Running Head: DEFINING AND ASSESSING VULNERABILITY

Title: Defining and Assessing Vulnerability: Perspectives across Law Enforcement and Public Health (LEPH)

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**Abstract**

Law enforcement has traditionally been considered to focus mainly on criminal justice issues. However, over the past decade, there has been a dynamic shift in focus, with law enforcement professional groups assuming more responsibility for tackling mental health issues alongside public health colleagues. The concept of vulnerability has also emerged, with the term ‘vulnerability’ now frequently used across Law Enforcement and Public Health (LEPH) in identifying those in need of access to emergency help. However, there are ongoing debates between policing and health as to which service should be accessed and when; how services should be aligned; and discussion about the associated cost implications. Therefore, effective vulnerability assessment is expected to prevent unintentional harmful health and criminal justice consequences, and manage the negative impact of such cases where prevention is not possible. However, there is a dearth of evidence on effective vulnerability assessment, therefore we conducted a scoping study from a LEPH perspective to: 1) conceptually map out and understand if and how the term ‘vulnerability’ is defined, and the context in which it is used across LEPH in different countries; 2) examine the models or methods of vulnerability assessment across LEPH; and 3) identify under researched areas within the context of vulnerability assessment in LEPH.

Prior to the scoping review, we carried out work aiming to co-produce five key areas for LEPH research across Scotland. This involved bringing together an Expert Advisory Group (EAG) of 26 senior level stakeholders, working across academia, policing, health, people with lived experience, and the third sector in a full day interactive workshop. This workshop event prioritised the development of vulnerability assessment, highlighting the need to share this understanding across LEPH professions. Follow up sessions at key time points in decision making for the scoping review maintained involvement of co-produced value with our inter-professional group of experts throughout the project. The current paper discusses the core findings of the scoping review. More importantly, it conceptualises the EAG group event as a co-production process, focusing on how key LEPH research priorities were derived. Essentially, this paper demonstrates the inextricable link between co-production (via the EAG group event) and co-creation of value (via EAG group consensus on LEPH research priorities), and how this can result in both public and social innovation.

**1. Introduction**

One in four people in the UK have a mental health problem at any given time, with mental health problems accounting for 28% of the overall UK disease burden. The emerging Law Enforcement and Public Health (LEPH) field seeks to bring together those in police and health practice touch points, with a growing recognition of the extent to which policing and public health share common ground. This has, however, been challenging, given the differing remits, underpinning theory and ethos across professional groups, budgetary differences, issues with data sharing across different information technology systems, and data protection concerns with sharing service user information. However, there is a growing need and sense across policing and public health that working in partnership is essential to improve services for users and for staff.

This project brought together a national Expert Advisory Group (EAG) of 26 members, hosted by five academics. The remit of the group was to inform and support the development of a co-constructed programme of LEPH research, capitalising on research opportunities of urgent relevance to frontline services. The group identified the top five priority areas for LEPH research in Scotland. Following this, one priority area – assessment of vulnerability – was followed up and investigated via a scoping review.

The aims of this paper are two-fold: first, to describe the process through which the EAG was formed and brought together to establish the national priority areas for LEPH research in Scotland; second, to provide an overview of the scoping review’s methods and key findings. To begin, an overview of the need for co-creation of value in LEPH will be presented to provide the underpinning context for the reader. This will be followed by an overview of vulnerability research across LEPH.

**1.1. The need for co-creation of value across LEPH**

The police are the gateway to the criminal justice system (CJS), and the Equality and Human Rights Commission Inquiry (2011) have argued that the CJS needs to increase responsivity and accessibility to victims of crime and disabled people to provide more effective support. A range of policy responses to well-being and vulnerability have been enacted, with the Police and Fire Reform (Scotland) Act 2012 making the “safety and well-being of persons, localities and communities the core policing principle for Police Scotland” (Scottish Parliament, 2012). Well-being, and consequently vulnerability and risk-management, therefore lie at the heart of the CJS. Given that police officers are frequently the conduit to mental health assessment, it can be argued that officer decision making can be further challenged when faced with multiple vulnerabilities. Equally, health practitioners, as frontline workers, are necessarily engaged with public protection and public health challenges such as violence, sexual exploitation, substance use and curbing the spread of blood borne viruses. It is imperative, then, that inter-agency working is facilitated and supported in this area.

Despite the numbers of vulnerable people in contact with the CJS, there is very little work exploring the impacts of decisions in the CJS on people with mental vulnerability and no work exploring the impact of these decisions on the individuals concerned. This is particularly important in the context of police being increasingly relied on as an emergency mental health service (Dodd, 2016). However, Police Scotland’s Strategy 2026 highlights the importance of having people with vulnerability at the heart of all policing decisions, indicating the increasing acknowledgment of the need to work across the intersect of law enforcement and public health.

