Research paper
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Blue remembered skills: mental health awareness training for police officers

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abstract

The Bradley Report (Bradley, 2009) has raised a number of important questions regarding the treatment of individuals who are experiencing mental health problems and find themselves in the criminal justice system. One of the key recommendations is that professional staff working across criminal justice organisations should receive increased training in this area. This paper explores the experiences of two professionals, a mental health nurse and a social worker, involved in providing training for police officers. It goes on to consider the most effective models of training for police officers.

key words

The Bradley Report, mental health problems, offenders, policing, mental health training

Introduction

Policing is a complex process. Police officers are called on to perform a number of roles in addition to detecting crime and arresting offenders. Police officers can have a key role to play in situations where individuals are experiencing some sort of crisis related to their mental health. They are the emergency service that is most likely to be contacted by relatives if those in acute distress are putting themselves at immediate risk. If a person in acute distress is in a public place, the likelihood of police involvement is increased significantly. Despite the fact that this is a very important facet of day to day police work, it is an area that is neglected in police training. Cummins (2007) showed that the majority of officers have little input in this field. As a result, the skills and knowledge that they acquire is largely through experience on duty or from their senior colleagues. This is a longstanding issue (Janus *et al*, 1980). Police officers, who had undertaken the training, showed increased empathy and understanding for those experiencing mental health problems. From the vantage point of 2009, the policy of diversion from the criminal justice system (CJS) outlined in the Home Office circulars 66/90, *Provision for Mentally Disordered Offenders* (Home Office, 1990) and 12/95 *Mentally Disordered Offenders: Inter-agency working* (Home Office, 1995) seems to have failed. However, access to appropriate mental health services for those in contact with the CJS, as Bradley (2009) shows, is still fragmented and disjointed. Models of good practice exist but these are not spread widely enough.

Steps were being taken to tackle this prior to the publication of *The Bradley Report* (Bradley, 2009). In 2004/05, the Home

10.5042/jap.2010.0410

Office and the National Institute of Mental Health in England made £155,000 available to improve training. As the Mental Health Act Commission (MHAC) report suggests (2005, p271) this amounted to £1 for every police officer in England and Wales.

One key element of training is to challenge some of the stereotypical views that police officers have of mental illness and about people experiencing mental distress (Pinfold *et al*, 2003; Cotton, 2004). Borum and colleagues (1998) argue that although responding to situations where people are experiencing acute mental distress is a significant aspect of policing, departments did not feel that the general response was a good one. In addition, they suggest that it is only in jurisdictions where specialist crisis police teams had been established that officers felt well-equipped to deal with these sorts of situations. Wolff (2005) has gone further. She suggests that police officers have always had a quasi-social work function in this field. As Penrose (1939) argued, there appears to be an almost hydraulic relationship between psychiatric and penal systems.

Police officers often have a significant role to play in mental heath services. This role has been expanded by the failure to develop robust community-based mental health services in the era of deinstitutionalisation. (Teplin, 1984; Rogers, 1990; Cummins, 2006). The MHAC regularly highlighted its concerns that health and social work agencies had failed to establish effective working relationships with local police services. These concerns have also been a recurring theme in inquiries into homicides (Ritchie, 1994). Further evidence to support this was highlighted in the *Modernising Mental Health Services report* (Department of Health, 1998). As *The Bradley Report* highlights, people with mental health problems are drawn into the criminal justice system at all points. The police have specific powers under section 136 of the *Mental Health Act 1983* (HM Government, 1983) to intervene in cases where an individual appears to need immediate assessment. Mokhtar and Hogbin (1993) argue that lack of training may lead to underuse of this power. There are a number of other scenarios where a police officer will need some understanding of mental health issues to carry out their job effectively. These will include liaison with local mental health units, situations where people with mental health problems are the victims of crime (Mind, 2000), and supporting other professionals to carry out *Mental Health Act* assessments. The extent and complexity of the mental health needs of the prison population has been well-established (Singleton *et al*, 1998). One would expect there to be similar levels of need among those the police arrest as the groups are likely to share many characteristics. Payne-James (1992) highlights the general and mental health care needs of those coming into custody.

