ongoing de-prioritisation of mental health-related referrals by police inevitably contributes to an increasing disincentive for police members to bring people to the ED for assessment and treatment. It is broadly acknowledged that the ED environment is not conducive to good mental healthcare (Clarke et al., 2014); quite fundamentally, EDs are not set up to adequately treat or respond to mental health-related incidents (Innes et al., 2013). There is accumulating evidence that people will actively avoid the ED given the significantly negative prior experiences but, at the same time, see ED attendance as inevitable due to the lack of 'alternative accessible destinations' (Wise-Harris et al., 2017). When people do present to ED in distress, all too commonly, they are left waiting too long for initial assessment and/or treatment without adequate information or reassurance (Morphet et al., 2012); this can lead to a panoply of negative consequences including dissatisfaction and frustration with healthcare services/providers, as well as, in some cases, agitation and aggression; the latter being commonly associated with substance intoxication (Alarcon Manchego et al., 2015).

Unfortunately, people can and do have poor experiences, with pejorative views of ED staff negating or minimising the distress being reported. Clarke et al. (2014) noted that people who present to ED feel that their concerns can be trivialised; some studies have reported people with mental distress have felt ritual humiliation in EDs, feeling like they were being punished as a result of their self-harming or suicidal behaviours. This lived experience directly resonates with the 'why bother attitude' reported by some ED staff (e.g. Hadfield et al., 2009), especially in response to frequent ED attenders. Of note, Clarke et al.'s review noted that negative attitudes of ED staff were associated with a lower likelihood of wanting to help the person in distress. Worryingly, one study (Doyle et al., 2007) reported that nursing staff based their response on the perceived 'genuineness' of presentations. Given the established links between repeat presentations and subsequent harm (Stanley et al., 2015), this kind of ill-informed approach is hugely problematic.

A recently published report by Victoria Legal Aid simply describes the system as broken; based on the experiences of 34 lived experience experts, it describes a system that harms instead of helping (VLA, 2020, p. 2). While there are certainly strong arguments supporting the position that the traditional ED environment is not the right place for a person experiencing mental distress, the question arises as to safe and viable available alternatives? Currently this missing middle is shunted between health and social welfare services; this is both dehumanising and undignified and

does little to build trust, rapport or faith that engaging with services can lead to positive change and outcomes. Given the common co-occurrence of comorbid mental health, substance use and physical health concerns, a viable alternative is challenging, but arguably increasingly necessary (Wise-Harris et al., 2017). Currently there is a real conflict at play—the police are trying hard to keep people out of the criminal justice system, but healthcare workers are also working hard to keep people out of hospital to prevent medicalising mental distress and long-term harm caused by inpatient care. It is of perhaps little surprise, therefore, that the current pathways and models of response are failing many of those experiencing mental distress.

Summary and Conclusions

The available evidence suggests the need for a system that is responsive to distress stemming from social factors. Rosenberg (2017, p. 1) posits that continued priority needs to be given to increasing the availability of secondary clinical and non-clinical mental health services to act as a 'glue to bind primary and acute systems and create a more durable continuum of care'. The author describes the need to better integrate physical and mental health services in primary care settings, as well as forming cohesive partnerships between primary, secondary and tertiary mental health services, and also providing provision for access to and support from other wraparound health and social welfare services. As noted by Bywood et al. (2015, p. 3), something as simple as a 'no wrong door' approach that can help the person navigate the system to get the support they need could go a long way towards addressing a good deal of this current unmet healthcare need. Weaver and Coffey (2017) importantly re-emphasise the need to prioritise the patient's views and experiences of care when considering a continuity of (integrated) care, noting the core differences between what professionals and service users see as priorities with respect to healthcare delivery.

Peer-led, peer-driven services have been proposed as both an adjunct to existing services and an alternative altogether. An early US-based study of peer support programme set up in the psychiatric service of an ED reported that a sustained, well-supported programme led to consumers feeling supported, respected and understood (Migdole et al., 2011). The viability and practicalities of providing a peer support service in the ED setting have more recently been explored by Minshall et al. (2020) who reported strong support for the peer support workers from consumers, support persons and also from ED staff; of note, the peer workers provided what was considered to be much needed support for the support persons as well as the person presenting in distress. Their report also cautions about the infrastructure and supports that are necessarily required to foster and enable successful peer support programmes. Based on this, and other cognate research, it is evident that a significant proportion of the ongoing barriers in responding to mental distress in the ED are structural; they are based around the built environment of the ED providing limited

space and being/feeling overcrowded. While these kinds of challenges have the potential of being ameliorated by changing the built environment, this does not overcome the challenge of time pressures that ED staff operate under. This is further compounded by increasingly complex and, at times, challenging presentations that stem from entrenched social inequalities (Dombagolla et al., 2019).

In conclusion, it is clear that the current binary systems of health and criminal justice are simply not working; we have a missing middle and a missing system. There is a need for bold reform and arguably a need for a new third system: a system that is responsive to people's needs; a service that does not unnecessarily criminalise or medicalise mental distress; and a service that serves to reduce structural issues within what is currently a severely over-stretched system. As a new service, it will be incumbent upon all involved to actively facilitate lived experience peer workers' roles to help facilitate best practice responses to people experiencing mental distress.

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