POLICE ENCOUNTERS WITH PEOPLE WITH MENTAL ILLNESS

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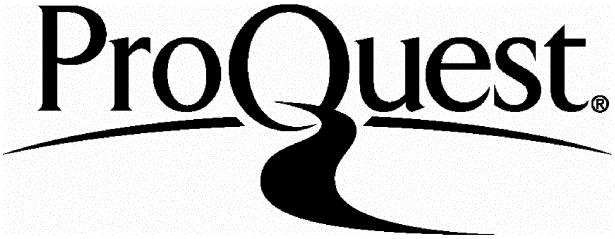

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CONTENTS

ABSTRACT

The closure of long stay psychiatric hospitals means that most people with mental illness now live within the community. The police are increasingly relied upon to intervene when people with mental illness are in crisis. Reduction in numbers of psychiatric beds and changes in involuntary hospitalisation laws have limited the options the police have when called to an individual with mental illness. Police officers are left making difficult decisions in an area in which many feel they are not qualified to intervene. The present research aimed to examine experiences of encounters between police and people with mental illness from the perspective of both police officers and people with mental illness. Twelve police officers and twelve offenders with mental illness took part in semi-structured interviews asking about their experiences. Data were analysed using Interpretative Phenomenological Analysis. Both police officers and offenders described difficulties in their encounters. These resulted in feelings of stress and dissatisfaction among police officers. People with mental illness felt misunderstood by the police, that the police had mistreated them and that encounters with the police could serve to exacerbate symptoms. People with mental illness also described times when the police had been more helpful and distinguished between experiences of being arrested for criminal activity and being helped when experiencing psychotic symptoms. The findings are discussed with reference to previous research and implications for police and clinical work are considered. The limitations of the study are considered using guidelines for qualitative research. Suggestions for further research are made.

CHAPTER 1: INTRODUCTION

Overview

Changes in policies surrounding the care of mentally ill people across the Western world have stressed that people, wherever possible, should be provided for within the community (Annandale, 1994). One of the most significant outcomes of moves towards community care has been the process of deinstitutionalisation, i.e. the discharge of patients from long-stay psychiatric institutions in favour of community-based placements, that began in the 1970s. This process has resulted in a significant increase in the number of people with mental illness living within the community. In the US, for example, state run psychiatric hospitals housed almost half a million people in the 1950's. By 1990 this population had fallen to around 130,000 (Davison and Neale, 1994). Although care in the community has undoubtedly resulted in a greater quality of life for people with severe and enduring mental health problems, life in the community has not been without difficulties (Kiesler, 1991). As the population of people with mental illness living within the community has grown, the presence of individuals who suffer breakdowns in their mental state, often resulting in behaviours that are difficult to understand and may be unlawful, has become a noticeable feature of life in cities and towns (Cordner, 2000). In the absence of the immediate availability of mental health professionals to offer assistance to such people, the task of providing an emergency service for this group often falls with the police (Cordner, 2000). Managing people with mental illness in the community has become a standard part of police work (Bittner, 1967).

For many years the police had three main options open to them when they were called to an incident involving someone who appeared to be suffering from mental illness. They could arrest them for disturbing the peace; they could remove them from the immediate situation and detain them overnight, giving them time to calm down; or they could transport them to the local asylum and have them committed for treatment (Cordner, 2000). These options gave the police a certain amount of power to intervene in situations involving people with mental illness. More recently, however, the options have been significantly reduced. Detaining people overnight fell into disfavour as police resources (e.g. cell space) became increasingly stretched and systems were introduced to make the police more accountable for how they dealt with people. Furthermore, cases of deaths of people with mental illness being held in police custody have been reported in the media. The third option, commitment to hospital, was largely removed following deinstitutionalisation and changes to the laws governing involuntary hospitalisation (Teplin and Pruett, 1992). At the same time, however, there is evidence to suggest that the frequency of police encounters with people with mental illness is higher than ever (Teplin, 1984; Cordner, 2000). The situation is now one in which the police are still expected to keep the peace and to assist people with mental illness in the community who might be disturbing others, but their options are limited. The police are expected to work out what is the right thing to do in a given situation, persuade the person to comply, and get the local legal and psychiatric services to co-operate.

Research on encounters between police and people with mental illness has tended to focus on the macro level of police involvement. For example, studies have estimated

frequencies of encounters with people with mental illness, the time spent in dealing with situations and the rates of outcome in terms of treatment or incarceration (Patch and Arrigo, 1999). Furthermore, existing studies have tended to ignore the perspective of the person with mental illness, yet research exploring service users' experiences of contact with mental health services has indicated that people find many aspects of their entry to psychiatric services traumatic (Rogers, Pilgrim and Lacey, 1993). Indications are that people in authority (e.g. doctors and the police) can be experienced as threatening and unhelpful by people who are suffering a deterioration in their mental state.

The present study aims to examine how both police officers and people with mental illness experience their encounters. This chapter reviews research looking at the frequency of police interactions with the mentally ill and the decision making process that impacts on how the police deal with mentally ill people. Research on vulnerable individuals and the police interview is considered within the context of the Mental Health Act (MHA, 1983) and the Police and Criminal Evidence Act (PACE, 1984) designed to protect people with mental illness in England and Wales.

Definitions and Terminology

Use of the term "mental illness"

The term "mental illness" is used throughout this thesis. This term is chosen because it is used in the Mental Health Act, 1983, and is also the term employed by professionals working in forensic settings such as secure hospitals and police stations. My own

experience of working with people being treated in secure hospitals is that they often describe themselves as "having" a mental illness. It was felt that the term "mental illness" would, therefore, make sense to the people who participated in this research. It is consistent with the terminology employed in publications focusing on forensic clinical psychology (e.g. the British Psychology Society published Journal of Legal and Criminological Psychology).

The fact that the term "mental illness" is the term of choice in the area of focus for this research does not imply a shared understanding of meaning. The Mental Health Act, 1983, itself did not include a definition. A definition was specified in a guide to symptoms associated with mental illness issued by the Department of Health cited in The Maze (The Bethlem and Maudsley NHS Trust, 1999). A mental illness is described as an "illness" that is characterised by the presence of one or more of the following features:

1. More than a temporary impairment of intellectual functions shown by a failure of memory, orientation, comprehension and learning capacity.
2. More than a temporary alteration of mood of such a degree as to give rise to the patient having a delusional appraisal of his situation, his past or his future, or that of others or to the lack of any appraisal.
3. Delusional beliefs, persecutory, jealous or grandiose.
4. Abnormal perceptions associated with delusional misinterpretations of events.

5. Thinking so disordered as to prevent the patient making a reasonable appraisal of his situation or having reasonable communication with others. (The Bethlem and Maudsley NHS Trust, 1999, page 6).

A number of objections can be raised about the above definition and about the term mental illness more broadly. The definition includes, for example, terms that warrant definition in their own right (e.g. "delusional beliefs"). Furthermore, using the above definition in order to categorise an individual as mentally ill involves a series of value judgements (e.g. how do you identify a "misinterpretation of events"?).

Mental illness is a social concept which is subject to variations across cultures and society (Fernando, Ndegwa and Wilson, 1998). It is rooted in the sociocultural, philosophical, moral and political contexts in which it is applied. As a normative discipline governed by social values, clinical psychology is concerned with conditions thought to be harmful on the basis of prevailing social values (Bean, 1983). There are several examples of how mental illness has been used for social or political reasons to control what has been perceived as threatening influences in society. In 1960's Russia , for example, political dissidents were confined in asylums on the basis that their political views indicated that they were "mentally ill" (Fernando et al., 1998).

A number of critics have questioned the medical model assumption that mental illness refers to some inherent condition existing within human beings (e.g. Stanley and Raskin, 2002). How can a 'mind' with no physical presence become diseased? The medical

model attempts to understand abnormal behaviour as if it were analogous to a physical illness or disease. Critics argue that the relationship between physical *disease* and mental *illness* is less concrete. Rogers et al. (1993) note that the medical model lacks construct validity in that, despite years of research looking at biological causes, no agreement on aetiology has been reached. Similarly, the diagnostic labels associated with the medical model lack predictive validity as they do not predict outcome in individual 'patients' (Rogers et al. 1993). Warner (1985) notes that social factors (e.g. levels of support) have more predictive validity than diagnostic labels.

There is a circularity in the argument that mental illness must exist because it can be defined (Stanley and Raskin, 2002) and that what is believed to be true about the behaviour (that it results from mental illness) affects the same behaviour it purports to explain (Eisenberg, 1988). We label an individual as suffering from schizophrenia, for example, on the basis of the observations we make about their behaviour. We then explain the occurrence of the same behaviour by saying that it is caused by the person's schizophrenia.

In summary, there are a number of theoretical and humanistic objections to the term "mental illness" and limitations in the medical model of abnormality. The term mental illness is used throughout this thesis as a shorthand way of referring to people who experience mental health problems which would be classified as "mental illness" under the Mental Health Act, 1983.

Use of the term "offender"

The term "offender" is used in this thesis to refer to individuals with mental illness who have broken the law. The term was chosen as a shorthand version of the term "mentally disordered offender," used in the Mental Health Act, 1983. It is the term employed within forensic settings and police stations and is also used in publications focusing on clinical psychology in forensic settings. The term 'mentally disordered offender' refers to an individual who has been convicted of breaking the law and meets one of the four categories for mental disorder specified in the Mental Health Act, 1983 (mental illness, mental impairment, severe mental impairment or psychopathic disorder).

Just as labelling an individual as 'mentally ill' involves judgements that are influenced by the social, cultural, temporal and political climate, labelling someone as an 'offender' is influenced by similar social forces. Criminologists note that, while the criminal justice system operates to punish the inherent 'corruptness' of the law-breaking individual, criminal behaviour may equally result from the corrupting influences of society (Blackburn, 1993). Critics of the criminal justice system argue that the law exists for the convenience of the state and that, although there are behaviours which most people would not condone (e.g. murder and rape), there are also examples of criminalised behaviours where the state appears to have made a moral judgement about what is wrong. Homosexuality, for example, was against the law in England and Wales until 1957 (Blackburn, 1993).

Concepts of offending and punishment become more complicated when considering people with mental illness who break the law. Harris (1999) has described the "mentally disordered offender" as a "borderline figure - between mental disorder and criminality, criminality and social problem, petty nuisance and social casualty..." (Harris, 1999, p. 14). The person with mental illness who breaks the law provokes difficult feelings within professionals who are torn between the need to care for an individual who is struggling to cope and the need to protect society from an individual whose behaviour is a cause for concern. This thesis focuses on individuals with mental illness whose behaviour has brought them into contact with the police. It is hoped that the problems with terminology noted above do not detract from a clear consideration of the issues.

The Frequency of Police Contact with People with Mental Illness

Studies have shown that dealing with people with mental illness is a commonplace, time-consuming and difficult part of police work (e.g. Walker, 1992). In a study involving the retrospective analysis of police records in Northumbria over a 63 day period, Berry (1996) found 238 calls to people with mental illness. Detailed records were available in 199 cases. One hundred and seventy nine involved incidents where no crime had been committed. Berry (1996) does not give examples of the types of incident the police were called to but one assumes that these included incidents when the police were called to assist the mental health services in 'removing' an individual from the community under a section of the mental health act. The 20 crime-related calls included cases where the

person with mental illness was involved either as a victim or witness as well as cases where the suspect had symptoms of mental illness (Berry, 1996).

Incidents involving people with mental illness took an average of 7.6 staff hours per incident (Berry, 1996). Berry noted that domestic burglary, over the same 63 day period, took an average of 4.1 staff hours per incident, i.e. officers spent 20% more time per incident dealing with people with mental illness (Berry, 1996). Police surgeons, usually referred to as Forensic Medical Examiners (FMEs), were called out to assess mental state on 48 occasions during the research period at a cost of 3% of the entire police budget for the county (Berry, 1996).

It is clear that the police spend a large amount of their time dealing with people with mental health problems, but why do this group require so much attention from the police?

Criminality and mental illness

Just as people often wrongly imagine the police spend all their time investigating crime and chasing criminals, one stereotypical view of someone with mental illness is as a dangerous individual with deviant interests (Blackburn, 1993). In reality, however, the relationship between mental illness and crime is not a simple one (Blackburn, 1993). Much of the research in this area suffers from questionable methodology and conclusions are, therefore, tentative. Monahan and Steadman (1983), for example, note that studies often focus on samples of detainees who have previously received treatment for mental illness. This represents an underestimate of the true prevalence of mental illness as it

ignores those with untreated conditions. Furthermore, there is considerable variability in the diagnostic tools and criteria employed by studies in order to detect and classify mental illness (Blackburn, 1993). Given these limitations, however, studies have considered the relationship between criminality (i.e. engaging in illegal behaviours) and crime (i.e. behaviour which is against the law) from two perspectives: by looking at rates of offending in people known to have received psychiatric treatment and by measuring mental illness in people arrested for crimes.

Mental illness amongst those arrested or questioned by the police

Teplin (1984, 1985) carried out an observational study of 1382 "police-citizen" encounters in Chicago. Evidence of mental illness was assessed using the Brief Symptom Checklist. Teplin found 30 out of the 506 people who were approached as suspects of crime reported symptoms of mental illness at a clinically significant level. Forty seven percent of people approached with symptoms of mental illness were arrested and detained by the police. The arrest rate for people with no symptoms was 28%. People who reported symptoms of mental illness were also more likely to be offered 'assistance' by the police at times when no crime had been committed (Teplin, 1985). Teplin concluded that, although there were no differences in patterns of crime between people who reported symptoms of mental illness and those who did not, people with mental illness were more likely to be arrested and detained. Teplin (1985) suggests that this trend may reflect more disrespectful behaviour among people with mental illness when approached by the police and that the police feel limited in their alternatives with people with mental illness.

Alternatively, it may reflect differences in police attitudes towards people with mental illness.

Crime amongst psychiatric patients

Studies of arrest rates among patients discharged from psychiatric hospitals have shown a changing trend (Rabkin, 1979). Studies carried out before 1965 in the USA concluded that former patients were less likely to be arrested than others (Rabkin, 1979). Studies carried out in the US since 1965, however, suggested that former patients were more likely to be arrested and for more serious crimes (Rabkin, 1979). It is suggested that changes in arrest rates are due to changes in policies surrounding involuntary hospitalisation that began in the 1960's in the US. As the criteria for involuntary hospitalisation became more strict individuals were discharged from psychiatric hospitals into the community. Former psychiatric patients were more likely to experience unemployment, poverty and poor quality housing than people with no psychiatric history leading to a greater likelihood of involvement in criminal activity for economic reasons (Rabkin, 1979).

The best predictor of future arrest in all studies involving former psychiatric patients , however, was a history of previous arrests (Rabkin, 1979). Similarly, Steadman, Cocozza and Melick (1978) found arrest rates three times that of the normal population among patients discharged from New York State hospitals in a 19 month follow up. Patients with no forensic history prior to hospitalisation, on the other hand, had a lower arrest

prevalence than the general population (Steadman et al., 1978). It was noted that the proportion of patients with forensic histories in psychiatric hospitals had increased from 15% prior to 1965 to 40% in the late 1970's (Rabkin, 1979). No explanation is offered as to the increasing proportion of patients with a forensic history in psychiatric hospitals in later years. It is possible, however, that this reflected greater police awareness of mental illness in the late 1960's and 1970's as a result of increases in the numbers of people with mental illness living in the community. At the same time there was a growing understanding that people with mental illness should be spared punishment in prison in favour of treatment (Blackburn, 1993). This, in turn, lead to an increase in the number of police detainees referred for psychiatric care.

Several studies of arrest rates among psychiatric patients have been carried out in Europe. Linqvist and Allebeck (1990) carried out a 15 year follow up study of patients with a diagnosis of schizophrenia discharged from a Stockholm hospital. Offence rates among male patients were only slightly higher than the general population. Arrest rates among female patients, however, were twice as high. It was not clear why there was a difference in rates for men and women, but feminist researchers have argued that police powers under Section 136 of the Mental Health Act (1983) in the UK have been biased against women (see review of Section 136, below). Hodgins (1992) in a longitudinal study in Sweden found that people with mental illness or learning disability were more likely to become involved in crime than members of the general population. Factors contributing to this finding included higher rates of unemployment and lower socio-economic status among people with learning disabilities and people with mental illness and an increased

tendency to be influenced by others who are involved in criminal activity among these groups.

Blackburn (1993) notes that studies involving discharged patients have often failed to control for variations in diagnosis either across time or between different hospitals and organisations. Such studies have also failed to offer explanations for changes in arrest rates and the reader is left to speculate as to factors that may have contributed to this. These studies also fail to consider arrest rates among individuals whose mental illness is not of a severity to warrant psychiatric treatment or who have avoided contact with the psychiatric services.

Mental illness amongst convicted individuals

A second approach to research in this area has been to screen for mental illness in convicted criminals. In a summary of nine US studies of court and prison populations carried out between 1918 and 1970, Brodsky (1972) found that rates of psychiatric disorder varied between 16% and 95%. Higher rates were reported in studies carried out more recently. High rates were often due to vague diagnostic criteria such as "behaviour disorder" and personality disorder, both groups of 'disorder' that are, in part, diagnosed on the basis of involvement in criminal activity. In many cases an individual qualified for a diagnosis of behaviour disorder by virtue of the fact they had become involved in criminal activity, i.e. anybody who found themselves in trouble with the law would

qualify. Rates of psychosis varied between 1% and 4% (i.e. were similar to those found in the general population).

Guze (1976) found high rates of psychiatric disorder among male and female prisoners in the US but psychosis and learning disability were both low. Sociopathy was the most common diagnosis accounting for 78% men and 65% women, (Guze, 1976). Once again, however, sociopathy was, in part, defined by engagement in antisocial, criminal behaviour. As regards rates of mental illness among UK prisoners, one study suggested that around 37% had a psychiatric diagnosis, 23% reported substance abuse, 6% were judged to suffer from affective conditions and 2% from psychotic illness (Gunn, Maden and Swinton, 1991). Blackburn (1993) notes that, when socio-economic status is controlled for, rates of mental illness among British prisoners do not differ significantly from that of the general populations.

The 'criminalisation' of mental illness

Several researchers have reported evidence which is consistent with what has been termed the 'criminalisation' of mental illness over the last two decades (e.g. Green, 1997; Teplin, 1984; Teplin, 1985). Society, it is argued, has reacted to changes in laws making involuntary hospitalisation among the mentally ill less common by opting for a criminal justice response via the police rather than a mental health response via psychiatry (Green, 1997). Unusual behaviours resulting from mental illness that cause concern to members of the general public but are not dangerous enough to warrant involuntary hospitalisation are now controlled by admission to the criminal justice system. Criminalisation is most

prominent in cases where arrest is not mandatory but mental illness appears to be present, for example, in cases of a disturbance to the peace (Teplin and Pruett, 1992).

Hospital admissions criteria that are experienced as cumbersome and time consuming by the police, combined with an individual police officer's inability to withdraw until situations are resolved, often force officers to use a criminal justice disposal in cases where they feel the mental health systems will not act (Green, 1997). Pressure from superior officers to deal with incidents quickly increases the officer's reluctance to instigate a time consuming psychiatric referral. As such, people with mental illness are more likely to become involved in the criminal justice process and behaviour associated with mental illness is criminalised. Higher arrest rates for people with mental illness as reported by Teplin (1985) may be testimony to criminalisation. Menzies (1987) found evidence in Toronto that police officers were more likely to arrest people with mental illness. Similarly, Robertson (1988) found people with mental health problems were arrested for more minor offences than people without mental health problems. Studies considering individual cases, however, have identified a tendency among police officers to exercise discretion (e.g. Bonovitz and Bonovitz, 1981; Green, 1997). Studies considering large numbers of cases over a period of time often overlook the individual factors that influence the way in which people with mental illness are dealt with by the police (Teplin and Pruett, 1992).

Police Approaches to Dealing with People with Mental Illness

Given the large number of encounters between the police and people with mental illness, often in cases where no mandatory arrest is indicated, researchers have examined in more detail how the police deal with this group of people and the pressures that affect their decision to respond. This section begins with a review of psychological theories of decision making that may impact on police behaviour. Research on police attitudes and police culture is considered. This section also includes a review of the literature on police behaviour with people with mental illness.

Psychological theories of decision making and the police

Although there is little research referring specifically to police officers, some researchers have begun to apply psychological theories of decision making to the investigative process (e.g. Chase, 1999). Two types of psychological theories of decision making have been identified. Normative decision making theories (e.g. Expected Utility Theory; Plous, 1993) describe how decisions *should* be made in order to maximise the mathematical probability of a favourable outcome. Although normative theories have been used by investigative psychologists to help manage investigations into serious crime, they are of little relevance to the policeman on the beat where the need to act quickly precludes mathematical appraisal of potential outcomes.

Descriptive theories of decision making attempt to explain *actual* decision making in the 'real' world. Descriptive theories assume that decision making in practice is not an ideal

process. Individuals are limited in their capacity to make ideal choices by limitations in their processing capacity (i.e. people do not have either the technical knowledge or cognitive space to calculate probabilities before making each and every decision). Furthermore, descriptive theories allow for the fact that decisions are made under conditions of stress and are subject to influence from other people. Descriptive theories, therefore, give insight into the kind of decision making carried out by police officers. Rather than advising how to optimise decision making, descriptive theories focus on the errors people make when making decisions (Tversky and Kahneman, 1974). The "availability heuristic" states that judgements about the causality of an event, for example, are made on the basis of the decision maker's own understanding of the world and not with reference to the *actual* state of the world. Some events are more salient than others, leading individuals to over-estimate their prevalence. People tend to over-estimate the prevalence of violent crime, for example, because this is more salient and attracts more attention than non-violent offending (Chase, 1999).

The "representativeness heuristic" states that judgements of the probability, frequency and causality of an event are subject to the extent to which the decision maker feels that the event is characteristic of the underlying causal process or class. There is a bias to recall events that confirm our beliefs about the world and to pay less attention to incongruent events. At the same time, however, unexpected events provoke dissonance by challenging the individual's own assumptions about the world and can, therefore, be more salient. A police officer who believed that women do not commit violent crime and

was investigating a woman charged with assault, for example, may be more likely to consider alternative explanations for this behaviour (e.g. provocation).

