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A front line police perspective of mental health issues and services

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ABSTRACT

Background *Changes in mental health service provision in most western countries have been associated with an increasing role of the police in the community management of people with mental health problems, but little is known about how the police perceive this in the UK.*

Objectives *To investigate police officers' views on their roles in dealings with people with mental health problems and with mental health services.*

Methods *Nine in-depth semi-structured interviews were conducted with front line police officers. These interviews were analysed for recurrent themes using interpretative phenomenological analysis.*

Results *The recurrent themes identified were: emotional aspects of dealing with people with mental health problems and with services, impact of incidents on police resources and on people with mental health problems, success through collaborative working with health services and failure in its absence.*

Conclusions *Police officers' experiences of work with people with mental disorder in the community in Scotland had much in common with those previously reported in the USA and in Australia. Development of more collaborative approaches and mutual respect between the police and mental health service providers would resolve many of the currently perceived difficulties.*

Introduction

The level of contact between the police and the mentally ill has increased substantially in recent years (Patch and Arrigo, 1999; Price, 2005), with the reasons for this frequently attributed to deinstitutionalisation, reduction in the number of psychiatric beds and ever more stringent commitment criteria (Lamb and

Weinberger, 2005; Wells and Schafer, 2006). Most data are from outside the UK, where the police may spend about 10% of their time attending individuals with mental health problems, with 60% of officers responding at least once a month to a mental health-related incident (USA, Swanson et al., 2001; Australia, Fry et al., 2002; USA, Watson et al., 2008). Other figures suggest that up to one-third of all emergency mental health referrals are made by the police (USA, Dossche and Ghani, 1998). Moreover, between 20–40% of people with severe mental illness are arrested during their lifetime (USA, Vermette et al., 2005). Thus, the police have an integral role in mental health service provision. They can be called to deal with disturbed individuals by family members, members of the public or mental health workers placed at risk by violent behaviours in a hospital or community resource centre (Lamb et al., 1995). As a result, especially in the USA, the police have adopted roles or earned titles such as 'street corner psychiatrist', 'psychiatric medics', 'forensic gatekeepers' and 'amateur social workers' (Teplin and Pruett,1992). These roles take the form of 'front line mental health worker' (Green, 1997).

Gillig et al. (1990), in a US study, report that the police are 'burdened with inappropriate responsibility for the mentally ill,' yet are 'unfairly criticised' by mental health service professionals (page 663). The latter have also been reported as viewing police referrals as the most 'undesirable' and have criticised the police for the challenging behaviours which individuals exhibit (Steadman et al., 1986). Also in the USA, police officers have, in turn, expressed frustration about people who they referred to as having been discharged from the hospital very quickly, or even having refused admission at all (Gillig et al., 1990, Green, 1997).

Very little is known about how police in the UK feel about their similarly expanding role in mental health, or about how they view mental health services and their recommendations for collaborative working. While US and Australian work provide an insight into the issue, findings may not be directly transferable to Europe, including the different countries that make up the UK, because of differences in service provision, legislation and local policies. There is a need for a study of police views on their role in the mental health system in the UK.

Method

Ethics

The ethical board of Glasgow Caledonian University approved this study. The participants volunteered to be interviewed and were free to withdraw at any point. Potential participants were provided with a briefing sheet and consent form by email, prior to the interview. They were reassured that they would not be identifiable in any report and that transcripts of their interviews would be anonymised.

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Sample and setting

The sample was derived through purposive sampling, which is a technique frequently used in interpretative phenomenological analysis (IPA, see below), with a small number of participants being the norm (Reid et al., 2005). Participants were selected from a list of serving police officers across a large urban area in Scotland to reflect the range of police roles and varied length of service in that police force. The officers had volunteered to participate after receiving the information, as above.

Design and procedure

A qualitative research method was chosen for this study in order to provide richness and depth of information. IPA was selected as the method of analysis because it is concerned with examining participants' views, experiences and perceptions (Reid et al., 2005). It focuses on understanding what the participant thinks or believes about the topic under discussion and participants are recruited because of their expertise in the subject. Here, the target for understanding was the lived experiences of the individual police officers. IPA has become widely used in studies examining health service organisations and policies from the perspective of the professionals or patients involved (Pope and Mays, 1995).

