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DO POLICE OFFICERS RECIEIVE SUFFICIENT TRAINING IN MENTAL HEALTH? A FRONT LINE PERSPECTIVE OF POLICE OFFICER'S ATTITUDES AND BELIEFS ON ATTENDING MENTAL HEALTH CALLS

by

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Abstract

There is a scarcity of research in the United Kingdom on mental health and policing with most being done by the same researcher Ian Cummins since the 21st Century. Police officers are dealing with an increase of mental health calls and it has been documented in literature that it is a core part of their jobs (Corlett, 2013; Pettitt et al., 2013). It has also been found that police officers need to be better equipped with more training to provide effective support to those suffering from a mental health issue (Edmundson and Cummings, 2014; Thomas and Watson; 2017). Despite the studies which have been conducted for mental health and policing, little has changed over the years since Lord Bradley's review in 2009 and Lord Bailey's review in 2010. Moreover, literature only shows that it is a growing concern for the police service in the United Kingdom rather than, explain what can be used to help increase the effectiveness of police officers supporting individuals with mental health issues. This thesis examines 'do police officers receive sufficient training in mental health?' and explores how police officers feel with attending mental health calls.

The main themes generated from the results were: police officers did not feel they should be dealing with mental health calls, the calls are frequent, their training for mental health was not good enough, outside services needs to be more co-ordinated and support structures and processes are beneficial. By analysing the themes and sub themes from the study, the recommendations consist of: more effective mental health training for police officers, better organisational skills of delivering mental health training and more effective working relationships between outside agencies and the police service.

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Introduction

In recent years, it has been highlighted in academic literature the impact of the police force becoming the primary service supporting those with mental health issues within the community due to, the closure of psychiatric hospitals also known as deinstitutionalisation (Perez et al., 2003). The use of social media has added to this especially in 2014, when a policeman from South Wales tweeted about a 16 year old , who was suffering from mental health problems, being kept in police cells due to the lack of NHS beds (Wise, 2014). The Assistant Chief Constable at Devon and Cornwall Police tweeted about the case and expressed how '*Custody on a Fri & Sat night is no place for a child suffering mental health issues'* and *'this can't be right!' (*Wise, 2014, P1). This is just one example that encapsulates how the police service throughout the United Kingdom are dealing with the increase of mental health calls they are attending in the community. This is not a new issue for the police service as, it has been expressed in literature how the intense changes that were made to mental health policies and legislation throughout the 1980s and 1990s started to effect the police service. This was because psychiatric hospitals were closing and this increased the number of people suffering from mental health illnesses in the community which, resulted in more mental health calls for the police service in England and Wales (Teplin, 1984). Literature available presents the same opening theme: an account of the impact of deinstitutionalisation, following the closing of psychiatric hospitals, on the police service (Teplin, 1984; Rogers, 1990; Cummins, 2006; Clifford, 2010). The early impact of deinstitutionalisation started to have consequences on the police service as they had to deal with an increased number of mental health calls in the community (Arboleda – Florez & Holley, 1998) as well, people who suffer from a mental health illness has been seen to increase overtime (Singleton et al., 1998; Brooker et al., 2002; House of Commons, 2009;

NHS Digital, 2016). This has led to the argument of police officers needing sufficient training in mental health and this has been a reoccurring theme in literature (Dew and Badger, 1999; Carey, 2001; Bradley Report, 2009; Edmundson and Cummings, 2014; Thomas and Watson; 2017). This is not just seen as an concern in the United Kingdom but also in other countries such as the United States of America (Compton et al., 2006; Watson and Fulambarker, 2012), New Zealand (O'Brien and Thom, 2014; Holman et al., 2018), Canada (Cotton and Coleman, 2010; Coleman and Cotton, 2014) and Australia (Al-Khafaji et al., 2014; Short et al., 2014) all supporting the idea the police service need to be better equipped to support individuals who are suffering from a mental illness.

The thesis will present the literature available for mental health and policing in the United Kingdom, in more detail, briefly mentioning other countries such as the United States of America, New Zealand, Canada and Australia. This will be to show what information has been produced from literature and why there is a need for more policing research in the United Kingdom. This will be followed by the study's methodology section, looking at ethical considerations, procedure and data analysis which, will be carried on by the results of the research that was conducted. A discussion will explain the results and show what was found during the analysis which will be further summarised in the conclusion. Recommendations will be made from the results of the study. The study was conducted to enhance knowledge in policing mental health with the main aim of looking at England and Wales police officers' views about attending mental health calls and mental health training they receive.

Discussion of Policing and Mental Health Research

Penrose (1939) proposed that the level of need for institutional mental health care would remain persistent in the community. Therefore, if societies have well-co-ordinated mental health structures, an individual who is at risk to themselves or to others will be most likely to be admitted to hospital to receive help. However, this may not be the best treatment for the individual and other services may not be available. Therefore, if the services do not exist it seen that the individual will be drawn into the criminal justice system (Cummins, 2007). The hypothesis of Penrose's (1939) research relates with the experiences of care in the community policies in the 1980s and 1990s with the closure of psychiatric hospitals (deinstitutionalisation). The police were starting to encounter more individuals with mental health issues due to the move of care in the community which, started to become a research focus and has continued to be monitored overtime (Teplin, 1984; Rogers, 1990; Cummins 2006; Clifford, 2010). From this, literature started to study the police service and the services available for people who were suffering from a mental illness and results were showing they were not effective enough. It was also recommended that there should be tighter and closer working ties to ensure that individuals were being given the right support (Reed Report, 1992). Throughout the 1990s a pattern started to emerge that care in the community was shifting from psychiatric services to emergency services (Green, 1997) and this was a result of the police service attending more calls that were mental health related (Arboleda- Florez & Holley, 1998).

Arboleda – Florez & Holley (1998) argued an unforeseen consequence of the closure of psychiatric hospitals was this shift away from psychiatric services and because of this the criminal justice system were dealing with an increased number of people who were suffering

from mental health issues. This was further supported by Borum et al (1998) who saw the increased pressure on the police service following the escalation of mental health issues happening in the criminal justice system. Psychiatric hospitals were still closing and despite these findings further research showed that the number of people being diagnosed with a mental health illness was seen to be increasing. (Singleton et al., 1998; Brooker et al., 2002; House of Commons, 2009; NHS Digital, 2016). Following this, studies showed that 7% of 999 calls were related to mental health (Deane et al., 1998) and Fry et al (2002) put this number at 10%. From this, it can be argued that police officers have experienced a shift in role as they were starting to be called 'de facto mental health providers' (Patch and Arrigo, 1999).