The overall picture is one of increasing police contact with those who are experiencing some form of mental distress. This is against a backdrop of the majority of officers receiving very partial and inadequate training to equip them for the situations they face on a fairly regular basis. The result is a frustration with mental health services (Cummins, 2007; 2008). As well as police frustration, Mind (2007) highlighted that people with mental health problems often feel they are treated very poorly by the police. The messages from Jones and Mason's (2002) study of people who had been subject to section 136 of the *Mental Health Act 1983* are just as forthright.

> *'Police procedures in the police station removed more than just their personal possessions; it also stripped them of a sense of being an individual in the real world.'*

In this section of the paper, we will outline two approaches to the training of police officers in the mental health field. The first was a joint working initiative between Hywel NHS Trust and Dyfed Powys Police. It had been acknowledged in the area for some time

that there was a need to improve the training of police officers in mental health awareness. A pilot study was undertaken that allowed police officers to spend time working in the local mental health unit as part of their initial training. This proved successful, and a service level agreement was established whereby all student officers undertook a programme of work in the mental health unit that covered the area of their base command unit as part of their basic training. The programme has now been developed further so that all student officers receive two days training in first aid in mental health. In addition, they spend four days at the acute psychiatric unit where they become personally involved in the care of individuals who are experiencing acute distress. As part of the programme, student officers are also introduced to community mental health teams, crisis resolution and home treatment teams, assertive outreach teams and the multidisciplinary teams working at the unit. The overall aim of this programme is not only to provide the student officers with background mental health knowledge, but also to provide an insight into the structure and workings of the agencies in their area that they are most likely to come into contact with in their work as police officers.

One of the great strengths of the Dyfed Powys model is that there is a very strong input from service users. The client group has welcomed the initiative and believes that there has been a positive change in attitudes by the police who have undergone the training. There are a number of examples of positive testimony. For example, a woman was admitted to hospital with police involvement in an acute psychotic and paranoid state. The officers involved had undergone the training. She informed staff that this was the first time that she had not been handcuffed during such an admission.

The police feedback has generally been very positive. The views of one officer that '*any opportunity whereby there is a greater understanding of what people with mental health problems go through can only be good*' were not uncommon. However, it should be acknowledged that some officers struggled to see the relevance of the training for their work. The 'canteen culture' does not see this sort of work as 'real policing' as it lacks the supposed glamour of other aspects of the work.

The second approach comprised a classroom-based training course. Custody sergeants have a key role under the *Police and Criminal Evidence Act 1984* (PACE) (HM Government, 1984) in the assessments of all individuals coming into custody. The mental health awareness course outlined as follows was the direct result of research carried out with the force (Cummins, 2007). This highlighted the lack of training that custody officers had received in relation to mental health issues. It was felt that custody sergeants could act as role models for other staff and, as a result, the training could be cascaded downwards. It was acknowledged that this was not the most satisfactory approach. However, it was the only feasible one given the scale of the issue and the resources being allocated to it at that point. The training sessions were part of the much wider PACE training that custody officers undertake. This meant that they had to be 'shoe-horned' into a very full curriculum.

The sessions were usually about three hours long including breaks. The content was discussed beforehand with the sergeant who had overall responsibility for the course. He was very supportive of this initiative. The key areas to be explored were some introductory work about the extent of mental health problems, some ideas about signs and symptoms, and a focus on the issues that arise in custody settings. The sessions have run on the custody sergeants' courses over the past three years so have been refined to meet the needs of the group of learners involved more closely. For example, in the initial sessions, the research that had been carried out in the area was reported to the group. However, pressures on time meant that this section was

removed to allow more discussion of practice and case examples.