Each participant was engaged in a semi-structured interview for approximately 1 hour. Open questions were used and participants were encouraged to discuss their experience of the phenomena without restraint. Questions were focused on examining the experiences and views of officers working with the mentally ill e.g. 'What type of experiences have you had with mental health service users?' This approach allowed the participant to mention any experiences or viewpoints they felt relevant to the topic. This interview approach also helped to develop a rapport with each participant. All the interviews were transcribed verbatim and analysed by the first author, using IPA. Re-reading and exploratory coding of the transcripts was carried out in order to identify meanings, patterns, comments and insights within the data. Similarities and recurrences of themes helped to identify the importance of a theme to the participants' experiences and these are grouped into emergent themes. The emergent themes were coded and clustered into super-ordinate themes. Super-ordinate themes are a way of grouping together the emergent themes which are identified during analysis. To facilitate inter-rater reliability, an independent analysis of a sample of the transcripts was undertaken by the second author with any discrepancies discussed and resolved.

Results

Nine interviews were carried out. Eight participants were male and one female, with the sample including police constables, community officers, sergeants and

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inspectors. The length of service in the police ranged from 6 years to 30 years. All participants had experience of working with mental health services and patients in the context of their policing duties. The types of experiences and the volume of encounters the officers had experienced differed across the sample, ranging from community policing response to non-criminal incidents involving a mentally ill person, to emergency call response to criminal offending by a mentally ill person.

Emotional aspects of dealing with mental health service users

This theme was shared by all participants. Officers displayed empathy toward the needs of people with mental health problems and were aware of the effect that police intervention may have upon them. A number of positive outcomes were reported and most police officers expressed a great desire to help service users. This positive motivation to help appeared to be a major coping mechanism for officers dealing with difficult and complex incidents.

> Other times you think it's worthwhile and you get that wee sort of spring in your step again and it pushes you on. (Officer C)

Many of the officers recognised the possible consequences of police intervention on mental health service users:

> At the end of the day how will that benefit the person, how will it benefit if they are going to end up with a criminal conviction and then it could … make it worse. (Officer G)

The police officers reported experiencing feelings of anger and frustration with certain aspects of their contact, particularly when they had problems accessing services for vulnerable individuals.

> I would say it's extremely frustrating … particularly when you have sat there hours and hours for them to walk out. (Officer C)

Feelings of powerlessness and resignation were experienced by all officers. Repeated incidents with unsuccessful outcomes, complex responsibilities and extended roles resulted in the officers feeling as though they were not helping anyone.

Impact on police resources and on people with mental health problems

Officers reported many complex mental health related incidents that involve the extensive use of police resources, including suicide and other self-harm by those with mental health problems (see also lack of collaboration, below). Many of the officers felt that there are inappropriate responsibilities being placed upon them

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and that they are dealing with mental health issues far beyond the initial crisis stage. They thought that the police were dealing with the consequences of the failure of health services.

> We feel as a police service that we are inheriting the problems of psychological services/ NHS services.
>
> We're catching problems caused by other services' lack of resources. (Officer I)

The officers reported that they were most likely to arrest individuals whose mental health symptoms had become disturbing to others in their community. These individuals ended up being supervised in police stations often on suicide watch, instead of being assessed in a hospital environment. This aspect of policing led officers to query care provision and often impacted significantly on police resources.

> We have to go along with having the cops watching these people and having to do the extra work but they don't appreciate the amount of resources it takes away. (Officer F)

The officers were insightful into the potential impact that their intervention had on patients or service users. They recognised that an individual with mental health problems may be traumatised by police intervention and that, as police officers, they were often perceived as a threat by such unwell persons. They did not want to cause or prolong distress for these individuals, but felt they were frequently placed in situations where they were the only service available to help individuals in crisis. Officers believed that the impact of their intervention in mental health crises had the potential to exacerbate the situation and increase risk both to officers and the service user.

> They don't necessarily understand why you're there … I've had a woman that thought I was trying to kill her … by taking her to the hospital. (Officer C)
>
> Part of the problem we get with mental health issues, people can react badly to seeing a police officer in uniform … they don't like it and they get frightened … is it fair to them; probably not. (Officer G)

Police officers felt that police cells were not a suitable environment for those with mental health difficulties as this environment may exacerbate their symptoms.

Collaborative working

The police officers thought that being able to assist individuals with mental health issues to access appropriate intervention in emergencies was a very

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positive aspect of their role. They attributed successful outcomes to collaboration with other services. An example provided by one officer of good practice involved a suicidal individual. The police and medical staff worked together to achieve a positive outcome:

> He, (the doctor), saved the day for everybody by persuading him to come out and walk back up to the hospital. (Officer G)

When support for service users was accessed successfully, the individual was not taken to the police cells. All the officers expressed a general desire to work collaboratively to avoid the service user acquiring a criminal record that may further exacerbate the possible stigma of their mental health problems:

> We try and do our best in terms of what needs to happen to them. (Officer B)

> It's a mental health issue more than a police issue so let's deal with it properly. (Officer G)

Often, officers viewed themselves as working to protect the interests of the service user by advocating for them to ensure they received the appropriate intervention for their needs.