Studies were still underlining ideas that the reduction of beds were continuing over the last 20 years (Gunn, 2000), which increased the number of mentally ill prisoners, making it difficult for the criminal justice system to provide the services they need as, they were not trained to deal with this. Furthermore, literature highlighted that this was a recurring theme in countries that have followed ideas around deinstitutionalisation (Wolff, 2005). The overall effect of deinstitutionalisation demonstrated that the police were not providing adequate care and support, for people who were suffering with a mental illness which led to ideas around the 'criminalisation of the mentally ill' (Borzecki and Worminth, 1985). This was because of the increased risks of people who suffer from mental illnesses face in the criminal justice system: they are most likely to enter and to be drawn into the system than others (Hartford et al., 2005), more likely to be arrested for minor offences (Teplin, 1984) and less likely to be granted bail (Robertson et al., 1996). This also created concerns around the idea that mental illness is a risk factor as this is due to their unpredictability and because of their health they are expected not to make bail (Taylor and Gunn, 1984) and this has led to longer periods in custody (Hiday and Wales, 2003).

Most of the literature presented is from overseas in such countries as the United States of America, Canada, New Zealand and Australia which makes it difficult to generalise the literature to the United Kingdom due to differences in experiences and structures. For instance, the policing systems differ in the UK to the USA as in America the healthcare is based on a private medical system compared to the UK's healthcare system. Police officers in the USA have scarcer options available to them when attending a mental health call if that person does not have any health insurance. They can hold the individual on a 51/50 which is where the police officer feels that the individual is a danger to themselves or others however, this can only be for 72 hours before releasing them (Massey, 2015). This creates a constant cycle as officers continuously return to the same person with little or no treatment being done. However, in the United Kingdom due to the number of people detained under the Mental Health Act 1983 (MHA 1983), mental health wards not accepting informal patients due to the lack of beds (Care Quality Commission, 2018b) and police stations not being used as a place of safety only in exceptional circumstance (Care Quality Commission, 2018a). It can be argued UK and US police officers are starting to have similarities when dealing with the same people that are receiving little or no treatment. There have been inquiries into United Kingdom's deinstitutionalisation process such as the Reed Report (1992), Ritchie Report (1994) and the findings in '*Modernising Mental Health Services'* (Department of Health, 1998) to show the overlap between the community's mental health services and the criminal justice system.

In the 21st Century care in the community had shifted to the emergency services but more importantly towards the police service (Perez et al., 2003; Clifford, 2010). Policy changes that have occurred have impacted on police officers as they have a key role in providing support to the mentally ill. The Police and Criminal Evidence Act (1984) provides police officers with their powers when deciding if a person is deemed vulnerable and provides key

safeguarding for the vulnerable person under the MHA 1983 (ACPO, 2006). Further advice on the safety of those with mental health problems forms some of the *Guidance on the* Safer *Detention and Handling of Persons in Police Custody* (ACPO, 2006). However, for the guidance to be used effectively in helping vulnerable people it is dependent on the police officers themselves who need to make the relevant assessments on the individual's mental state. Yet, this is problematic for the police service as if a person has committed a crime and is suffering from a mental health illness the evaluation and treatment will take place whilst they are in custody. If they can't make the relevant assessments, then this will be missed. In some cases, mental health illnesses may be missed due to the person being alcohol or drug intoxicated. Additionally, another factor which can cause confusion for police officers is they may not recognise signs of someone who is potentially suffering from a mental health illness who, is being arrested for a crime (Lamb and Grant, 1982). Also, the occurrence of violence has been shown to increase the potential of the person with mental illness going unnoticed and being taken to jail (Robertson et al., 1996).

In 2003 – 04 Section 136s was recorded at 4,400 and they started to rise annually and as of 2016 it stands at 63,622 (Government Statistical Services, 2006; NHS England, 2016). In addition, police officers are involved in several areas that deal with mental health issues such as: executing warrants under Section 135 of the MHA 1983, dealing with violent and aggressive incidents in society and in other settings such as psychiatric wards and supporting in multi-health system assessments. However, this was causing problems as findings showed that the bar for people with mental health needs were sufficiently low and police officers were not able to identify, if an individual was suffering from a mental health illness (Vaughan et al., 2001; Prins, 2005; Bather et al., 2008). As well as this, studies were showing an increase in psychiatric diagnoses in societies that was linked to deinstitutionalisation (Laing et al, 2009; Royal College for Practitioners, 2016). From this, it started to emerge that mental

health was becoming an important part of police work and this was being highlighted in literature (Bradley Report, 2009; Laing et al, 2009; O' Connor, 2009; Cummings and Jones, 2010).

Although literature focused on the impact of mental health calls on the police service, McLean and Marshall (2010) saw that there was little known about police officers' views on working with people who were seen to be mentally ill and further research showed officers felt unskilled and out of their depth with dealing with mental health calls in society (Cummings and Jones, 2010). Further statistics showed that a quarter of the population are seen to experience a mental health problem in year in the United Kingdom (Pettitt et al., 2013; Mind, 2014b). This increased police's contact with people who were suffering from mental health problems and the police service were now seen to be the 'front line for mental health' as, 23,036 arrests were made under Section 136 which was an increase from 16,995 in 2005- 06 (Home Office, 2014). This has suggested that attending mental health calls is now a core part of police business and that was an area of concern due to the ineffectiveness of the police service supporting the mentally ill (Corlett, 2013; Pettitt et al., 2013). Lord Adebowele's Independent Commission on Mental Health and Policing (2013) also recognised that attending mental health calls is recognised as as a core part of police business and this should be reflected in operations in the police service. As well as reflecting that staff training is needed and the development of skills and confidence in police officers. This has led to recent research supporting the idea that police officers need sufficient training for mental health to be able to support the mentally ill (Edmundson and Cummings 2014; Thomas and Watson, 2017).