The sergeants' course was classroom-based, which clearly has limitations. However, the groups were usually small (10–12 officers) and, as is standard practice, the officer in charge of the course was present throughout. A number of fairly standard icebreaker exercises were used. These included a 'post-it' note exercise, where officers were asked to write down one question that they would like answering over the course of the session. The majority of these were very practice orientated such as '*why does it take so long to get a social worker/doctor to a police station?*'. A minority were of a more technical nature, for example, asking questions about medication and services. As the groups consisted of experienced officers, the answers to these questions usually came from group members themselves. The sessions also included a brief outline of the structure and range of services available to meet the needs of individuals with mental health problems. The feedback from the force training department and individual officers was generally very positive indeed. The practice issues that were most frequently raised were section 136 – particularly cases where the individual was not admitted to hospital; delays while people are in custody; difficulties in securing the services of an appropriate adult; and liaison with psychiatric units. These points actually reflect some of the wider concerns in *The Bradley Report*, but have been consistent features of this field for some time. These issues cannot be solved in a classroom; however the sessions not only enabled officers to vent their frustrations, but also provided a forum where some of the ways to resolve these difficulties could be explored. All sessions were formally evaluated by the officers.

Discussion

These are two examples of attempts on a local level to begin to tackle a number of complex issues. The National Police Improvement Agency (NPIA) is in the process of finalising an e-learning package for all officers looking at mental health issues. Given the historical under-investment in training in this area and the large numbers of police and now civilian staff involved, this has to be a start. E-learning is the only way of ensuring that material is made available quickly and relatively easily to large groups of staff. However, it must be part of a wider process.

Both models had some measure of success. The strengths of the approach taken in Dyfed Powys are obvious. It gives officers a very clear picture of acute services and community-based mental health resources in the area in which they will be working. Service user experience is at the core of the programme. The powerful testimony from a member of a local service user group has been one aspect of the training that has produced the strongest feedback. The sessions took place away from the police training base. The officers were not in uniform for these sessions. It was felt that these factors had a very important impact on the conduct of the training. The officers were placed in a situation where their own views and possible prejudices could be challenged more effectively by the facilitator. The contacts made with local agencies can have an immediate positive impact in terms of improved multidisciplinary working. This approach requires a strong commitment from senior management. This is not only a question of providing the necessary resources and allocating time, but also supporting the project and recognising the value it has for the force and the wider community.

A classroom-based approach is clearly a limited one. It can only involve small numbers of staff. In this case, it was focused only on custody officers rather than the whole force. However, it allows for the challenging of some stereotypical ideas within these limitations. It also provides a forum for a constructive and positive discussion of the issues that face staff

who work in community-based mental health services. The aspects of the Dyfed Powys model that have been most effective – time on the unit and service user testimony – were not present here. The feedback indicated that the most valued parts of the classroom sessions were the discussion of practice examples, information provided about the structure of services and the insight into how other professionals approach the assessment of mental health problems.

One of the interesting aspects of these training courses is the importance of support from senior management. Without such support and commitment, such initiatives will almost certainly fail. The training of police officers requires that they cover an enormous amount of material. If, as the authors argue, mental health awareness training needs to be given a higher prominence and more time devoted to it, this will be at the expense of another area. In a managerialist culture, forces will need to demonstrate that such training presents good value for money. This is not always as easy as it might appear if the overarching measures are financial ones.

One of the aims of the training was to make officers question their own views and some of the stereotypes that are attached to mental illness. One recurrent feature of the classroom-based sessions was the response to a PowerPoint slide outlining some of the features of depressive illness. This initially provoked some flippant remarks such as '*That's me*'. However, it opened the door to a discussion about the pressures and burdens faced by police officers in general and custody sergeants in particular. This is an area that is often neglected. This proved to be a very valuable part of the session. In these settings, experiential learning and/or the linking of service users' experiences with our own or those of family members is highly effective. It helps to break down stigma and the barriers between 'professionals' and 'service users'.

Conclusion

The Dyfed and Powys model was clearly the more effective approach. In some senses, it is far more challenging than a classroom session. The student officers were taken out of a policing environment. Although the officers were welcoming in the classroom sessions, it would be naïve to ignore the power that they had – as a group, in uniform and in the familiar environment of the police college. To roll out the Dyfed and Powys model requires a commitment and level of resourcing that might not be that easy to replicate across 43 police forces. The needs of these forces and the pressures that they face are markedly different.

