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Rivka Smith

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Identifying risk work tensions in policing and mental health partnerships in England

Rivka Smith

School of Law, University of Sheffield, Sheffield, UK

ABSTRACT

This paper advances understanding of risk management within Police Mental Health Triage (PMHT) partnerships. It highlights the contrasting approaches taken by police officers and mental health practitioners, recognising the ways in which their wider organisational logics, framed by social and economic pressures, impact individual risk worker identity and frontline practice. Using risk work theory, it explores how these professionals construct their risk worker identities and manage tensions between risk knowledge, intervention strategies, and social relations, in a partnership setting. Based on empirical research conducted across three English sites using a qualitative-led mixed methods approach, the findings reveal that police officers and mental health practitioners approach risk management in fundamentally different ways, shaped by organisational structures and accountability mechanisms, while still grappling with the impact of the austerity decade. For police officers, the main tension arises between risk knowledge and intervention, driven by concerns about personal accountability, reputational risk, and organisational scrutiny. In contrast, mental health practitioners experience tension between interventions and social relations, particularly within the limitations of an underfunded and overstretched crisis care system. These differences create significant challenges in aligning risk management practices within PMHT schemes, raising questions about the effectiveness of such partnerships in achieving their desired aims. While PMHT may improve user experiences in some cases, it is unlikely to achieve meaningful reductions in detentions or address the broader systemic issues that drive mental health-related demand on police services. Broader reforms in mental health services are necessary to bridge these persistent gaps in risk approaches.

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Introduction

> You end up almost feeling like a pawn. I had 136'd somebody and there were arguments going on between my Inspector screaming in my ear "why are you still at the s136 suite with this person, you need to be on the street, you're the only officer I've got with a taser, we've got these jobs coming in so get out of there" and the Consultant at the same suite saying, "you can't leave because they're being violent". I'm standing there thinking what do I do? Their policy says they should have enough staff to deal with this patient and they'll say well they haven't because two have phoned in sick. That's not the police's problem; that's the NHS's problem. The policy says unless they're [the person in crisis] being violent then we leave and they're not being violent, so

CONTACT Rivka Smith rivka.m.smith@sheffield.ac.uk School of Law, University of Sheffield, Bartolomé House, Winter St, Sheffield S3 7ND, UK @rivvie1

> my boss is saying get out, but human nature is saying I can't leave this person. I'm trying to help, but I've now got two gaffers above me going head-to-head through me. So yeah, the policies are formalised, but they break down very, very, quickly on the ground, very quickly. [Police Officer – Hilltop Constabulary]

The context underpinning the opening quote is one of the 34,685 instances a year in England and Wales whereby the police have responded to a mental health crisis incident in the community and utilised their main detention power in such cases, s136 of the Mental Health Act 1983 (MHA 1983, Home Office 2023). S136 allows an officer to detain a person they believe to be in immediate need of care or control and to take them to a place of safety for the specified purpose of receiving an assessment from a health professional. Responding to such incidents is a well-documented aspect of the police role, which is considered to be that of a social service, peacekeeping, or public health function (Banton 1964, Bittner 1967, Reiner 1985, van Dijk and Crofts 2017).

The scenario occurred after a police officer received instruction via a health practitioner employed as part of a police mental health triage (PMHT) partnership scheme based in the police control room to take the person they had detained to that named place of safety. The individual actions of the PMHT practitioner, the police officer, their Inspector, the receiving health workers, and the Consultant leading the mental health suite were all independently yet synonymously guided by their individual perception of risk, despite being faced with the same incident and 'end user', i.e. the unwell person. By virtue of their roles, each of these individuals is a 'risk worker'. By that, I mean their occupations involved 'working practices framed by concepts of risk' (Gale *et al.* 2016, p. 1047).

In cases such as this, including those involving the identification and management of risk associated with those experiencing mental ill-health, there has been a global shift towards combined approaches to law enforcement and public health (van Dijk and Crofts 2017), along with the development of targeted partnership interventions that have sought to enhance working relationships between agencies (Reveruzzi and Pilling 2016). Implemented from 2012, PMHT schemes are an example of such, aiming to reduce the s136 detention rate which had risen significantly since 2008. Despite their introduction, the national s136 rate continued to rise (Home Office 2023). This article submits that one reason for this is the contrasting risk management approaches between police and health practitioners, which cannot be mitigated through this form of targeted partnership intervention.

Though differences were noted in the approaches that different partner agencies take to risk in one localised evaluation (Irvine *et al.* 2016), further critical study around the nature and implications of this has been neglected. It is unknown how the practitioners within these partnerships perceive their risk worker identity, nor what the implications of this are for partnership practice or service users. These unknowns form the basis of this article, which offers an original contribution to understandings, not only of the occupational milieu of risk work in policing and mental health partnerships, but also to the broader trajectory of contemporary policing where combined approaches to policing mental health are mounting.

Drawing upon empirical data, this article depicts how police officers and health workers within PMHT partnerships perceived their risk worker identities, founded on a novel application of risk work theory (Gale *et al.* 2016, Brown and Gale 2018). It systematically considers the interconnectedness of the key features of risk work, which include: 1. translating risk into different contexts; 2. minimising risks in practice; and 3. caring in the context of risk. These are used to understand how these features stand in tension with one another at an individual practitioner level. This enables conclusions to be drawn about whether the perspectives of police and health workers have and can be reconciled through targeted partnership initiatives.

This article is structured around three sections. The first provides the relevant background behind the shift towards joined up work between policing and mental health agencies. It goes on to outline the emergent risk work theory and maps extant knowledge to its three core elements, drawn from policing and health literatures. After depicting the methodology, the penultimate section presents empirical findings, the first of its kind to extend the application of risk work theory to policing practice to contextualise the inner workings of police and mental health partnerships. The concluding

discussion considers the empirical and theoretical implications for knowledge and practice, building upon the analysis to draw conclusions about whether the perspectives of police and health workers can be reconciled through targeted partnership initiatives.