Despite literature establishing that individuals suffering from a mental health illness were increasingly having more contact with the police service, studies have shown how police officers feel when they attend these calls. Bittner (1967) suggested that the police become

frustrated when they are involved with situations where the call is mental health related as they do not see it as ‘proper police work’. This is because it is not dealing with offenders and this has increased since the period of deinstitutionalisation making this situation worse. This was echoed in Dunn and Fahy (1987) as they suggested that community interventions in mental health emergencies such as the use of Section 135 and Section 136 under the MHA (1983) are not seen as real police work in the perceived ‘canteen culture’. Robertson et al (1996) argued that since the closure of psychiatric hospitals it has created a conflict between police functions. These included: bringing offenders to court, crime detection and the welfare role that police officers perform. These police functions become more complex across the police role as they may rely on accessing mental health services in the community, that are not available, that deal with assessments under the MHA (1983) with the reliance on the little training they have received for mental health. In cases where people are suffering from a mental health crisis police officers can take the person to a place of safety for care and/or control under Section 136 however they must be assessed by an approved social worker and a psychiatrist. Bartlett and Sandland (2004) suggested that due to this overlap of different professions it creates variations which can cause problems and harm to the people who need support.

The Mental Health Act Commission (2005) outlined several flaws with the system and procedures when the police try to help the mentally ill such as: their use of power, poor recording, regional variations and police stations as a place of safety was not appropriate. The latter was researched to find that mentally ill people should not be held in police stations (Docking et al., 2008). As it has been briefly noted, police officers receive little training that relates to mental health to help them when attending mental health calls and the training they do receive is attentive on legal or procedural issues such as Section 135 and Section 136 of the MHA 1983 (Cummins, 2007). The lack of training police officers receive has created

confidence problems when they attend mental health calls and frustration of the social care systems that are in place due to their lack of support (Dunn and Fahy, 1987; Home Office, 2002). Due to these confidence problems both studies suggested police officers have felt that organisational perspectives conflict with organisational values in the police structure which also has a negative impact on their job.

The term '*vulnerable adult'* is said to be difficult to produce an agreed definition. Police and Criminal Evidence Act (1984) rely on terms such as mental disorder when it looks at identifying who is in need for care or control. These reasons are because of: stress levels become higher when arrested, the impact of custody on their mental health, police cells not being appropriate and the nature of the lonely environment. This has been shown in studies that 'vulnerable' or people who are having a mental health crisis will be exploited and this can lead to false confessions in testimonies (Gudjonsson and Mackeith, 2002). This was further stated in Her Majesty's Chief Inspector of Constabulary (HMIC) which saw police service were not able to identify people who were mentally unwell, and they were excessively arrested and detained in custody than people who were not seen to be suffering from a mental health illness (Her Majesty's Chief Inspector of Constabulary, 2015). This has been focused on studies in the past about the police's coercive acts when it comes to transporting the mentally ill as well as their unnecessary use of physical force (Engel and Silver, 2001; Novak and Engel, 2005). Therefore, it is important police officers can ensure they can meet the needs of the mentally ill appropriately when they encounter them especially as in 2015 Her Majesty's Inspectorate of Constabulary estimated that one-third of people who were in contact with the police service in England and Wales had an identified mental health problem. This figure rises even higher once other vulnerabilities such as substance use and dependence are included (Her Majesty's Inspectorate of Constabulary, 2015) reiterating that police officers need to be prepared for dealing with mental health calls. There has been

research to suggest that a mental health service model can be practical when used in police custody to help identify the people who may be suffering from a mental health problem which was effective during a study which was piloted for 19 months and dealt with 1092 referrals (Forrester et al., 2016). Though, this has not been followed up since the research.

The literature that has been presented has briefly identified that attending mental health calls has become a core part of police work (Corlett, 2013; Pettitt et al., 2013) and sufficient training is needed for police officers which, will help them progress in the understanding of mental health problems to provide further help that the mentally ill need from the police service. It is important that mental health officers understand mental health as they have a crucial role in working and supporting people who suffer with mental health problems. They must make quick decisions to assess the situation which has an impact on the needs of the individual suffering from a crisis and ensuring their safety as well as the people in the community (Scantlebury et al., 2017). Their choices also have important implications for the long-term results for the people suffering from mental health problems. Because of this, it is crucial that police officers can recognise and assist people who are suffering from mental health problems and are trained and supported to do so with this being sufficiently researched to show that police officers are (Mind, 2013). The literature in recent years share the common theme of recommending ideas on how to help the police service provide support to individuals who are suffering from a mental health issue. It can be argued this is because of the changing views of how mental health is seen in society and the positive reception it has received (Mind, 2014a). Charities such as 'time to change' have showed that public attitudes to mental health have improved by 9.6% since 2007 and, people's attitudes with being friends and living with someone who is suffering from a mental health issue have increased 6-15% (Time to Change, 2017).

However, there has been insufficient research into mental health in the United Kingdom and much of it has been done by the same researcher Ian Cummins (Massey, 2015). Early research on Section 136 of the MHA 1983 indicated that police officers were using their powers appropriately when seeing if someone is seen to be vulnerable however; it showed indicators that can potentially become problematic when making the decision if someone is needed to be sectioned (Mokhtar and Hogbin, 1993). Research which has been conducted since the 21st Century has given the insight of police officers feeling mental health crisis calls are problematic and they do not feel sufficiently trained to tackle these calls (Dew and Badger, 1999; Carey, 2001). The studies highlighted the main concern of police officers was they felt most of their learning took place when they attended mental health calls. The lack of confidence and police officers feeling that their training was taking place from experience being 'on the beat' was reverberated in further studies (Cooper et al., 2004; Wells and Schafer, 2006). Carey (2001) also showed police officers had confidence issues in the mental health services as well as not understanding what they did. Studies started to reiterate that police officers training for mental health was inadequate and failing to support those with mental health issues (Fry et al., 2002; Cummins, 2007). A key element of the training which was needed to be examined was police officers' attitudes of stereotypical views of mental health, not only in the United Kingdom (Cummins, 2007) but also in other countries such as Canada (Cotton, 2004) and Australia (Fry et al, 2002). Pinfold et al's (2003) study revealed the introduction of short training courses on mental health was tackling stereotypes that were held by the police officers. This had further benefits as it helped improve the communication barriers between the officers and the mentally ill when they were attending the call. Although the police officers did feel more confident when attending the calls, they still expressed the difficulty in tackling the violence that occurred. Confidence will be regained in community health services if improvements can be made to increase effectiveness to issues such as: poor

organisation structural skills, under funding and lack of agencies working together (Cummins, 2007).

