

Volume 2 | Number 2 | June 2014

scottish justice matters



HEALTH AND (IN)JUSTICE

Edited by Andrew Fraser and Maggie Mellon

Featuring: Health Inequalities • Older Prisoners
Mental Health • Drug Misuse • Neuroscience

ALSO: Current Issues • History • International

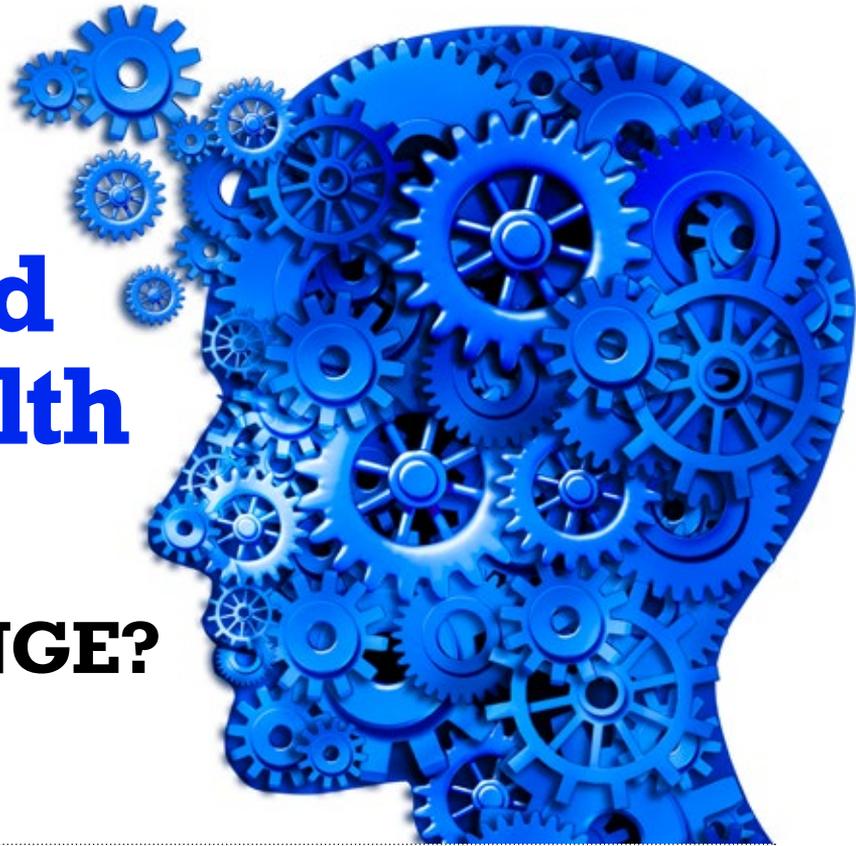
ISSN 2052-7950



9 772052 795005

Police in Scotland and Mental Health

TIME FOR CHANGE?



Bridget McKinnon

IT HAS BEEN estimated that up to 15% of all incidents police deal with 'have some kind of mental health dimension' (Bather et al., 2008:1), and in 2010 the World Health Organisation found that at least 10% of community police time is spent dealing with incidents concerning those with identified mental illness (as cited by Chappell, 2011). Whereas emergency first aid training for police has been prioritised so that responses to injured casualties are appropriate, this approach is not applied to mental health issues.

In Scotland, training covers legal aspects of emergency protection and detentions relating to mental illness where there are perceived risks of serious harm to self or others. Most officers report that their learning is effectively 'on the job'. The relatively new Adult Protection reporting measures are designed to prevent people slipping through a net if concerns are raised about welfare, and to encourage multi-agency approaches and appropriate action. These emphasise awareness by police officers

of mental health issues, but also concern mental disability, and do not necessarily change immediate responses in mental health crises where police attend as first responders.

Police are often first responders in situations where people with mental illness are presenting as problematic to be managed according to risk

This relative neglect in police training contrasts sharply with the amount of interaction police officers tend to have with people with mental illness or mental health service users. These have increased due to cutbacks in funding in mental health specialist services, and reductions in availability of long and short term beds. Pressure on support services can quickly lead to people losing structure, reassurance and practical help to maintain stability: a combination of circumstances that can result in crises where more support might

have prevented police involvement. Discourses of danger and risk around mental illness can be fuelled by lack of community care and police approaches may reflect these perceptions. This problematising of people with mental illness could, paradoxically, be a potential driver for better basic training for police in mental health issues.

Police are often first responders in situations where people with mental illness are presenting as problematic to be managed according to risk (Peay, 2011: 109). Assumptions are often made about dangerousness and violence, and police themselves may react to this cultural stereotype, without the benefit of training or experiences which provide alternative images and realities. Research actually reveals that people with mental illness are more likely to be victims than perpetrators of crime (SAMH report 2010: 6). Unfortunately, stereotyping has prevented general and police awareness of this alternative experience and this needs to be addressed in training.