Studies have shown that individuals are only accurately able to predict relationships between variables that are either highly correlated or have a very low correlation (Chase, 1999). We tend to rate events that have a moderate relationship with one another as being either highly correlated or not at all correlated. This bias is likely to affect a police officer's judgement as it predicts that officers will over-estimate relationships between events. Furthermore, individuals tend to ignore the non-occurrence or absence of events. Fictional police officers in the Sherlock Holmes case "The dog that did not bark in the night" overlooked the fact that the dog did not bark at the time of the crime, indicating that the perpetrator was known to the dog.

Finally, descriptive decision making theorists have examined the influence of small group processes on decision making. This is particularly relevant to police officers who go on beat with a partner and work as part of a small team. Kaplan (1978) predicts that normative influences (i.e. failure to question assumptions made by the group, failure to consider alternative explanations and a tendency to avoid information that is inconsistent with the group's decision) are most important when the group is long term and conditions of stress are apparent. This is just the case with police officers and it is predicted that decision making will, therefore, be subject to bias due to the group process.

Psychological theories of police attitudes

The sources of bias identified by descriptive decision making theories are influenced by attitudes and beliefs. Researchers have investigated whether police officers, who are recruited from the general population, are representative in their attitudes and beliefs (Horn and Hollin, 1997). Several researchers have studied claims for a specific "police personality." Evidence for this is mixed (McConville and Shepherd, 1992). Shernock (1988), for example, found that the police personality resulted from socialisation during training and induction into police forces (i.e. raw recruits did not differ in personality from the general population). At the same time, however, the police personality varied from force to force. Certain common features are noted. Police officers tend to be white men who favour action centred approaches, display high levels of internal solidarity and share stereotyped views of 'outsiders' (McConville and Shepherd, 1992). Smith and Gray have argued that central to the phenomena of police culture is the "cult of masculinity" (Smith and Gray, 1985, page 372). They define the features of this as placing an emphasis on remaining dominant in every situation, not backing down or losing face, supporting one's partners even if they are in the wrong and an overt display of physical courage (Smith and Gray, 1985). Features of the 'masculine culture' have also been identified in female police officers (Brewer, 1991).

Given a broader tendency within the police to make sense of the world according to stereotypes (Young, 1991; Arnold, 1989), several studies have investigated police attitudes towards specific groups, including people with mental illness, who break the law. In the USA, Patch (2001) examined the relationship between police attitudes about

people with mental illness and decision making in cases where prosecution was not mandatory. Attitudes were measured using a self-report questionnaire. No relationship was found between individual officers' attitudes to mental illness and choice to prosecute. Similarly, no relationship was found between attitudes to mental illness and length of police service; there was no evidence for a change in attitudes due to socialisation into the police force. Patch (2001) suggests that officers appeared to make their decisions according to policy rather than their personal feelings but noted that the research was subject to response bias from the officers who participated.

In the UK, Horn and Hollin (1997) investigated beliefs about female offenders within the police. A self report questionnaire was used to rate attitudes towards male and female offenders. Police officers were found to view offenders as less similar to non-offenders and as less trustworthy than a control group of civilians. Both police officers and members of the public felt that there were differences between male and female offenders in that female offenders were less fundamentally 'bad' than their male counterparts and were more similar to non-offending women. Horn and Hollin (1997) concluded that police officers, like the general public, tended to view female offenders as 'normal' people who had deviated on a temporary basis.

Harris (1999) notes that the criminal justice system is designed to 'deal with' able bodied men who break the law. The criminal justice system struggles when it encounters other groups (e.g. children, women or men who are suffering from mental illness) because it was not designed with these individuals in mind (Harris, 1999). Police attitudes to groups

such as women and people with mental illness may be influenced by their own experiences of the limitations of the criminal justice system. It may be, therefore, that just as officers in the Horn and Hollin study were found to be less deterministic and more lenient with female offenders, officers would be expected to be more lenient with people with a mental illness. Alternatively, 'traditional' stereotypes of people with mental illness as dangerous criminals (discussed above) may lead the police to deal more harshly with this group of people.

The decision to arrest or refer

The most important factor in the debate surrounding the criminalisation of mental illness focuses on the police officer's decision to arrest an individual with mental illness or to refer them to the mental health services (Green, 1997). This decision making process often rests with the officer who first attends the scene. Officers must decide whether they are acting as protectors of public safety or are providing care and protection for individuals who are in need (Foucault, 1977). Researchers in this area have referred to the police, therefore, as, "forensic gatekeepers," (Menzies, 1987) and "street corner psychiatrists" (Teplin, 1984). The evidence suggests that the police do exercise discretion when dealing with people with mental illness but that their ability to act is influenced by certain factors as described below (Green, 1997).

Research looking at police discretion with people with mental illness has focused on the following areas:

- Offence severity (Teplin, 1984).
- Whether the severity of mental illness appears to meet "sectionable" levels (Teplin, 1984; Teplin and Pruett, 1992).
- Previous experience of individuals, i.e. people who are already known to the police (Teplin, 1984).
- Demands placed on officers by either the police force or local psychiatric facilities (Teplin, 1984).
- The race and ethnicity of suspects (Rosenfield, 1984).

In contrast to findings reported by Menzies (1987) and Robertson (1988), Bonovitz and Bonovitz (1981) found a reluctance to make arrests of people with mental illness when arrest was not directly mandated. Officers in this study attempted to persuade relatives of people with mental illness who were disturbing the peace to seek involuntary commitment before considering arrest. In the UK, Robertson, Pearson and Gibb (1996) found that most cases of people with mental illness are dealt with on an informal basis by the police attending the scene. Hiday (1991) reports lower re-arrest rates among people with mental illness than found in people with previous convictions with no mental illness. There is evidence to suggest greater variability in police officers' approaches to cases involving mental illness, due, in part, to uncontrolled variables affecting these interactions (Green, 1997). Patch and Arrigo (1999) suggest that police work with mental illness is best investigated qualitatively by considering individual interactions in detail, allowing for consideration of the phenomenology of the experience.

The decision to arrest or refer: North American studies

The seminal piece of research in this area was published by Teplin and Pruett (1992). This research is described in detail as it is the most comprehensive of only a few papers on the area. They argued that police interactions with people with mental illness are based on a conflict between the duty to protect public safety and the duty the police have to protect people who are not able to protect themselves. In working with people with mental illness, therefore, the police are often in conflict because protecting the public and looking after an individual's rights may be mutually exclusive (Teplin and Pruett, 1992).

Police behaviour is guided by the law. In the case of people with mental illness the law in most countries instructs the police to act if the mentally ill person is a danger to himself/herself or others or is not able to provide for his/her own basic needs as a result of mental illness (Teplin and Pruett, 1992). What the police *actually* do, however, is influenced by the complexity of the social process of their interactions with people with mental illness. The law cannot dictate an individual officer's emotional reaction to situations (Teplin and Pruett, 1992). Furthermore, the police are called to deal with situations involving people with complex difficulties at a time of crisis and have no body of psychiatric knowledge or training to assist them (Rumbaut and Bittner, 1979).

Police officers are expected to exercise discretion in deciding the most appropriate way of resolving often complicated situations involving people with mental illness. The appraisal of situations, therefore, involves a complex social decision making process and is subject to the sources of bias as discussed above. Teplin and Pruett (1992), for

example, found evidence that the police had developed an informal operating code, a shared understanding of how things "should" be done, to guide their work with this group of people. Evidence for the existence of such codes has been found in other studies looking at police behaviour. Bittner (1967) found that officers were reluctant to make referrals to psychiatric services and used these only in situations where they felt there was a significant risk of escalation of violence. Schag (1977) found a reluctance among officers to refer cases to mental health services because this was perceived by officers as being time consuming. Similarly, Mathews (1970) reported that officers' decision making when dealing with people with mental illness was often biased by previous experiences of lengthy delays if a psychiatric referral was initiated.

Teplin and Pruett (1992) examined 2,122 police-citizen interactions in a mid-western city in the US. 85 of these interactions involved individuals judged to be suffering from mental illness. Hospitalisation was instigated in 13% of cases involving a crime and 11% of cases involving an individual with mental illness who had not committed a notifiable offence. The researchers in this study were asked to keep a diary of their qualitative observations of police behaviour. They found there were a number of inter-related and contributing factors that influenced the officer's decision as to whether to refer the individual on to the psychiatric services. For example, officers were aware of the reduced numbers of admissions beds as psychiatric institutions had been replaced by community based mental health facilities. Officers felt, therefore, that people were unlikely to be admitted unless they were actively suicidal or delusional. They did not think that behaving in a 'dangerous' manner alone would qualify for hospital admission. At the

same time, officers did not generally feel incidents involving people with mental illness warranted a criminal justice intervention and were, therefore, often left with no clear alternatives. Researchers felt that the officers in this study did not hold their work with people with mental illness in high regard. It was noted that this kind of work was time consuming and was not included on department time sheets or activity indices, i.e. was perceived as going un-rewarded by the department. Furthermore, people with mental illness were often discharged from police or hospital care very quickly and this was perceived as being a slight on the judgement of the arresting officers.

Teplin and Pruett (1992) suggested that the arrest of people with mental illness was more likely in cases where symptoms were judged to be too mild for hospitalisation and where the individual's behaviour was too public to be ignored, i.e. too many "decent" people were being upset. Furthermore, evidence suggested that arrest was occasionally the only option in cases where an individual's behaviour was judged to be too dangerous to be contained within a hospital environment; officers felt that the psychiatric facilities available to them often lacked appropriate levels of security. Arrest was also more likely in cases where the mental health services seemed to have "given up" on an individual. One officer observed, "The police don't give up on patients the way doctors, psychiatrists and psychologists do. They keep locking people up and the court system doesn't give up on people." (Teplin and Pruett, 1992, p. 151).

Teplin and Pruett (1992) noted that psychiatric symptomatology was only one of a number of factors that influence an officer's decision making process with people with

mental illness. Other factors included previous experience of difficulties in initiating a psychiatric admission and pressure from the police force to avoid this if possible. Furthermore, the legal structure did not dictate the resolution of police encounters with the mentally ill; the most commonly used disposal was an informal one, e.g. driving an individual home or contacting relatives on their behalf (Teplin and Pruett, 1992). An informal disposal was the outcome in 70% of interactions.

Although Teplin and Pruett's study represents an early attempt at an empirical investigation of this area, critics have argued that its findings are of limited value due to a lack of clear qualitative methodology and a predominately observational design. Green (1997) notes that much of the previous research in this area has focused on nominal or categorical variance in police behaviour and only considered the formal options available to the police. Green (1997) studied police approaches to people with mental illness in a qualitative study involving eleven officers based in Honolulu. All felt they were able to identify serious mental illness but were less sure if substance or alcohol misuse was present. None of the officers who took part in this study mentioned training they had received on mental illness.

It was noted by several respondents in Green's study that taking a mentally ill individual to the police station could lead to the officer involved being in trouble with the custody officer for tying up limited resources 'unnecessarily' (Green, 1997). Officers also complained of lengthy delays if they took 'suspects' to the hospital emergency department. Pressure placed on officers either directly from custody officers or indirectly

as a result of inadequate health facilities led to the vast majority of cases in Honolulu being settled on an informal basis. The officers who took part in Green's study felt unhappy about the way in which the system worked and suggested that it was the responsibility of the health services to improve things by facilitating access to treatment. Green concluded that the officers interviewed exercised a great deal of discretion in dealing with people with mental illness, that disposal options were inadequate and that officers often acted informally to try to "fix" things on a temporary basis. Furthermore, arrest was used only as a last resort and was discouraged by superiors in the police department.

Although Green's (1997) qualitative approach to investigating police interactions with people with mental illness represents an attempt to give a detailed account of individual officers' experiences of people with mental illness, Green does not specify which qualitative methodology was adopted. Furthermore, this research was specific to officers working in a particular culture, i.e. Honolulu. One of the aims of this thesis is to investigate police officers' experiences of mental illness in the UK using a specified qualitative methodology.

The decision to arrest or refer: Studies in England and Wales

Although no qualitative research has, to date, been published looking specifically at police interactions with people with mental illness in the UK, several researchers have investigated police approaches in England using quantitative methodology.

Robertson, Pearson and Gibb (1996) found that the police in England and Wales were generally able to identify cases of mental illness but officers complained of a lack of training in this area. It was noted, however, that this research involved extreme cases of mental illness and no attempt was made to measure identification of more subtle presentations. A small number of "non-notifiable" cases, i.e. breach of the peace cases, were studied. Robertson et al. (1996) found that people taken in by the police under Section 136 of the Mental Health Act (see below) were generally not detained in hospital as they were not considered to be "dangerous" enough. Cases where the police referred breach of the peace charges involving people with mental illness to the magistrates were discharged in court. The result was that mentally ill people taken to police stations under Section 136 often did not get admission to psychiatric care. Robertson et al. (1996) did not comment on individual officers' feelings about how this affected their professional or personal identity. Of the eleven notifiable cases involving people with mental illness identified, just one resulted in involuntary hospitalisation. In seven cases the charges were dropped, two people were charged and one received bail. Robertson et al. (1996) found that mental illness played a decisive role in five of these cases. Once again, this study did not consider the mechanics of the decision making process that led the police to act as they did, or the experience of encounters.

Vulnerable Groups

One aim of the current study was to examine the experience of police involvement from the perspective of individuals with mental illness. An extensive literature search, however, failed to identify any research specifically examining this. This section reviews

literature considering vulnerable groups and the police, legislation designed to protect such people (i.e. the Police and Criminal Evidence Act; PACE, 1984), and police powers to intervene with vulnerable people in the community (Section 136 of the Mental Health Act, 1983).

Studies considering vulnerable groups and the police

Several studies have considered factors which complicate police involvement, particularly police interviews, in cases involving 'vulnerable suspects' (the term used in The Police and Criminal Evidence Act, PACE, 1984). People with mental illness are considered to be "vulnerable" because many of the associated symptoms (e.g. perceptual abnormality, difficulties processing information, cognitive distortions) can potentially increase the likelihood of individuals admitting to crimes they did not commit (Gudjonsson, 1993). Studies have focused, however, on "vulnerable people," including people with learning disabilities, children and people who do not speak English as well as people with mental illness. Furthermore, studies have not, to date, included qualitative analysis of the experience of encounters with the police. They do, however, offer insight into some of the difficulties faced by vulnerable suspects.

The main area of focus of studies looking at vulnerable suspects and the police has been the police interview and confessions made to the police. Brandon and Davies (1973) reported that false confessions accounted for the second most common cause of wrongful imprisonment in England and Wales. Several well known cases have been reported in the media involving false confessions made by people who have been shown to have been

vulnerable at the time of their arrest. The earliest such case involved Timothy Evans who was executed in 1950 having confessed during the course of his detention by the police to the murder of his daughter (Kennedy, 1988). Evans' landlord Christie was eventually found guilty of several murders including that of Evans' wife and was executed in 1953. It was suggested that Christie was also responsible for the death of Evans' daughter and the Appeal courts decided in 1966 that Evans' conviction was unsafe granting him a full Queen's pardon. Evans' mental state at the time of the police interview in which he confessed and the strategies employed by the interviewing police officers were questioned at appeal (Gudjonsson, 1993).

A second case, the Confait case, involved three young men, Latimore, Leighton and Salih, 2 of whom had learning disabilities, who confessed to arson during the course of police interviews. The fire which they were believed to have set led to the death of another young man, Maxwell Confait, and Latimore, Leighton and Salih were all convicted despite having retracted their initial confessions. Their convictions were quashed when the case went to the Appeal courts and all three men were released having served three years in prison (Gudjonsson, 1993). The Royal Commission on Criminal Procedure, 1978, was set up to examine police interviewing procedures as a result of the Confait case. This eventually led to the introduction of the Police and Criminal Evidence Act, PACE, 1984, see below.

Several subsequent cases have been identified in which convictions made on the basis of confession during police interviews have subsequently been quashed as 'suspects' were

found to have been psychologically vulnerable at the time of interview (e.g., the Guildford four; the Tottenham three). These cases have raised awareness among the police and court authorities of the effects of psychological and psychiatric vulnerabilities on an individual's behaviour during police interviews and in their other dealings with the police (Gudjonsson, 1993). Gudjonsson (1993) notes that legal advocates often argue in court that encounters with the police cause high levels of anxiety even among experienced criminals who have been arrested on a number of occasions. Pearse, Gudjonsson, Clare and Rutter (1998) found levels of anxiety that were higher than those recorded in clinical populations when the State-Trait Anxiety Inventory was administered to a sample of 160 police detainees before police interviews. It is likely, therefore, that people with mental illness or other vulnerabilities will also find this experience highly anxiety provoking such that their mental well-being and the resulting behaviour is likely to be affected. Gudjonsson (1993) also argues that many people who are arrested by the police are potentially vulnerable to giving misleading information due to the presence of a learning disability, a disturbance in mental state or heightened suggestibility (i.e. a tendency to being readily responsive to suggestions made by others).

Irving (1980) and Irving and McKenzie (1989) carried out a series of three observational studies of police interviews in Brighton in 1979, 1987 and 1988. 60 subjects were observed both prior to and during police interviews in 1979. 26% of detainees were judged to display signs of vulnerability either due to intoxication (18%) or behaviour indicating the presence of mental illness (8%). A further 16% of detainees were judged by the researchers to be in an abnormal mental state due to high levels of anxiety (Irving,

1980). The two follow up studies involved observations of a further 136 detainees prior to and during interview, in 1986 and 1987. Again high levels of anxiety were noted. It was noted that a lower proportion of the detainees observed in 1987 were judged to be in an abnormal mental state (31% in 1986 compared to 13% in 1987). The authors suggested that the introduction of the Codes of Practice as specified in PACE in 1987 meant that people who were intoxicated were not interviewed in the 1987 study and that this accounted for lower rates of abnormal mental state (Irving and McKenzie, 1989). The above studies, however, relied on observation only and judgements on detainees' mental state were, therefore, made on the basis of appearance and behaviour alone.

The Royal Commission on Criminal Justice commissioned a detailed investigation into psychological vulnerability among police detainees (Gudjonsson, Clare, Rutter and Pearse, 1993). Three clinical psychologists carried out a detailed psychological assessment of detainees' mental state prior to police interviews in Peckham and Orpington police stations. 164 detainees took part in assessments looking at mental state, intelligence, anxiety and suggestibility. Assessment included both clinical interview and psychometric assessment. The mean IQ of detained persons was 82, but the researchers were mindful that this probably represented an underestimate due to the context in which testing took place and the high levels of anxiety observed in participants. 20% of participants reported levels of anxiety that were significantly higher than those found in the general population, and reported that they found detention at the police station unduly stressful. It was noted, however, that the participants in this study, despite high levels of

anxiety, were no more suggestible than members of the general population (Gudjonsson et al., 1993).

The evidence from studies looking at vulnerable suspects and the police interview indicates that the process of arrest and police detention is stressful and can lead to an increase in psychological disturbance.

Section 136 of the Mental Health Act (1983)

Section 136 of the Mental Health Act, 1983, gives the police the power to remove an individual from a public place to a place of safety if they are deemed to be suffering from a mental illness. It allows for an individual to be detained until he/she can be assessed by a psychiatrist and an approved social worker (ASW) for up to 72 hours. Section 136 is an unusual piece of legislation as it allows for removal of an individual from a public (rather than a private) place and gives a non-mental health worker the mandate to initiate compulsory hospitalisation on the basis of their (lay) judgement about the individual's mental state (Rogers, 1990). This is because the historical origins of Section 136 lie in the Vagrancy Acts of 1714 and 1744 which allowed for the removal of people with mental illness from the community (Rogers and Faulkner, 1987).

Rogers and Faulkner (1987) reported that 90% of Section 136 assessments in police stations in England and Wales in the late 1980's took place in London and the surrounding area. Typically those detained were young, white, single, unemployed men who were often of "no fixed abode", had no GP, and suffered from symptoms of chronic

psychotic illness (Rogers and Faulkner, 1987). A similar profile of people detained under Section 136 has been reported in Sheffield, Birmingham and London six years after Rogers' and Faulkner's original study (Mokhtar and Hogbin, 1993). Similarly, a study of Section 136 detainees subsequently admitted to hospital showed this group to be more socially dislocated and have more severe symptoms (often of psychosis or mania) when compared to a group of voluntary in-patients (Szmuckler, Bird and Button, 1981).

Spence and McPhillips (1995) carried out a six month study of Section 136 detainees in Westminster. In 67% of cases the police initiated an arrest under Section 136 as a result of "bizarre" behaviour (Spence and McPhillips, 1995). Although a diagnosis of schizophrenia was the most common diagnosis it was noted that a diagnosis of personality disorder was equally common among individuals who had been detained under Section 136 on more than one occasion (Spence and McPhillips, 1995).

Concerns about the role of the police in dealing with vulnerable groups have been raised by several organisations in the UK. Officers' abilities to assess and diagnose mental illness in the absence of specific training on this area has been called into question (Rogers, 1990). Despite the 'profile' described by Rogers and Faulkner (1987) of the Section 136 detainee being a young white man, MIND (1996) reported a disproportionately high number of requests for assessment from an approved social worker under Section 136 for non-white people. 10% of requests involved black detainees in an area where black people accounted for 6% of the population (MIND, 1996). The authors did not state whether this difference was statistically significant.

Browne (1997) found that approved social workers said they would be more likely to call for police assistance in cases involving involuntary hospitalisation of black people than with whites. The social workers interviewed felt there was a greater risk of violence from black people but were not able to provide objective evidence in support of this (Browne, 1997).