There have been steps to try and improve funding in training for police officers with the Home Office and National Institute of Mental Health in England made £155,000 available to improve training however, this amounted to £1 for every police officer in England and Wales (Mental Health Act Commission, 2005, P271). The neglect in this area has been highlighted since the Bradley Report (2009). The recommendations consisted of: the police should how strategic plans with respective local mental health trusts to help create efficiency around S136, the police to seek application and diversion to help the people suffering from mental health issues at the earliest possible stage they need help. More importantly, it was recommended that there was a need for mental health training to every police officer. This has been echoed in following studies since the Bradley Report (2009) with the focus on societal views of the people who were suffering with a mental health illness in the United Kingdom and elsewhere (Laing et al., 2009; O'Connor, 2009; Cummings and Jones, 2010). The lack of training has been documented as police officers were seen to be making their assessments by influential decisions such as their personal attitudes and stereotypical views. This included police officers holding authoritarian opinions and saw people with mental illnesses to challenge their own authority (Bonfine et al., 2014; de Tribolet- Hardy et al., 2015). This has been something that had been addressed already (Cotton, 2004) and was seen to be combated effectively (Pinfold et al., 2003). Police officers were still feeling unskilled and out of depth when attending mental health calls (Cummings and Jones, 2010). This shows why it is vital that mental health illnesses are understood by police officers due to conflicting ideas in literature showing that they are not providing the correct support to those who are suffering from a mental health illness as they have a lack of training. Michael Brown, also known as the 'mental health cop', starting a blog due to police officer's worries

in training of mental health. The blog was started as police officers were only receiving two hours of mental health training and his blog was to help officers who wanted an internet resource to mental health (Burkitt, 2013).

There is little literature on the economic costs of mental health for England in recent years. The literature that is available is more about how much mental health costs England rather than how much has been spent on how to support individuals suffering from a mental health illness. A report in 2007, estimated that 1.6 billion is spent annually on arresting, convicting, supervising and imprisoning people who have been recognised to have a mental health problem (Revolving Doors Agency, 2007). Treating the physical aspects of people who are suffering with mental health problems have been estimated to put a 45% extra cost on the health system than treating those without mental health problems (Welch et al., 2009; Naylor et al., 2012). In recent years, it has been estimated that it costs more than £105 billion per annum to help the support those who are diagnosed with a mental health illness around: costs to the NHS, productivity of helping people in 'crisis' and impacts on people who have suffered with mental health illnesses' educational and employability results (Department of Health, 2014). For the spending on mental health services in the United Kingdom, statistics uncovered England spent an average of 1.36% of their public health budget which accounted for less than £40 million (Mind, 2014b). Furthermore, it was filed as 'miscellaneous' by Public Health England although it accounted for 23% of the total burden of disease in the United Kingdom (Mind, 2014b). Recently, the literature available has come from sources of newspapers from political talks in the United Kingdom Government. In, 2015 Prime Minister Theresa May awarded £15 million into health facilities to try and deter people with mental health illnesses from staying in police stations and in a place of safety instead. This was because of police stations were seen to aggravate mental health problems (Travis, 2015). The same year saw an additional £1.25 billion in mental health services for budgets over five

years to help young people who were suffering with mental health problems (Clegg, 2015). Yet, no academic research is available to assess the changes made since this contribution was made and to see if there has been any impact on helping people suffering from a mental health issue.

Literature has still echoed in recent years that sufficient training in mental health is still needed for police officers (Edmundson and Cummings, 2014; Thomas and Watson, 2017) and spending on the police service is not expected to rise in the future (Institute for Government, 2017). A literature review of mental health and policing in the United Kingdom, whilst comparing specialist training programs to normal training programs, saw gaps in detail for these types of studies and could not draw conclusions about mental health training in programs for the police service (Booth et al., 2017). This has been further restated in Parker et al (2018) which presented that due to the lack of training insight to mental health training it is hard to distinguish what models of training are beneficial and effective towards police officer's teaching which furthers points to the idea that there is a need for policing mental health research in the United Kingdom.

Application of Methodology in Policing Literature

There is a scarcity of research on policing and mental health with much of the research in the United Kingdom being carried out before the 2000's (Laidlaw et al., 2010). The research that was published were either discussions about mental health or review articles such as the Reed Report (1992), Ritchie Report 1994) and Department of Health (1998). Most of the literature available comes from overseas such as the United States of America, Canada, New Zealand and Australia. This has resulted in the United Kingdom not understanding the perceptions of their police officers' views on their increased work attending mental health calls (McLean and Marshall, 2010). There has been a massive focus on the Bradley Report (2009) however,

little research has been conducted to find out whether the report has made an impact or not for police officers dealing with mental health calls (Cumming and Jones, 2010, Cummins, 2012a; Cummins, 2012b). Literature reviews have been conducted to look at the research into policing mental health for England and Wales (Booth et al., 2017; Home Office, 2014; Kitt and Rogers, 2017; Kane et al., 2017). However, literature reviews do have their limitations as they only produce the information that is already known from studies and does not produce a clear understanding of the relationship between the police and people who suffer from a mental health illness. There have been interviews for studying police officers' views (McLean and Marshall, 2010) and studying the improving of outcomes of police interactions with the mentally ill (Cotton and Coleman, 2010) although these were small studies. Larger scales have been carried out however this is international literature such as: Canada (Cotton, 2004) using questionnaires, United States of America (Borum et al., 1998), New Zealand (O'Brien et al, 2010.) and Australia (Al-khafaji., 2014) all using police data as their methodology.