Situating the concept of risk in a policing and mental health context

There has been an absence of research into the present policing and mental health landscape, leaving a catalogue of interrelated problems largely unconsidered (McDaniel 2019, p. 90). How risk manifests through the individual actions of both police officers and mental health crisis care practitioners in partnership is one such area. While the multifaceted and often contested role of the police in society has received plentiful attention (Millie 2014, Crawford 2024), research considering the intricacies of officers' s136 use, let alone in partnership with crisis care practitioners, has been absent. Similarly, despite mental health crisis teams existing from the late-twentieth century in the USA, Australia and mainland Europe, and in the UK from 2000, this literature has focused largely on efficiency and the impact on hospital admission rates, rather than the lived experiences of the professionals within them or those of service users (Johnson 2008).

During the austerity decade, the UK public sector shrunk to the lowest among major economies and all public sector organisations were looking to do more with less (Taylor-Gooby 2012). The pressure to end siloed policies and improve service delivery through networks and partnerships between a range of public and private agencies had become considerable (Solar and Smith 2022). As health agencies such as the National Health Service (NHS) were seeking to reorganise, however, the number of people coming to the attention of the police increased to the extent that some forces could barely cope, and were in danger of 'running on empty' (van Dijk *et al.* 2019). Considering the increasing levels of mental health demand and with s136 detentions at an all-time high, the collaboration between mental health service providers and the police had become critical (Normore *et al.* 2016).

PMHT schemes sought to introduce mental health expertise to what were traditionally police only responses to community mental health crisis incidents (Reveruzzi and Pilling 2016). S136 detentions have, however, continued to rise, and one suggested explanation for this has been the presence of what is described as a risk-averse culture amongst police officers (Loughran 2018, Thomas and Forrester-Jones 2019, Cresswell 2020). 'Risk aversion' within policing refers to a combination of reputational risk to forces and disciplinary risk to individual officers (Heaton 2011). Given shifting policy priorities and the need for agencies to reorient themselves towards new policy frameworks and practices, understanding how risk perpetuates in the policing and mental health context is vital in better placing the opportunities and barriers of the shift towards partnership work to address complex societal issues.

As for the concept of risk, Heyman and Heyman (2013, p. 1) deconstruct it, asserting that it is underpinned by 'values, categories, timeframes and interpreted probabilities' which may surface independently or in combination with each other, at any given time and with any level of unease. These features refer to: the range of values present when deciding whether something is adverse and thus risky; the categorising, which is the grouping of apparently similar situations together and the linking of these to homogenised groups of risk factors (e.g. people or places); the time frames employed which are rarely explicitly stated; and the ambiguous way in which statistical probabilities are deployed in practice. Risk work theory (Gale *et al.* 2016, Brown and Gale 2018) adopts this deconstruction and provides a useful mechanism through which to consider the contemporary challenges of individuals managing risk within a PMHT partnership setting, both in terms of the knowledge base of risk and the interpersonal tensions it creates.

Risk work theory

Risk work theory synthesises and develops insights from classic sociological studies of risk, which were foundational in recognising the need to understand risk in the context of everyday lives

(Giddens 1991, Beck 1992, Ericson and Haggerty 1997). The concept of risk work, developed from critiques of grand sociological theory, was intended to convey the diversity of risk-related practices observable in individuals' real-world actions; for example, how people in their everyday lives select and interpret risk-related issues, and how they account for their actions in relation to their understanding of risk (Horlick-Jones 2005). The concept therefore recognises that a more nuanced understanding of risk rationality is required in social science research involving human actors and interactions, such as those working within healthcare and policing settings.

Building upon this concept to develop a more defined sociology of risk, risk work theory outlines a framework of three core components present in all types of risk work, namely, 'risk knowledge', 'interventions', and 'social relations' (Gale *et al.* 2016, Brown and Gale 2018). Fundamental to the theory is the need to consider the interconnectedness of these features systematically, to recognise how these features may stand in tension with one another, when the key features of risk, i.e. the probabilities, categories and values, become challenging in everyday practices (Heyman and Heyman 2013). It is the interconnectedness of these features that helps to configure a risk worker's identity, and these are introduced below, drawing upon extant police and health knowledge.

Risk knowledge

The first component, risk knowledge and the necessary translation of risk knowledge into different contexts, is often concerned with how probabilistic risk based on population-level data is translated to individual cases. Population-level data can be made up from a variety of sources, e.g. registered deaths by suicide that are analysed by age, sex, region, deprivation and suicide methods (Office for National Statistics 2023). It is these values that a practitioner may consider when deciding if an individual case is risky or not (Heyman and Heyman 2013). Due to concerns about the quality of s136 data, forces have been required to record data on the age, sex and ethnicity of people detained, as well as the place of safety and the method of transportation used, since 2014. This captures how individual risk often also needs to be converted upwards into auditable data for organisational use and how this process may impact risk knowledge in future, creating a full-circle motion of malleable risk knowledge.

The formation of new risk knowledge, whether through statistical data, advancements in evidence-based medicine or through the more recent phenomenon of evidence-based policing (Sherman 2013), can go on to affect the structures, processes and policies within which practitioners operate. For example, emerging knowledge about the potential benefits of PMHT for reducing the number of s136 detentions went on to underpin its national expansion (Reveruzzi and Pilling 2016). While new forms of probabilistic knowledge may lead to changing dynamics within the interactions and relationships between professionals and end-users, non-probabilistic forms of knowledge will continue to inform practitioners' understanding of risk and these different ways of knowing can either sit alongside each other or in tension.

In a policing context, when officers undertake a decision-making process, they become enlightened as to the particularities and subtleties of the circumstances and the consequences that different courses of action might cause. Any process of translating risk is a fundamentally social process, and different methods of implementing interventions may have unintended consequences for those who access them (Ericson and Haggerty 1997, Walklate and Mythen 2011, Weston and Mythen 2022). Health workers also have to draw on non-probabilistic forms of risk knowledge in the translation process, with a variety of terms used to describe this, e.g. 'tacit knowledge' (Scamell and Stewart 2014); 'intuition' (Warner and Gabe 2004), and 'expertise and embodied knowledge' (Godin 2004).