There is therefore little doubt that there has been a global escalation in police and health practice touch points, with a growing recognition of the extent to which policing and public health share common ground. This has brought about a call to consciously ‘join forces’ to more effectively and efficiently co-create value across LEPH by addressing the complex needs of vulnerable people and communities. Although such imperatives have drawn agencies closer together, such unions are complex. In this rapidly emerging field of LEPH, there remains a gap to bridge within the collaborative policing and public health research agenda. This entails building a robust evidence base to support informed, effective, efficient collaborative policies and partnership practice. This position must shift to mobilise research that is specifically relevant to frontline collaborative police/health practice and inform joint strategy and policy initiatives. This paper describes an initiative to develop a cross-sectional EAG to explore the LEPH intercept, particularly around mental health, distress, vulnerability and risk.

**1.2. The need to focus on vulnerability across LEPH**

Despite vulnerability appearing across a myriad of policy documents, directives, and being noted as a priority area for LEPH professions, as detailed above, there is, as yet, no shared definition of vulnerability across LEPH research or practice. This, at best, means that shared understandings will be muddied and a loss in meaning may occur. At worst, it may indicate that service users who are deemed as having vulnerability in both law enforcement and public health services will receive fragmented services, potentially at odds with each other. This has potential to cause unintended negative consequences for such service users. This section will provide a brief oversight of the state of the vulnerability research across the LEPH field.

Vulnerability is a key concern with LEPH (Murray et al., 2018), with an increasing recognition for the need to prioritise the identification, assessment, and management of people with vulnerability – both as victims and as perpetrators of crime (College of Policing, 2018; Department of Health, 2014). To this end, the Police Scotland Strategy 2026 stated that their primary priority is to protect vulnerable people (Police Scotland, 2017). Despite this, and as stated, there is no unified definition of vulnerability across policing and public health, or even within the various policy documentation and academic literature. This inhibits shared understandings of what vulnerability means at the intersect of policing and public health, and makes the identification, assessment, and management of vulnerable people challenging across LEPH professionals. Having such a shared understanding of vulnerability has the potential to improve communication, decision making, and management of vulnerable people with complex needs across the criminal justice and health systems.

The scoping review, which followed on from the co-created national priorities for LEPH research in Scotland was also undertaken by us, and aimed to identify how vulnerability is defined and assessed in relation to the adult population across LEPH. It focused on collaborative partnership working across LEPH. Within this paper, we use ‘Law Enforcement’ in a broad sense, to refer to the sector, rather than imply that this is the core function of the police. We recognise that the role of policing professionals is much broader than enforcement. We therefore include working with the public and other partners, community engagement, etc, within our operational definition. Similarly, our operational definition of Public Health is purposefully broad, including any health and social care professional who works with individuals who could be considered or who consider themselves as experiencing vulnerability.

**2. Methods and Findings**

This section will first present a description of the core methods used to bring together the EAG to co-produce the key LEPH research priority areas, and the outcome of this process. It will then provide an overview of the core methods and findings for the scoping review, which followed on from the EAG process and was informed by it.

**2.1. Bringing together the EAG to establish the top research priorities for LEPH**

***2.1.1. Expert Advisory Group Event***

A one-day event brought together the 26 EAG members from across the academic sector, people with lived experience, the Scottish Ambulance Service, Police Scotland, the Scottish Police Authority, the Scottish Government, the Violence Reduction Unit, SACRO, the NHS, and the Scottish Centre for Telehealth and Telecare was hosted (Table 1).

|  |  |  |
| --- | --- | --- |
| Professional Membership | Number within EAG | Percentage of EAG |
| Academic sector | 8 | 28.6 |
| NHS | 5 | 17.9 |
| Scottish Government | 5 | 17.9 |
| Police Scotland | 3 | 10.7 |
| Violence Reduction Unit | 2 | 7.1 |
| People with Lived Experience | 1 | 3.6 |
| Scottish Ambulance Service | 1 | 3.6 |
| Scottish Police Authority | 1 | 3.6 |
| SACRO | 1 | 3.6 |
| Scottish Centre for Telehealth and Telecare | 1 | 3.6 |
| *Note. Some members of the EAG aligned to more than one professional grouping, hence the numbers will add to more than the 25 people within the EAG itself. These roles are indicative of the employment of members when invitations were sent; some EAG members have since moved positions or changed roles.*  *Note 2. Table previously published in Murray et al. (2018)* | | |

Table 1. Breakdown of professional group membership across the EAG.