The Black Health Workers' and Patients' Group (1983) suggested that a disproportionate usage of Section 136 to detain black people might indicate that it is used on the basis of discrimination rather than when mental illness is apparent. Rogers and Faulkner (1987) suggest that the use of Section 136 among black people may reflect a broader misinterpretation of behaviour due to ignorance on behalf of the police and other agencies about cultural norms within non-white populations. Similarly, feminist campaigners have noted that women are more likely than men to be detained under section 136 in certain areas of England (Women and Mental Health, 1984). Patient welfare groups, e.g. MIND, have suggested that in practice the law has not only failed to protect vulnerable groups when they come into contact with the police but has also led to discrimination against non-whites and women.

Rogers (1990), however, suggests that such concerns are based on a misunderstanding of the ways in which the police implement Section 136. They do not, for example, consider the social context in which policing occurs and under-emphasise the contributions made by other organisations (Rogers, 1990). Rogers (1990) notes that members of the general public call for the police on the vast majority of occasions that result in the use of Section

136 and, as such, the police are essentially operating as the second stage in the road to detention. In a study of the use of Section 136, Rogers (1990) found that officers were advised by the person reporting the incident in 25% of cases that mental illness was an issue. In 63% of cases officers approached a scene not knowing what to expect. In these cases officers needed to make decisions quickly at the scene with little organisational back up or support (Rogers, 1990). The primary reason for instigating Section 136, cited in 89% of cases, was a feeling of uncertainty about what might happen next. Officers reported trying to implement informal dispositions (e.g. offering a lift home) before resorting to Section 136 (Rogers, 1990). Officers also said they felt pressured to act quickly due to the public nature of many of these incidents.

A further criticism of the way in which Section 136 is implemented by the police points to the frequency of arrests made under the Section from private addresses, i.e. not in public places. Rogers (1990) found 19% of arrests under Section 136 were made from private premises. Again, however, Rogers (1990) points to specific details of individual incidents to account for this unlawful use of the Section. Officers involved in 26 of the 28 incidents studied acknowledged that removal from private premises was not lawful but felt they had no alternative action available to them because of the severity of behaviour, e.g. the risk of self harm. Officers also suggested that the need to be responsive in certain situations was the immediate priority and indicated that Section 136 could be used as a means of removing an individual from the immediate situation in order to consider assessment of mental health and risk in a more settled, containing environment.

One of the proposals considered for the new Mental Health Act was to extend the use of Section 136 so that the police could have the power to remove individuals from private premises (The Mental Health Act Review Experts Group, 1999). The review committee were, however, "reluctant" to extend police powers to private premises (p.21). The committee felt that an extension of police powers to include private premises could represent "too fundamental" a breach of human rights (The Mental Health Act Review Experts Group, 1999, p. 36).

Rogers (1990) found evidence to suggest that officers considered an individual's mental state, intentionality and responsibility for their actions in more detail once they were back at the station. In essence, officers conducted an informal insanity defence before deciding how best to resolve a situation. It was noted that experience of the local court and psychiatric services were considered by officers in their decision making process. The use of Section 136 was higher in an area in which the magistrates were perceived as particularly negative towards officers who sent people with mental illness to court. Similarly, areas which suffered from a lack of psychiatric services or services with more strict admissions criteria led to lower use of Section 136.

Rogers (1990) also found evidence in some areas of local psychiatrists attempting to dissuade officers from opting for psychiatric disposal. Officers felt the questions they were asked relating to an individual's catchment area and whether or not they qualified for specific services were one way in which mental health professionals tried to influence the use of Section 136. When mental health staff began questioning whether an individual

qualified for admission to a particular hospital because of the catchment area in which they lived, this was perceived by police officers as the hospital staff being unnecessarily difficult. Officers felt the underlying message from hospital staff was, "we do not want this patient." Similarly, the lack of feedback received from psychiatrists about the suitability of referrals was interpreted by officers as a means of dissuading future referrals. In contrast, officers noted that local GPs who became involved in police referrals with physical problems often informed officers what had happened and how situations had been resolved (Rogers, 1990).

Rogers (1990) also investigated police officers' ability to correctly identify the presence of symptoms of mental illness. Officers made their decision on the basis of information received about the person and from their appearance and behaviour. 88% of psychiatric referrals made by the police resulted in admission to hospital. There was a high positive correlation between diagnoses made by police officers and psychiatrists. Officers were found to be cautious in their use of psychiatric diagnoses, excluding other causes for unusual behaviour such as intoxication before referring to psychiatric services (Rogers, 1990).

Rogers (1990) found no evidence to support the claim that Section 136 was used disproportionately by the police with certain groups. Just under 50% of cases in her study involved women and it was noted that female detainees were treated more leniently than their male counterparts (Rogers, 1990). 39% of Section 136 detainees were of African-Caribbean ethnicity (the population consensus for this group was 18%) but it was noted

that many of these cases were not instigated by police officers (Rogers, 1990). Police calls to black people that resulted in the use of Section 136 were frequently initiated by strangers and passers-by rather than by relatives or friends. Rogers (1990) argues that police use of Section 136 in these cases was more a "conveyor belt" (Rogers, 1990, p. 233) for community prejudice rather than an example of prejudice originating within the police force. No differences were noted in the ways in which African-Caribbean detainees were treated in the police station.

Rogers (1990) concluded from her research that, in their use of Section 136, the police in England and Wales are not acting as autonomously as others have often assumed. Just as Teplin and Pruett (1992) and Green (1997) found evidence of discretion in police encounters with the mentally ill in the US, police activity in the UK does not follow a set of ordered steps. The application of Section 136 is, in practice, a socially constructed process involving decision making in a wider context, and research into this area needs to be mindful of this.

The Police and Criminal Evidence Act (PACE, 1984)

The codes of practice in the Police and Criminal Evidence Act (PACE, 1984) instruct the police on how they should behave when arresting and interviewing suspects. The aim is to prevent unreliable convictions and to ensure vulnerable suspects are given support when they come into contact with the police. Code C.1.4 specifies:

"If an officer has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or mentally handicapped, or mentally incapable of understanding

the significance of questions put to him or his replies, then that person shall be treated as a mentally disordered or mentally handicapped person for the purpose of this code." (PACE, updated 1991, p.392).

PACE specifies that all people identified as vulnerable according to the above definition must have a mentor or 'appropriate adult' to support them in the police station. The appropriate adult's role is to offer peer support and to intervene if they feel the individual is being treated unfairly or bullied (Nemitz, 1996). The appropriate adult should be provided with the same basic advice as the suspect and is entitled to a private interview with the suspect *prior to* the police interview (PACE, 1984). The duty of the custody officer in cases involving a vulnerable person is to call for an appropriate adult at the same time as they call for the police surgeon, i.e. there is no need to seek medical advice first (Nemitz, 1996). PACE also required officers to tape record all interviews to allow retrospective examination of interviewing strategies.

PACE suggests that the appropriate adult could be a carer, parent or guardian caring for the vulnerable person in the community. Alternatively, custody officers can call on anyone who has experience of working with learning disability or mental illness, e.g. a social worker. The individual's own wishes, however, must be taken into consideration. Critics have noted that although relatives are often easily available they can become over-involved in the situation and are often naive about mental illness and police procedures. Professionals, on the other hand, are not always the detainee's choice and are of limited availability (Palmer, 1996). In a study carried out in the north of England, people who had acted as appropriate adults for individuals with mental illness said that custody officers did not explain their role when they arrived at the police station (Palmer, 1996).

They often felt naïve about the process of police interviewing and did not really know whether the approaches adopted by interviewing officers were fair or not (Palmer, 1996). Furthermore, the people acting as appropriate adults in Palmer's study reported that they rarely contributed during the course of police interviews (Palmer, 1996). Palmer (1996) suggests that the power differential between investigating officers with years of interviewing experience and an appropriate adult who often does not really know what they are supposed to do may account for this lack of involvement.

Although PACE is clear in the guidelines it gives for working with 'vulnerable suspects', and it is easily applied in cases involving juveniles and people with marked disabilities, its application with people with mental illness is potentially more troublesome (Nemitz, 1996). PACE does not define mental illness but repeats the MHA (1983) definition, "... mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind." Research has already been reviewed that found that the police in England and Wales are able to diagnose mental illness accurately (e.g. Rogers, 1990) but no research was identified that considered the identification of "psychopathic disorder." It is likely, given the nature of police work, that officers encounter high rates of people who could be judged "psychopathic" on the basis of their antisocial behaviour. Neither PACE nor the MHA attempts to assist the police in this matter by offering specific definitions as to what constitutes "psychopathic disorder." It is likely that this is one area in which PACE guidelines are not reliably implemented.

Nemitz (1996) found evidence of a failure to implement PACE guidelines in a study involving the examination of 20,805 custody records collected over a 12 month period in four police stations in the north of England. Custody sergeants in all four stations 'often' (no specific figure is given) waited for assessment by the police surgeon before requesting an appropriate adult (Nemitz, 1996). Furthermore, Nemitz notes that the police surgeon was often a local GP who had little or no psychiatric experience. Officers in this study said that senior officers often complained about unnecessary delays if an appropriate adult was called (Nemitz, 1996). In the study commissioned by the Royal Commission on Criminal Justice, as described above, Gudjonnson et al. (1993) estimated that between 15% and 20% of suspects detained in a central London police station qualified under the PACE guidelines as 'vulnerable.' An appropriate adult was called in just 4% of cases.

Palmer (1996) examined police views of PACE in a study involving interviews with 44 custody officers, police surgeons, solicitors and court staff in South Yorkshire. Custody officers felt that PACE was often difficult to apply because of the difficulties they had in recognising mental illness (Palmer, 1996). It is noted that this contradicts the findings of Rogers' study (1990), which suggested that the police are able to identify the presence of mental illness. Custody officers in Palmer's study, however, suggested that, although severe cases were easily identified, it could be difficult to differentiate mental illness from the types of unusual behaviours seen in many suspects, e.g. behaviour resulting from intoxication (Palmer, 1996). Custody officers also noted that they saw a lot of people detained under Section 136 in the course of their work and felt that this had

affected their perception of what qualified as 'normal' behaviour. Custody officers felt an increase in the use of civilian officers who specialised in mental illness would lead to more reliable use of the codes of practice as specified in PACE (Palmer, 1996).

The police have now introduced a short questionnaire, Form 57E, completed by all suspects detained in police custody which asks, amongst other things, whether they have ever suffered from mental illness or are on any medication. Although this relies on 'insight' and honesty in a situation where many people are not feeling particularly co-operative, it does provide individuals with an opportunity to identify themselves as vulnerable at an early stage. The metropolitan police force also now employs the services of "crisis teams" of mental health professionals who are available to assess individuals in police custody. The Royal Commission on Criminal Justice working party (1995) advocated the introduction of similar teams across England and Wales.

A second part of Palmer's research involved interviewing police surgeons about the requirements laid down by PACE. Police surgeons suggested appropriate adults might not be necessary if the offence was a minor one or if the suspect was known to have support in the community. They also questioned whether an appropriate adult was required at all if suspects were not to be interviewed (Palmer, 1996). Palmer (1996) notes, however, that most police surgeons interviewed tried to divert the people they felt were mentally ill away from the criminal justice system. Palmer (1996) also noted that most police surgeons in England and Wales are GPs and their experience of mental illness, therefore, varies considerably. Interviewees suggested that a police surgeon's

assessment of a suspect's fitness to be interviewed was sometimes made on the basis of their physical fitness alone without consideration of mental state (Palmer, 1996). Once again, the introduction of crisis teams working in police stations is intended to minimise these limitations.

Norfolk (1996) examined police surgeons' attitudes to 'vulnerable suspects' in a questionnaire based study involving all members of the Association of Police Surgeons. A total of 818 questionnaires were sent to all full members of the association. It is estimated, however, that there are between 1500 and 2000 medical practitioners working as police surgeons in England and Wales. This research probably, therefore, involved doctors who did more police work and were more likely to have received specialist training. Of the questionnaires sent, 67% were returned. Responses reflected an overall concern among police surgeons in terms of the precise guidelines surrounding the use of appropriate adults, a reluctance to assess fitness to be interviewed, and confusion about the potential difficulties that could result from mental illness (Norfolk, 1996). 61% of respondents said they routinely assessed an individual's fitness to be interviewed even if they were not specifically asked to do so by the custody officers. 50% of police surgeons, however, felt confused about what was meant by fitness to be interviewed. 21% requested specific guidelines on the areas which should be covered in a fitness to be interviewed examination. 88% of police surgeons who took part rightfully said that calling an appropriate adult was not their responsibility. 20%, however, said they would not become involved in the decision to request an appropriate adult. 66% said they knew what the appropriate adult was supposed to do but 42% said there was no need to call an

appropriate adult if the suspect was not going to be interviewed. Just 22% of respondents said that all people with mental illness being detained in a police station should have an appropriate adult present. 77% of police surgeons in this study felt that if the suspect appeared to be rational, well orientated and understood questions put to him then there was no need to request an appropriate adult. Norfolk concluded that his study revealed a worrying disregard for the welfare of vulnerable groups and a tendency towards increased suggestibility in the hostile environment of the police interview (Norfolk, 1996).

Research on the implementation of guidelines for police involvement with vulnerable suspects as specified in PACE have identified limitations in current practice (e.g. Palmer, 1996; Nemitz, 1996). Once again, no research was identified that considered the vulnerable suspect's own perception of the appropriate adult scheme or experience of police surgeons.

Research on Service Users' Experiences

There has been a growing increase in assessing consumer satisfaction in recipients of health care. Whereas people who have accessed physical health care have been involved in evaluating services for some time, however, the experiences of mental health service users has not been as well researched (Rogers et al., 1993). The growth of mental health service users groups that began in the 1980's was, in part, testimony to the fact that service users felt their views were often not taken into consideration (Rogers and Pilgrim, 1991). The users' groups movement has resulted in an increasing amount of research focusing on experiences of mental health care (Bowl, 1996) and users' views are now

more represented when it comes to decision making about service development (Bowl, 2002). This section reviews some of the research looking at service users' experiences of 'care'. Although no research was identified that focused specifically on experiences of the police, several studies considered experiences of people in authority (e.g. doctors and nurses). These are reviewed as it was felt that findings might be extended to other authority figures like police officers. Research projects like the People First project (Rogers et al., 1993) have investigated the experience of contact with psychiatric services and have given some insight into the user's perspective of their entrance into psychiatric 'care.' The People First project is described in some detail as it involved a large number of service users from across the UK, some of whom were involved in the design and running of the research.

The People First project included qualitative examination of individuals' experiences of psychiatric care. Over 500 service users from across the UK took part in the research. Data collection itself was carried out by service users. In 8% of cases the police were listed as being the first point of contact with the mental health services (Rogers et al., 1993). Although no comments were offered on experiences of the police, participants commented on their experiences of other professionals. Nurses, for example, were experienced positively when they were felt to be respectful, empathic and providing good physical care. Less positive experiences of nurses came when they were felt to be placing their professional duties (e.g. note writing) above caring for service users, when they seemed cruel or authoritarian (e.g. pushing service users about) and when they used physical interventions (e.g. forcing people to return to the ward).

Psychiatrists were criticised for not listening to service users and failing to communicate with them. There were times when service users felt they had been given no information about their situation. This was experienced as portraying a limited understanding of their difficulties. Psychiatrists who behaved in this way were often experienced as being reserved and detached (Rogers et al., 1993).

Several other studies were identified that considered service users' experiences that might give insight into experiences of the police. In a small scale study Kumar, Guite and Thornicroft (2001) used grounded theory to examine six service users' experiences of violence in psychiatric care. Service users experienced an imbalance of power between themselves and hospital staff. Experiences of institutional aggression (e.g. being restrained or forced to take medication) were reported and participants did not feel the services were helpful in this respect. Murphy, Estien and Clare (1996) investigated users' experiences of a specialist challenging behaviour service for people with mild learning disability. Twenty six service users took part. Participants reported strongly negative experiences of all aspects of the service that restricted their freedom (e.g. locked doors, being supervised by members of staff). Similarly, Goodwin et al. (1999) examined users' experiences of an adult acute psychiatric inpatient service. Participants reported difficulties with the use of power and control on the ward and were concerned that the service often seemed as restrictive as a prison.

Although no research was identified which looked specifically at experiences of the police, service users' experiences of professionals and mental health care systems that were perceived as being authoritarian or restricting personal freedom tended to be very negative. The findings of the above research would suggest that being arrested and taken away by the police would also be likely to be a difficult experience for people with mental illness.

The Present Research

The present research aims to explore experiences of encounters between police and people with mental illness from the perspective of both police officers and of people with mental illness. Research has confirmed that encounters between the police and people with mental illness occur on a frequent basis (Walker, 1992) and at times of crisis (Cordner, 2000). Existing research looking at encounters between the police and people with mental illness from the perspective of police officers (e.g. Green, 1997; Teplin and Pruett, 1992) has suggested that such encounters are often difficult for officers to resolve. Previous research did not, however, consider the thoughts and feelings of those concerned. Research looking at service users' experiences of psychiatric care (e.g. Rogers et al., 1993; Goodwin et al., 1999) has indicated that being told what to do by health professionals leads to negative experiences. It seemed likely, therefore, that encounters with police officers, especially when these involved arrest, would be difficult for people with mental illness.

Previous researchers have noted that many different factors can influence encounters between the police and a person with mental illness (Green, 1997; Rogers, 1990). When attending a call, for example, police officers may be influenced by the instructions they have received from senior officers, by information they receive before they arrive at the scene and by their previous experiences of people with mental illness. At the same time, a person with mental illness may be influenced by his/her previous experiences of the police and by his/her state of mind at the time when he/she encounters the police. Previous researchers have suggested that the only way to consider all the different influencing factors in a single encounter is to adopt a phenomenological stance, examining the event as a unique experience (Rogers, 1997). This study aims to capture the essence of individuals' experiences of police encounters with people with mental illness and, therefore, a qualitative research methodology was adopted.

It was decided, therefore, to use Interpretative Phenomenological Analysis (IPA; Smith, 1995) enabling investigation of individuals' experiences of specific events and to explore the meanings they associated with them. IPA also allows consideration of common themes noted by more than one participant. IPA was chosen instead of similar qualitative methodologies (e.g. Grounded Theory) because it is designed specifically to give insight into individual participants' worlds and aims to gain an understanding of the quality and texture of experiences (i.e. to explore the nature of the phenomena). Grounded Theory, which aims to account for social phenomena on the basis of contextualised social processes, does not focus as strongly on providing insight into individual participants' psychological worlds (Willig, 2001).

Research questions

The study addresses two sets of research questions. The first set is aimed at understanding the perspective of police officers:

- How do police officers experience their encounters with people with mental illness?
- How do officers feel the presence of mental illness impacts on their work?
- What do officers feel influences their behaviour in cases involving people with mental illness?

The second set of questions aims to understand the perspective of individuals with mental illness:

- How do people with mental illness experience their encounters with the police?
- How do people with mental illness feel their illness impacts on their encounters with the police?
- Do people with mental illness feel protected by police legislation?

CHAPTER 2: METHOD

Overview

This qualitative study looks at the experience of encounters between the police and people with mental illness. Participants were twelve serving police officers and twelve people convicted of offences and detained under the Mental Health Act, 1983. Each took part in a semi-structured interview asking about their work with people with mental illness or about their experiences of the police respectively. Interviews were tape recorded and transcribed. Data were analysed using Interpretative Phenomenological Analysis (IPA).

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Ethical approval was obtained from the joint University College London/University College Hospital Committees on the Ethics of Human Research on 6 April 2001. Approval was also obtained from the Local Research Ethics Committee of Barnet, Enfield and Haringey Health Authority on 25 September 2001. Letters from Ethics Committees can be found in Appendix 1.

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There were marked differences in response from the three different police forces approached. Although the lack of explanation from the two forces who decided not to participate prohibits an understanding of why they felt they could not participate in the research, it is possible they felt it would be unwise to allow their officers to engage in an activity that involved reflecting on their practices with people with mental illness. The same argument suggests that the force who did take part were more open to critical reflection. The officer with whom initial contact was made indicated that the force felt

that working with people with a mental illness was an important issue for them, not least because the local health services did not always seem supportive.

The police officers who participated in this research worked in a force which was willing to consider limitations of practice with an external researcher. The views expressed by the police officers who took part, therefore, represent a police force with a sense of openness that may be less apparent in other forces. It is likely, therefore, that this group of participants was not fully representative of all police officers working in the UK. Their willingness to support research also suggests that they worked within a generally supportive organisation. Officers working in such a setting might be expected to have a different experience of their work than those working within less supportive forces. The issue of sample bias is discussed further in Chapter 4.

Offenders

Mentally ill offenders were recruited from a forensic mental health service in North London. All participants were being held in medium secure or low secure hospital accommodation. All Responsible Medical Officers (RMO's) working in the service were provided with information about the study (see Appendix 3) and asked to pass information sheets on to patients they considered met the inclusion criteria (i.e. held under a criminal section, not learning disabled, well enough to take part in the research and not likely to find the interview traumatising). Patients then expressed an interest in taking part in the research to members of the nursing staff or clinical psychology team

who provided names to the researcher. Individuals were then approached directly and invited to take part.

Participants

Police Officers

A total of twelve police officers participated in the research. All officers who expressed an interest in taking part and agreed to meet the researcher to discuss the study decided to participate. Ten of the twelve participants completed a questionnaire asking for basic demographic information (see Appendix 4). One participant did not complete the questionnaire relating to demographic information as he was called to an urgent job at the end of the interview. One other participant decided not to complete the questionnaire.

Eight male and four female officers took part. Seven of the participants were white British, two were white European and one was black British. The average age of participants was 32 years (range 21 to 44 years). Six of the participants were police constables, one was a probationer and three were police sergeants. The average length of service in the police force was 10 years and six months (range 6 months to 25 years). Participants were asked if they, or members of their families, had ever suffered from mental illness. One participant had suffered from post natal depression and one participant reported having had post traumatic stress disorder. Two participants reported depression in members of their immediate families and one participant had a brother who was autistic. Finally, participants were asked if they had completed any training or work in addition to their work as police officers that had brought them into contact with people

with mental illness. Three participants had studied either psychology or sociology at A level or at university. Background information about police officer participants can be found in Appendix 5.