The lack of research, or research that has little depth and detail, has created difficulties as it has limitations for trying to present generalizable data and find relationships within policing and mental health. This links directly to the United Kingdom as the diminutive literature gives no scope for the findings that are available from the research that has been conducted. It makes it even harder as it cannot be generalized with overseas literature due to cultural and national dissimilarities. The United Kingdom's main source of research is now seen as the access of police data (Docking et al., 2008; Laidlaw et al., 2010; McKinnon and Grubin, 2010; Cummins, 2012a). Docking et al's study (2008) was part of the Independent Police Complaints Commission and remains the only literature in the United Kingdom that had access to police data from all 43 police forces in England and Wales as well as, 18 police forces who took part in telephone interviews and a 6 police forces which agreed to be a study

sites. This study produced in-depth information around its aims of describing the nature of Section 136 across England and Wales and police custody as a place of safety. The conclusion from the study saw that results had inconsistencies and were incomplete due to the poor recording of Section 136's in police stations. Also, the study saw that staff are not trained in police stations to deal with mental health problems and that police stations are not a suitable place of safety. The information produced was thorough due to the combination of research methods used and this was helped with the financial background of the study. Although, studies have not replicated the amount of police data used in studies it was one of the first to use police data and voiced opinions over mental health concerns from a policing perspective.

Laidlaw et al (2010) use of police data was from the county of Gloucestershire and cross-referenced police data with NHS data for over two years. It is one of the only studies in the United Kingdom that highlighted the lack of literature and provided in-depth findings that are helpful although, it cannot be generalized due to being in one county and failed to understand the limitations of using generated data from the police and NHS. Nevertheless, it still had similarities to the literature that is available around people who suffer from mental health issues are more likely to be a victim of crime rather than committing a crime (Choe et al., 2008; Khalifeh and Dean, 2010; Hughes et al., 2012). Furthermore, the study reiterates the lack of literature available for mental health in the United Kingdom and recommended that more research is undertaken. An area which was highlighted in the study to have insufficient literature was around individuals detained under Section 136 who are not admitted for help at a place of safety. This has not been researched since the recommendation was made from the study in the United Kingdom.

McLean and Marshall's (2010) study used semi-structured interviews and was the first to show police officers views on attending mental health calls through police officers in

Scotland. Although, the research is not based in England and Wales it still provided rich information in the area on the training of police officers in mental health by, looking at the emotional experiences of the officers who attend mental health calls. Furthermore, the study underlined issues faced by police officers when supporting people who suffer with mental health illnesses such as: the lack of mental health services available which caused frustration among police officers, the emotional stress of sitting with a person who is suffering from a mental health problem to see them being released receiving little or no help and the impact from cuts to the public sector such as a reduction in psychiatric beds. The findings from the study supports academic sources from the United Kingdom as well as other countries (Borum et al., 1998; Cotton, 2004; Cummins, 2007). However, McLean and Marshall's study does have limitations as it has been questioned to have selection bias among police officers chosen. This is because of how officers talk about the positivity of helping people who are suffering with mental health problems and how it is emotionally uplifting. This is disputed with other literature such as Mind (2007) who showed that people who suffer with mental health problems feel they are treated unfairly be the police, and Jones and Mason (2002) who showed that the police procedures to support the mentally ill harmed them rather than help them. Yet, recent literature from the Care Quality Commission saw that people from the United Kingdom who had experienced a mental health problem had positive experiences with the police in terms of: being provided sufficient support and advice, being treated fairly and seriously and felt they had a voice. More importantly, they felt that the police were more positive than mental health services that were available (Care Quality Commission, 2014). Nevertheless, McLean and Marshall's study (2010) provided rich information which can be used to help in the training received for police officers and, has yet to be repeated in United Kingdom Literature.

Although, there is literature that conflicts this is seen to always be a threat with empirical research as people who are more likely to participate, due to ethics, are going to be more sympathetic (Massey, 2015). There are further ethical considerations when researching mental health making it a difficult area to produce research in. Mental health research can carry stigma, fear and prejudice which can produce unreliable results due to these ethical issues. Research that has been conducted shows that police officers can hold very strong feeling about people who suffer with mental health problems for such reasons as not seeing it as proper police work (Bittner, 1967; Dunn and Fahy, 1987). This has been furthered by ideas that they are protected by Equality and Diversity Laws as well (Massey, 2015). This can result in the participants choosing to present a more positive outlook with providing help to people who are suffering from a mental health issue where, this may not be true and conflict in literature. McLean and Marshall's (2010) study saw that police officers have a positive mentality and attitude with attending mental health calls however, other studies have showed how people who have suffered from mental health felt underappreciated by the police service (Jones and Mason, 2002) and how the bar for mental health is low at police stations ((Vaughan et al., 2001; Prins, 2005; Bather et al., 2008). Furthermore, seeing that one in four people are to experience a mental health problem in any given year (Pettitt et al., 2013) this means it is likely that a police officers has experienced or is suffering from a mental health problem or someone close to them such a family member has or is. This may lead to officers being reluctant to reveal certain information about their views and emotions on attending mental health calls. This further adds to ethical issues when attempting to produce research in mental health and policing and can result in bias results being presented in studies.

Summarising Policing and Mental Health Literature

This chapter has identified the available literature for mental health and policing for the United Kingdom. To summarise, the main theme of early studies was looking at the early impact of deinstitutionalisation on the police service (Teplin, 1984; Rogers, 1990) and how this was impacting on the police service. Studies started to show that the police service were starting to deal with an increased number of mental health calls in the community (Arboleda-Florez & Holley, 1998) and people who were being diagnosed with a mental health illness was seen to be increasing overtime in the United Kingdom (Singleton et al., 1998). Care in the community started to shift from psychiatric hospitals to the emergency services and this has been documented in literature (Green, 1997; Borum et al., 1998; Cummins 2006). This pointed further to the police becoming the first point of contact for people who were worried about someone's mental health or their behaviour in the community (Bradley Report, 2009; Cummings and Jones, 2010). There has been steps to try and improve funding for police officers training however, with the Home Office and National Institute of Mental Health in England made £155,000 available to improve training however, this amounted to £1 for every police officer in England and Wales (Mental Health Act Commission, 2005, P271). In recent years it has been documented that mental health issues has become a core part of police work (Corlett, 2013; Pettitt et al., 2013) and there is a need for mental health training for police officers in England and Wales (Edmundson and Cummings, 2014; Thomas and Watson; 2017). Furthermore**,** literature has provided us with information that it is not just the United Kingdom who faces this problem as there is literature from other countries such as the United States of America presenting similar ideas around de-institutionalisation (Wolff, 2005). There has been little variation since the 1990s as literature has just repeated itself around themes such as: the impact on the police service from de-institutionalisation (Teplin, 1984; Rogers, 1990; Cummins, 2006; Clifford, 2010), the need for mental health training (Edmundson and