Given the assertion that it may be a risk-averse police culture underpinning the continued rise in s136 detentions, it is relevant to consider this in the context of risk knowledge to understand how

knowledge in this context is being translated by officers. Heaton (2011) highlighted how the 'risk is bad' perspective has engendered a shift from 'probabilistic' to 'possibilistic' attitudes, in which risk has intensified and viewed through the lens of the worst-case scenario. The dominant risk faced by the police is the threat to organisational reputation in the event of failures. He identifies the impact of legislation, judicial inquiries, and police leadership as contributing factors threatening this; for example, litigious consequences for officers if negligence is established by a breach of their 'duty of care'. In addition, the police organisation has an enduring experience of examination by public inquiries, and many incidents are also subject to oversight by the Independent Office for Police Conduct (IOPC), which publishes public case summaries (IOPC 2024). In summary, translating risk knowledge into practice is largely a social process, informed by informal rules for both police and mental health workers. For the police, however, the additional layers of scrutiny impose an additional set of burdens, which may contribute to their risk-averse practice. The translation of risk knowledge into practice, whether probabilistic or not, is enacted in practice through interventions to tangibly minimise the risk.

Interventions

Brown and Gale (2018) use this term broadly to refer to concrete interventions, which in the context of PMHT may be the use of s136, but also more tentative interventions which still involve action, for example, communicating with a person in crisis. Intervention also encompasses collecting and interpreting information as part of a risk assessment that may form the potential basis for a future intervention, which may not involve any tangible action at all, for example, PMHT practitioners deciding not to intervene.

New forms of risk knowledge often lead to wholly new interventions when a freshly considered 'at risk' population becomes the focus of a specific action, like PMHT itself. Though PMHT interventions have been devised according to local need and vary in nature, the premise is that mental health professionals can provide advice and support to officers attending incidents where an individual appears to be in crisis and s136 is a possible intervention. The partnerships have predominantly adopted co-response (at the scene) or virtual (control room/telephone) models (Reveruzzi and Pilling 2016). The intervention model may therefore vary depending upon whether there is a health worker 'at the scene' with an officer, or whether the encounter resembles a traditional police-only response with the added 'intervention' of receiving virtual advice either via a control room or telephone line.

Interventions as a result of PMHT contact are thus not limited to the use of s136. Indeed, s136 was not designed as a catch-all intervention for all police contact with people in crisis. This is reflected in the wording of the legislation itself, which states an officer 'may, if he thinks it necessary to do so' (MHA 1983), suggesting that there is more than one course of action. This is an example of administrative freedom, which allows officers to choose the fairest course of action from a number of lawful courses of action, also known as the exercise of police discretion (Lustgarten 1986). Despite this administrative freedom, where the principles of 'necessity' and 'immediacy' as required for s136 are not met, the legislation does not provide clarity on alternative courses of action (McDaniel 2019). There is huge incongruity, therefore, between s136 and the social situations that officers encounter on the ground.

In choosing an intervention, mental health practitioners are encouraged to adopt 'positive' risk management, which is the process of collaboratively ensuring the safety and wellbeing of service users, while promoting their quality of life (Just *et al.* 2023). Due to its nature, much like police discretion, few examples can be found in the literature of standardised approaches to positive risk-taking, though there are three broad considerations: structured clinical judgement, actuarial methods, and unstructured clinical judgement; the latter of which is utilised in community crisis team settings (Doyle and Dolan 2002). This typically involves health workers making judgements based on their clinical experience, opinion, intuition or 'gut feeling' due to the need for rapid

assessment. However, this somewhat differs from police discretion because it can be perceived as the natural professional judgement of qualified accredited mental health practitioners, for which, when making mental health care decisions, police officers are not (McCanney *et al.* 2022).

Social relations

The third component of risk work is social relations. These can be difficult to reconcile with the other components and can create conflicts of role and tensions in practitioner-end user relationships (Fox 2002). Douglas (1992) described how intervening based on risk knowledge is always a moral act and one that can have profound consequences not only at the moment in time, but also for the longer-term relationship between the practitioner or organisation they work for, and the 'end user'. This can either enhance or limit the future possibilities of working or interacting with the person again, particularly with regard to the quality of future communication.

Compassion is a key component of social relations between professionals and end-users. It is widely recognised as being core to quality health care (Cleary *et al.* 2015). People in crisis have deemed compassionate care to be when they can form supportive person-centred and trusting relationships, retain some control, and feel their safety is collaboratively balanced with independence (Farrelly *et al.* 2014, Farr and Barker 2017). Within policing, compassion is most closely associated with what has been categorised as 'soft' policing tasks, requiring the use of soft skills, e.g. adopting a calming tone of voice or using humour to encourage people to comply with advice or instruction (Innes 2005). These skills can be perceived as more effective and provide a fairer or more procedurally just response than punitive measures like arrest or, in the case of PMHT, s136 detention (Bayley and Bittner 1984, Lind and Tyler 1988).

It becomes easy to see the tensions that may arise between interventions to minimise risk and social relations with someone in crisis when detention under s136 has been described as a custodial rather than therapeutic experience and one that fuels a feeling of criminalisation (Jones and Mason 2002, Riley *et al.* 2011). Within health, the tension between service efficiency and the interpersonal and relational aspects of care have been shown prior to detract from service user priorities such as compassion and their psychological safety when in crisis. Interventions that seek to minimise risk might challenge practitioners' commitments to enhance patient choice or control. While mental health practitioners may perceive their role primarily as risk managers (Downes *et al.* 2016), their assuming this role has been shown to limit the ability to form therapeutic relationships with the people in their care (Slemon *et al.* 2017), highlighting the tensions between intervention and social relations.

Resolving risk work tensions

Brown and Gale (2018) introduce a range of analytical trajectories to understand how tensions within risk worker identity remain veiled as mere tensions, rather than resulting in more explicit contestation. This final section outlines two these: practitioners' deference to expert knowledge and practical obligation amid organisational logics. For practitioners' deference to expert knowledge, it is suggested that frontline workers may assume or believe that those positioned higher within the organisational hierarchy possess greater understanding or expertise than they do and, as such, do not question their validity. Both police and health services are hierarchical organisations, and these dynamics, wherein power and knowledge are intertwined within hierarchical structures, can mean practitioners suppress their own questioning of knowledge, resigning to an assumption that knowledge held by their superiors constitutes the truth (Bourdieu 1977). As a result, any underlying tensions are either rationalised or left unvoiced, allowing the veracity of risk-related knowledge to remain operationally unchallenged. While both practitioners are frontline workers in hierarchical structures within their respective organisations, within PMHT, one is a 'qualified' mental health professional and one is not. This opens a dialogue around the extent to which PMHT is enabling officers to defer to expert mental health knowledge in decisions to utilise s136, which is legally their own.