Offenders

A total of fifteen individuals with mental illness expressed an interest in taking part in the research. One individual decided not to participate having discussed the project with the researcher. Fourteen interviews were conducted. One interview was discontinued after ten minutes as the participant was not able to understand questions asked of him. A further interview involving a man with a strong regional accent who spoke very quietly was not included in the analysis as it was not possible to transcribe the content of the interview due to poor tape quality. All twelve participants who were included in the analysis gave their permission for demographic information to be gathered from the Part I summaries of the medical notes.

All twelve participants were male. Eight of the participants were of black British origin. One was black African, one was Asian British and two were white British. The average age of participants was 36 years (range 21 to 63). Three of the participants were detained under Section 37 of the Mental Health Act, 1983. The other nine participants were detained under Section 37/41 of the Mental Health Act, 1983. All participants were diagnosed as suffering from paranoid schizophrenia. In addition to this, five participants had also been diagnosed with drug or alcohol dependency and one participant had been diagnosed as suffering from borderline personality disorder. Index offences included

wounding, Actual Bodily Harm, kidnap and indecent assault. Eleven participants had previous convictions (i.e. had been in trouble before the Index Offence). The average length of detention before taking part in the research was 3 years and 6 months (range 1 to 8 years). Appendix 5 contains more detailed demographic information relating to research participants with mental illness.

Procedure

Each of the police officers and mentally ill offenders participated in a semi-structured which was tape recorded.

Police Officers

Interviews with police officers were conducted over a four month period in the summer of 2001. Interviews were conducted in the sergeant's office of the PACE designated police station of an outer London police force. Participants were asked to sign a Consent Form (see Appendix 2) agreeing to take part and giving their permission to be tape recorded. Before the study began participants were reminded that they were free to withdraw their consent without giving a reason for doing so at any time. Interviews were then conducted as described below.

Offenders

Interviews with offenders with mental illness were conducted over a four month period in the autumn of 2001. Interviews were conducted in ward-based consulting rooms in medium secure and low secure hospitals in outer London. Participants were asked to sign a Consent Form (see Appendix 3) agreeing to take part and giving their permission to be tape recorded and for basic, non-identifying demographic information to be collected. Before the study began participants were reminded that they were free to withdraw their consent at any time without giving a reason for doing so. Interviews were then conducted as described below.

Interviews

Separate semi-structured interview schedules were constructed for police officers and offenders on the basis of my previous experience of issues in this area and with reference to the research questions and literature reviewed in Chapter 1. Interview schedules were discussed in detail with clinical psychologists working in the area who were supervising this project. Appendix 6 contains copies of the interview schedules used.

The interview schedules were intended to function as a guide for interview rather than as a direct protocol, allowing for exploration of any new information that arose during the course of the interview (Smith, 1995). Attempts were made to phrase questions in open terms that did not suggest specific answers. Where possible participants were asked to think of specific examples. Interviews with police officers began with the question:

"I am interested in police work that involves people with mental illness. Can you tell me about an incident when you have been involved with someone with mental illness?"

Interviews with offenders began:

"I am interested in what happens when people with a mental illness come into contact with the police. Can you tell me about a time when you have been involved with the police?"

Although attempts were made to avoid biasing the interview with particular questions, the need to point participants in the general direction of the research questions was inevitable during interviews. In this way qualitative interviews can never be entirely free of bias (Pidgeon and Henwood, 1996). Interviews were designed to last about 50 minutes.

Police Officers Interview Schedule

Interviews with police officers were designed to cover specific examples of encounters with people with mental illness for criminal offences and as witnesses or victims. Specific attention was paid to the use of Section 136 and factors that influenced approaches adopted by officers with people with mental illness. Officers were asked to give their personal feelings about working with this particular group and to discuss how they felt this group differed from the other groups of people they encountered. They were asked to comment on any difficulties relating to risk or communication with people with mental illness and were given the opportunity to discuss how the current structure of services could be modified to facilitate this side of police work.

Offenders Interview Schedule

Interviews with offenders were designed to cover specific examples of the participant's experiences of the police both at times when they had been arrested and any other situations in which they had encountered the police (i.e. as a victim or witness of crime). Participants were also asked about incidents when they had been arrested under Section 136 of the Mental Health Act. Participants were asked for their personal feelings about the police and how direct experience had influenced these. They were asked if they felt their mental illness had been taken into consideration by the police and to discuss any assistance they had been given or felt they needed as a result of this. They were also asked to suggest changes which could have facilitated their encounters with the police.

Analysis

Interview transcripts were analysed using Interpretative Phenomenological Analysis (IPA; Smith, 1995). IPA represents a dual approach to qualitative analysis including investigation of the participant's individual psychological world on the basis of what they say during the course of interview (phenomenological) and allowing for the researcher's own interpretation of interview text in an attempt to clarify meaning (interpretative).

The process of IPA was followed as described by Smith, Jarman and Osborn (1999). Essentially this involved careful reading of transcripts on a number of occasions in order to identify themes and then to relate themes to specific domains or groups of themes. Transcripts were read and initial meanings of specific units of text and initial

interpretations of these were made. These initial jottings were then refined into themes that were felt to reflect the original meaning of the text. As additional themes were identified in subsequent transcripts a process of referring back to previous transcripts was instigated to allow for consideration of these in light of new themes and domains. Finally, themes were ordered hierarchically with similar themes being grouped under the same domain. Quotes from individual transcripts were included to illustrate individual themes.

It is important to address the notion of 'quality control' when carrying out qualitative research. It is not possible to apply the concepts of reliability and validity, as used in quantitative research, to qualitative research (McLeod, 2001). A number of qualitative researchers have, therefore, developed guidelines to address quality control with qualitative research (e.g. Smith, 1996; Elliott, Fischer and Rennie, 1999; McLeod, 2001). The following section describes how quality control procedures were employed in this study. Chapter 4 describes alternative strategies and discusses wider quality control issues in detail.

Issues of reliability and validity are clearer in quantitative research than in qualitative research (McLeod, 2001). In quantitative research a series of well-defined, well known criteria can be applied to judge reliability and validity. In qualitative research, however, data is generated and analysed via the researcher's personal relationship with an area of interest. What is produced will be influenced by the researcher's own approach and beliefs about the area. Validity in the quantitative sense can not, therefore, be applied directly to qualitative research. Furthermore, unlike quantitative research, which deals with numbers, qualitative research seeks to explore an individual's experience by

studying the words they choose to describe it. Unlike numbers, which are usually un-emotive, words affect us in an individual way as a result of the connotations we bring to them. Ambiguities in the ways in which individuals describe their experiences may affect the credibility of a piece of qualitative research.

Smith (1996) and Elliott et al. (1999) describe approaches to checking the credibility and trustworthiness of the categories or themes identified by the researcher. Perhaps the most democratic of these involves presenting interpretations of the data to the participants themselves and asking them to comment on the accuracy or plausibility of the analysis. This can be done at an early or later stage of data analysis. In the current study interpretations of the data were presented, both verbally and in written form, to nine of the police officers who took part. The officers felt that the analysis had captured the essence of their experiences and highlighted the difficulties they faced. Unfortunately, it was not possible to present the data to the offenders who took part in the research because I no longer worked in the units where data had been collected by the time analysis had been completed. For reasons of security it is difficult to access patients in secure units as a visitor.

A second approach to checking the credibility of qualitative analysis is to conduct a peer review of the analysis (Smith, 1996). This approach was implemented in the present study. A second researcher who was familiar with Interpretative Phenomenological Analysis carried out initial analysis of two interviews (one police officer and one offender). The themes identified by myself and by the second researcher were then

compared. A discussion of each of our interpretations of the data clarified some of the subtleties in the participants' accounts. In particular, the second researcher identified a sense of ambivalence about police officers that led to a re-conceptualisation of some of the data. Further issues concerning validation, and 'good practice' in qualitative research, are discussed in the Chapter 4.

Researcher's Perspective

As qualitative research relies on the reading and understanding of data, the experiences and identity of the researcher influence the outcome of analysis (McLeod, 2001). The personal nature of qualitative research is one of its distinguishing features. Self reflection (i.e. consideration of the researcher's perspectives and beliefs at the start, during and after the research) is, therefore, an important component of qualitative research. Essentially the researcher must ask how his/her values and beliefs affected the process of research from designing the project, carrying out interviews and analysing the data. Qualitative researchers (e.g. Elliott et al., 1999; McLeod, 2001) recommend that researchers state their assumptions and beliefs in the Method section of the write up.

The initial idea for this piece of research came from the experience of observing a medico-legal assessment of a man suffering from a severe anxiety disorder who felt the police had overlooked his symptoms at the time of his arrest. He described how the experience of being detained in a police cell had exacerbated his anxiety and resulted in an extremely difficult experience of the police. In the context of my work with convicted offenders in prisons and secure hospital accommodation I then came across several

individuals who complained of having negative experiences of the police. Offenders with mental illness told me that the police often seemed to pay little or no attention to the symptoms of their illness. This made me think more deeply about the role the police play with people with mental illness and how their approaches might affect vulnerable individuals. I realised that people with severe and enduring mental illness living within the community are, perhaps, more likely to be approached by the police than others, and that such encounters might be an added stress in their lives.

In addition to these experiences I received lectures from police officers while undertaking a Masters Degree in forensic psychology. They raised some of the difficulties they encountered in their work with people with mental illness. They suggested that the police were often not the most appropriate point of contact for people with mental illness but that there may not be any other service available to act at short notice. The lectures made me realise that, just as encountering the police can be stressful for people with mental illness, encountering people with mental illness can be difficult for police officers. I began thinking about the complexity of a situation in which neither side feels that the encounter is entirely appropriate.

My experiences of hearing both offenders' and police officers' accounts suggested that both sides were dissatisfied with the outcomes of their encounters. The impact of these experiences is discussed further in Chapter 4, which also includes consideration of how conducting this piece of research has affected my beliefs.

CHAPTER 2: METHOD

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compared. A discussion of each of our interpretations of the data clarified some of the subtleties in the participants' accounts. In particular, the second researcher identified a sense of ambivalence about police officers that led to a re-conceptualisation of some of the data. Further issues concerning validation, and 'good practice' in qualitative research, are discussed in the Chapter 4.

Researcher's Perspective

As qualitative research relies on the reading and understanding of data, the experiences and identity of the researcher influence the outcome of analysis (McLeod, 2001). The personal nature of qualitative research is one of its distinguishing features. Self reflection (i.e. consideration of the researcher's perspectives and beliefs at the start, during and after the research) is, therefore, an important component of qualitative research. Essentially the researcher must ask how his/her values and beliefs affected the process of research from designing the project, carrying out interviews and analysing the data. Qualitative researchers (e.g. Elliott et al., 1999; McLeod, 2001) recommend that researchers state their assumptions and beliefs in the Method section of the write up.

The initial idea for this piece of research came from the experience of observing a medico-legal assessment of a man suffering from a severe anxiety disorder who felt the police had overlooked his symptoms at the time of his arrest. He described how the experience of being detained in a police cell had exacerbated his anxiety and resulted in an extremely difficult experience of the police. In the context of my work with convicted offenders in prisons and secure hospital accommodation I then came across several

individuals who complained of having negative experiences of the police. Offenders with mental illness told me that the police often seemed to pay little or no attention to the symptoms of their illness. This made me think more deeply about the role the police play with people with mental illness and how their approaches might affect vulnerable individuals. I realised that people with severe and enduring mental illness living within the community are, perhaps, more likely to be approached by the police than others, and that such encounters might be an added stress in their lives.

In addition to these experiences I received lectures from police officers while undertaking a Masters Degree in forensic psychology. They raised some of the difficulties they encountered in their work with people with mental illness. They suggested that the police were often not the most appropriate point of contact for people with mental illness but that there may not be any other service available to act at short notice. The lectures made me realise that, just as encountering the police can be stressful for people with mental illness, encountering people with mental illness can be difficult for police officers. I began thinking about the complexity of a situation in which neither side feels that the encounter is entirely appropriate.

My experiences of hearing both offenders' and police officers' accounts suggested that both sides were dissatisfied with the outcomes of their encounters. The impact of these experiences is discussed further in Chapter 4, which also includes consideration of how conducting this piece of research has affected my beliefs.

CHAPTER 3: RESULTS

Overview

Analysis was conducted using Interpretative Phenomenological Analysis (IPA), as described in the Method section. All themes identified and included in the Results were present in the accounts of at least three participants (i.e. were shared to a lesser or greater degree). The focus of this piece of research is individual experiences rather than the frequency of shared experiences.

During the course of analysis themes that related to similar issues were identified and grouped together under domains. Themes were grouped in this way as a means of organising and interpreting the data. Names for themes and domains were chosen, where possible, using participants' own words.

Themes are illustrated using examples from interview transcripts throughout the Results section. Police officer respondents (referred to as P.O.) gave detailed accounts of their experiences and it was not necessary, therefore, to include the interviewer's questions in text included in the Results. Offenders, however, (referred to as Off.) tended to give a more brief account and needed prompts from the interviewer in order to stay focused on the subject in hand. For this reason the interviewer's questions are included in text from offenders' interviews where this was needed to help structure a response.

Table 1 presents a summary of the themes and domains identified in the analysis of the police officers' accounts. Table 2 presents the themes and domains from the offenders' accounts. At the end of the Results Chapter an integrative summary focuses on the similarities and differences between the two sets of themes.

Table 1: Domains and themes from police officers' accounts

Domain	Themes
Encounters with people with mental illness are complicated	People with mental illness are unpredictable and aggressive
	How do I identify mental illness?
	Feeling scared of people with mental illness
	Feeling out of control
	Reluctant to use physical restraint
	Mental health services are unsupportive
Feeling impotent	It is difficult to communicate with people with mental illness
	Disturbed behaviour becomes worse when officers arrive
	Police powers are limiting
	The police station is not a place of safety
	Feelings of sadness
	Police knowledge and expertise is limited
	Pressure to deal with incidents quickly
Coping with the personal impact of encounters with people with mental illness	"Do your best"
	Remain objective
	Supporting each other emotionally

Table 2: Domains and themes from offenders' accounts

Domain	Themes
Encounters with the police are difficult	The police don't care
	Officers treated me badly
	The police don't tell you what's happening
	Officers seemed frightened of me
	Being locked in a cell was frightening
	The police doctor doesn't help
	Police interviews are bad
There are times when the police can help	Not all coppers are bastards
	The police can help
	Appropriate adults are helpful

Police Officers

Themes from the interviews with police officers were grouped into three domains (see Table 1) which are described in detail below. The results, however, need to be considered in the context of a high frequency of police encounters with people with mental illness.

Context: Police Encounters with People with Mental Illness Occur on a Daily Basis

Most of the police officers interviewed noted that they came across mental illness frequently during the course of their work. Several participants said that encounters with mentally ill people occurred on a daily basis:

"...in my capacity I've dealt with lots and lots of people that have suffered from mental illness..." (P.O.2)

"To be honest we deal with this sort of thing on a day to day basis. On a day to day basis there are calls going out where there are mental problems of some description." (P.O.4)

Participants who had served as police officers for longer noted an increase in the frequency of encounters with people with mental illness in recent years:

"...over the years, I don't know what it is, there just seem to be more and more people suffering from mental health in the community. ...and we get more and more calls to people; it's something we've just got used to dealing with. (P.O.2)

"With care in the community we are dealing with these people more and more because, I'm not saying they should be, but because they are not in hospital, because they are out in the community, we come across them so much more than we have done in the past." (P.O.5)

Domain 1: Police encounters with people with mental illness are complicated

Most participants noted that encounters with people with mental illness tended to be more complicated than their encounters with other groups of people. Complicating themes related either to the person with mental illness (e.g. a feeling that they were more aggressive than other people), to the police officer involved (e.g. feelings of anxiety about people with mental illness), or to the system (e.g. feeling unsupported by other agencies).

People with mental illness are unpredictable and aggressive

Participants said that they felt people with mental illness were more unpredictable than other people. They felt this made their work more risky, challenging and dangerous. Officers tended to relate this to a higher risk of violence or aggression, often directed at the police, making work with people with mental illness more anxiety provoking and stressful.

"...it's the unpredictability of them. One minute they can be as sane as can be. Especially like with your schizophrenics...they can turn just like that and have done. ... you think you've got a rapport going with somebody and you've actually let your guard off slightly because you're actually getting on OK but all of a sudden they can turn on you or go for you." (P.O.5)

"I suppose it's the not knowing, that they may flare up at any time. That obviously makes it very difficult." (P.O.11)

It was noted by several participants that officers had been injured during the course of their work with people with mental illness. Increased levels of aggression also led to incidents requiring large numbers of officers with the inevitable pressure on resources.

"I mean, he was abnormally aggressive... He was frothing at the mouth. His pupils were completely dilated... He struggled the whole time and he tried to bite people... There were about nine of us holding him down. He was still struggling and managed to get free. He was very, very strong and he was only quite a slim guy." (P.O.12)

"... they needed about 20 officers to carry him in because he was fighting and screaming and foaming at the mouth. He was just in such a state. I mean, that was quite traumatic for everyone that was involved, some of them got bitten." (P.O.3)

How do I identify mental illness?

Most participants said the ability to identify the presence of mental illness quickly and accurately was an important part of their role as beat police officers. Officers felt they needed to identify mental illness quickly in order to minimise the risk of a situation escalating but at the same time acknowledged limitations in their ability to make such a decision. Participants indicated that an awareness of this conflict made their work with people with mental illness more difficult.

"Sometimes you've got somebody in the street and you just have to make a decision for their safety and other people's safety as well. You have to make a decision on their mental state even though we're not a doctor, that's why it's very difficult to say that person is suffering from mental illness and that person is not." (P.O.1)

Many participants cited a lack of training as a complicating factor in their ability to identify people with mental illness at an early stage. Other difficulties arose when people were intoxicated at the time of police involvement and came from the need to make decisions quickly and in a public place:

"I don't know. It's very difficult. [Identification of mental illness]. ...you don't really know for sure until you start speaking to them and even then it may be masked by drink

or drugs...I think the main difficulty is probably not having the training whether to recognise it or to know what you're doing is the best way to do it." (P.O.9)

Feeling scared of people with mental illness

Officers felt that the fear or anxiety they felt when approaching a situation involving somebody with mental illness had an effect on how effectively they were able to deal with situations. They acknowledged that these feelings could have an effect on decision making.

"But every person gets scared. You've got to try and deal with it with other police officers, you've got to try and overcome those feelings and do what's best for the situation." (P.O.1)

"So that's why they tend to just get whisked away, brought to here away from the scene as soon as possible. Yeh, some officers are a little nervous of dealing with them." (P.O.11)

Feeling out of control

Closely related to the theme that emerged around individuals with mental illness being unpredictable and prone to sudden and extreme aggression were suggestions made by officers that they often felt out of control in their encounters with people with mental illness. This was noted in the context of it being an additional source of frustration or fear:

"I mean everyone else who was in custody was backing off and that is very frightening because you have no control over them. And they have no control over themselves." (P.O.3)

"So, everything that we're trying to do is being held up by the fact that this guy is dictating to us the control of the situation. He won't do anything that we want until he has consulted this other person, imaginary or whatever, I don't know. So that's another source of frustration." (P.O.8)

Reluctance to use physical restraint

Many participants described cases involving people with mental illness who had had to be restrained in some way in order to gain control of the situation or minimise the risk posed to the person with mental illness, the officers attending the scene or members of the general public. This was often something that officers mentioned in the context of them feeling reluctant to use restraint with people with mental illness. Several participants demonstrated an awareness that restraint may provoke an aggressive response from a mentally ill individual and that the conflict between needing to rely on some force to protect individuals' safety but not wanting to antagonise people or cause undue suffering was difficult for officers to resolve:

"So, if things get nasty, how far do we go? What sort of force do we use and how far do we put ourselves in a situation that's going to antagonise him? But obviously, there are issues we've got to be aware of. The officers' safety, the safety of the team and the safety of the person we're talking to. Like I say, he could have had a knife in his pocket... The restraint side of things is somewhat difficult. We do handcuff people, mentally ill people to take them to the hospitals for their safety as well as our ours." (P.O.8).

In one case it was suggested that one of the reasons people with mental illness are more prone to behaving aggressively towards the police was because of previous experience of being manhandled:

"...people with mental health were interviewed and they said the reason they got very aggressive when they were found by the police out wandering or what ever was because hands were laid on and they didn't like it at all. They just wanted to be left alone, they

didn't want to be touched...so I try not to touch unless they are being aggressive, unless they have to be controlled." (P.O.12)

Mental health services are unsupportive

Most officers noted that their work with people with mental illness often relied heavily on support from other agencies, either in the use of the police surgeon (FME) or local mental health crisis team who were asked to attend the police station to assess people. Officers also worked closely with other agencies when they were requested to attend a scene from which social workers and medical staff intended to remove an individual who was suffering from mental illness. Although most officers said that support from the crisis team generally facilitated work with people with mental illness, several problems were identified. Many participants noted that delays incurred while awaiting the crisis team could serve to make an individual more distressed, see Time Delays, below. Several participants also noted that the police surgeon or crisis team often disagreed with the assessment made by beat officers and it was implied that this made officers feel they had made a mistake. It was noted that this may be because an individual's behaviour and presentation could change dramatically once they reached the police station:

"That is sometimes the frustrating thing, because you see them either in their home environment or in an environment away from the police station and sometimes they do change when they get to the police station. So that is frustrating because then the FME that sees them obviously has to gauge what he sees and whether the person needs the crisis team. And there are occasions where he says, "No, I don't think this person needs an assessment." (P.O.2)

Several participants noted that there was a reluctance on behalf of the crisis team to attend requests to assess an individual's mental state in their own home. This meant that

they were not able to assess this in the natural context. Officers would have preferred not to have to arrest people in order to take them to the police station for assessment.

