'Don't Know, Don't Care'? Police and the mentally ill

Anthony Columbo compares the attitudes of police officers and other professionals to the mentally ill.

Police respondents (N=35) were surveyed as part of a larger study on professionals' attitudes towards mentally disordered offenders. The other key groups included in the research were approved social workers, probation officers and mental health practitioners. During the interview respondents were asked to complete an attitudinal questionnaire after reading a case description of a person named Tom (see Appendix), whose behaviour showed signs of aggression ("sudden outbursts of anger"), and violence ("strike out at his wife") and symptoms suggesting schizophrenia (American Psychiatric Association 1994). The use of a case description has the advantage of presenting the subject within a more realistic context than would normally be achieved through using arbitrary labels such as 'mentally disordered offender' (Hall *et al.* 1993).

The findings

The numerical results showed that the police respondents demonstrated significantly more negative attitudes toward Tom than any of the other three professional groups. In fact, the police were considerably more likely to think: that Tom "should be held responsible and blameworthy for his actions"; that "society had a right to restrain Tom against his will"; that "Tom's behaviour should be viewed as bad and wrong"; that "Tom should receive punishment for his actions"; that society had a right to "restrain Tom in a secure mental health facility"; and that Tom did not have an automatic right to be "shown sympathy and understanding".

In more specific terms, these results suggest that the police seem less willing than others to view Tom as mentally ill and entitled to the status of someone who is sick. Instead, their focus appears to be on Tom's disruptive behaviour and potentially unlawful actions. This low level of sick role support for Tom, suggests that the police are generally uncaring when it comes to dealing with people who experience mental health problems and have broken the law. As one social worker put it: "The police know little about the health and social needs of people with mental illness ... to be quite frank they don't see it as their responsibility and so probably *don't care* about that side of things". However, judging from the interview data the role of the police is defined by a range of competing concerns, which present a far more complex picture as to why the police apparently 'don't care'.

The following themes emerged in discussion with the police respondents.

Identifying mental disorder

Did police appear not to care because they were unable to detect that Tom was experiencing mental health difficulties? Actually, all the police respondents recognised that there was something wrong with Tom: "the guy has mental problems"; "he's lost it – flipped"; "seriously disturbed in his mind". This suggests that, at least on first contact, the police are capable of making a low level diagnosis as to the nature of someone's mental state. In fact, such a finding is encouraging given that the police are often the first point of contact with mentally disordered offenders and in accordance with S.136 of the *Mental Health Act 1983* the police must be able to determine whether a person is "suffering from mental disorder and in immediate need of care and control".

A further point of interest from the findings was that the police respondents tended to make their diagnosis on the basis of social and moral factors rather than established psychiatric criteria. Thus the police talked about Tom being: "a danger to his wife and kids"; "showing unusual outbursts of anger"; "babbling a lot about nothing"; and "not caring for his family". The mental health practitioners in contrast defined Tom's problem in terms of "being withdrawn and preoccupied"; "experiencing hallucinations"; and "psychomotor catatonic difficulties". Thus, despite their respectively different interpretation of Tom's situation, both professional groups managed to reach the same conclusion.

Protection of the public

It could be that the police apparently 'don't care' because as one officer put it: "The bottom line is public safety ... that's what I'm paid to do ... I'm not here to baby-sit disturbed people waiting for the duty doctor to arrive". In fact, most respondents had a great deal to say about how police resources were being stretched as a result of care in the community initiatives. A typical view was: "There appear to be a large minority of disturbed people out there who no-one is prepared to take responsibility for looking after and so they roam the streets, get arrested for minor offences, and are dealt with by the courts. Once they are back in society the cycle starts again".

Related to the need to protect the public from harm was a desire to empathise with the injured party: "It

is no comfort to the victim of an offence to find out that the culprit was mentally disordered". Another openly admitted: "There's one instance I'm involved in right now which makes me tear my hair out ... I've been trying to get this woman sectioned, not because it will do her any bloody good ... but at least it will give her partner a rest from her threats and assaults".

Nature of policing practice

Another important consideration relates to the fact that the rules and regulations governing the daily work of the police with regards to issues such as making arrests, detention, and the preparation of cases for the Crown Prosecution Service are largely defined within a legal context: "While I accept that Tom is mentally ill I find it difficult to ignore the moral and legal issues involved". As a result, the initial orientation and mindset of the police is more likely to be shaped and defined by notions of determining responsibility and blame, assessing harm, and collating evidence. Within this context, the police seemed to view offenders as initially culpable for their actions; the presence of a mental disorder only serving to partially mitigate such a finding: "While the welfare and rehabilitation of the offender should be borne in mind, society's overriding duty is to protect itself. Having a mental illness is one thing, but in respect of those committing serious offences society has a right to gain retribution ... society should ensure that there is an element of punishment".

Definition of responsibility

The notion of responsibility raises another interesting point. An analysis of the remarks made by the other three professional groups included in the study showed very little discussion about the notion of responsibility in terms of its association with blame and punishment. Instead, responsibility was seen more in terms of how it might be used during the course of treating mentally disordered offenders. For example, it was felt that "Of course patients should learn to take responsibility for taking medication"; and that: "They need to learn about their illness so that they know when things are starting to go wrong in the future". Clearly, it would appear that the difference between police and mental health practitioners' definition of responsibility is closely linked to their respective occupational priorities – protection of the public or care of the patient/offender.