Furthermore, the concept of practical obligations within the framework of organisational logics often renders impractical a more thorough critical reflection or a practitioner questioning of knowledge. This is particularly evident given the pressures of time, which are shaped by organisational logics that prioritise economic imperatives. In such contexts, practitioners may perceive their role as one focused not on questioning, but on task execution (Thomas 2016). Consequently, knowledge-related tensions are likely to remain unresolved, fostering additional conflicts between formal compliance mechanisms and informal operational logics (Horlick-Jones 2005, Brown and Calnan 2011). This is pertinent to the implementation of PMHT itself, which occurred shortly after the United Kingdom embarked on a decade-long austerity agenda, impacting the organisational logics and the need to manage the economic pressures this was creating for both police and health organisations. Within policing, austerity hindered a practical compromise on the nature and form of service provision, creating higher demands on an already struggling police organisation, and within health, agencies were seeking to reorganise extant provision (Cummins 2011, Solar and Smith 2022). The implications of such are returned to in the concluding discussion, after the penultimate section has framed the empirical findings around the three core components of risk work, as outlined above.

Methodology

This article is based on data collected during a qualitatively led mixed methods study into the operational and occupational milieu of PMHT. This was grounded in a pragmatic epistemology that prioritised practical utility over theoretical allegiance (Tashakkori and Teddlie 2003). Fieldwork was undertaken in three sites across northern England and the Midlands between March 2018 and February 2019. To protect the voices in this paper, these have been assigned pseudonyms (Northfield-City; Eastbrook-Town; Hilltop-Rural). Sites were purposively selected to reflect demographic and geographic variation and England's varying PMHT models – co-response, control-room, and telephone partnerships (Deane *et al.* 1999, Patton 2002). Two sites had shifted from earlier models, enabling comparison of past and present practice.

Data collection engaged a two-stage approach that reflected the QUAN – QUAL data sequence (Tashakkori and Teddlie 2003). Stage one was a self-report servicer user postal survey sent to all individuals in Northfield, who in 2016 had a 'Police Street Triage' incident recorded in their medical notes. This was predominantly quantitative, though it included some open-ended questions and ample space to provide additional written comments. Stage two encompassed qualitative (the priority decision) data collection methods (Tashakkori and Teddlie 2003). These were 214 h of ethnographically informed observation and 64 semi-structured interviews. Quantitative data played a relatively auxiliary role when considered as part of the wider methodological context (Hesse-Biber 2010, p. 64), but was sequenced first to cast a recruitment net to identify people with lived experience of PMHT – a hard-to-reach population. Sensitising concepts for the survey were garnered from the limited localised evaluations of PMHT and extant literature. Preliminary analysis of the qualitative data generated through the returned surveys allowed a narrowing of potential interview questions to four key PMHT themes (access, delivery, partnership, and experience).

Though semi-structured, these interview conversations were informal in nature and a sensitive approach was essential given the nature of the subject area, particularly for those with lived experience. The guiding ethical regulatory framework for this study was the NHS Health Research Authority. This regulatory body stipulated that all research instruments follow their template, and these were reviewed independently by a Research Ethics Committee and Confidentiality Advisory Group. In addition, a lived experience advisor was engaged from project inception, and early drafts of research materials and analytic directions were reviewed with a lived experience group. Their input ensured that the study design and interpretation remained grounded in service-user perspectives and ethically attuned to participant experience.

Purposive sampling was used to recruit stakeholder and practitioner interviewees based on their position within their respective organisation and their knowledge or experience of PMHT.

Participants varied between sites but included a wide range of roles. Within policing, they included senior officers holding the mental health portfolio (Superintendent or Chief Inspector), force mental health leads, control room staff, and frontline officers from a variety of police force area districts/stations/teams. Within the NHS, interviews were conducted with all of the frontline health practitioners who worked within PMHT (a mix of social workers, mental health nurses, approved mental health professionals, and paramedics), MHA managers, and relevant heads of services. Stakeholder participants included Police and Crime and Mental Health Commissioners, College of Policing and National Leads, and relevant members of parliament (MPs) with a policing portfolio.

At the root of interviewing is the intent to understand the lived experiences of other people and the meaning they make of that experience (Seidman 2013). The interviews allowed interviewees to candidly express their opinions and reflect on their experiences of PMHT and crisis care more broadly. Each lasted between 60 and 150 min and permissions were sought to record for the purpose of transcription.

Observing the operation of different PMHT partnerships was deemed key to addressing the central research objective, as ethnographic approaches have proven unparalleled for understanding the internal workings of the police organisation (Bittner 1970) and health settings (Goffman 1968). My observation drew upon ethnographic principles, e.g. immersion when examining the cultural aspects of the social setting (Jackson 2020). Settings included crisis team offices, police ride-alongs, the police control room and attendance at multiagency meetings. Keen to maintain rapport and minimise any perception of being a 'management spy' (Reiner 1992), observation was systematically recorded by way of fieldnotes which were written as soon as practicable after the event. Given that I wanted to be as unobtrusive as possible, writing was rarely done in the company of practitioners and when it was, I would only make brief notes – 'little phrases, quotes, key words' at inconspicuous moments' (Lofland and Lofland 1995, p. 90). To member check, like Skolnick (2011, p. 29), I found that 'the most informative method was not to ask predetermined questions, but rather to question actions that [the worker] had just taken or failed to take concerning events or objects just encountered'. The process of discussing these (in) actions created an air of informality when opinion seemed to be more openly expressed. I ensured that the notes made in the company of practitioners were descriptive rather than analytical and never contained anything I would not want them to read. Whilst the research did recognise local variations within each site, it sought to identify the broader themes that could be applied to the field more widely.