"One of the problems obviously is dealing with the crisis team. They've obviously got a lot of demands on their time and I've got a lot of praise for them to be honest with you, but getting them to... I mean traditionally, in the past, they've said to me, "We'll come to the police station," or, "We'll come to the hospital," to inspect someone in effect. But getting them to come to someone's current address can sometimes take hours... so, in effect, sometimes they get shifted to the police station before the mental health team can actually go there." (P.O.10)

Other participants mentioned frustration at seeing people released from police custody as a result of the crisis team not feeling that the difficulties warranted hospital admission. In these cases frustration seemed to come from a combination of feeling they had made the wrong decision on the street with the feeling that person was not going to get the care they seemed to need (see Feelings of sadness relating to people with mental illness, below):

"Sometimes you can get them to the police station and the crisis team say, "No, we're not sectioning them," and they get released on to the street. And our decision is that they are suffering from mental illness, but, like I say, you're not a doctor. We don't have any training in how to diagnose things..." (P.O.1)

Participants also talked about incidents when they had been asked to assist other agencies in the removal of individuals from private premises to hospital. In these cases officers felt uninformed by the health care agencies and suggested that they were often asked to act either beyond their powers (see Limitations due to police powers, below) or beyond their expertise.

"If you get called to a house where somebody's being removed physically and they want our assistance then that's another thing. Especially when people are screaming and

hanging on to door posts and so on. Some of the frustration of that is not having the background information. The previous history. It's all very well going, "We'll call the police to assist us," and the police turn up, "This person's being removed to hospital can you help us?" And we go in, "You're coming with us!" sort of thing. It would be nice to understand some of the issues that have gone on." (P.O.8)

"They [doctors and social worker] will go and try to assess somebody in a house but they really want the police there. So we hide up around the corner so if it kicks off and gets violent we can come in. So, it's like the next thing all the doctors come running out of the house and we've got to go in. Crash, bang, wallop, you know, and you restrain the guy on the floor because it's kicked off and they might come in and criticise. But if they've asked the police to be here and it's got a bit violent then you've got to go and deal with it. And we're not trained, we do the best we can and use what force we have to use." (P.O.2)

Domain 2: Feeling impotent

All participants noted that the difficulties they experienced in their work with people with mental illness made them feel that they were not able to carry out their work effectively and left them feeling that they had been unable, at times, to act as they would have liked. The following themes emerged when considering specific areas of difficulty that made officers feel that they had been unable to provide the service they would have liked. The themes identified as contributing to a feeling of impotence related either to the person with mental illness (e.g. communication difficulties), to the demands of the police department (e.g. not being able to resolve incidents quickly enough), or to limitations in police powers under the law (e.g. having no power on private premises).

It is difficult to communicate with people with mental illness

It was predicted that communicating with people with mental illness would be one source of difficulty in police interactions and participants were asked to give their views on this. Most officers identified that communication difficulties complicated their work with people with mental illness.

"I managed to get her name but apart from that she wouldn't talk to me. ...She was very distant, she was very withdrawn. But it was also sometimes that she wasn't actually hearing me. I was speaking to her and looking into her eyes trying to gauge a response, if I was getting through. Sometimes I was but she was deciding she wasn't going to speak to me. At other times it was quite clear she was not with me at that time. So, yeh, that is difficult..." (P.O.4)

Several participants suggested that the frustration they felt at not being able to communicate effectively with people with mental illness was probably shared by the person with mental illness who was not able, in turn, to understand or communicate their wishes to police officers.

"...they probably have difficulty communicating their wishes, what they want. Everyone we deal with is different. Some of them have more ability to communicate than others. They're probably frustrated in that respect." (P.O.4)

Disturbed behaviour becomes worse when officers arrive at the scene

Many officers indicated that they felt their presence in some way led to further deterioration in behaviour in the person with mental illness. These observations were based on the way in which people with mental illness reacted when officers arrived at the scene and led to feelings of dissatisfaction among officers in the way in which situations were resolved.

"Well, it makes them, a lot of the time, worse, because they think there's no reason for the police to be called so they think they've committed a crime or done something wrong. ... we don't think it's good to arrest people for the Mental Health Act, it's not good for anyone that's involved in it." (P.O.1)

"We walk in and the person can initially be quite upset about it saying, "what do you need the police for? I'm not a criminal, I don't need the police." ...but she was angry anyway, but more so when we arrived." (P.O.7)

Furthermore, participants seemed resigned that the nature of their work often placed them in situations where they may not be able to help. They mentioned the great variability in the range of problems they are called to and that mental illness was one area among many in which they were not always able to have an impact and where police involvement was often not the most appropriate intervention. One officer noted that mental illness was one area in which "a policeman's lot" is often "not a happy one." At the same time, however, participants seemed resigned to the fact that they would continue to be called to attend to incidents involving people with mental illness and, although they often felt they were not able to help, this was an inevitable part of police work.

"I think it's just a policeman's lot. We have to deal with thousands of different things and I think it [mental illness] is just another thing. This might sound rubbish but I think if people need to call the police, I think it's nice that people can call the police for anything. If the trains aren't running we get a phone call. If they've lost their cat or dog they call the police station. If there's a smell of gas they call the police. It doesn't matter what the problem is, they call the police. While we still respond to calls and give people advice they call us. And if the police are not doing that a lot of these people out there would be lost. If somebody was running about naked there'd be a breakdown wouldn't there?" (P.O.2)

"We end up being the sticking plaster I'm afraid. The buck stops with us because every other agency, they've washed their hands of these people." (P.O.3)

Police powers are limiting

Section 136 of the Mental Health Act, 1983, limits police powers of arrest to public places. The majority of participants felt that their work with people with mental illness had been complicated at some stage as a result of their lack of power to act in private premises. This led to feelings of being useless and unable to help.

"You just get so down with the things you deal with, with the situations you deal with...Especially in their own home. I think if one thing could come out of it we'd have the power to remove people from their own home...that would be far better because then you don't feel so useless. If somebody's obviously very ill you go around and say "Well, we can't really do anything." It's stressful when you get calls like that." (P.O.9)

On several occasions this had led to an escalation in the person's distress over a period of time:

"She hadn't been aggressive towards anybody in the family so all we could really do was warn her to stop...you couldn't arrest her for a breach of the peace, you had to leave her there which is, I wasn't particularly happy with because it was clear she did have some sort of mental health problems...But I think the next day she was arrested in the street and I actually saw her the day after in custody and it was very clear then. I think she had stripped in the cell and she was banging on the door and trying to rip her blankets and things like that. It was, it had definitely got a lot worse. She was relatively normal the night before. It was sort of sad." (P.O.12)

Several officers noted that the need to get around the lack of power in private premises had led to the police acting in ways which they would have rather avoided:

"...we couldn't do anything ourselves hands on because she was in private premises...So, in the end we sort of, basically she ended up being forced out of her house by her boyfriend and near enough locked out of her house...I mean, that's distressing getting pushed out of the house by a boyfriend. Someone she felt she could trust... I don't know, you felt like you wanted to do something but couldn't in the role you were playing." (P.O.9)

Limitations in police powers under the Mental Health Act also led to officers having to rely on criminal law in order to intervene with people with mental illness. Once again, participants felt this was far from ideal.

"We have to deal with people under other pieces of legislation like common law which, although appropriate, isn't necessarily the best way of dealing with them." (P.O.10)

The police station is not a place of safety

Although some police forces have hospital facilities available for use as a place of safety when people with mental illness are arrested under Section 136 of the Mental Health Act, the force that took part in this research had no such facilities. Participants noted that they felt bringing people to the police station as a place of safety was not ideal and that this made them feel they were not able to deal with situations as they would have liked. Many participants were worried that taking people with mental illness to the police station as a place of safety may confirm delusional beliefs of persecution and could make symptoms worse.

"And sometimes that can make them a lot worse, more anxious. And if they've got some sort of complex that someone is going to come after them, to be locked in a cell makes them worse sometimes. You're proving their fears basically." (P.O.1)

Furthermore, participants were aware of the risk of criminalising an individual's behaviour by taking them to the police station:

"To take someone to a place where, a police station, or to lock them in a cell, which is normally associated with doing wrong, is likely, I would think, to increase someone's sense of persecution and guilt. And to up the ante and not help them in the short term. Perhaps make them worse." (P.O.10).

Several participants noted that people often remained in police custody for long periods of time while awaiting assessment from the crisis team and others and that this made the use of the police station even more inappropriate.

"That person ended up being here for about 20 hours without any decision being made. So nothing is quick and it all takes a long time...it basically ends up that the person is in the police station for a long time, Because of the way the local health authority have decided mental health should be dealt with." (P.O.5)

Feelings of sadness

Many participants discussed their feelings of sadness for some of the people with mental illness they had encountered. These feelings inevitably had an impact on the officers' own sense of well-being and were, at times, upsetting. Officers tried to offer care, support and, even, informal counselling to people with mental illness and felt that this was one way of "doing the right thing." Officers were often, however, unable to offer the care that they felt people with mental illness needed and an additional sense of frustration was reported.

"For me, I feel genuinely sorry for these people because there is a reason for them to be in this condition and nobody will really know the reason or what's brought it on. ...I think it's very sad that these people have to suffer like this....It must be very traumatic in those situations [involving the police] for them. So I do feel sorry for them and it would be nice to meet people who've been through that and say, "I'm better now, thank you for your help, I'm better and these people really did me some good." But you never see that." (P.O.7)

Police knowledge and expertise is limited

Participants noted that, although they dealt with mental illness on a regular basis, they had no particular expertise or specialist knowledge in the area. This made officers question the quality of their interactions with people with mental illness and often led to a feeling that they may not have acted as well as they could have done.

"We don't have any training on it... We get taught in hours. Basically we make an opinion as any normal person would... We're not trained in any other way than a normal member of the public." (P.O.1)

"...you don't get trained to do it. There's a big myth that people have that we get told how to do it. We don't get taught, it's just how you react... It's more a case of if they warm to you or not... And if they don't then the situations' going to get more and more inflamed..." (P.O.3)

Pressure to deal with incidents quickly

Several participants noted that there was a pressure on officers to resolve incidents quickly but that this was not always possible when working with people with mental illness. In such cases there was a sense of conflict between the officer's desire to do a good job and pressure from more senior officers to reach a conclusion quickly. It was not possible in some cases for the officers involved to give the individual with mental illness the time and attention they felt they deserved and to satisfy senior officers at the same time. This led to feelings of impotence among patrol officers.

"So, it's quite hard. For us, you've got to look after them so you're wary for them, you're wary for yourself because if anything happens to them then that reflects on you. But it's a drain on resources as well. I mean, that was an officer off the street looking after someone..." (P.O.3)

"And, as you are probably aware, there are not many police officers on the street any more and a lot of our time is reduced because of it. If there was better care for them in the first place then we probably wouldn't have to deal as often." (P.O.12)

Domain 3: Coping with the personal impact of encounters with people with mental illness

Although all participants acknowledged additional difficulties in their work with people with mental illness and noted that they often felt unable to provide this group with a high standard of service, officers also discussed how they coped with the impact of these negative feelings. Themes relating to coping mechanisms either related to the individual officer and how they rationalised their work on an individual level or related to how the team of officers supported each other emotionally.

"Do your best"

Participants noted that one of the ways of coping with the negative impact of their encounters with people with mental illness was to maintain high personal standards of behaviour. Participants noted that they were able to cope with the emotional impact of working with people with mental illness as long as they were able to leave the incident knowing that they had done all they could possibly have done to help the individual and to resolve the incident effectively.

"...the main thing on my mind is, have I acted correctly? Has what I've done tonight been professional? Have I used my powers within my rights?" (P.O.4)

"Well it's you do the best you can. You do the best you can and as long as you know that you've acted with integrity and with somebody's care and their best interests at heart that's all you can do and then you move on to the next." (P.O.6)

Remain objective

While participants noted that they often felt sad when dealing with people with mental illness it was also noted that they could not allow themselves to get too close to individuals. The importance of maintaining clear professional boundaries and objectivity was noted as an important protective factor.

"But you have to become somewhat divorced from [difficult experiences relating to mental illness], I don't take this job home with me." (P.O.8)

"In the end I had to leave there. I'd been there as I say all that time late at night, and there comes a time when you've literally just got to come away...it wasn't an ideal end but what can you do?" (P.O.11)

Supporting each other emotionally

Most participants talked about how the team of police officers worked to support itself. Although formal support services were available there was a sense that officers rarely used these:

"...there is counselling if you want it but it's still very hard for police officers, especially the older ones, to acknowledge that they need help." (P.O.11).

"There are special units who can deal with trauma in the police. You can call them out for anything, not just mental health, that you feel upset about...But, like I say, I've never needed to get involved with that." (P.O.1)

Participants preferred to rely on less formal ways of coping with difficult feelings within the team.

"You hear about the sort of 'police culture' where we have a laugh and a joke. Most of the time have a few drinks. Not a laugh and joke at other people's expenses but the way of dealing with it [stress] is you can either talk to a counsellor or talk to your mates on the team and have a laugh, have a couple of drinks and hopefully you've got everything you need to get off your chest." (P.O.1)

"If you can laugh about it, I think that's the police way of dealing with most things, death, destruction, anything like that. If you can laugh about it then it can't be as bad as it was." (P.O.3)

Offenders

Themes derived from analysis of the data collected from offenders were grouped under two domains (see Table 2) which are described below. As with the themes elicited from

the police accounts, the themes from the offenders' accounts need to be considered in the context of frequent encounters with the police.

Context: Encounters with the police happen frequently

Most of the offenders who took part in the research had experienced frequent encounters with the police. Several participants noted that they had been in trouble with the police for a long time.

I: "Could you describe an incident when you were involved with the police?"
Off: "I can think of about ten. ...I started hanging around with a rough crowd. The crowd I was with used to get up to robberies and things like that...and it became a habit, into something like a job of mine...So a few times I got arrested and when I got arrested I felt ashamed of myself, disappointed in myself." (Off. 1)

"I've always been on the wrong side of the law since I was quite young." (Off. 3)

Many participants noted that they felt they had been identified by the police as trouble causers and that the levels of attention they received from the police felt unfair.

"They've been on my case ever since [first experience of arrest]...Ever since then I got a visit from the police about once a month. Questioning me about all sorts of things. But I never got caught. I never got a conviction." (Off. 7)

"I think they [the police] just harass people sometimes...I thought it [contact with the police] was a waste of time and all that. I could have been going to somewhere important or something. I wasn't, but even then they just harass me. Wasting my time." (Off. 11)

Domain 1: Encounters with the police are difficult

All participants said that they had experienced difficulties in their encounters with the police. These related to times when they felt they had been mistreated by police officers

and to elements of the process of arrest that they had found particularly difficult, e.g. being locked in a cell.

The police don't care

Many offenders described times when the police had acted in what felt like an uncaring manner towards them. They had experienced an uncaring approach from the police both when they were arrested as suspects and when they had encountered the police as victims of crime. Participants said these experiences had left them with little confidence or trust in the police.

"As long as they see that they're doing their job they don't give a monkey's about who they're arresting or how they arrest them, do you understand what I'm saying? With me, I've just got a bad thought or feeling towards the police." (Off. 4)

"I've been a victim of crime as well. And the times when I needed the police they wasn't there for me, so I thought to myself, "when I need them they're not going to be there for me"... So I decided to be rebellious." (Off. 1)

I: "If you were a victim of crime again, how confident would you be that the police would help?"
Off: "Not very confident at all. I wouldn't be confident at all. I'd report it but I would think to myself, 'They're not going to bother doing anything'. It's just another piece of paper on a file that they are just going to throw away at the end of the year." (Off. 4)

Participants also felt that the police adopted an uncaring approach to mental illness.

"They seem to bypass the fact that you might have a mental illness. They think that you're normal and that you are just using that as an excuse to try and get away from your crime... they don't understand where you are coming from because they don't understand about things like schizophrenia or anything else." (Off. 4)

"They don't really care if you're mentally ill or not...All they're interested in is getting a result. That's all they want, results. They don't care about people." (Off. 7)

Officers treated me badly

In addition to feeling there had been times when the police did not care about their welfare, most participants cited examples when the police had mistreated them. This included examples of times when offenders felt intimidated or threatened by the police or had been beaten up by officers.

"But, you know, it was frightening. For one because they were calling me in the wrong fashion and because they asked me what was proper police procedure...I was assaulted. They pushed me in my back, that's assault." (Off. 9)

"They were shouting their heads off at me...it was a harrowing experience." (Off. 3)

"The police chased me and I stopped. The police officer just dragged me out of my car, banged my jaw and head on the floor. I was cut and everything. He just threw me in the back of the van and took me away." (Off. 4)

Furthermore, many participants described incidents when they felt the police had treated them in a racist manner.

"That's their method of arrest regarding a coloured person. They go for you straight like that, not giving you a chance for them to read you your rights or whatever. They just go for you." (Off. 8)

"They told me to sit in the back and the smaller one said something about niggers and stuff...So I got out of the car and they got my right hand behind my back like that. The driver was pulling in my back and he had something in his hand. Before he got out of the car he had said, "One thing with these niggers, I want them to show they've got blood." And he put his hand on my shoulders and pushed me forwards and I fell down." (Off. 9)

Several participants noted that they had felt provoked by the way in which police officers had approached them.

"They shouldn't harass people who have done nothing. They accuse you of doing this and of doing that and some people might get annoyed by that kind of harassment. It can lead to more trouble." (Off. 9)

I: "What do you think they were trying to do by behaving like that towards you?"
Off: "They wanted to get me to kill the police or something like that." (Off. 8)

Several participants talked about times when they had made complaints about the police but these had been unsuccessful. There was a sense that offenders felt the police closed ranks to protect one another.

"I tried complaining. Nothing happened...They wrote it all down and got me to sign it and nothing else happened." (Off. 6)

"Well, when they assaulted me and I complained. I gave the names of the police officers to another police officer. And he passed it down to another police officer who shredded it." (Off. 9)

The police don't tell you what's happening

Several participants noted that not being told what was happening when they were arrested had made them feel confused and frightened. Offenders said that this had made their experience of the police more problematic and had had a negative effect on their mental state.

"But when they were there I was hearing voices and I thought they wanted to take me to beat me up. Instead of driving to the police station they drove in a completely different direction. I knew it wasn't the direction the police station was in. I was frightened. I was hearing voices saying, "We're going to take him to the bushes and beat him up." And me

hearing these voices made me panic and I was going to jump out of the car but my hands were handcuffed together... They wasn't talking to me or anything like that so it made me feel they were against me." (Off. 1)

"That's how the police act in the city; they don't tell you nothing. That's how they treated me." (Off. 4)

Officers seemed frightened of me

Several participants noted that there had been times when police officers had seemed scared of them. This left participants feeling self conscious and low, especially at times when they had hoped the police would be able to help them in some way.

I: "Why do you think they [the police] behaved in an aggressive manner towards you?"
Off: "Maybe they were scared of me or something." (Off. 8)

"I got the impression he was frightened of me because he was acting nervously... I didn't want him to be scared of me, I just wanted him to help me." (Off. 10)

Being locked in a cell was frightening

Most participants said that one of the worst things about being arrested was being locked in a police cell. Offenders complained that being locked up made them feel like they were treated like animals and they often did not know how long their detention would last.

Off: "...they put me in the cells. And I stayed in the cells for about 48 hours before they even interviewed me."
I: "What was it like, being in a police cell for so long?"
Off: "Terrible. Terrible. Being caged up like an animal. Having no rights what so ever. You're really just locked up and they throw away the key sort of thing." (Off. 4)

"It's just a cell and you're there for a long time. They give you food and tea and all that. They treat you alright but it's not very nice. All you can do is lie down really...you think you can handle it for about half an hour but as time goes by it drags on. You want to get out of there and you'd do almost anything to get out." (Off. 11)

Several offenders felt that being locked in a cell had exacerbated the symptoms of their mental illness.

"I felt like I was in hell. I was on a trip as well, do you know what I mean?...I was just kept in the cell for, I don't know how long it was. It just seemed like ages. I had terrible hallucinations and everything, they just left me down there...We're not supposed to be locked up. We need our freedom...It's worse for us because with voices and hallucinations it can be like you're living in hell." (Off. 4)

The police doctor doesn't help

Participants who had seen a police surgeon (FME) often said this had not helped them cope with the process of arrest at all. On one occasion it was suggested that the police doctor had added to the participant's sense of persecution.

"That [seeing the FME] was scary as well because I was ill, I thought they were all after me, all trying to set me up." (Off. 12)

Others felt the FME was untrustworthy because of his allegiance to the police.

"They don't understand it [mental illness], do you know what I mean? They're just with the force, they're with the police force, they're not on my side, they're on the police's side so they're no help really." (Off 4)

One participant noted, however, that his experience of the FME was not the only time he had felt bemused by a doctor's questions:

"They do ask you some silly questions but there's other psychiatrists who act like that anyway!" (Off. 11)

Police interviews are bad

It was predicted that police interviews would be especially difficult for people with mental illness and participants were asked about their experiences of interviews. Most offenders remembered times when they had felt intimidated or threatened during police interviews. This had led to occasions when participants confessed to crimes they had not committed.

"Well, they told us if you plead not guilty you'll go to prison. They said just plead guilty and they'll bind you over, you know. So that's what we did. We pleaded guilty." (Off. 6)

"I remember one occasion when they didn't read me my rights. They interviewed me first and tried to get me to make a confession without reading me my rights. So that wasn't fair...It made me say things unnecessarily." (Off. 10)

"There was a Mr. Nice and Mr Nasty. And the Nasty one kept, I kept saying to them, "I just want to go home, mate." Because I was young again, I was quite young. I said, "I'll admit to anything you say." And he goes, "Well, we can make you admit to that anyway if you know what I mean." With, you know, that he could get a bit heavy with me. So I said I did it in the end." (Off. 11)

Several participants said that police interviews often had a foregone conclusion and that interviewing officers seemed to have already made up their minds before the interview began. Offenders felt, therefore, that they were powerless to influence the course of the interview and that police interviews were essentially a waste of time.

"They think you're guilty before they even start interviewing you, do you know what I mean? They've already made up their minds about you and they could have been wrong.

It's just that they think that you're guilty and they don't really care what you've got to say, really." (Off. 4)

Participants also noted that mental illness made police interviews even more difficult.