Interaction with mentally disordered offenders

As a front line service, the police are often the first authority to come into contact with instances of serious psychiatric disturbance. However, it would seem from the present findings that such situations are on occasion viewed as frightening and difficult to handle "Dealing with call-outs to scenes where all you know is that someone is behaving strangely can be frightening ... at least normal offenders are predictable".

Furthermore, it could be argued that constantly dealing with mentally disordered offenders under such conditions (i.e. only while they are at their worst), may serve to reinforce the generally negative view of the police. Over time, this may result in the police becoming less tolerant and more frustrated with the conduct of mentally disordered offenders, especially those whom they encounter on a regular basis: "I would be lying if I said that I never felt uncomfortable around some mentally ill people, you have a stereotyped image of what they might do, but I also need to make sure that I am not prejudiced. This is difficult when you are called out to deal with the same people for the same problems time and time again". And another officer stated "There are always jokes over the radio about calls to attend a scene in which someone is behaving in a weird way; it's a shame because it really gives the mentally ill an image problem".

Combination of factors

It is also quite possible that the quality of interaction between the police and mentally disordered offenders may significantly deteriorate as a result of the convergence of several conflicting factors. For example, due to the new business orientated approach towards policing (Home Office, 2003) there exists a growing perception that dealing with persistent offenders with minor psychiatric problems drains resources. Such concerns have also come at a time when there are increasing numbers of vulnerable patients roaming the streets and rising public expectations regarding the quality of services provided by the police.

The difficulty for the police is that they recognise that in many cases involving mentally disordered offenders prosecution is not an option: "Many disordered offenders languish in prison tormented and abused, or discarded on the streets without any official offer of help". Equally, the police consider current diversionary and community care support strategies as inadequate. As one respondent observed "I have noticed that there are many mentally ill offenders who are not bad enough to be sectioned and have been denied psychiatric treatment while in custody, which has meant that they end up in ordinary prisons or back out on the streets with no support". Yet another commented: "Psychiatrists take what we have to say with a pinch of salt. If they refuse to section then we are left dealing with the problem ... The only time they (the offenders) get noticed is when things go terribly wrong. By then there is no point in saying 'I

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APPENDIX

Case Description

Tom Smith is 30 years old, married with two children and until recently he was in good health.

About six months ago, however, Tom had started to become increasingly withdrawn and preoccupied. It seemed to both his family and friends as though he was in a world of his own. He became less interested in his work and his children. Most of the time Tom would sit upstairs on his own or stand in a stiff upright position in the middle of the room, though on occasion he would become excitable and leave the house, sometimes not returning for several hours. During the last month Tom has started to express ideas which his wife finds strange and difficult to understand. Tom's speech was also often not clear as he would mutter very quickly and about things that just didn't make sense.

Sometimes he would show sudden outburst of anger and strike out at his wife, claiming that she was plotting against him. Tom also began to complain of hearing voices which he said were getting stronger. Fear of an attack from his wife increased, and generally his whole behaviour became more bizarre.

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told you'".

The future treatment, management and care of mentally disordered offenders can no longer be viewed as the purview of a single agency. However, the police often feel that they are too quickly dismissed by other professions as not competent to deal with mental health matters (Bean, 1996). This research attempts to draw out some of the potential conflicting difficulties between different multi-agency groups by showing that policing mentally disordered offenders is a complex business and one in which it would be misleading to assume that the police simply 'don't care'.

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Cannabis and mental illness

Rethink, formerly known as the National Schizophrenia Fellowship, is the charity for people who experience severe mental illness and for those who care for them. It is both a campaigning membership charity, with almost 400 services across England and Northern Ireland, and over 7,000 service user and carer members.

In September, Rethink gave evidence to the Advisory Council on the Misuse of Drugs, which was considering the classification of cannabis at the request of the Home Secretary. Rethink called for a long-term, properly funded public health campaign highlighting the mental health dangers of using cannabis. Rethink's position is the result of a membership survey in which awareness of the link between cannabis use and schizophrenia was a repeated concern.

Rethink's position is that it would be a waste of money to reclassify cannabis from a Class B to Class C drug and would not deter people from using it. It urged the government instead to invest in a massive public education campaign to inform users and potential users of the well-founded mental health dangers of using cannabis at a young age and over a long period of time. Rethink chief executive Cliff Prior told the committee: "Cannabis is still seen as a risk-free drug despite mounting evidence that it can lead to serious mental health problems, particularly amongst young teenagers, people with a family history of severe mental illness and in long-term users...The government has a responsibility to inform people of the real risks and not hide behind a knee-jerk criminal justice response to what is a mounting health crisis."

Rethink's submission to the advisory council highlights compelling anecdotal evidence from sufferers of schizophrenia and their carers. It also summarises some impressive research findings: several longitudinal population cohort studies showing clear association between use of cannabis and psychosis; and epidemiological and neuroscientific research suggesting that cannabis use in adolescence is a component cause of psychotic disorders.

The full report is available on the Rethink website: www.rethink.org