Using NVivo software for computer-assisted qualitative data analysis (Dalkin *et al.* 2021), all data were analysed thematically through a hybrid process of deductive and inductive reasoning (Layder 1998). Initial coding was both data-led and conceptually informed, drawing on sensitising concepts from the relevant literature and guided by the theoretical frameworks of *risk work* and also *collaborative advantage* – within which risk was a predetermined theme. Codes were iteratively compared, merged, and refined through repeated reading, memo-writing, and comparison across sites and participant groups. This iterative dialogue between pre-existing knowledge and emerging data enabled the identification of higher-order themes and subthemes, which were subsequently reviewed for coherence, representativeness, and explanatory power.

Findings

Reaffirming earlier attestations about risk (Irvine *et al.* 2016), individual police and health practitioner approaches to their risk work within PMHT were found to have varied markedly, being characterised by both groups of participants as 'polar opposites' of one another that were 'fundamentally incompatible'. The tensions identified within PMHT risk work for each individual were found to be fundamental to how officers and their health counterparts formed their own identities. Without resolving these tensions at an individual level, the mere 'joining' of frontline partners through a targeted intervention was insufficient to reconcile such incompatible perceptions, rendering the potential value of PMHT in reducing s136 use superfluous.

The biggest tension for officers undertaking this type of risk work rested between risk knowledge and intervention, whereas for health it was between interventions and social relations, which were underpinned by positive risk management techniques. This difference was due to the particularities of the economic restraint facing mental health services and how practitioners working within them were still grappling with the impacts of austerity on their service provision. This had reformulated their risk knowledge to available interventions which they were translating into practice using unstructured clinical judgments. Notwithstanding the police organisation also facing economic restraint, the risk knowledge they had differed, with officers focusing on threats to reputation and self. The findings indicate that while there may be some value in PMHT for improving end-user experience where it allows a joint presence, the necessity of the joint response was not one that rested in law or practice, nor could this reconcile the variances in their risk worker identities.

Risk knowledge

The risk knowledge that health workers were drawing upon was grounded primarily in localised resource knowledge over wider probabilistic knowledge, with non-probabilistic knowledge taking precedence, e.g. a 'gut feeling they weren't going to kill themselves' regardless of how 'ill' a person may present. Though population level probabilistic knowledge was translated secondary to the localised resource availability knowledge, if the first translation showed there was no provision, then regardless of the population probabilistic knowledge, they were limited in the interventions they could take irrespective of how 'risky' a situation presented.

As the quote below reflects, mental health practitioners were operating within a system that could not meet the needs of everyone who required it due to economic pressures. Because of this, they were undertaking their role in a less-than-ideal way of identifying and translating their non-probabilistic knowledge to identify the 'most risky' cases, rather than offering support to those who needed access to the limited provision or appropriate intervention 'the most'. The quote also reflects how different levels of forethought and forward planning about an individual's potential risks were required between the police and mental health practitioners within PMHT (and beyond) when considering the use of interventions such as s.136:

> Let's say I know there is one hospital bed available, I'd love to be able to see a person I know is risky and be able to say they need hospital care and they'd be in that bed waiting for them, but I also know there's then the potential that two minutes later I might get a job for someone who is even riskier than the first and I need them to go in as well, so what am I doing to do, tell the first person to get out of that bed? [Health Worker, Eastbrook]

This knowledge translation process was limited to mental health workers only, with officers unconcerned with resourcing issues beyond having an open place of safety and sufficient staff available to meet them there. Officers reported vast discontentment with the risk approach taken by health workers, due to both potential physical and emotional implications for the person in crisis, showing concern about the impact of the tensions between the intervention and social relations, which are returned to below. Within co-response PMHT models, the intervention was also determined by the workers' availability. The quote below reflects how on quiet shifts (and generally the first incident to come to the attention of the team), the decision to attend *any* incident was preferred to remaining in the office:

> To put it bluntly, if it's quiet and I'm bored I will see anything. I will just drop things to go and see people, anyone, and that's fine. If I'm busy, I will start to triage things, and I'll go right you're an intoxicated male that's saying you're suicidal and you're a sober guy standing on a bridge. I know exactly which I'm going to go to next. It depends on what's going on really, I can't put in words how I would prioritise [Health Worker, Northfield]

This example shows how probabilistic knowledge was only considered *after* the localised resource knowledge and availability of the mental health worker due to the 'busyness' of the specific shift, e.g. here the worker identifies risk factors such as age, gender, and intoxication. Where circumstances

meant that the preliminary triage function was necessary, health practitioners reported undertaking the process in the same way they did when triaging calls to the crisis team. The decision to attend an incident or not was found to be that of the mental health worker within PMHT, not that of their police counterpart.

The risk knowledge that police officers were translating into practice was less about population-led probabilistic knowledge and more about personal accountability. The risk-averse nature of officers reflected what Irvine *et al.* (2016) highlighted in that officers pooled their knowledge from what was a perception of the 'worst-case scenario'. Officers were not found to be drawing upon population probabilistic knowledge related to mental health, such as those factors seen in the health workers' role, reflecting the lack of any specific mental health training officers receive.

Officers were concerned that the worst-case scenario would involve being criticised by colleagues and their organisation; giving evidence in a Coroners Court; being viewed as incompetent; being subject to an IOPC investigation; losing their job; and having to live with 'what ifs' had they taken a different course of action. All such reasoning centred upon being held personally accountable for their actions, leading to officers reporting a common belief that such outcomes would 'never be a risk worth taking'. Officers were unanimous in explaining the need to try and eradicate those risks because of their duty of care, and their approach to doing so was a 'very conscious' one. Officers did not translate population probabilistic risk knowledge such as suicide 'risk' factors, and many suggested they did not know that kind of information; rather, they were led by organisational risk knowledge and 'risks to self'.