"...the police were asking me to tell them what happened and I thought they were against me and refused to tell them and things like that. I thought by them asking me they were trying to pressure me into doing things. They're not pressuring you but they badger you and it kind of makes an ill person think they're against them." (Off. 1)

I: "How well do you think that interview went?"
Off: "It went very badly for me. I was ill. I was hurt. Talking incoherently." (Off. 7)

Domain 2: There are times when the police can help

Although participants described difficult experiences of the police, most also noted that there had been times when the police had been helpful. Offenders noted that some police officers were more caring than others and talked about times when the police had helped them to access the care they needed. Several offenders also noted that having an appropriate adult present during police interviews had helped them to cope.

Not all coppers are bastards

Many participants said that they had positive experiences of police officers as well as the negative experiences they described. There was an appreciation of different personalities within the police force and most offenders noted that not all police officers were bad.

"So, there was a bad experience with one police officer and there was a good experience with another copper. So, you've got to say this, not all coppers are bastards...There's a lot of good coppers out there doing a great job." (Off. 6)

"But now I see them [the police] helping people. Some are ignorant but some are alright." (Off. 1)

Furthermore, many participants showed an appreciation for the difficulty of the task facing the police and noted that the police played an important role in society.

"I understand the police a little bit more than I used to and I try to understand that they've got a job to do. Sometimes it's not an easy job to do but they try their best. I can't say that I hate the police, sometimes they do have a nice side to them but sometimes they don't have a nice side to them." (Off. 2)

"I believe in law and order. It's something the police should do. The police are there. So, it's just at the heat of the moment when you are getting arrested that you don't like it. But if you really look at it from all views you can see that they are there for the good sake of it." (Off. 5)

"I'm not against the police. We need them for our own protection. But they've got a tough job. There's a lot of crime in the country." (Off. 7)

The police can help

Most participants described incidents when they had found the police to be helpful in facilitating access to psychiatric care. Often this occurred in the context of Section 136.

"They've [the police] taken me to hospital but not a secure one...Actually I phoned them myself to take me there once because I couldn't find the transport...One of the police men said, "Why have you called the police?" That's all they said. They drove me back. No handcuffs, nothing like that. They took me back to the hospital then they left. That's it. No trouble, nothing like that...they were very helpful." (Off. 5)

"One police man came and said, "It's alright, we'll take you in the ambulance now and we'll take you back to hospital."...I knew it was a fact I was going back to that hospital, I knew they would put me back in there. The put me in the ambulance. They didn't treat me bad, they treated me quite alright." (Off. 4)

I: "Have the police ever picked you up on a Section 136?"
Off: "I think so, yeh. Maybe once or twice when I first started getting ill..."
I: "What's it like when the police get involved in that way?"
Off: "Well, it's good because you are ill and you need to be somewhere really, so I suppose it's alright...they're not the most sensitive bunch in the world but they do try their best I suppose sometimes." (Off. 11)

Appropriate adults are helpful

Several offenders described having an appropriate adult present when they were interviewed by the police. All those who had had this experience felt it had been helpful.

"It was helpful to me. I wasn't in a fit state to talk to anybody. She supported me." (Off. 10)

"It made me feel a bit less nervous, do you know what I mean? To know there was someone else on my side as well as my solicitor. And they were there on my behalf to make sure it went the right way. To make sure they didn't rough me up." (Off. 4)

"It felt like I was safe." (Off. 1)

Integrative Summary of Findings

Although the themes from the police officers' and the offenders' accounts have been described separately above, a number of similarities can be noted. The theme 'Being locked in a cell was frightening', identified in the offenders' interviews related to the officers' theme 'The police station is not a place of safety.' Both these themes included accounts of why police cells are inappropriate for people with mental illness. Furthermore, both police officers and offenders mentioned the same reasons for police cells to be inappropriate (e.g. being locked up reinforces thoughts about persecution, people can spend long periods of time in cells). The theme 'Feeling scared of people with mental illness' related strongly to the theme 'Officers seemed frightened of me.' The

themes 'The police can help' and 'Not all coppers are bastards' included an appreciation that sometimes officers did try their best to assist individuals with mental illness and that the job the police are asked to fulfil can be difficult. Similar observations were made by police officers in the theme 'Do your best.'

Both police officers and offenders described experiences that had been very difficult. Although participants were not describing the same incidents, both offenders and police identified similar complicating factors. Offenders noted that the police often did not appear to care about the presence of mental illness ('The police don't care'). Limitations in police knowledge about mental illness were acknowledged by the police and there were indications that this influenced behaviour with people with mental illness ('How do I identify mental illness?' and 'Police knowledge and expertise is limited'). There was a sense that lack of confidence when working with people with mental illness made some officers approach situations in a rigid and distanced manner. This style of presentation could be experienced by offenders as uncaring.

Several offenders described incidents when they had been seriously mistreated by the police ('Officers treated me badly'). Although police officers did not describe incidents when they had mistreated people with a mental illness, they described difficulties that might contribute to the development of a situation where an individual could be mistreated. Officers noted, for example, that 'People with mental illness are unpredictable and aggressive' and described how they needed to be vigilant when working with people with mental illness. This could also be experienced by others as officers being distanced,

uncaring or neglectful. Furthermore, officers described how disturbed behaviour became worse at times when the police arrived and this led to officers needing to resort to physical intervention. At the same time, however, the officers noted that they used physical restraint as a last resort with people with mental illness and appreciated how frightening this could be for offenders ('Reluctant to use physical restraint').

Offenders' experiences of the police had been complicated by officers not explaining what was happening. Officers acknowledged difficulties in communicating with people with mental illness and suggested that this was probably just as difficult for the detained individual as it is for themselves ('It is difficult to communicate with people with mental illness').

Finally, some of the themes from police officers' and offenders' accounts focused on different issues. Differences that were noted between themes elicited from the police and themes elicited from offenders related to experiences that were specific to either offenders or the police. These included themes that related to aspects of police encounters that were not shared by police officers (e.g. the experience of having the support of an Appropriate Adult or of consulting the police doctor) because they related specifically to the experience of being a vulnerable detainee. Similarly, themes were identified that were peculiar to the police. These were most apparent in themes identified which considered how officers coped with the emotional impact of work with people with mental illness (e.g. 'Police officers support one another emotionally').

CHAPTER 4: DISCUSSION

Overview

This chapter discusses the findings of the study with reference to previous research reviewed in Chapter 1. The chapter begins by considering the high frequency of encounters between the police and people with mental illness reported by both police and offender participants. The following two sections discuss the experiences of police officers and offenders respectively; areas of overlap between their experiences are noted. Implications for clinical and police practice are then discussed. A critique of this study is then offered following guidelines for qualitative research proposed by Smith (1996) and Elliott et al. (1999). Finally, the implications for further research are discussed.

Findings

Frequency of encounters between the police and people with mental illness

All participants who took part in this research noted that there was a high frequency of encounters between the police and people with mental illness. In 1967 Bittner noted that crisis management of people with mental illness living within the community was becoming a standard part of police work. More recently, Cordner (2000) observed that the police are often the only emergency service to be called upon when a person with mental illness begins to cause concern to others. The police officers who took part in this study described dealing with people with mental illness on a daily basis. They felt the mental health services relied heavily on the police to act in situations involving

individuals living within the community, i.e. in practice the police often were the only emergency service who dealt with people with mental illness in crisis.

No previous research was identified looking specifically at mentally disordered offenders' views of the police. It was noted by Blackburn (1993), however, that the relationship between involvement in criminal activity and mental illness is not a simple one. The complex nature of this relationship was reflected in the accounts given by offenders with mental illness. All participants described a number of contacts with the police. Most acknowledged that some police contacts were due to their involvement in criminal activities. Other police contacts were either as victims of crime or in the context of arrest under Section 136 of the Mental Health Act. Offenders described very different experiences of the police depending on the context. When they were approached in relation to criminal activity, for example, officers seemed uncaring and, even, abusive. When they were detained under Section 136, however, police officers were experienced as being caring and protective.

There was variation in terms of the degree to which offenders felt their mental illness had led to the high frequency of encounters described with the police. Some participants felt that mental illness had led, in part, to their involvement in crime and their need to be arrested as a means of accessing care. Others, however, were not sure if they had ever had a mental illness. In the latter cases, however, participants described beliefs, e.g. that they were being monitored by the police or other organisations, that were associated with

psychotic thought processes and that could lead to behaviour that would make an arrest more likely (e.g. being aggressive towards police officers).

Police Officers

Mental illness complicates encounters with the police

All participants described incidents where the presence of mental illness had complicated encounters with the police. This was consistent with previous research in the area (e.g. Teplin and Pruett, 1992; Green 1997).

Most of the police officers interviewed felt there was an increased risk of unpredictable, aggressive behaviour when working with people with mental illness. This particular perception of an increased level of risk was not reported in previous qualitative research on this area (Green, 1997). It was noted, however, in studies considering the criminalisation of mental illness, that people with mental illness are more likely to be arrested for minor offences (Robertson, 1988). Robertson suggests that social control, i.e. the need to protect society from the difficult behaviours of people with mental illness, was the reason for this increased rate of arrest. An alternative reason for this may be police perception of an increased risk of aggression in individuals with mental illness. Studies of decision making under pressure identify ways in which underlying beliefs (heuristics) bias decision making (Chase, 1999). Officers' beliefs about the risk of aggression in people with mental illness will influence their behaviour and affect decision making, perhaps leading to a higher arrest rate as a means of containing perceived risk.

In addition to suggesting an increased risk of violence in suspects with a mental illness, police officers reported a reluctance to use physical restraint with individuals with mental illness. Participants described incidents where difficult behaviour had escalated in severity necessitating the use of handcuffs and talked about a conflict within their own feelings when they needed to use physical restraint. Officers suggested that using a physical intervention to *control* an individual who appeared to be mentally unwell was in direct conflict with their instinct to *care* for the individual. One of the most complicating factors in police work with people with mental illness appeared to be conflict between the demands of the job (i.e. to prevent further disturbance and remove the individual to a safe place), the demands of the person with mental illness (an increased risk of aggression or violence) and the wish of the police officer to be helpful and caring. Respondents reported that they felt a great deal of stress as factors combined to create a situation in which they were obliged to use physical restraint in order to control against the perceived risk of further aggression, but felt this was an uncaring approach to adopt. Teplin and Pruett (1992) also identified conflict between police officers' duty to protect public safety and their duty to protect vulnerable individuals (e.g. people with mental illness). Conflict between the two roles adds to officers' reluctance to use physical restraint. It is also consistent with difficulties identified with working with people with mental illness who break the law. Harris (1999), for example, notes that there is often a conflict between the wish to care for a person who seems in need of assistance and the wish to protect oneself and others from someone whose behaviour is unlawful.

Although previous research (Green, 1997; Teplin and Pruett, 1992) has suggested that officers might feel pressured to deal with people with mental illness on an informal basis to minimise the time it takes to deal with incidents, accounts from officers in the present study were not consistent with this. Several participants noted that dealing with people with mental illness often took longer than superior officers would have liked and led to officers being unavailable for other jobs for periods of time. This was discussed in the context of it being inevitable that work with people with mental illness was time consuming and that the only way around this would be to increase police resources by employing more officers. Participants believed their task was to do what they could to assist people with mental illness and if this involved time consuming referrals to the mental health services then so be it. This finding was in direct contrast to the findings of Green (1997) and Teplin and Pruett (1992) who both found evidence that officers would do anything to avoid referring to the mental health services. The officers who took part in this research, however, had access to a 24 hour mental health crisis team who were available to assess mental state, making it easier, perhaps, for the police to refer to mental health services. Furthermore, all officers came from the same police force. It is possible, therefore, that the research was carried out in a police force which was more sympathetic towards people with mental illness and in which officers did not feel under pressure from their superiors to deal with these issues very quickly (see Methodological Issues, below).

The police are not equipped to deal with mental illness

Rumbaut and Bittner (1979) noted that, as the process of deinstitutionalisation gathered pace, the police were increasingly required to provide emergency assistance for people

with complex difficulties in times of crisis (e.g. relapse) despite the fact they had no specialist training in this area. The police officers who took part in this study confirmed that this remains the case. Participants reported that a significant part of their work involved people with mental illness whose behaviour was causing concern to others or was against the law. Participants were often called upon to approach situations with little or no background information and were required to identify factors contributing to an individual's behaviour or current mental state. This included identifying the presence (or absence) of a mental illness and referral to the local crisis team for formal assessment. Officers demonstrated an appreciation of the important role they often played in facilitating an individual's access to emergency psychiatric treatment. As such, the officers who took part in this study could be accurately described as "street-corner psychiatrists" (Teplin, 1984).

Research carried out by Robertson et al. (1996) and Palmer (1996) suggests that officers would be uncomfortable in this role and feel unequipped to intervene with people with mental illness. This was indeed the case. Police officers in the present study reported that they received little or no specific training on identifying mental illness or how to deal with an individual with mental illness. They noted that the mental health services often relied upon the police to take a leading role in situations involving individuals who were deemed to be aggressive. The officers felt unsupported by mental health professionals in this respect. Officers taking part in research in the US looking at encounters with people with mental illness (Teplin and Pruett, 1992) also felt unsupported by the mental health services.

Officers reported that they often felt out of control or anxious in situations involving people with mental illness. Feeling out of control was probably a particularly difficult feeling for police officers to tolerate as so much of an officer's role is dependent upon being able to calmly approach situations and quickly take control. Research looking at 'police culture' and 'masculinity' among police officers suggests that a need to be dominant in every situation is common among officers (Smith and Gray, 1985). The difficulties described when working with an individual with mental illness often lead to a situation where officers are not able to remain dominant and this is likely to be particularly challenging to the officers concerned, leading to an escalation in their attempts to dominate the situation. It is also likely that police officers behaving in a dominant manner would be experienced as difficult by people with mental illness which may, in turn, lead to an increase in their resistance.

Participating officers noted that, although the mental health crisis team was an invaluable resource allowing for detailed assessment of an individual's mental state, a referral to the crisis team often entailed a lengthy delay. This led to individuals being detained in police custody, usually a cell, for extended periods of time and officers felt unable to care for individuals in this situation. Furthermore, officers often noted a deterioration in an individual's mental state and increasing distress as people with mental illness were detained pending assessment by the crisis team. This made officers feel as if they had failed to assist the person with mental illness. Again, this situation caused conflict with the officer's desire to look after and care for distressed individuals. Several officers said

that they coped with these feelings by trying to do everything in their power to provide a high quality of service for people with mental illness. Officers noted, however, that it was important to remain objective and that there may come a time when they had to stand back in order to protect themselves from becoming over involved. Again, as previous research looking at police encounters with people with mental illness has focused on organisational issues, there is no previously published data considering the personal impact of this work on police officers.

Police powers are limiting

Previous research considering police powers under Section 136 of the Mental Health Act (e.g. Rogers, 1990) and issues raised by The Mental Health Act Review Experts Group (1999) suggests that officers might find limitations in their powers of arrest on private premises frustrating. The findings of the present study were consistent with this. Most participants had been involved in situations where they had been unable to act because an individual was on private premises. This had led to situations in which the police had spent long periods of time attempting to persuade an individual to agree to a mental health assessment or had had to resort to 'persuading' an individual to leave their house so that they could be arrested under Section 136. Officers felt uncomfortable about resorting to this kind of strategy, describing it as essentially deceitful, but noted that there were situations in which there was no alternative. It was also likely to be experienced by people with mental illness as an abuse of police powers and to contribute to the experience of officers as uncaring.

Several officers described situations in which they had been unable to remove an individual under Section 136 because they were on private premises and had seen the same person several days later and noted that their mental state had deteriorated during the intervening time. Officers felt saddened by this and reported a sense of responsibility for not having been able to act sooner. Research into 'police culture' has identified that many police officers prefer a proactive approach to difficulties (Horn and Hollin, 1997). Being unable to act due to limitations in police powers are, therefore, likely to be experienced as particularly stressful as they prevent officers from acting proactively.

One of the proposals made for the new Mental Health Act was to extend police powers under Section 136 so that the police are able to act on private premises. It is unlikely, however, that powers will be extended in this way. The Mental Health Act Review Experts Group (1999) are "reluctant" to extend powers to private premises as this would "constitute too fundamental a breach of principle," (p.36). It is proposed, however, that police powers may be extended to private premises in an emergency situation on the authority of a medical practitioner of "appropriate seniority and experience," (p.37). Given the experience of officers who took part in this study of lengthy time delays in awaiting the local crisis team, let alone a senior practitioner, it is unlikely that this change will do anything to prevent officers from feeling frustrated and disempowered by their lack of power on private premises.

Offenders

Mental illness complicates encounters with the police

Participants with mental illness reported difficulties in their interactions with the police. Most participants reported that they had been mistreated by the police on at least one occasion. Offenders felt that the police had harassed them, paying them a disproportionate amount of attention. It was not clear whether this related to an increased vigilance towards the police because of involvement in criminal activity, to a sense of paranoia about the police, perhaps associated with mental illness, or was due to the fact that police officers were paying them an undue amount of attention. Most participants, however, described being in trouble with the police from an early age and it is possible, therefore, that they had been identified by the police as "trouble-causers." The resulting repeated experience of being approached by the police could then have increased feelings of persecution. This pattern may have begun before respondents became mentally ill but may later have contributed to feelings of paranoia.

Most participants described specific examples of being seriously mistreated by the police. These included being beaten up, shouted at and abused racially. It was not clear whether the presence of mental illness had contributed to the mistreatment participants reported in the hands of the police. It was also not possible to assess if there was any exaggeration in descriptions of the severity of mistreatment. Several participants noted that they had

provoked the police at times when they were mistreated, e.g. by running away or threatening officers with a knife. Most participants, however, also complained of being treated badly by the police, representing an alarmingly high frequency of mistreatment. Their experience of the police at times when they had been arrested was often very negative and participants described being frightened of the police. Aspects of police officers' presentation and behaviour, perhaps influenced by 'police culture' (Horn and Hollin, 1997) was particularly difficult for people with mental illness. Difficult traits identified in nurses and psychiatrists by mental health service users (e.g. being authoritarian, forcing individuals to do things, not listening, not seeming to understand; Rogers et al., 1993) are likely to be shared by some police officers making the experience of police encounters seem more abusive.

Most participants reported aspects of their encounters with the police that were difficult because of the symptoms of their mental illness. Many participants noted that being locked in a cell had been especially difficult at times when they had suffered from delusions or hallucinations and that this treatment had served to confirm their beliefs that the police were out to get them. Police officers also acknowledged that police cells were inappropriate for people with mental illness and described an awareness that such treatment often made matters worse. Furthermore, participants could often not remember the police explaining things to them when they were arrested and this made the arrest procedure more frightening and confusing. Again, police officer participants described how communication difficulties served to make encounters more difficult for all parties.

The combination of difficult experiences with the police due to mistreatment and difficulties relating to mental illness made participants feel more persecuted by the police and become more sensitive to perceived mistreatment in future interactions. Many participants noted that their experiences meant they felt they could not trust the police and that they now expected to be treated unfairly. Previous research by Gudjonsson (1993) has highlighted how stressful encounters with the police are, even for experienced criminals who are not suffering from mental illness. It is hardly surprising that the presence of mental illness makes experiences of the police even more stressful. Pearse et al. (1998) have noted that high levels of anxiety caused by encounters with the police have a marked effect on mental state and behaviour. It is hypothesised that this degree of expectancy makes offenders with mental illness more sensitive to perceived mistreatment by the police and that this in turn could contribute to 'delusional' ideas about police persecution.

Ethnicity

There was a marked difference between the ethnicity of the police officer and offender participants. Just one of the police officers who took part was black British. Eight of the offenders who took part, however, were black British, one was Asian British and one was black African. A number of studies report an over representation of Afro-Caribbean ethnic groups in mental health services (e.g. Fernando et al., 1998; Chakraborty and McKenzie, 2002), secure hospitals (Cohen and Eastman, 2000) and the prison system (e.g. Blackburn, 1993; McKeown and Stowell-Smith, 2001). The fact that most of the offenders who took part in this research were black was consistent with the above studies.

The accounts from offender participants indicated that differences in ethnicity had a significant impact on their experiences of the police. In some cases this included racial abuse. This will be considered in the context of studies looking at the effect of ethnicity on police attitudes and beliefs.

McKeown and Stowell-Smith (2001) suggest that the social construction of ethnic differences among professional groups in the UK accounts for a propensity to view certain behaviour in black groups as either indicative of psychological disturbance or as dangerous. Black people, it is argued, are likely to be arrested and to come into contact with mental health services as a result of public misperception of culture specific behaviour (Fernando et al., 1998). The experiences of repeated unwanted contact with the police and of police behaviour that was experienced as 'racist' described by the offender participants is testimony to these processes.

A great deal of media attention has been directed at police attitudes towards ethnicity and to police forces' inability to recruit officers from ethnic minority groups. Several studies have identified racist beliefs and attitudes within police forces. In the US, for example, Georges and Daniel (2002) described a process of "petit-apartheid" (Georges and Daniel, 2002, p. 227) in police officers. They suggest that this is associated with officers' intimidation and insults towards people from ethnic minority groups. Similar behaviours were experienced by black people who took part in this research. In the North of England (Bradford and Sheffield) Goodey (2001) identified a tendency among police officers to criminalize the behaviour of young Asian males following a series of riots in the mid

1990's that involved large groups of Asians. Police beliefs about ethnicity, crime and mental illness represent an important group of heuristics that will influence decision making bias, as described in Chapter 1 (e.g. Tversky and Kahneman, 1974). Similarly, public enquiries into the levels of care at two of the three special hospitals in England (Broadmoor and Ashworth) identified that non-overt racism (e.g. a disproportionate use of restraint or additional medication) was part of the culture (Blom-Cooper, 1999).

Finally, Ackerman et al. (2001) investigated beliefs about the police in ethnic minority groups across the US. They found that black people rated police honesty and ethical standards more negatively than white people. It seems likely that individuals' experiences of the police will have contributed to these beliefs. At the same time, however, it is hypothesised that these beliefs in turn will affect behaviour towards the police. If one does not expect to be treated fairly by the police, for example, then one is less likely to be open and co-operative when approached by officers. This could lead to a self-fulfilling prophecy in which officers, in turn, are more likely to respond to an unco-operative presentation in a discriminatory manner.