Both approaches were based on key principles that should form the underpinning values of any work in this area. There was recognition that people using mental health services should be treated with dignity and respect. This should be the case with whichever mental health service they are in contact with. To challenge the stigma attached to mental health issues, professionals need to take account of and learn from the experiences of service users. Finally, sound interprofessional practice is based not only on a recognition of and respect for the skills of your fellow workers, but also of the organisational and other pressures that they face.

The Bradley Report calls for much improved training for staff across the criminal justice system in mental health issues. The review provides reams of evidence to support the case for an investment in such training. This will be an enormous logistical task as this is an area that has been neglected for far too long. Investment in training needs to be accompanied by a renewed commitment to ensuring that involvement with the criminal justice system does not mean that an individual's mental health needs are overlooked.

Acknowledgement

This paper is the result of a joint workshop at Nacro's 9th Annual Mental Health and Crime Conference. The authors would like to thank Nacro for the invitation to present and the delegates who attended the workshop.

References

Borum R, Deane MW, Steadman HJ & Morrissey J (1998) Police perspectives on responding to mentally ill people in crisis: perceptions of program effectiveness. *Behavioural Sciences and Law* **16** (4) 393–405

Bradley Lord K (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health.

Cotton D (2004) The attitudes of Canadian police officers toward the mentally ill. *International Journal of Law and Psychiatry* **27** (2) 135–146.

Cummins I (2006) A path not taken? Mentally disordered offenders and the criminal justice system. *Journal of Social Welfare and Family Law* **28** (3) 267–281.

Cummins I (2007) Boats against the current: vulnerable adults in police custody. *The Journal of Adult Protection* **9** (1) 15–24.

Cummins I (2008) A place of safety? Self-harming behaviour in police custody. *The Journal of Adult Protection* **10** (1) 36–47.

Department of Health (1998) *Modernising Mental Health Services: Sound, safe and supportive*. London: Department of Health.

HM Government (1983) *Mental Health Act 1983*. London: OPSI.

HM Government (1984) *Police and Criminal Evidence Act 1984 and Codes of Practice 1988*. London: OPSI.

Home Office (1990) *Provision for Mentally Disordered Offenders. Circular 66/90*. London: Home Office.

Home Office (1995) *Mentally Disordered Offenders: Inter-agency working. Circular 12/95*. London: Home Office.

Janus SS, Bess BE, Cadden JJ & Greenwald H (1980) Training police officers to distinguish mental illness. *American Journal of Psychiatry* **137** (2) 228–229.

Jones SL & Mason T (2002) Quality of treatment following police detention of mentally disordered offenders. *Journal of Psychiatric and Mental Health Nursing* **9** (1) 73–80.

Mental Health Act Commission (2005) *In Place of Fear? The Mental Health Act Commission eleventh biennial report 2003–2005*. London: TSO.

Mind (2000) *Environmentally Friendly? Patients' views of conditions on psychiatric wards*. London: Mind.

Mind (2007) *Another Assault: Mind's campaign for equal access to justice for people with mental health problems*. London: Mind.

Mokhtar A & Hogbin P (1993) Police may underuse section 136. *Medicine Science and Law* **33** (3) 188–196.

Payne-James JJ (1992) Work patterns of a Metropolitan police forensic medical examiner. *The Police Surgeon* **42** 21–24.

Penrose LS (1939) Mental disease and crime: outline of a comparative study of European statistics. *British Journal of Medical Psychology* **18** 1–15.

Pinfold V, Huxley P, Thornicroft G, Farmer P, Toulmin H & Graham T (2003) Reducing psychiatric stigma and discrimination. Evaluating and educational intervention with the police force in England. *Social Psychiatry and Psychiatric Epidemiology* **38** (6) 337–344.

Ritchie J (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: HMSO.

Rogers A (1990) Policing mental disorder: controversies, myths and realities. *Social Policy and Administration* **24** 226–237.

Singleton N, Meltzer H & Gatward R (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. London: Office for National Statistics.

Teplin L (1984) Criminalising mental disorder. *American Psychologist* **39** 794–803.

Wolff N (2005) Community reintegration of prisoners with mental illness: a social investment perspective. *International Journal of Law and Psychiatry* **28** (1) 43–58.