The health workers did not place the same emphasis on being held personally accountable for their actions due to their risk knowledge around this. Health workers talked about the 'service(s)' within which they were one person 'trying their best' to do their job within 'a not perfect' organisation'. This was reflective of the issues around available service provision and the functional implications of under-resourcing and how this impacted frontline practice. The varying accountability mechanisms of each organisation were observed to have contributed to this divergence in risk knowledge and the emphasis officers placed upon it as knowledge of personal accountability had not been formulated in the same way, the implications of such were noted:

> No matter what assessment we do and what decision we come to, those officers feel that their name will be attached to any possible incident that happens subsequent to that. Because their disciplinary systems are much more stringent than ours. I'm not saying ours aren't stringent, but as an NHS service our disciplinary services tend to take the human element into it at a higher account than the police do, and acknowledge that not all risk can be removed and acknowledge that some people will bring harm to themselves and other people … yet there's an element of anxiety about what will happen to that officer, what punitive measure will take place, what consequence there'll be for them if something happens to someone based on our assessment [Health Worker, Northfield]

One of the key points alluded to in the quote from the worker above was the punitive aspect associated with the initial investigation process itself after a death, which was not felt in the same way by health workers. A nurse who had experienced the investigative process in the NHS following patient deaths described how they remained at work with a review taking place sometime after. At no point after the death did the worker feel they were subject to punitive action like a suspension from work or criticism from colleagues. Reflecting a common perception, one health worker stated, '*without sounding like a complete psychopath, if you work in crisis services*, *at some point*, *some people are going to kill themselves*'. Officers reported how they felt they were expected 'to make the same decisions' as their health counterparts but without the same accreditation, which would professionalise the level of probabilistic risk knowledge that they could draw upon. Many spoke of being at a significant 'disadvantage' with respect to dealing with incidents of mental ill-health, feeling that they were being held accountable to a higher standard than their health counterparts, which was perceived as 'unfair'.

Interventions

Outside of PMHT, the health organisations' primary crisis intervention was a 24/7 single point of access telephone number. Callers were greeted by an answering machine and required to leave a message so staff could triage them according to perceived need, within a four-hour target period. Within policing, when a mental health call came through to the control room the most common intervention was to send an officer to the scene on blue lights.[1] Co-response models of PMHT enabled an in-person mental health practitioner response to incidents in a way that organisational health logics could not facilitate otherwise, e.g. PMHT could provide a concrete intervention that otherwise would have been tentative or information gathering. 'Positive risk' had become somewhat of a mantra for health workers, heard in the majority of interventions. It was cited when explaining why they had taken any particular course of (in)action, i.e. intervention. The following observation notes highlight how this approach to risk work served as an accepted and justifiable way of reconciling the tensions between risk knowledge and intervention, but often at the expense of social relations with service users:

> Listened to the mother of a young woman distressed that her daughter had taken the third overdose in three weeks, crying and angry at staff saying she needed to be seen. She has received no follow-up after her discharge from hospital and was still in crisis expressing plans to harm herself again. The worker told the mother that her daughter has the capacity to kill herself, and if that's what she chooses to do then they can't stop her. They told the mother the decision for her daughter to take her own life was hers to make, that people make unwise choices every day and there is nothing they can do from the other end of the phone. They advised if concerned to attend Accident and Emergency (A&E) again but that she'll not receive an assessment there so she's wasting her time. If I hadn't already witnessed this kind of conversation numerous times, I would be shocked at the lack of apparent compassion, maybe I have become immune to the shock factor I felt when I started the research. When I asked the worker about this conversation, they explained that they have to take positive risks every day as they don't have the resources to see everyone who 'claims' to be suicidal. "If every suicidal person in Northfield got a service, we'd need another hundred hospitals". They said the girl had become well known to them in recent weeks, ringing most days, but was 'demanding' a service that 'we don't do' because they didn't think she needed an assessment and the best person to 'manage' her was her doctor during working hours. [Observation notes, Northfield]

In their risk assessment processes, health workers reported how 'people exit their crisis as quickly as they enter it' and so the primary consideration they had was whether the person in crisis could 'survive' at that moment, usually until the next working day when doctor services resumed. Their judgements about the risk for people in crisis had a low threshold and were deemed to be about immediate risk in terms of 'is this person going to be alive in an hour's time?' In that case, the practitioner assumed that they would be based upon tacit professional knowledge and experience.

The practice of recording that 'positive risks' were taken was sometimes explicitly documented, though it was sometimes not. Where not, mental health practitioners were observed to record their rationale for their intervention, for example, 'advised they could attend A&E' which was described as a 'safety net' to justify the risks they as practitioners had assumed. Health workers spoke about being constrained by a 'risk barometer' that impacted their practice and the decisions they could make about an individual in crisis. Given limited inpatient bed capacity, only the very highest risk patients could be admitted, who did not always equate to being the 'most poorly' or those who 'needed that intervention the most'. They operated on a 'tightrope system' which focused solely on risk management, over being able to provide an appropriate response to patient needs, often attributed to local reductions in hospital beds. This had led to a situation whereby people who were deemed further down the scale, i.e. lower risk but who nonetheless were incredibly unwell and who would, in an 'ideal world' have benefited from inpatient hospital care or intensive home treatment, no longer met the threshold for it. This was, as observed and reported, often made explicit to the service user, reflected through the quote below:

> Sometimes I've been told [when suicidal], literally, you're the bottom of the list or there's people that are ill-er than you, when requesting support [Service User, Northfield]

Attributing this to the economic constraints exacerbated by austerity, the threshold for receiving continued care or treatment after the assessment was described by health workers as being 'so much higher than it was even five years ago', though practitioners were unanimous in explaining that the provision even before austerity was not able to meet the needs of the population in a way one might expect.

Social relations

For health, it was this component of risk work that was the most difficult to reconcile with the other two, in a way that within policing it was shown not to be. This was due to the variances in what risk knowledge was available to each practitioner and how this was translated, for example, the s136 intervention for officers was not reliant on there being available mental health provision, should a person have required it post-detention. To highlight how these tensions within risk work were felt in practice, this section draws further upon the perspectives of individuals with lived experience of crisis interventions, both through PMHT and prior siloed police and health-based responses, as well as the risk workers themselves.

Beyond the potential for physical harm, service users discussed the infliction of what they described as the 'hidden harms', viewed as inevitable after contact with mental health practitioners. The term described the emotional turmoil that resulted from attempting to 'do the right thing' in contacting health services when they no longer felt they could remain safe from harm, only to experience more distress at the realisation that they did not meet the threshold for any kind of concrete health intervention, beyond that call. This fed into a feeling of 'being beyond help', and this feeling became heightened with every subsequent period of crisis described as an 'additional layer' of distress on top of the initial crisis, and this deepened the more it was experienced. It was reported that upon contacting crisis teams and 'reaching out for help' as encouraged to do when suicidal, the intervention was not helpful in practice; i.e. the intervention taken with positive risk management was incompatible and stood in tension with social relations, dissected further below. Health practitioners described this feeling from service users as a 'sense of false entitlement' when referring to service user 'demands' for 'a service we don't provide'.