There were indications from the findings of the present study that differences in ethnicity between the police and offenders with mental illness had contributed to difficulties. Offenders experienced overt racial discrimination from the police. It is suggested that underlying police assumptions and beliefs (which are common in Western society) relating to the perceived higher likelihood of either mental illness or criminal behaviour in members of ethnic minority groups affected the way officers were experienced by

offenders. Interestingly, none of the officers who took part identified any specific difficulties relating to encounters with people from different ethnic groups. This is consistent with research suggesting that 'racist' values operate at an unconscious level within professional groups (e.g. Blom-Cooper, 1999; Rogers, 1990). Alternatively, it may be due to the sample of officers who were recruited; they may have been more open minded or aware of these issues than other officers. A third possible explanation relates to social desirability. It would have been difficult for officers to admit to racist behaviour in any context, let alone while participating in an external research project.

Police interviews can be difficult

Research carried out by Gudjonsson and others (e.g. Gudjonsson et al., 1998) suggested that people with mental illness would find the police interview stressful. Most offenders described being interviewed by the police as a further example of how badly the police had treated them. Participants described being pressurised by interviewing officers to confess, sometimes for crimes they claimed to have had nothing to do with. Offenders also described occasions when they had been threatened by interviewing officers and had been frightened that they would be attacked physically if they did not co-operate. Furthermore, several participants noted that interviewing officers did not take the presence of a mental illness into account at the time of the interview and did not seem to appreciate how symptoms could make concentrating difficult. Several participants noted that interviewing officers appeared to have reached their own conclusions about what had happened before the interview even began and that it was not possible to influence these beliefs during the course of the interview. Experiences of the offenders who took part in

this research were consistent with findings that people with mental illness find police interviews difficult (e.g. Gudjonsson, 1993).

Previous research (Palmer, 1996) has suggested that the presence of an 'appropriate adult' during police interviews has limited value. Participants who had been interviewed in the presence of an appropriate adult, however, expressed positive views about this. Several participants said that they had felt supported by the appropriate adult and it had felt like they were not alone when an appropriate adult was provided. From the offender's view point, therefore, the appropriate adult scheme was perceived to be serving the purpose as intended in PACE, i.e. a source of peer support. It was noted that previous research on the use of appropriate adults has concentrated on the number of times appropriate adults were employed and on the views of police officers and people who had acted as appropriate adults (Palmer, 1996). No published research was identified that considered vulnerable individuals' perceptions of how useful it was to have an appropriate adult. The results of this research suggest that offenders do feel protected by the presence of an appropriate adult and value this service.

More positive experiences of the police as providers of care

Although most offenders taking part in the research described times when the police had treated them badly, they also described times when the police had been helpful. This was often in the context of them being taken to a safe place by the police under Section 136. Participants described the police as presenting a caring manner at these times. Several participants felt that the police were the only people who seemed to want to help, i.e. they

felt that the health care services had given up on them. No previous research was identified that considered the views of people arrested under Section 136 of the Mental Health Act. This research suggests, however, that people who have experienced this route into psychiatric care will feel pleased in the long run that the police were available to help at their time of crisis.

Research considering the perspective of the person with mental illness on the use of Section 136 has focused on perceived inequalities in its application, e.g. the disproportionate use of Section 136 with black people (MIND, 1996; The Black Health Workers and Patients' Group, 1983; Browne, 1997). Many participants described feeling racially discriminated against by the police. It was noted, however, that when black participants described their experiences of being arrested under Section 136 this was not in the context of further discrimination. Offenders who took part in this research felt the police had acted in a caring way in their use of Section 136 and there was a sense that participants had been relieved to have been picked up by the police on these occasions.

Most offender participants described mixed feelings about the police. On the one hand, they felt persecuted and harassed by the police who often seemed to be paying them a disproportionate amount of attention and treated them unfairly when they were taken into custody. On the other hand, however, there were examples of times when the police had been the only people who seemed to care for them, often at times of crisis, i.e. a break down in mental state. Offenders discriminated clearly between different experiences of the police.

It may be that the mixed feelings about the police as described by the respondents in this study reflect an exaggeration of what might be considered a 'normal' opinion of the police among offenders. Alternatively, high levels of ambivalence may be related to fluctuations in mental state due to mental illness. A third explanation would be that police officers' behaviour changes depending upon the context of their involvement with an individual. It seems likely that officers are more likely to behave in a strict, authoritarian manner when they are arresting an individual who is suspected of involvement in serious criminal activity than when they are trying to 'help' an individual access care. Further research comparing offenders with mental illness and offenders without mental illness would allow further investigation of views about the police.

Clinical Implications

The findings of this piece of research indicated that working with people with mental illness is a significant issue for the police and that current practice does not always work effectively. Observations made by offender participants also suggested that the police could have dealt with them more sympathetically and effectively. Perhaps the most obvious area for improvement on the basis of the results of this piece of research is police training. Although officers encounter people with mental illness on a daily basis and are often required to contain situations involving individuals who are acutely unwell, officers currently receive little or no training on mental illness. It is acknowledged that there are undoubtedly many areas in which the police would benefit from further training. The

officers who took part in this research, however, indicated that mental illness has become such a significant issue for the police and that training in this area ought to be a priority. Detailed training on the identification of mental illness and how best to approach individuals who appear unwell could assist the police in dealing with situations efficiently and may ultimately result in encounters with people with mental illness being resolved more quickly. Furthermore, greater understanding among officers about mental illness would be reassuring for individuals with mental illness and further training may result in a more positive experience for individuals with mental illness who encounter the police. Findings from offender participants indicated that experiences of the police at times when officers adopted a more caring, empathic approach were more positive. Police training could, therefore, facilitate a more understanding approach to people with mental illness which might, in turn, decrease the likelihood of situations getting out of control, of offenders becoming aggressive, and of the police resorting to physical restraint.

Several police officer participants suggested the kind of additional training that might be useful. An on-going training program for officers on the beat which included direct exposure to people with mental illness would help officers to identify the presence of mental illness and suggest how best to approach individuals. One officer suggested that probationer police officers could partake in a short period of auxiliary psychiatric nursing work as a means of learning about people with mental illness. This may have the additional benefit of making people with mental illness more familiar with seeing police officers in a caring role, i.e. might lead to a change in perceptions of the police. Local

mental health services could also become more involved in additional training for police officers. This would allow for officers to be trained on issues that are pertinent to specific geographical areas. Furthermore, it would allow for a greater sense of collaboration between police officers and the mental health services (many officers felt unsupported by the mental health services).

Most police officer participants also identified difficulties due to a lack of resources. It was noted that low numbers of available officers made the time delays associated with working with people with mental illness more stressful. More resources in the form of additional officers would, therefore, be useful. Furthermore, it was suggested that detailed training for a few 'specialist' officers would allow for a better quality of service for people with mental illness. Perhaps specialist officers could be made available on each shift to deal specifically with calls relating to mental illness.

It was noted by both offenders and police officers that cells are not a good place in which to hold people waiting for assessment by the crisis team. Many police departments now have arrangements with the local mental health services allowing them to take people who appear unwell directly to hospital rather than to a police station. This kind of arrangement should be encouraged. If no such arrangements are possible, however, police stations should be equipped with holding rooms better suited to people with mental illness. These should allow for high levels of observation and should be designed in such a way as to not add to the stigmatism that comes with being taken away by the police, i.e. should not look or feel like being locked up in a cell. Consultation with people with

mental illness who had previous experience of being held in police cells could provide suggestions as to the kind of facilities a holding room should have.

Finally, officers noted that limitations in police powers under Section 136 of the Mental Health Act, 1983, preventing them from removing an individual from private premises, had made their work more stressful. This sometimes resulted in situations in which an individual's mental state deteriorated because the police were unable to act. The police officers who took part in this piece of research advocated an extension of police powers to allow officers to act on private premises. This is a complicated issue due to concerns about human rights and it is likely that the new Mental Health Act will not increase police powers. At the same time, however, one would like to think that one could trust a well-trained police officer not to abuse an increase in powers under Section 136 and would only arrest an individual on private premises if this was really necessary. Perhaps an improvement in police training and expertise in working with people with mental illness would make it easier to consider extending police powers to include private premises. Further debate on this issue is required.

Experiences of the police reported by participants with mental illness also suggested that higher levels of police training on mental illness should be a priority. Offenders felt the police often did not understand or appreciate the effects of their illness. This resulted in a feeling that the police could not, therefore, provide the right care for them. Further police training could help officers to adopt a more caring, empathic approach to individuals with mental illness.

Offenders noted that their experiences of the police were more positive when health care professionals were available to support them. Having a social worker available to support them during the course of their involvement with the police had the effect of decreasing levels of anxiety and distress. Participants noted, however, that the police surgeon (FME) often seemed unable to offer the support they felt they needed; they were worried that the FME was not to be trusted because of his/her close ties with the police. Participants felt more comfortable with members of the mental health crisis team. Both officers and offenders valued the input of the crisis team and this facility could be extended to further improve the services available to people with mental illness at the police station.

Most offender participants noted that police interviews had been difficult for them and described occasions when they felt they had been bullied by interviewing officers. Despite the introduction of PACE in an attempt to try to improve police interviews, this remains an area of concern. The results of this study indicate that further investigation is needed on the police interview and that procedures need to be tightened to prevent individuals with mental illness feeling pressured to confess to crimes they did not commit.

On a more positive note, participants said that having an appropriate adult who understood their mental illness present during police interviews made them feel more confident in this situation. All participants who had had the experience of being interviewed with an appropriate adult present said how helpful this had been. Steps

should be taken, therefore, to ensure that appropriate adults are available to all people with mental illness. If there is any doubt about an individual's mental state then an appropriate adult should be offered in order to minimise risk of missing people out. Once again, further training on PACE and the use of appropriate adults would be useful.

Finally, as noted above, many of the offenders who took part in this research described having a negative perception of the police. This led to situations in which they expected to be treated badly by the police and were, therefore, uncooperative and hostile. Some offenders had limited experience of the police acting in a caring manner. Increasing offenders' understanding of the different roles the police serve (e.g. as fighters of crime, as carers for people with mental illness, as support for victims of crime) might serve to change their perceptions of the police. This could be beneficial as it might help avoid situations in which offenders adopt an uncooperative, hostile presentation when approached by the police. One way to facilitate a greater understanding could be to include input from the police in mental health awareness treatment groups for people with mental illness.

Methodological Issues

Generalisability of findings

The very nature of qualitative research, i.e. relatively few participants drawn from specific populations, raises questions about the generalisability of findings. It is acknowledged that the results of this piece of research represent beliefs about police encounters with people with mental illness in two closed populations, i.e. police officers working in one particular police force and offenders being treated in secure hospital settings. Furthermore, it was noted that all the offenders who took part in this research had a diagnosis of schizophrenia. As such, it is likely that there would be some variation in beliefs and experiences if the research was repeated in different settings with different groups of participants. At the same time, however, this particular piece of research was concerned with the experiences of police and people with mental illness during their encounters. Although some of the difficulties identified are likely to be shared by others, this study aimed to investigate a series of individual experiences in detail.

Situating the sample

Basic demographic details were provided in order to provide the reader with an idea of the research participants and their life circumstances as a context in which to consider the implications of the findings. It was noted that police officer participants all came from the same police force and that this was the only one of three forces contacted that agreed to take part in the research. Although the two forces that did not take part in the research did not give any reasons for their decision it seemed likely that this reflected differences in

organisational beliefs about external research projects and, perhaps, people with mental illness. The force that agreed to take part had an open policy about research and allowed an external researcher into the organisation to explore officers' experiences. It is likely that officers' experiences would be affected by wider, organisational issues. One might speculate, for example, that a force that is willing to support an external research project might also be more supportive of its officers. This would impact on their experiences of working in difficult areas such as mental illness. If they did feel supported by the force, they might be more able to spend time dealing with individual incidents without criticism from superior officers. It would be interesting to repeat the research with officers working in different forces in order to investigate how organisational differences between forces affects individual experience.

It was also noted that the police officers who took part in this research all volunteered to do so. One can speculate that the participants included officers who felt strongly about working with people with mental illness. It is less likely that participants included officers who were not interested in working with people with mental illness. This could have affected the range of experiences identified as the sample probably did not include officers whose underlying beliefs about mental illness were dismissive or more negative.

Similarly, the offenders who took part in this research all volunteered to do so. It is likely, therefore, that participants included people who had views about the police they wanted to share with another person. The sample probably did not include offenders who

did not really have an opinion on the police or offenders whose experiences of the police were too upsetting to describe.

Police officer participants were all beat officers whose experience of people with mental illness was predominately in the form of people committing minor criminal offences or disturbing the peace. Police officers' involvement in more serious offending was as an initial point of contact as the arresting officer. (Further investigation of serious offences is carried out by specialist CID officers). At the same time, offender participants were all individuals who had been convicted of serious offences, including sexual offences and serious assault. As such the two groups of participants were talking about slightly different circumstances. However, most police officers participants had come across more serious offenders with mental illness and offender informants all described contact with the police when they were not suspected of committing a serious offence, e.g. when being arrested under Section 136 of the Mental Health Act, 1983.

Accounts of participants

Just as recruiting police officer participants from a single police force could have implications on the range of experiences reported, researchers have suggested that self-report data provided by police officers may represent a socially desirable account (Horn and Hollin, 1997). One of the features associated with 'police culture' is a high level of internal cohesion between officers. This is expressed by a tendency to cover up for colleagues, a reluctance to criticise police practices and sensitivity to accusations of prejudice (McConville and Shepherd, 1992). This aspect of police officers will influence the kind of information provided to others, especially to an external researcher. One must consider, therefore, that the officers who took part in this research may have been responding during the course of interviews in a socially desirable manner.

All twelve of the offenders who took part in this piece of research had diagnoses of schizophrenia. There were times during the course of several interviews when participants began describing experiences that seemed to be delusional in nature (e.g. that they were under constant police surveillance or that they were being persecuted by Alcoholics Anonymous). Furthermore, the offenders who took part in this research were all in a secure hospital partly as a result of them being caught or identified by police officers. Some offenders may, therefore, have felt bitter about the police and that this may have influenced the material they presented during the course of interviews. At the same time, however, most participants gave a balanced account of the police including both negative experiences when they were arrested and positive experiences at times when the police had helped them to access care.

This piece of research aimed to investigate experiences of police encounters with people who were suffering from mental illness at the time of their arrest. The purpose was to examine individuals' experiences rather than to obtain an 'objective' view of what occurs during encounters between police officers and people with mental illness. Researchers who advocate phenomenological approaches to research stress the importance of individual experiences when trying to understand the psychological world. Kvale, for example notes, "The important reality is what people perceive it to be"(Kvale, 1996, p.52).

Owning one's perspective

Elliott et al. (1999) advocate that authors make their own perspectives and orientations explicit and acknowledge how these affected the research process. My initial perspectives on policing and people with mental illness are described in Chapter 2, "Researcher's Perspective". Smith (1996) argues that the researcher should consider his/her presence in a piece of research and how this contributes to the investigation and outcomes. The participants, as collaborators in the investigation, will be influenced by the researcher's approaches (based on their beliefs and assumptions) and are also subject to the forces of self-reflection. It is important, therefore, to define and describe one's own reflection on the research process.

I began this research believing that the police, on the whole, try to maintain high professional standards and do their job to the best of their ability with all groups of people. At the same time, however, I was aware of well publicised examples of officers mistreating suspects with mental illness. I was also aware of individuals with mental illness who felt that the police had not taken their illness into account at the time of their arrest and of how distressing this had been. I had worked with offenders both in prisons and secure hospitals for several years and had come to expect clients to describe difficult backgrounds and unsatisfactory encounters with services, including the police.

Self reflection during the course of analysis and writing up the research has made me aware that I held conflicting views about the police and people with mental illness. On the one hand, I respected the police force and individual officers and felt that they were generally trustworthy and non-abusive of their powers. On the other hand, however, I knew about cases where vulnerable individuals with mental illness had been treated very badly by police officers who had abused their powers. As I continue to reflect on my previous experiences of people who alleged police mistreatment and on the meaning of the results I am becoming increasingly aware of dissonance between these two views.

My position as a researcher was different within the two different institutions in which the data were collected. Police officers were interviewed in a police station. I was a visitor in this situation, someone who had been *invited* to visit and carry out my work. This influenced the power differential between myself and the participants. Although I was conducting the interview, I was working in the participants' environment. Interviews

were carried out in a room which the participants would normally use to interview suspects or victims of crime. Furthermore, all police officer participants were on duty at the time of taking part in the research and wore their police uniforms. It was difficult, under these circumstances, to doubt the veracity of the accounts provided by the officers who took part. While reflecting on factors that may have influenced accounts provided by the participants, it struck me that I was predisposed to believe what I was told by police officers. This reflected my underlying assumption that the police were a trustworthy group of people. Self-reflection during the course of writing up this research, and further consideration of the literature (e.g. Horn and Hollin, 1997), has made me suspect that this view may have been naïve.

Interviews with offenders were carried out in secure hospitals. I was working as a trainee clinical psychologist in the hospitals at the time of carrying out the interviews. Unlike my visits to the police station, interviewing participants in the hospitals felt more familiar to me. Many of the participants had met me before they took part in the research and viewed me as one of the professionals working in the hospital. I was aware that my appearance alone, i.e. a white man wearing a shirt and tie, made me very different from many of the research participants. The power differential during this series of interviews was marked. I was less likely to be impressed by a sense of unquestionable truthfulness of the experiences described by the offenders in the way that I was by the police.

As I continue to reflect on this assumption, I am increasingly aware of how this may have influenced the course of the interviews and my initial analysis of data. My experience is

that all professionals working in forensic settings consider the truthfulness of material presented to them very carefully. People being held within the forensic system are, therefore, used to not being fully believed by professionals. At the same time, however, as a phenomenological enquiry, this piece of research aimed to explore individual experiences of police encounters and what is really useful is the participants' own ideas about what happened to them. Continued reflection on this issue has served to remind me that all experiences are subject to the actor's interpretations of what happened and, although uniformed police officers may seem more reliable than convicted criminals, their descriptions are essentially subject to the same sources of influence and bias.

Moral Uncertainty

As is often the case in qualitative projects, this piece of research was essentially a moral activity exploring what offenders and police officers believed to be right or wrong about their encounters and considering how they felt about the ways in which they were treated. McLeod (2001) describes areas of "moral uncertainty" (p. 197) that are an important consideration. The researcher can not predict, for example, how participating in the research will affect participants. The impact of recalling a traumatic arrest, for example, is unknown. McLeod (2001) argues that a poorly handled interview may serve to upset participants but a well structured interview may have more dramatic effects as the participant may develop new insights into their experiences. As such, it is important to allow the participants to withdraw from qualitative research at any time. This was clearly stated to participants both in written form (see Information Sheets, Appendices 2 and 3) and verbally prior to commencing the interview.

Grounding in examples

Interpretative Phenomenological Analysis, like other qualitative methodologies, relies heavily on the researcher's interpretation of participants' statements. The reader must be provided with examples of the data both to give a sense of what interviews looked like and to illustrate analytic procedures used in the study and how these were understood. Examples of data are, therefore, included throughout Chapter 3.

Maximising Credibility

The importance of addressing the credibility (or quality control) of qualitative research is introduced in Chapter 2. Credibility allows the reader to judge the quality of a piece of research (McLeod, 2001). It is noted that the standards that are used to rate validity in quantitative research are not applicable in qualitative projects.

McLeod (2001) describes several strategies for dealing with credibility. One way of maximising credibility is to adopt a clearly defined qualitative methodology and to include a description of how this has been applied in the Method section (see Chapter 2). Further to this, presentation of the interpretations should include enough raw data to allow the reader to understand how and why the researcher arrived at their understanding of the text (Elliott, Fischer and Rennie, 1999). Examples from the raw data are included throughout Chapter 3.

A series of standards that can be used to judge the validity of qualitative research have been described (e.g. Smith, 1996; Elliott et al., 1999). The first of these is internal coherence. The researcher should present a coherent argument in which any loose ends and contradictions are identified and addressed. Ambiguities within the analysis must be considered in a clear and ordered manner. The researcher should also consider alternative interpretations. Attempts were made to present a coherent argument in describing and discussing results (Chapters 3 and 4).

A second strategy involves conducting an independent audit of the process of data analysis. Smith (1996) suggests that the researcher could create a "paper trail" while carrying out analysis, detailing what happened at every stage of the research and explaining how interpretations were reached. The aim would be to leave a detailed trail that could be followed by a second researcher. Smith (1996) notes that researchers who utilise this means of maximising credibility rarely actually ask a third party to audit their interpretations but attempt to leave a trail that *could* hypothetically be followed by a third party. Smith (1996) also notes that this strategy allows the researcher to check his/her own interpretations of the data and does not generate alternative explanations.

A further method of considering validity is triangulation. This process involves using a number of different methods or sources of information to approach the same question. If several different approaches to the same topic arrive at a similar understanding it is more likely to be correct. Had it been possible, for example, to identify arresting officers and

the people they arrested and ask them to describe the same events then the experience of specific arrests could be approached from two different perspectives.

As noted in Chapter 2, Smith (1996) and Elliott et al. (1999) describe approaches to validation of qualitative research by others. One such method involves asking the participants to consider the credibility of the analysis. In this piece of research interpretations of the data was presented, both verbally and in written form, to police officers who took part. The officers felt that my interpretation of the data captured the essence of their experiences and highlighted the difficulties they faced.

It was not possible to present the data to the offenders who took part in the research because I no longer worked in the units where data was collected by the time analysis had been completed. Offenders were offered a brief verbal summary of the 'results so far' immediately after they had taken part in the research.