Failures in multi-agency working

The gaps in services provided by agencies charged with assisting those with mental health difficulties in the community resulted in the police being called upon to fill those gaps:

> I don't think Care in the Community works because it's failing people who are coming to the attention of other agencies like the police who then have to deal with it. (Officer G)

Lengthy waiting times, strict referral criteria, local mental health service policies and lack of resources all contributed to the police officers' negative experience of mental health services. Some officers reported that even trying to communicate with appropriate services was extremely difficult. The officers also felt that some mental health services did not recognise the work that the police do to assist them:

> Unfortunately a lot more that we see just doesn't look joined up, it doesn't look holistic and it certainly doesn't take other partners, namely us into account for doing what we are doing. (Officer I)

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> When we go up, we always get the impression that we're a problem, we're bringing a problem, well we are but it's not our problem, so please don't take it out on us. (Officer C)

In some cases, the officers felt that the health services were failing these vulnerable individuals:

> The police have ended up being left to deal with everything where I think he's been failed by the medical profession, in some respects. (Officer G)

A lack of collaboration meant that officers sometimes had to sit for several hours waiting in hospital accident and emergency departments with service users. They could also be called upon by mental health services to find service users in the community and detain them. As many of these incidents were time consuming, officers reported that they were very aware of the impact this could have on their primary role of public safety.

Discussion

The police officers interviewed expressed compassion and understanding of people with mental disorders and reported that they have an appropriate and sometimes positive role with them and in working with mental health services. As in earlier research, when the officers in our sample felt that there were no successful outcomes from incidents, or that their role was being misused, they reported high levels of frustration (Fry et al., 2002). This was related to a perception of receiving minimal support from other professionals, and even criticisms levelled at them by health professionals when they presented an individual in crisis and requested assessment.

A dilemma reported by these police officers in Scotland reflected that in previous research in the USA, when called to resolve situations involving the mentally ill, there may be no indication for arrest, but they may be unsuccessful in securing care or hospital admission for the individual (Steadman et al., 1986; Gillig et al., 1990; Watson et al., 2008). Any subsequent criminalisation was recognised as being both a further stigma and a failure to address real needs. The officers in our sample emphasised that they did not want to arrest individuals unnecessarily, but gaps in services or failures in collaborative working could result in inappropriate detention in police cells, an echo of the so-called 'mercy booking' reported in the USA (Watson et al., 2008).

Our study highlights police perception of increase in contact between them and people with mental disorders, attributed by some officers to failures of the mental health system. This also shows common ground with samples of US police (Abram and Teplin 1991; Patch and Arrigo, 1999; Price, 2005). Further,

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officers in our sample did not feel that their assistance was always appropriately acknowledged by fellow professionals, despite the level of input they have. Steadman et al. (2000), in the USA, highlighted two factors which may be vital in changing this. The first is ensuring rapid access to mental health services, thus reducing waiting times and police time spent away from usual duties; the second is strong collaborative working relationships with community partners. This fitted with reports in our study, where positive experiences and viewpoints expressed by officers generally resulted from examples of effective collaborative multi-agency working, and specifically where this resulted in speedy access to services. It appears that, in Scotland, the police service role with respect to mental health crises generally supports the community policing philosophy. Specifically this includes non-enforcement tasks, non-emergency services and partnership working in order to serve and protect communities, maintain order and prevent crime (Borum, 2000, Home Office 2004).

Our study is among the first to provide an in-depth examination of the increasing role that police officers play in the mental health system, but it is limited by the small sample having been drawn from a single urban area in one country within the UK. Replication is required to validate the findings. To enhance the strength and validity of the findings, a combination of qualitative and quantitative approaches could be utilised, and officers from both rural and urban settings across the UK included. This would also allow exploration of whether the different legal systems operating in the UK impact on police responses.

While this study can provide no definitive conclusions with regard to police views of their role with individuals with mental disorder, it does highlight the importance of collaborative working by all agencies involved with them. Local health authorities could make more effort to work with police services in developing protocols when dealing with mental health crises in the community. By utilising a model similar to the Multi-Agency Public Protection Arrangements (Scottish Government 2008), a joint working structure could be established to deal with the gaps highlighted by the officers in this study. Alternatively, collaborative working approaches such as the Emergency Psychiatric Assessment Facility and the Joint Police and the Mental Health Response Teams could be piloted, as used in the USA and Australia (Hails and Borum 2003; Frank et al., 2005). Clearly, neither the police nor the mental health services can provide effective intervention for crises in the community alone; the two must work together (Lamb et al., 2002).

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