Telephone provision was depicted as the 'standard' intervention by both health practitioners and service users, in the absence of PMHT. For the majority of all calls, there was no further intervention available for staff to provide beyond that call:

> The thing is, the crisis team isn't there to respond to a crisis, they are not an emergency service, they've got a 4-hour response time, that's not an emergency response. If people need an emergency response, they should go to A&E like they would if they were critically ill. [Health Worker, Hilltop]

> The police do things, don't they? If you ring the police, generally, there is an expectation in society that they will turn up and something will happen, even if it's the wrong thing, something will happen that will change the course of where it is going. And I do think that they know ringing mental health services up, actually nothing may happen [Health Worker, Northfield]

> The two staff on out-of-hours, their role is to either talk to somebody and deescalate it or to direct them to [a charity] 24-hour helpline for people who are distressed but not psychiatrically distressed … they'll be picked up by them [Health Head of Crisis Services, Eastbrook]

The quote above alludes to the distinction health practitioners were required to make in translating risk knowledge based on available interventions, between suicidal ideation and psychiatric emergencies. They understood this to mean 'serious' psychotic episodes, though even when psychosis was apparent, if the person was 'bumbling around hearing voices in public but causing no bother', such instances were not deemed emergencies that they had the capacity to respond to. The perception was that their team could only provide a concrete intervention when someone was deemed 'detainable', and this was 'only a handful of people – the rest are probably just distressed'.

The nature of most call interventions primarily centred-on distraction techniques, for example, practitioners advising callers to 'have a bath' or 'make a cup of tea', with service user participants expressing how such intervention felt patronising when in such a state of distress. One participant recalled being told to 'go for a walk along the platform to calm down', while she was there only as she contemplated ending her life on the platform's edge. This later became a police matter when a member of the public called them, and they attended, spending the rest of their evening shift, approximately six hours, with her.

In navigating their risk knowledge of available provision, not only of further service provision but also the functioning capacity of the crisis team itself, practitioners spoke of what they perceived to be widespread misrepresentation of what a 'crisis' or 'out of hours' mental health team is and does, leading to what has become a broader misunderstanding held by both the police and the public about their service capabilities:

> I think there is a huge difference in people's expectations and the reality and I think that's the hardest thing to manage … because we get a lot of 'what's the point of you if you don't do anything' but then people are phoning us up with situations that aren't psychiatric emergences and it's hard to try and convey to somebody what really is a high risk emergency versus their distress [suicidal ideation] at that time because it is an emergency for them [Health Worker, Northfield]

> I think there's quite a protective point of view from police, a parental view. "These people have mental health problems you guys need to go and fix them". It's not quite as simple as that [Health Worker, Eastbrook]

Every frontline practitioner and service user interviewee described how they perceived the 'official' role of the police during a PMHT encounter to be that of a 'taxi driver', transporting the mental health worker to the person in crisis for a health-based intervention that otherwise did not exist. This perception was not founded in legal or practice reasons. It was this absence of provision that health workers recognised was often a cause of end user frustrations and further distress, noting how their receiving 'abuse' was an 'occupational hazard' of their role.

There was a perception from service users that if the police were in attendance, they could provide checks and balances on the behaviour and interactions through the intervention of the health worker, to avoid the 'abuse', 'rudeness' or 'lack of compassion' they had felt during previous encounters with crisis care practitioners. As the quotation below reflects, people felt the impact of prior interactions harshly, long after the experience itself:

> The crisis team have traumatised me. Never again will I seek help, they do more harm than good. Police should be better trained, but even now, without it, they are caring and give a damn about what happens to you. [Service User, Northfield]

This reflects the tensions that interventions can cause for future communication and engagement with an organisation. Though positive risk was well evidenced, compassion when delivering it was widely reported as absent not only in the choice of intervention, but also in the delivery of that intervention. Common service user accounts included receiving direct criticism of their personal situation, e.g. '*you're a mother/nurse/teacher and should know better [than being suicidal]';* using derogatory language within earshot, e.g. 'they spoke about me like I was a dog'; exerting the power imbalance, e.g. 'all they kept saying was I'm a Band 7 nurse, I know better than you'; and putting the onus on keeping a person safe back on the person, e.g. 'If you want to kill yourself, I can't stop you' and 'stupid but your choice'. When practitioners were asked about what I had documented in fieldnotes as a 'panorama worthy culture', referring to the British current affairs television programme that often involves covert filming, health practitioners primarily attributed such comments in response to the behaviour and/or unrealistic expectations of the service user. The nature of the interactions between staff and the 'humour' observed within all three teams, however, was indicative of a wider culture that practitioners did not recognise as something that would ever leave the confines of their offices:

> Most people don't listen to suicidal people every night. I think it's probably more part of the job, you know when they have like '24 hours in A&E' [another observational British TV show], we laugh and say they'd probably be about three seconds of footage they could show of us when we're not just laughing at something that is awful … and we know it's awful [Health Worker, Northfield]

It is outside the scope of this article to theorise the occupational culture of mental health crisis care provision more broadly, but it is relevant here only in so much as that it was a recognised method of 'coping' in the challenges they faced in their translation of risk, highlighting how tensions between intervention and social relations for these practitioners remain veiled. While not diminishing the impact that a visible police presence created, prior experience had shown service users that the negative connotations attached to a police presence were generally counterbalanced by the nature of the interpersonal interaction that ensued; i.e. that officers overall would show them compassion. Officers noted in equal amounts what they perceived to be their health counterparts having to navigate available provision over meeting a person's needs, or indeed treating them with compassion:

> The mental health worker had a different agenda [that was] about resources rather than the safety and the needs of the person, and that is a scary thought. That was horrendous, it was disgusting. We look at the needs of the person and it's rare that mental health staff will do the same [Police Officer- Hilltop]