Bloor (1997) has highlighted several areas of difficulty in member checks of validity. It can be difficult, for example, to engage research participants in taking part in further research after the data collection stage. Although I explained at the time of the initial interviews that a summary of the results would be available and that I would be interested in participants' own thoughts about this, it was difficult to involve police officer participants in discussion of the results when these were fed back. I got the impression that limitations in police time made officers reluctant to spend time reading and discussing the results in detail. Bloor (1997) notes that there is often a marked power

differential between researchers and participants that can result in situations in which participants are reluctant to comment on results that have been written or presented by the researcher. Similarly, the rules of polite conversation might make participants feel it would be rude to say anything negative about the researcher's understanding of the data. It is important, therefore, when conducting member validity checks to give participants explicit permission to identify any areas in the interpretation that they disagree with. Although there are potential difficulties with this kind of validity check, it is encouraged as a diplomatic process that can engage research participants in the role of co-researchers (McLeod, 2001).

An alternative approach involving a third party is to conduct a peer review of the analysis. This method was employed in this piece of research, see Chapter 2. The difficulties identified by Bloor (1997) that can affect the quality of a member check of validity, however, may also be present when conducting a peer review of the analysis. Attempts were made to control against these influences by conducting a peer review with a researcher who was also using IPA and, therefore, was fully aware of the purposes and importance of considering credibility in this way.

An alternative method of considering the validity of interpretations from a service users' perspective, given that it was not possible to check the validity with the offenders who participated, could have involved presenting an overview of the findings to either a different group of offenders with mental illness or to a group of people with mental illness who had had contact with the police. This would have allowed a more global

consideration of credibility as it would have been checked by participating police officers and by people with mental illness who had experienced the police.

Although there are limitations in this piece of research as a result of failure to check the validity of the analysis with the offender participants, attempts were made to consider credibility in other ways. The police officer participants did give their views on the analysis and interpretations were discussed in detail with a second qualitative researcher (leading to re-conceptualisation of some of the data). Furthermore, attempts were made during the write up to present a clear and cohesive account of the way in which the analysis was carried out (see Chapter 2). Chapter 3 includes excerpts from the interviews illustrating each theme allowing the reader to see where interpretations came from.

Coherence

Attempts were made to present the results of this study in a coherent manner in order to tell a story and, therefore, facilitate the reader's understanding of the data and implications. At times, however, having data sets from both police officers and offenders made it difficult to present data in a coherent manner and a certain degree of selectivity in terms of what was presented and where is acknowledged. Attempts were made to ensure that personal bias did not have a significant influence over what was excluded. This was done by initially writing up all the results achieved and discussing what could be excluded with a senior academic lecturer who was familiar with IPA.

Accomplishing general vs. specific research tasks

The specific aim of this piece of research was to provide an understanding of encounters between the police and people with mental illness. Elliott et al. (1999) stress that qualitative research that attempts a specific task must acknowledge potential limitations in terms of extending the findings to other contexts. Limitations in extending the findings of this research are addressed in the section "Generalisability of findings," above.

Resonating with the reader

Elliott et al. (1999) suggest that qualitative research manuscripts should 'resonate' with the reader in order to provide a clear understanding of the subject matter and implications of the research findings. It is hoped that this manuscript provides a clear account of police encounters with people with mental illness and that the issues raised in data analysis provoke further reflection with the reader.

An ethical issue

At the start of this project, the ethics committee suggested that the wording of one questionnaire item, "Have you ever seen a psychiatrist, psychologist or psychiatric nurse?" (see Appendix 4: Police officer demographic information questionnaire) be amended to include the words "as a patient" to avoid a situation in which officers might answer "yes" on the basis that they had seen psychiatric give evidence on court. Unfortunately, this change was not made, due entirely to human (my) error. As questionnaires were completed in my presence, however, officers were able to ask if

questions seemed ambiguous. It was noted that the only officers who answered "yes" to this question were those who reported that they had suffered from mental illness. However, it is acknowledged that the ethics committees have an important role in supervising research involving people and that researchers have a moral obligation to follow their advice.

Areas for Further Research

As noted above, it is important to acknowledge limitations in the generalisability of the research findings. One obvious avenue for further investigation in this area would be to repeat the methodology with different groups of research participants. It would be useful to repeat the study with officers from different police forces, thereby investigating variations in organisational settings and approaches to people with mental illness, perhaps dictated by individual forces' policy or the local mental health services. It is predicted, on the basis of previous research (e.g. Teplin and Pruett, 1992; Green, 1997), that police experiences of people with mental illness would be influenced by higher level police force and health care policies. A police force in which superior officers stressed the need to minimise time consuming interactions with individuals, for example, might lead to officers having a more negative and critical view of people with mental illness. Research conducted in an area in which hospital accommodation is available as a place of safety for people with mental illness picked up on Section 136 might reveal less feelings of impotence and stress among police officers.

This piece of research concentrated on beat police officers. It was noted, however, that specialist officers (e.g. CID) also become involved in the investigation of people with mental illness suspected of committing serious crimes. Further research is needed considering specialist officers' experiences of people with mental illness. It would be predicted that, by definition, higher levels of expertise (e.g. being a CID officer who specialises in investigating serious offending) facilitates a greater understanding of the individuals under investigation. At the same time, however, it might not follow that these levels of expertise would be automatically transferable to people with mental illness. Investigation of this would offer further insight into the experience of police encounters with people with mental illness.

It has been noted that the published research considering police encounters with people with mental illness has focused on the way in which pressure from more senior officers and the local health services to deal with people with mental illness in specific ways impacts on beat officers. It would be interesting to involve more senior officers in a piece of research looking at their perceptions of people with mental illness and how they feel the police should deal with this group of people. An additional area of focus for research involving senior officers who have more influence at a policy area would be to investigate different approaches to working collaboratively with the mental health services. A reciprocal investigation could be carried out with mental health service managers.

Investigating different groups of people with mental illness who have encountered the police would be useful. It was noted that the participants with mental illness in this study represented a group of relatively serious offenders who all had a diagnosis of schizophrenia. It is suggested that investigating experiences of the police in a group of people who had not been convicted of serious criminal offences might reveal a different experience of the police. Similarly, a study involving people with different diagnoses would be useful. It might be predicted, for example, that people who did not suffer from psychosis might not feel as persecuted by the police. In this study it was noted that offenders often held two distinct views of the police, one as providers of care at times when they were mentally ill and needed assistance, and one as protectors of the law who seemed to be acting unfairly when investigating crimes. People with mental illness who had never been suspected of committing a serious offence, or who suffered from different types of mental illness, may not have negative experiences of the police. Alternatively, differences of experiences may be symptomatic of mental illness. Further qualitative research on perceptions of the police, within mentally ill and non-mentally ill respondents, is needed.

An overall lack of research on 'user satisfaction' of the police was identified when carrying out literature searches for this piece of research. Just as no published research was identified looking at the perceptions of the police held by people with mental illness, there was no research looking at non-mentally ill offenders' perceptions of the police process. Further research is, therefore, needed to investigate 'normal' offenders'

experiences of the police. This would allow for research aiming to identify differences in experiences of the police that are specifically related to mental illness.

A clear implication of the results of this piece of research was that the police need further training on working with people with mental illness. Suggestions were made as to how this could be organised (see Clinical Implications, above). Future research could focus on the impact of training police officers on mental illness. It would be interesting to compare current approaches to training across different police departments or, even, between different countries. It would be predicted that officers working in areas where training in mental illness is prioritised would report less difficulty and stress resulting from their work with people with mental illness. Similarly, it would be predicted that people with mental illness who had encountered more highly trained police officers would describe a more positive experience. An alternative approach to studying the impact of additional training on police interactions with people with mental illness would be to evaluate the quality of interactions before and after a period of specialist training. This would allow the researchers to identify specific elements of training that are more effective than others.

Finally, this piece of research was carried out using a qualitative, phenomenological approach in order to allow investigation of the experiences of encounters between the police and people with mental illness. Previously published research strongly advocates this approach allowing for full consideration of the influence of individual differences within different officers, offenders and situations (e.g. Green, 1997). As our

understanding of the psychological experience of such encounters increases, however, there will be an increasing scope for quantitative investigation of some of the issues raised. Questionnaire based studies, for example, would allow a researcher to investigate issues such as variability in the amount of specialist training received or in offenders' experiences of mistreatment by the police.

CONCLUSIONS

This research aimed to examine encounters between the police and people with mental illness from the perspective of arresting officers and individuals with a mental illness. Both police officers and offenders reported that such encounters occurred on a frequent, almost daily basis and were often very difficult.

Police officers felt unequipped to deal effectively with people with mental illness due to a lack of training, limitations in their powers under the Mental Health Act, 1983, limitations in resources, and a lack of support from the local mental health services. This resulted in officers feeling they were not able to offer people with mental illness a high level of service. Officers said they often felt they were unable to help individuals who were in need of care in the way they would have ideally liked to. They noted that people with mental illness often became more distressed when police officers arrived and, although reluctant to do so, they often needed to resort to physical restraint in order to contain individuals with mental illness. Officers felt that people with mental illness behaved in an unpredictable manner and could become very aggressive. Officers also noted that the local mental health services seemed to rely heavily on the police in crisis situations. There was a sense that the police felt unsupported by psychiatric services. Previous research (Teplin and Pruett, 1992; Green, 1997) suggested that police officers would feel pressured by their superiors to deal with people with mental illness quickly and without involving other services. The officers who took part in this research did not describe undue pressure from their superiors to deal with people with mental illness in

specific ways, although several officers noted that their superiors complained about time delays incurred when officers became involved with people with mental illness.

The offenders who took part in this research described different experiences of the police. Most described incidents when they felt the police had treated them badly, including occasions when they had been physically and racially abused by police officers. Furthermore, respondents felt the police had failed to take the effects of symptoms of their mental illness into account and said that encounters with the police could make them feel worse. Participants described being locked in police cells, for example, as being especially frightening. Similarly, it was noted that police interviews were especially difficult for people with mental illness. On the other hand many participants described times when the police had been able to help them to access psychiatric care. They talked about being arrested under Section 136 of the Mental Health Act, 1983, and experiencing the police as providers of care who tried hard to help at times of crisis. Many respondents said there were times when the police had seemed to be the only people they could turn to. Similarly, offenders described times when having an appropriate adult or mental health care worker present in the police station had helped them to cope with a difficult situation.

The implications of the findings of this piece of research were discussed. Further research is needed looking at encounters between the police and people with mental illness. This study highlighted some of the complexities of such encounters; further research would improve our understanding of what is often a difficult situation. An improved

understanding of the area would, in turn, highlight improvements that could be made to make encounters easier for police officers and individuals with mental illness.

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APPENDIX 1: Letters from ethics committees

UCL HOSPITALS

The University College London Hospitals

The Joint UCL/UCLH Committees on the Ethics of Human Research

Committee Alpha Chairman: Professor André McLean

Please address all correspondence to:
Iwona Nowicka
Research & Development Directorate
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1st Floor, Vezey Strong Wing
112 Hampstead Road, London NW1 2LT
Tel. 020 7-380 9579 Fax 020 7-380 9937
e-mail: iwona.nowicka@uclh.org

J Feigenbaum
Lecturer
Sub-Department of Clinical Health Psychology
UCL
Gower Street

April 6, 2001

Dear Dr Feigenbaum

Study No: 01/0062 *(Please quote in all correspondence)*
Title: **Mentally disordered offenders and the police interview**
~~Study No:~~ 01/0064
Title: **Self harm in male prisoners: the role of psychological factors**

Thank you for sending us your two interesting applications concerning police and prisoners. The Committee agreed with the proposals on conditions that there was appropriate approval from police as well as consent by individual police officers, prisoners and 'appropriate adults'. One minor point is, it was thought that the question "Have you ever seen a psychiatrist?" might be followed by the words "as a patient". I can just imagine a policeman telling you that he has seen lots of psychiatrists in court.

Please note that it is important that you notify the Committee of any adverse events or changes (name of investigator etc) relating to this project. You should also notify the Committee on completion of the project, or indeed if the project is abandoned. **Please remember to quote the above number in any correspondence.**

Yours sincerely

Professor André McLean, BM BCh PhD FRC Path
Chairman

Fax: 020 8272 5700
☑ Tick box as appropriate

Tel: 020 8201 4700
Fax: 020 8201 4701
☐ Tick box as appropriate

Chair Marcia Saunders
Chief Executive Christine Outram

28 September 2001

942 – Mental Health and the Police

Acting under delegated authority, I write to inform you that the above study was considered by the LREC at its meeting held on 25 September 2001 and was approved.

The LREC have asked that the following be taken into consideration with the information sheet:

1. The first paragraph would seem to bias the participant to view the police interview as particularly difficult for people with mental health problems.
2. To add to the information sheet that the tapes will be wiped at the end of the study.

To also point out that the R&D lead at the Trust should be informed of the study as and when they are identified.

Please quote LREC number 942 on any future correspondence.

The committee looks forward to receiving a copy of our interim report in six months time or at the end of the study if this is sooner.

With best wishes.

Yours sincerely

C A Hamilton

Christine Hamilton
LREC Administrator

Minicom: 020 8272 5606
Website: www.beh.nhs.uk
E Mail:
I:\LREC\942.doc

APPENDIX 2: Information sheet and consent form for police officers

Information sheet

Thank you for considering taking part in the study **"Mental health and the police."** This research looks at what it is like for someone with mental health problems to be approached by the police. The aim is to identify and highlight the difficulties people with mental illness have when they are involved with the police and hopes to make suggestions as to what could make this easier for both the police officers and the person with the mental illness.

Participation will involve completing a short questionnaire and tape recorded interview. You will be asked questions about your own experience(s) of people with mental health problems. Interviews will last no longer than one hour. Any information you provide will be done so on an anonymous basis; we will not write your name on the questionnaire or interview tape. **Information will be treated as highly confidential.**

Please note: you do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason.

All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the joint UCL/UCLH Committees on the Ethics of Human Research.

You may keep this Information Sheet.

Researchers: Mr H. Wood
Dr R. Halsey
Dr J. Feigenbaum

Contact Address: Department of Clinical Health Psychology, University College London, Gower Street, London. WC1E 6BT.

Consent form

Thank you for volunteering to take part in the study **"Mental health and the police."** Before we proceed please answer the following questions:

1. Have you read the information sheet about this study? Yes No

2. Have you had an opportunity to ask questions and discuss the study? Yes No

3. Have you received satisfactory answers to all your questions? Yes No

4. Have you received enough information about this study? Yes No

5. Do you understand that you are free to withdraw from this study at any time without giving a reason for doing so? Yes No

6. Do you agree to take part in the study? Yes No

Signed:

Print Name:

Date:

In the presence of (Harry Wood):

APPENDIX 3: Information sheet and consent forms for offenders

Information sheet (RMOs)

I am currently recruiting participants for the research project **"Mental health and the police."** This research looks at what it is like for someone with mental health problems to be approached by the police. The aim is to identify and highlight the difficulties people with mental illness have when they are involved with the police and hopes to make suggestions as to what could make this easier for both the police officers and the person with the mental illness.

Participation will involve completing a tape recorded interview. Participants will be asked questions about their own experience(s) of the police. Interviews will last about 50 minutes. Any information provided will be on an anonymous basis. I will also need to collect basic demographic information about each participant and hope to collect this from the Part I summary in the notes. Tapes will be wiped clean at the end of the study.

I am hoping to interview about 15 patients at [name of hospital] and wondered if you would be able to pass information sheets on to suitable candidates. The inclusion criteria for the research are English speaking patients held under a hospital order section. Patients with a learning disability are not included in this research. I will contact you shortly to discuss the research further.

All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the joint UCL/UCLH Committees on the Ethics of Human Research.

Yours sincerely,

Harry Wood.

Researchers: Mr H. Wood
Dr R. Halsey
Dr J. Feigenbaum

Contact Address: Department of Clinical Health Psychology, University College London, Gower Street, London. WC1E 6BT.
0207 679 1897

Information sheet (offenders)

Thank you for considering taking part in the study **"Mental health and the police."** This research looks at what it is like for someone with mental health problems to be approached by the police. The aim is to identify and highlight the difficulties people with mental illness have when they are involved with the police and hopes to make suggestions as to what could make this easier for both the police officers and the person with the mental illness.

Participation will involve completing a tape recorded interview. You will be asked questions about your own experience(s) of the police. Interviews will last no longer than one hour. Any information you provide will be done so on an anonymous basis; we will not write your name on the questionnaire or interview tape. I will also need to collect basic background data (e.g. age) from your notes. **Information will be treated as highly confidential and will not affect your treatment in any way. Tapes will be wiped clean at the end of the study.**

Please note: you do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason. Your decision whether to take part or not will not affect your care and management in any way.

All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the joint UCL/UCLH Committees on the Ethics of Human Research.

You may keep this Information Sheet.

Researchers: Mr H. Wood
Dr R. Halsey
Dr J. Feigenbaum

Contact Address: Department of Clinical Health Psychology, University College London, Gower Street, London. WC1E 6BT.
0207 679 1897

Consent form

Thank you for volunteering to take part in the study **"Mental health and the police."** Before we proceed please answer the following questions:

1. Have you read the information sheet about this study? Yes No

2. Have you had an opportunity to ask questions and discuss the study? Yes No

3. Have you received satisfactory answers to all your questions? Yes No

4. Have you received enough information about this study? Yes No

5. Do you understand that you are free to withdraw from this study at any time without giving a reason for doing so and without affecting your future medical care? Yes No

6. Do you agree to take part in the study? Yes No

Signed:

Print Name:

Date:

In the presence of (Harry Wood):

APPENDIX 4: Police Officer demographic information questionnaire

Please answer all the questions in this questionnaire by circling the appropriate response(s) or writing in the spaces provided. This questionnaire is anonymous: **do not write your name on it**. The information you provide will be treated as confidential.

1. Background Information

Age:

Gender: Male Female

Ethnicity:

What is your marital status? Single

Married/Cohabiting

Divorced/Separated

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2. Police Experience

How many years have you been in the police force?

What is your current rank?

Please give brief details of any training you have received in the area of investigative interviewing:

Please give brief details of any training you have received on mental illness:

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3. Mental Illness

Have you ever seen a psychiatrist, psychologist or psychiatric nurse? Yes No

Have you ever been diagnosed as suffering from:

Depression

Anxiety

Alcohol Dependence

Drug Dependence

Schizophrenia

Manic Depression

Post Traumatic Stress

Personality Disorder

Other (Specify):

Are you on any medication? Yes No

If you answered 'Yes' to the last question, what medication are you on?

Have members of your family or friends ever suffered from:

Depression

Anxiety

Alcohol Dependence

Drug Dependence

Schizophrenia

Manic Depression

Post Traumatic Stress

Personality Disorder

Other (Specify):

Have you ever experienced mental illness in any other way, e.g. as part of a previous job, learnt about during a university/college course etc.? Yes No

If you answered 'yes' to the previous question, please give details:

Thank you for completing the questionnaire.

APPENDIX 5: DEMOGRAPHIC INFORMATION

Police officers

(Note: demographic data, other than gender, for police officers 7 and 10 not available)

Gender:	Male = 8 participants Female = 4 participants
Ethnicity:	White British = 7 participants White European = 2 participants Black British = 1 participant
Age:	Average Age = 32 years Age Range = 21 years to 44 years
Rank:	Probationer = 1 participant Police Constable (PC) = 6 participants Police Sergeant (PS) = 3 participants
Length of Service:	Average = 10 years and 6 months Range = 6 months to 25 years
Previous experiences of mental illness:	None = 3 participants Suffered from mental illness = 2 participants Relative suffered = 3 participants Studied psychology = 2 participants

Offenders

(Note: Most participants had been convicted of more than one index offence. As such the frequency of index offences is greater than 12).

Gender:	All participants were male.
Ethnicity:	Black British = 8 participants White British = 2 participants Asian British = 1 participant Black African = 1 participant
Age:	Average Age = 36 years Age Range = 21 years to 63 years
Mental Health Act Status:	Section 37 = 3 participants Section 37/41 = 9 participants
Primary Diagnosis:	All participants had a primary diagnosis of paranoid schizophrenia
Additional Diagnoses:	None = 6 participants Drug/Alcohol Dependency = 5 participants Borderline Personality Disorder = 1 participant
Length of Detention:	Average = 3 years and 6 months Range = 1 year to 8 years
Index Offences:	Theft = 1 participant Robbery = 1 participant Attempted Robbery = 1 participant Burglary = 1 participant Attempted Burglary = 1 participant Threatening Behaviour = 1 participant Possession of a Firearm = 2 participants Actual Bodily Harm = 2 participants Grievous Bodily Harm = 2 participants Attempted Wounding = 1 participant Wounding = 1 participant Wounding with Intent = 1 participant Abduction = 1 participant Indecent Assault = 1 participant Affray = 1 participant
Number of Previous Offences:	Average = 3.5 Range = None to 15

APPENDIX 6: Interview schedules

Police Officers: Semi-structured interview schedule

Could you describe what happened when you were last involved in the arrest of somebody who was mentally ill?

How did you know they were mentally ill?

What happened before they reached the police station, when they reached the police station, before the interview, during the interview, after the interview?

Thinking about your experience of interviewing people with mental health problems, is there anything that makes these interviews different to other ones?

Does interviewing people with mental health problems give rise to specific feelings and emotions?

Some people find mental illness frightening; does this ever affect police interviews (yours or others)?

Sometimes it can be more difficult to communicate with people with mental health problems. Does this ever affect the interview?

How do you think other officers find these interviews?

Is there anything that would help when interviewing people with mental health problems?

Are there procedural changes that might make things easier?

Offenders: Semi-structured interview schedule

Could you describe what happened the last time you were arrested by the police?

What happened before you reached the police station, when you reached the police station, before the interview, during the interview, after the interview?

How did you feel during the course of your interview(s)?

Who was present when you were interviewed?

What feelings did you have towards these people?

How did you feel they treated you? What did they think about you?

How did you feel during the course of your interview(s)?

Was there anything that might have made the interview different than it might be for someone who did not have a mental illness?

Did this make the interview easier or more difficult?

What would have helped make the interview easier for you?

How could the interviewing officer have changed things to make the interview more successful?