The event aimed to identify the top priority areas for research in LEPH as identified by the EAG, with the ambition to identify five key areas. There was a core focus on addressing the complex issues that limit individual disciplines and academic communities’ efforts to develop strong cross-agency police and public health research. By building on and developing original multi-agency partnerships, common research priorities can be ascertained, unions can be established, specialist expertise can be shared to more effectively leverage cross cutting research and limited resources. This was facilitated through guided discussions in four smaller groups, each facilitated by a member of the project team, and these small group discussions were summarised and later brought together as whole group discussions led by a session chair. Groups were composed of people crossing the professional memberships and therefore represented an interdisciplinary approach within the discussions.

The first guided discussion focused on identifying areas of shared organisational challenges associated with LEPH. The second focused on distilling the key problems, challenges, and the identification of the research priorities per table. A final session brought the groups together as a whole to consolidate the key findings of the discussions. The table discussions were audio-recorded and each of the table facilitators within the project team took detailed notes of the discussions. Both the audio-recordings and the notes taken on the day were used to inform the key findings.

***2.1.2. Key findings from the EAG***

***2.1.2.1. Preliminary Findings***

Prior to the event, EAG members were invited to send their priority areas for LEPH research via email, and these were shared on the day within an information pack to help inform discussions. Overarching categories present within this precursory list included:

1) The importance of those with vulnerabilities, including people with mental health, communication and substance misuse issues and missing persons;

2) The need for technology to enhance collaboration and communication, and to enhance and support assessment and decision making;

3) The need for intra and inter-service collaboration and education, both for formal education and in day to day practice such as risk assessment and management; and

4) The need to consider the mental health and wellbeing of staff in addition to service users.

***2.1.2.2. Findings from the EAG Event***

The notes from the table- and broader- discussions were collated using ‘Padlet’; an online software which allows users to collate notes, images, and other resources into an online ‘pinboard’. Photographs of the notes were taken initially and posted to a private Padlet board to allow for easy visualisation of the overarching notes and discussions held on the day. This allowed a full reading and viewing of the event’s core discussion points in an accessible way. In total, 27 pages of handwritten notes were taken throughout the discussions.

The next stage involved one of the project team (JM) reading through each of the discussion pages and making a list of the (up to) three key points from each page. The meeting notes per table and the three key point summaries were then re-read whilst listening to the audio-recorded group discussions to assess for accuracy and validity, and if needed, alterations were made. A Padlet was again created and used to facilitate collation and ease of reading the summaries. The key points were then collated and considered across each group’s discussion and across the groups’ discussions. A final set of discussion across the research team was held to determine agreement across the findings, and consensus was agreed. A brief report of the event and findings was also circulated back to the EAG after the event for feedback and views. All responders agreed that the findings were an accurate representation from the day’s discussions.

From the outcomes of the EAG event discussions, there were several overarching findings. These related not only to the shaping of specific key themes and challenges for research, but also for the approach needed and the need for cross-professional collaboration. At the centre of all discussions, the way in which current systems are organised were considered to act as a barrier to cross-professional innovation. While it was acknowledged that this is difficult to change, and ideally a whole systems change would be preferable, cross-professional collaboration was acknowledged as possible. To achieve this, both higher level strategic ambitions (e.g., at head of service, head of profession, or Government level) and buy in from front line and managerial staff must be being met, with local and national priorities aligning.

The ambition of a LEPH programme of research must therefore be ‘lofty’ and broad reaching, but also be practicable and meaningful at the local level. Projects should not be conducted in ‘silos’ but should be programmatic and interconnected within a wider-reaching strategic ambition. Discrete projects must also be collaborative across multi-agency partners, including the Police, Health, Academia, the Third Sector, and People with Lived Experience. Any research must be meaningful to services and service users, and should be carried out to identify, address and meet people’s needs; there will be some difference between what is needed by services and what is wanted to be carried out; compromise between ‘blue skies’ research and service focused and practical research will therefore be central to successful project implementation. One such example of this lies in the need for speedy projects and collaboration versus longer term research using best practice methods of evaluation, such as Randomised Controlled Trials: some projects or evaluations may be planned as longer term strategic initiatives, while others in the meantime use faster methods such as action research, tests of change, and/or implementation science techniques to achieve “small wins” which can be initiated and evaluated quickly and with little alteration to normal service delivery. Ownership over the leading of projects within collaborations must also be discussed and roles and responsibilities within these projects made clear.