Cummings, 2014; Thomas and Watson, 2017) and mental health calls becoming an increasing part of police work (Bradley Report, 2009; Corlett, 2013). It has been outlined that it is important for police officers to understand mental health illnesses as they have a crucial role in supporting people who are suffering from a mental health crisis. Their choices are needed to ensure the safety of the person who is suffering from mental health problems as well as the people in society (Scantlebury et al., 2017) as well as long term effects on the person (Mind, 2013). Policing and mental health is a sensitive area to research however, the literature simply explains there is a problem and it is under-valued and under-resourced. As well as showing the ethical considerations needed for researching in the field that may not be controlled by the researcher. Literature does not go suggest what should be done about this issue for the police service although, this is an exemption from the Edmundson and Cummings study (2014) which, offered recommendations from the study. As well as provide us with information that not much is known about police officers' views on attending mental health calls (McLean and Marshall, 2010). This shows why it is important for research to be conducted in policing and mental health to help police officers with best practices on how to support the people who are suffering from mental health problems.

The Need for More Policing Research in the United Kingdom

The reason for the study is because although mental health and policing has been studied, it has not been studied in-depth to evaluate what is helping police officers when they are emotions and views about attending mental health calls. Furthermore, the research that is available for mental health and policing in the United Kingdom shows that little has been achieved over the years following the Reed Report (1992), Bradley Report (2009) and Bailey Report (2010). It has been established that it is a core part of their police work (Corlett; 2013; Pettitt et al., 2013) and there is a need for mental health training for police officers in England

and Wales (Edmundson and Cummings, 2014; Thomas and Watson, 2017). However, this has not been researched enough to understand whether anything has changed as well as understanding the views of police officers who provide support to people in ‘crisis’ (McLean and Marshall, 2010). It is important that police officers understand mental health illnesses as literature states that mental health calls takes up a high percentage of police work in England and Wales with, statistics showing it is between 20% - 40% of police time for police officers in the United Kingdom (College of Policing, 2015). Police officers deal with several areas of mental health related matters such as: implementing warrants under Section 135, dealing with violent incidents in psychiatric wards and supporting multi-health system assessments. Their focus is on making the assessment if someone is deemed vulnerable and is in need for help under Section 136. Therefore, if police officers are not able to do this then they cannot make the correct assessments on individuals’ mental states to whom they attend to on mental health calls. Therefore, it is important for police officers to be equipped with better training to understand those who suffer from mental health illnesses. The research conducted was aimed to produce findings on ‘do police officers receive sufficient training in mental health?’ as it has insufficiently researched in England and Wales. The specific objectives of the study were to find out police officer’s views on whether they felt they received sufficient training on mental health and their views on attending mental health calls which, has been highlighted in research to be limited (McLean and Marshall, 2010). Thematic analysis was used to analyse the data which has been promoted in literature (Braun and Clarke, 2006). The study had issues around generalisability/reliability and validity due to the low volume of participants however, it can be used as a basis for further studies. The thesis will look to enhance knowledge in policing mental health with the main aim of looking at, United Kingdom’s police officers’ emotions and views about attending mental health calls and the mental health training they receive

Methodology

The Present Study

The number of people diagnosed of having a mental health issue has increased overtime (Singleton et al., 1998; Brooker et al., 2002; House of Commons, 2009; NHS Digital, 2016) and literature has shown how the police have been affected by this due to the increase of mental health calls they attend in the community (Green, 1997). It has been constantly mentioned in research that police officers need to be sufficiently trained in mental health due to the ineffectiveness of the police service when, supporting those who are suffering from a mental health crisis (Fry et al., 2002; Cummins, 2007). This has been documented overtime for the police service in England and Wales (Dew and Badger, 1999; Bradley Report, 2009; Edmundson and Cummings, 2014; Thomas and Watson; 2017).

The study aimed to increase knowledge and awareness of the training police officers receive in mental health and to show their views on how they feel about attending mental health calls. The research question: ‘do police officers receive sufficient training towards mental health?’ had sub questions which questioned: how much training do police officers receive on mental health? And has the increase of mental health calls in the community put a strain on police officers?

Methodology Used

The study was conducted from May 2018 to July 2018 with semi-structured interviews being used as the methodology. Interviews were conducted with serving police officers from different police forces in England and Wales. The police officers that were interviewed answered 7 questions from the interview schedule which, had sub questions to prompt

participants to produce more information (Appendix 1). The questions aimed at discussing the participant's experiences when: attending mental health calls, the impact this has had on their job, the training they receive for mental health, their perceived training needs and the support structures and processes that are available to them if they are affected by what they experience on mental health calls. Sub questions were underlined to prompt participants to produce more information.

Participants

Participant recruitment resulted in 10 interviews being conducted with serving police officers (8 male, 2 female). Table 1 provides the demographic information in more detail (pseudonyms are used to protect confidentiality and anonymity of the participants). The recruitment for participants started with, attending a policing weekend at Canterbury Christ Church University reaching out to students across the curriculum inviting them to participate in the study. However, due to time restrictions on their job and having deadlines throughout May for their courses it created difficulties. The participants that were interviewed were emailed to promote the research on two occasions in May 2018 and June 2018 and the help of my supervisors was requested to reach out to their students. Also, attending groups in London were used to promote the study to police officers. The best impact for the study which achieved most of the participants was the use of social media from a Senior Lecturer at Canterbury Christ Church University who promoted the research to search for volunteers. This was used as it has been documented in literature the effectiveness of using social media (Andrews, 2012; Adair, 2015). Still, it was not straightforward in conducting the interviews due to the time constraints on their job which, led to some difficulties in finding a suitable time and day to conduct the interview with each participant. The low number of participants in the study means that it can act as a basis for further studies as it can't be generalized. Also,

as the participants were self-selecting they may have only participated in their study because they are interested in mental health.