There was a sense of belief expressed by service users that the officers they had experienced genuinely cared about helping them, and this aided trust. It was reported how often the person in crisis felt they 'knew the system' better than the officers who attended. Though the officers would often state 'we're going to get you some help' prior to using s136, and despite the person knowing that they would not meet the threshold for any subsequent crisis care, they still valued the genuine efforts taken by the officers in those instances. Health workers, however, reported dismay with officers making such promises, as they reported how such assumptions made the reality of their role more challenging:

> It's really unhelpful and takes a lot of backtracking. Sometimes I think they believe it and others I think they've done it to keep a lid on a situation, sometimes I've turned up and the persons packed a little bag because they genuinely think they're going to hospital, and I have to talk them through that's not going to happen [Health Worker, Northfield]

The police were therefore valued in their own right as an alternative to accessing specialised crisis care from the existing landscape. As the quote below reflects, the reasons for this were that effective communication, body language, and manner were paramount to kindness in action, which people reported as 'usually a given' when the police attend:

> From the minute she spoke to me on the platform, all I could see were her feet, she was so kind in her voice, how she spoke to me, her body language, everything was thought out. She had her arm around me on the way back to the office, and the first thing she did was get water and tissues, like a friend really. She was very compassionate and validated what I was saying in terms of how let down I was by services. [Service User, Northfield]

The perception was that the encounter with the mental health practitioner owing to PMHT would be 'better' than if they were alone, as 'I don't think they [health worker] would get away with that'. This perception that it would be 'better', reflects how receiving a compassionate response in any capacity, may itself form an intervention that was present for policing but not perceived to be in crisis care. In summary, the risk work tensions for officers between intervention and caring in the context of risk were much less so in nature due to their translating risk process being one of avoiding reputational and personal harm, as opposed to their health counterparts who were drawing on resource-led knowledge of available subsequent interventions. This section has shown that there was a desire for a police presence through PMHT which rested upon: (a) the want for there to be an immediate, emergency in-person practitioner response which could ensure their physical safety, i.e. a concrete intervention; and, (b) the need for a response to be one of compassion, which was associated more with police officers than it was with crisis care provision.

Concluding discussion

So far, the paper has depicted how the components of risk work are translated into practice to form the risk worker identities of officers and health workers working within a PMHT partnership. There is now scope to consider whether these individual tensions have been mitigated or overcome through working in partnership. Both practitioners were found to be constrained by their practical obligations and organisational logics, making any individual reconciliation of risk work irreparable. Whether officers were translating their risk knowledge in a less-than-perfect way or not, health workers were fulfilling their practical obligations within organisational logics constrained by their risk knowledge that was underpinned by economic pressures and service availability, creating little leeway for movement through a joined-up frontline approach. NHS mental health under-resourcing, whilst undoubtedly the primary root cause of mental health demand on policing (HMICFRS 2018), is also shown to be the key contributor to the inability to reconcile contrasting approaches to risk through PMHT.

The variations in risk knowledge largely underpinned why officers did not approach incidents in the same way as mental health staff, and considering these findings, it is proposed, nor should they be expected to. The only way for PMHT as an intervention to tangibly reduce the use of s136 in its current form would be for officers to defer to the expert knowledge of their health partner in making the decision, which is contrary to their legal obligation. While mental health workers discussed the success of being able to 'convince' officers that s136 was not necessary, this is problematic not only from a legislative perspective, but also due to the impact on end users who felt this translation process harshly.

This article has moved beyond traditional grand sociological frameworks that are broader in scope (Ericson and Haggerty 1997) to aid in developing a more nuanced sociology of risk, which offers a focused exploration at the individual level of risk management within multiagency settings. By examining how risk is conceptualised and addressed in everyday practice across both police and health domains, it provides a nuanced context-specific understanding of the complex dynamics at play when practitioners from these fields collaborate. Existing literature on risk work has predominantly centred on health and social care, but this study expands the discussion to the multi-agency landscape of policing, revealing that simply bringing together different organisations does not resolve the inherent challenges of risk management on the frontline. Rather, risk is shown to be a lived practical reality, shaped by the professional and systemic contexts of the practitioners involved. Risk work theory has thus been a valuable lens through which to illuminate the complexities of risk management in PMHT partnerships. Introducing a new dimension to risk work theory, understanding how systemic and economic pressures interact with interventions such as underfunded healthcare systems, which fundamentally alter how risk interventions are performed and perceived by professionals, is key to the success of a targeted intervention.

Despite efforts within policing to reduce risk aversion, particularly in mental health crises, this research highlights that promoting positive risk management may deepen the tension between police officers' roles as both enforcers and caretakers. This continues to be a prominent concern, with the development of further 'reworked' partnership approaches in this area, such as that of the right care right person (RCRP 2023) national agreement which once again centres on innovative approaches to managing demand. Policing by consent remains central to police legitimacy, but public confidence in this consent may be affected by the evolving complexities of risk management in crisis situations.

While the impact of austerity on frontline services has been quantified (Cummins 2011), this study contributes a new perspective by highlighting the experiences of frontline workers grappling with the tensions between service constraints and providing an effective crisis response. The research highlights that while positive risk-taking has been promoted as a valuable tool in health and social care, its application in crisis settings is fraught with difficulties. Police presence, despite its limitations, was often preferred by participants over mental health crisis lines, reflecting a deeper crisis in the provision of mental health care services.

The findings indicate that current PMHT partnerships do not reconcile the differing approaches to risk management between these fields; they remain contested or veiled as unreconciled tensions. While health organisations can benefit from additional resources such as increased staffing often funded by police budgets (e.g. Hilltop was wholly OPCC funded), the broader goals of reducing demand across both sectors remain unmet. For meaningful progress, new knowledge is required to address the structural, procedural, and policy challenges that underlie these partnerships. Without significant changes to crisis care provision, such as creating an alternative emergency response for mental health crises, the tensions in risk management approaches between police and health practitioners will persist, and targeted interventions like PMHT will continue to fall short in fully addressing these complex issues.

Note

1. Fieldwork was undertaken before the national roll out of the National Partnership Agreement – Right Care Right Person (2023) which may have since altered the standard blue lights response described.

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ORCID

Rivka Smith http://orcid.org/0009-0001-8741-6417

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