The potential for secondary use of routine de-identified data was also discussed, as was information sharing between services, with the conclusion that data science had strong potential to inform more in real time whether shifts in practice were demonstrative of a desired effect. Therefore, the group concluded that provided sufficient engagement with people with lived experience was done to inform changes in practice, existing data and other forms of evidence should be used to inform changes to avoid duplication of effort and potential for waste. Ideally, a repository or improved communication around local successful and unsuccessful initiatives should be established to help inform practice.

The five key research priorities identified were:

1. *Vulnerability*: The central area of investigation was the need to assess vulnerability, ways to do this meaningfully, and identifying/establishing the evidence base for assessing vulnerability. The intersect between policing and health in assessing and triaging people who are vulnerable was central.
2. *Mental health crisis*: The focus here was on assessing and managing people who are undergoing mental health crisis. The investigation on how decisions are made and best practice (under realistic constraints) is achieved when all decisions are essentially uncertain, the need for training, particularly around suicide assessment, the need for identification of the most suitable place of safety and out of hours’ service, and sharing information, risk and decision making across the sectors were considered key.
3. *Decision making around assessment and triage across professional groups and professional roles*: Better working together and shared decision making and risk practices/processes were needed. Appropriate triage of vulnerable people and people in mental health crisis as agreed across professional groups, ideally based on an evidence-based or evidence-informed model. Technology assisted decision making and assessment was further indicated as an area for exploration to improve assessment times and to reduce the need to attend an emergency department for assessment or take the person into custody for safety/assessment reasons (e.g., through tele-health technology).
4. *Peer support and organisational well-being*: Supporting others both within professions and across professions. Examples include sharing the decision making burden and risk across professional groups, making information available when possible to other professional groups if working with the same person across services, and sharing education and training. Through shared education and training across professions, the language and procedures used will be more aligned, leading to less confusion and replication of roles. Staff wellbeing and mental health needs and developing supportive processes and procedures to ease workload burdens may help reduce stress related to work are central.
5. *Information and data sharing*: The need for accessible information sharing, as easily and smoothly as is possible, across professions to inform decisions and person centred care was discussed at length. Shared information could reduce response times, help to signpost towards the most appropriate service response for the person, and ultimately inform the best outcomes and reduce service burden.

**2.2. An overview of the scoping review key findings**

This section will now briefly present the purpose, main methods, and findings of the scoping review that was carried out post-EAG event. At key decision points, a sub-committee of the EAG were involved (N=5), consisting of people with a special interest in vulnerability. These decision points included the generation and finalisation of the research aim, the inclusion/exclusion criteria, the search strategy, and interpretation of the initial findings from the practitioner perspective.

The current scoping review was carried out to conceptually map and understand how ‘vulnerability’ is defined across LEPH (Anderson et al., 2008), and to identify whether any models or methods of assessing vulnerability existed across LEPH published papers (Grant et al, 2009). Through these aims, any gaps in understanding around defining and assessing vulnerability would become apparent (Ehrich et al., 2002), allowing the identification of key research priorities for future research in vulnerability and assessment across LEPH.

The methodological approach taken aligned with Arksey and O’Mally’s (2005) six stage framework, and incorporated recommendations provided by Levac et al. (2010). The stages of the framework are described below in the forthcoming sub-sections. Further information on the full scoping review process and findings outwith the scope of this paper, will be published elsewhere (REF). Therefore, this paper will summarise key elements of the scoping review only, as follows.

**2.2.1. Stage 1: Identifying a research question**

The research question which we addressed is: *What can we learn from extant literature about how LEPH professional groups define and assess vulnerability within the adult population?* This was divided into two sub-questions to address the critical elements (vulnerability definition and vulnerability assessment):

1. From a LEPH perspective how is vulnerability defined within the adult population?
2. Considering this demographic, do models for vulnerability assessment exist within or across LEPH professional groups?

**2.2.2. Stages 2 and 3: Finding and selecting appropriate studies**

A literature search was carried out on the databases CINAHL, MEDLINE, PsycINFO, Criminology Collection, and Sociology Collection, for peer reviewed journal articles published in English between 2010-2018, focusing in those aged 18 years old and older. Articles were only included if they discussed vulnerability, and its assessment in either law enforcement or public health contexts, or both.

**2.2.3. Stage 4: Conducting content analysis**

Relevant articles were exported from the databases into *Endnote* reference management software for storage and referral purposes. Following title and abstract screening, the remaining papers were subsequently exported to *NVivo* (qualitative data analysis software), to enable effective, efficient and transparent content analysis. Specifically, a *Text Search Query* was conducted to retrieve discussions on vulnerability. The data extracted included: first author name and date; article title; journal name; research country; research context (Law Enforcement, Public Health, or both); discussions involving definitions of vulnerability and brief descriptions of vulnerability assessment, if any; vulnerability associations; research gaps.