Table 1: Demographic information of participants

Name	Age	Gender	Rank	Length of Service	Police Service
Jack	37	Male	Sergeant	16	Eastside Police Service
Mark	36	Male	Sergeant	12	Eastside Police Service
James	35	Male	Sergeant	15	Eastside Police Service
Robert	29	Male	Police Constable	5	Eastside Police Service
Elliot	38	Male	Sergeant	17	Eastside Police Service
Sarah	36	Female	Police Constable	14	Eastside Police Service
Ryan	33	Male	Detective Constable	13	Sunrise Police Service
Andrew	39	Male	Special's Sergeant	21	Delton Police Service
Charlotte	52	Female	Superintendent	29	Boddington Police Service
Michael	42	Male	Sergeant	13	Holton Police Service

Ethical Considerations

An ethics form was submitted for the study (Appendix 2) and was approved from the Ethics Review Committee at Canterbury Christ Church University (Appendix 3). Participants had an information sheet that contained information about the study, assertion of anonymity, confidentiality and the option to withdraw from the study. Confidentiality and anonymity issues were discussed before the interview was conducted with each participant. A signed consent form (Appendix 4) was also attained and the results from the study are presented in a way that no participants would be recognised. The data collected was password protected on

an encrypted USB drive with the voice recordings on the dictaphone being deleted once transcription was completed.

The semi-structured interviews with the police officers lasted up to 60 minutes and were recorded by a dictaphone with consent from each participant. Before the interviews began, participants read the information sheet which presented the main aims of the study also, confidentiality and anonymity issues were discussed with each participant. All participants signed a consent form electronically before the interview could commence. All participants conducted in telephone interviews due to time constraint which, could have resulted in less detailed information as more rich information could have been produced if the interviews were in person. Furthermore, there were differences in interviewees with the information that was produced. Reasons for this could have been due to the environment where the interviewees were taking the call. Some of the participant's interviews were conducted on their break which, meant they were time restrictions on how long the interview was conducted for and the information they produced. This was apparent at times when these participants became very quiet when there was background noise of voices throughout the interview. Others who were in a more undisturbed environment did not present this behaviour and seemed more relaxed when they were talking.

Data Analysis

The data analysis that was used was the systematic method of thematic analysis suggested by Braun and Clarke (2006). Thematic analysis is the most commonly used qualitative approach for examining interviews. Braun and Clarke (2006) outlined thematic analysis as 'identifying, analysing and reporting patterns (themes) within the data' (Braun and Clarke, 2006, P97). However, the main reason the methodology was chosen was because it offers a 'rigorous thematic approach can produce an insightful analysis that answers particular research

questions' (Braun and Clarke, 2006, P97). To start of the analysis, all the files were loaded into NVivo, a qualitative data analysis computer software package. This was helpful and easy to use, and its auto coded setting was used to generate main themes from my research. However, the 'bottom up approach' was used as well (Braun and Clarke, 2006) which consisted of reading the transcriptions repetitively to identify common themes and sub themes from the results.

Results

The results will be summarised with a table showing the main themes and sub themes from the research analysis conducted (Table 2). Each theme will be analysed from its sub themes that were generated and will be explained whilst, using quotes from the participants to provide a further understanding.

Table 2: Main Themes and Sub Themes in research analysis

Main Themes	Sub Themes
'Coping' with mental health	- It stops us from solving 'real crime' - The calls are time consuming
Attending mental health calls	- Impact of police varies - Calls are frequent - Frustration in attending mental health calls - Uniform is a barrier
Mental Health Training	- Training is basic - Training is poor - NCALT[1] is not helpful
Police responding with mental health	- Police are the worst possible people to be dealing with mental health - Police cuts influence how we do our job - Police officers have accepted mental health is a part of their job
Police and Outside Services	- Frustration with working with outside agencies - Lack of external resources and mental health teams available - Needs to be more partnership focused
Support Structures and Processes available to police officers	- Support structures are beneficial - Changes needed to be made - More co-ordination needed

[1] NCALT is an e-learning training approach used in policing.

'Coping' with mental health

Most of the participants (8 out of 10) stated that they 'coped' with attending mental health calls that had become more frequent within their job. They expressed emotions such as frustration, stress and pressure around attending this type of call and the consensus was that the police service should not be dealing with mental health calls. This was explained by Officers such as Mark, Jack and Elliot who represented Eastside Police Service.

> It's a sense of frustration that tends to be born out from experience so it's generally before you go to the call you are already aware that the police are the worst possible people to be dealing with it. It's almost a bit of a feeling of doom. (Officer Mark, Sergeant, Eastside Police Service)

> You think that these calls are quite rare and don't expect them so often. I think that as you, well for me you go on and realise that these calls are very frequent (Officer Jack, Sergeant, Eastside Police Service)

> It is frustrating at times particularly if you are on time constraint with calls. The lack of help we give to people within our powers and knowledge does not help as well. (Officer Elliot, Sergeant, Eastside Police Service)

Participants also expressed their feelings around mental health calls being time consuming for the police service which, also left them frustrated with their job (7 out of 10). Police officers also stated that they felt it took their time away from solving 'real crime' and enlightened the harm that these calls can have on their colleagues. This was described by Officers Charlotte, Ryan and Andrew from their respected services.

> It takes resources away from other policing issues. The aftermath of having people with mental health issues who harm themselves in custody for example has a massive impact on my staff. (Officer Charlotte, Superintendent, Boddington Police Service)

> I think it takes time away from investigating crime and it takes time away from community policing from patrols. I think there should be another agency or another team that deals with mental health rather than police. (Officer Ryan, Detective Constable, Sunrise Police Service)

> Mental health calls take up a lot of our time and it shouldn't be like this but if we are the ones that have to answer the calls then there is not a lot we can do about it. (Officer Andrew, Special's Sergeant, Delton Police Service)

This was noted to have an impact on how police officers questioned their role as police officers with they were solving crime or supporting people with mental health issues.

Moreover, it supports literature which is already available such as Bittner (1967) and Dunn and Fahy (1987) where police officers do not see mental health as 'real crime'. However, it has to be mentioned that this conflicts with how some police officers acknowledge that, attending mental health calls is a part of their job (McLean and Marshall, 2010) and it is seen as an important part of police work (Corlett, 2013).

Attending mental health calls

When speaking about their experiences of attending mental health calls, several different situations where mentioned which included: depression, intoxication through drink and drugs, attempted suicides, self- harm, concerns of safety through relatives, fixation, overdoses, schizophrenia and these have been in places such as home addresses, on the streets, motorways, premises, construction cranes, high bridges and cliffs. All the police officers noted that mental health calls were frequent in their job and some produced statistics around this. This included Officers Elliot from Eastside Police Service and Michael from Holton Police Service.