Officers are left to apply 'common sense' and tactics based on experience

to fragile mentally ill people and sometimes inappropriate responses can escalate rather than de-escalate situations. These encounters can quickly spiral into aggressive exchanges driven by fear and mistrust. Obviously officers may also deal very well with these situations, and when the outcome is safe for all, it is less likely to attract attention or comment, or a '9 o'clock jury' of after the event analysis. However, this in itself impedes dissemination of knowledge of good practice. Service users I spoke to in 2013 whilst researching their experiences with police, spoke of feeling criminalised by the way officers dealt with the situation, "as if I'd done something wrong" by being unwell.

Perceptions of people with mental illness as risky and dangerous are promoted by media coverage of incidents and TV soap operas. Police officers are as influenced by cultural media stereotyping as the rest of the community. In the absence of training or personal exposure to alternative images they may adopt risk averse tactics whereby the actual risk of harm is increased, through fear, leading to aggression and lack of empathy. This situation could be improved through training, discussion and reducing the stigma associated with mental illness within the police, and the general population.

For example, a research participant described attending hospital due to feeling suicidal, was arrested for carrying a knife, which was in his pocket and intended solely for self harm, kept in cells over the weekend without seeing a doctor or having any medication, then was named in local papers as a 'knife man'. The court accepted the psychiatric reports that his behaviour was due to illness at the time: "... all I needed was the proper medication, and a wee rest, a wee rest in the psychiatric wards, and get myself sorted out, and get a blether with somebody that you can talk to, without them judging you like, an' to cap it all, it was in the newspapers." More and better police awareness could avoid situations developing in this way.

If it is accepted that there is room for improvement in police training in dealing with mental illness, then the new national Scottish police service is surely an opportunity to incorporate fresh approaches, and strive for best practice. In addition, it must not be forgotten that there is inevitably a potential for a slippage in best practice between what is taught, absorbed, or accepted in theoretical terms, and what action is actually taken by officers in real life situations. Responses may vary according to unanticipated factors such as the effect of adrenaline after a 'blue light run', or officers' personal feelings which result in resistance to the training inputs. Added to the possibilities of people with mental illness in crisis presenting bizarre behaviours, it is always going to be hard to train in consistently appropriate first line responder reactions, but as with physical health first aid there are steps which can strengthen the probability of a good outcome, and lessen risks to all concerned. Tactics to de-escalate encounters, and raising officer awareness of effects of mental illness, and some medications, could be incorporated into initial training, as a compliment to legal powers to detain. For example, common medication for schizophrenia can cause slurred speech which can be interpreted as drunkenness.

Using mental health professionals as team members alongside police, especially if 24 hour availability is possible, can reduce poor outcomes after police encounters with people in crisis or distress, (Ogloff et al., 2013: 66-7) but this is often not a practical or financially viable option. Therefore putting in place ways that officers can be confident in their knowledge and preparation around first response to mental health issues could be very productive. De-escalation and negotiation can increase efficiency through preventing situations becoming so conflictual as to require additional police units to attend. It has been suggested that people with mental illness and mental health service users should be involved in police training so that officers can increase their understanding of how mental illness can affect people, and better empathise. Sometimes it is very simple issues where big differences can result, such as taking time to 'verbally communicate well' with people's supporters and advocates, and 'provide an accessible written record' to them for later as those who are 'very depressed or experiencing breakdown or crisis' may not absorb information in letters or leaflets (SAMH, 2009:12). Understanding reasons for this type of approach could save police time later lost in communication confusions.

Prioritising a standardised and professionalised approach for police officer initial training which incorporates greater awareness of mental health issues beyond legal powers to detain and relevant legislation is surely overdue, with mental health awareness deserving of at least the level of training that police receive in public order operations (ICMHP report 2013: 41). Police training which encourages engagement with people with mental illness, would enhance police understanding and enhance better responses to a sector of the community that has often only received negative attention after media highlighted violent encounters. This preventative approach whereby officers are encouraged to have more positive images of, and confidence in their own abilities to deal with people with mental illness in crisis with minimal recourse to force, linked to mental health first aid training from the outset, could then provide linkages not breakages between police and community.

Bather, P., Fitzpatrick, R. and Rutherford, M. (2008) *The Police and Mental Health* Sainsbury Centre for Mental Health Briefing Paper 36

Chappell, D. (ed.) (2011) *Police Responses to People with Mental Illnesses* Routledge

Independent Commission for Mental Health and Policing (ICMHP), May 2013

Ogloff, J., et al. (2013) 'Policing Services with Mentally Ill People: Developing Greater Understanding and Best Practice' *Australian Psychologist*, 48(1): pp 57-68

Peay, J. (2011) *Mental Health and Crime* Routledge

Scottish Association for Mental Health (SAMH), September 2009 Involvement Event – Justice Disability Steering Group

Scottish Association for Mental Health (SAMH) *Criminal Justice Research Briefing* 2010

Bridget Mackinnon is a former police officer who has also worked in prison and mental health services. She undertook research into policing and mental health issues as part of a post-graduate degree at Glasgow University.