**2.2.4 Stage 5: Recording, organising and summarising the results**

155 records were identified. Eight duplicates were removed. Following the application of the inclusion and exclusion criteria, an additional 113 records were removed. After the full paper reading of the remaining papers, two were removed because they failed to address the research question. The 34 remaining records met the inclusion criteria and were considered eligible for screening and content analysis.

The scoping review revealed that definitions of vulnerability are at best fragmented, with only four of the 34 reviewed articles providing explicit definitions of vulnerability. Models for assessing vulnerability also lack uniformity across LEPH because it is prioritised differently across these organizations. From a Law Enforcement perspective, only one model for vulnerability assessment was identified (Table 3). It was based on how likely individuals think they may be suitable crime targets, and their ease of accessing social support (Gaitan & Shen, 2018). The assessment model indicated that vulnerability was associated with poverty and perceptions of risk. From a Public Health perspective, five different models for vulnerability assessment were identified. Within this context, vulnerability was associated with mental health, social risk, risk environment, risk of abuse, level of risk, access to health care, experience of abuse, and breakdown.

From a LEPH perspective, six different models for vulnerability assessment were identified; the use of risk factors to assess vulnerability appeared in three of the six models identified. From this perspective, vulnerability was associated with forensic histories and high-risk population, risk of death, HIV, mental health, feelings of weakness and helplessness.

The current review reveals conflicting priorities across LEPH in relation to vulnerability. Vulnerability is considered context-specific from a Law Enforcement perspective, relating to a specific circumstance or situation. It is viewed as person-specific from a Public Health perspective, taking into account personal matters relating to patients’ physical health, mental health and access to pre-hospital emergency services and/or health care.

At the intersect of LEPH, the selected studies looked at a range of criminal justice and public health issues in tandem. These include but were not limited to policing practices, police contact/custody, inequitable sentencing, arrest, incarceration/correctional setting, community treatment, psychiatric hospitalization, parole, forensic, counter-terrorism, victimisation, public health systems, learning disabilities, drug users, court cases, social care and others.

The concept of vulnerability from a LEPH perspective was wide; extending well beyond the concept of mental health. This explains the inconsistencies and lack of explicitness in vulnerability definitions and assessments across LEPH. Likewise, the LEPH focused studies included confirmed that partnership working between policing and public health is unavoidable and necessary.

**2.2.5. Stage 6: Stakeholder Engagement**

Stakeholder engagement in this project was in the form of the EAG, as described previously. This was an integral part of the scoping review to ensure its applicability to LEPH practice.

**Conclusions**

The findings from the scoping review revealed that vulnerability is context-specific from a Law Enforcement perspective, and person-specific from a Public Health perspective. The review also showed that definitions of vulnerability are at best fragmented, while models for assessing vulnerability lack uniformity across LEPH because it is prioritised differently across these departments. The implications are two-fold. For “vulnerable groups”, lack of evidence-based definition and assessment of vulnerable groups could introduce a raft of problems. These include preventing access to relevant LEPH services; exacerbating issues of multiple vulnerabilities, co-morbidity, and/or dual diagnosis. All could inadvertently enable social exclusion of vulnerable groups from political discourse and policy interventions. For LEPH departments and by extension, Federal Governments, the lack of consistency regarding vulnerability definitions and assessments may result in reactive crisis responses as opposed to proactive preventative measures.

From a co-production and social innovation perspective, Whitelock (2009) stresses the need to develop a personalised definition of vulnerability that includes people with lived experience’s voice as a critical step towards the care planning and support process. The current research and co-production innovation primarily sought to bring together relevant groups with expertise across LEPH, and it also included some incorporation of people with lived experiences’ voice. Greater involvement of people with lived experiences at the key stages of a project, from the outset to completion is an area for development in future research in this area.

Therefore, based on results from our scoping study, this paper contributes to the public management discourse by developing a new model for assessing vulnerability from the law enforcement context, informed by the public health context, but it could have gone further in including more people with lived experience in the decision-making process. To support and inform decision-making and triaging, any development of vulnerability assessment models or tools must focus on a unified definition and understanding of vulnerability, should seek to include a range of LEPH professionals and people with lived experience, and importantly must be designed to work both within specific contexts and be useful across LEPH settings. Careful consideration for feasibility, acceptability and usability of assessment models for vulnerability across LEPH settings is essential and can only be achieved through co-creation of values and shared understandings.

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