> Figures bounced about that 40% of our calls are related to concerns of safety and mental health so it's becoming a large part of our business. (Officer Elliot, Sergeant, Eastside Police Service)

> In terms of volume it's increasing I would say it is at least 10% of the calls that I go to now but on a bigger picture it is probably more than that. (Officer Michael, Sergeant, Holton Police Service)

Participants had mixed views on the impact of the police when attending mental health calls. Sometimes the person in 'crisis' would be supportive with help where others would react violently to the police arriving on the scene. However, some police officers did feel that the response from the police has changed overtime and has become better within the community, but they are still not effective enough. This was outlined by Officers Sarah, Ryan and Jack.

> From one extreme to the other you get people who become violent because they don't want intervention from anybody least of all someone in a uniform to people who generally want help and don't know how else to deal with the pain and everything else in between. (Officer Sarah, Sergeant, Eastside Police Service)

Some people are fine and some people the minute the car comes around the corner they see them are they start to throw their arms around and panic. (Officer Ryan, Detective Constable, Sunrise Police Service)
Initial reactions were 'we don't want to see the police' but now they call the police because they say, 'we deal with it better'. (Officer Jack, Sergeant, Eastside Police Service)

It was voiced by police officers that the reason they felt the emotions they had mentioned was because of a wide range of reasons which included: getting their powers right, not being effective enough whilst attending these calls, not seeing themselves as a mental health professional and the diversity of mental health calls compared to other types of calls they attend. This was stated by Officers Robert and Andrew:

Because it's such a diverse incident to go to it's not a simple as you know what is going to happen and you know what the circumstances are going to be. It is quite diverse so your turning up to the unknown which if you compare to other incident types you basically know what's happened (Officer Robert, Police Constable, Eastside Police Service)

Attending that type of call tends to be very volatile. (Officer Andrew, Special's Sergeant, Delton Police Service)

Certain barriers were revealed which participants felt affected them when they were attending mental health calls. The main consensus was that the uniform was the main barrier which, they thought influenced the potential behaviour of the person who was in 'crisis'. Officers Sarah, Robert and Ryan spoke around the confusion this occasionally created and volatile situations they had been involved with.

You get people who become violent because they don't want intervention from anybody least of all someone in a uniform. (Officer Sarah, Police Constable, Eastside Police Service)

The uniform is a barrier so all the calls I've turned up in uniform so that's been the first reaction and there've not been receptive to engage in any communication or try to respond at all. There's always barriers there that you have to overcome before helping them or connect to them. (Officer Robert, Police Constable, Eastside Police Service)

They've been fine with being in uniform, but some don't. It triggers something inside them. (Officer Ryan, Detective Constable, Sunrise Police Service)

Although some officers found themselves in volatile situations, one participant noted that they would take off their jacket and hat when they attended to the scene which, helped the situation and stressed how other police officers should do the same.

> I found the jacket off and the hat off can often work wonders. So, it's a very strange thing this symbolic communication and I recommend it to other police officers. I've still got my safety covered and it has worked well with people who suffer with schizophrenia. (Officer Andrew, Special's Sergeant, Delton Police Service)

The officer who produced this information was more shocked over how something as simple as this has not been promoted effectively enough to other police officers and explained how this was part of a bigger problem the police service was facing.

Mental Health Training

Most participants across all police services saw that the mental health training they received was 'very basic', poor and only certain 'things' stuck in their minds from the training. Participants expressed that their training came from 'on the job' with their experiences of attending mental health calls and that common sense was used to face their problems. Although the training was described with being 'very basic' the participants did feel it helped in basic understanding of mental health and legislation, but it was not enough.

> It is more on the job training sort of learning through experience. (Officer Jack, Sergeant, Eastside Police Service)

> Training of mental health power points and presentations informed how I approach jobs and how I deal with them. (Officer Ryan, Detective Constable, Sunrise Police Service)

> It does help however it doesn't give me the tools in my toolbox that I need for a mental health profession. (Officer Charlotte, Superintendent, Boddington Police Service)

Participants explained that the training they did receive consisted of comprehensive class room exercises with: mental health presentations, visitors coming in from the field, Officer Safety Training and Progression Development Days. Topics that were mentioned to have

been covered in the 'little' training they received were around: legislation around Sections 135 and 136, powers, policies, referral practices, out of hours numbers. Participants spoke about voluntary seminars run from MIND and how effective they were but felt that is was not 'rolled out enough'.

> If I put it in percentage wise say out of the hundred percent training, we get I would say on five percent of it is useful or effective and that five percent is probably contact details on how to get help. I have received no training I don't even know of any training especially where they build up on these skills to try and speak to someone and trying to break down them communication barriers. (Officer Robert, Police Constable, Eastside Police Service)

> We don't deal with it good enough. Don't have a good enough understanding on dealing with mental health issues. (Officer Jack, Sergeant, Eastside Police Service)

> There were seminars run by MIND and I went to one of those and they actually got people who had been through problems and had dealings with the police that were good and bad and then come through it. We then covered their pain and experiences of what they were thinking and what was going through their mind at the time. It was pretty good training and I was disappointed in that it wasn't rolled out more across the service. Everyone can benefit from that. Officer Elliot, Eastside Police Service)

Participants did explain with the increase of mental health calls and the implementation of triage cars in some police services that the mental health training had increased. One participant explained how he had just moved to a new police service and described their mental health training as 'immensely good' compared to the training he received at his previous service which was at Holton Police Service.

> Training was non-existent when I first started apart from initial training. It was less than a morning and was on powers around 135 and 136 but since the triage system has been put in place there have been a lot more input, videos, half a day. We also have training leads you can contact for questions. (Officer Michael, Sergeant, Holton Police Service)

> More recently I have attended service training as part of my transfer and it was more victim focused, it was more focused on the individual that calls for help. It was a mix, so it was classroom delivered and powerpoints to challenge our thinking and get us to reel of experience what we've seen signs and symptoms of. Then it was reinforced by some great videos from people who were able to explain what they were actually going through. It was immensely good. Previous training felt very rushed. (Officer Andrew, Special's Sergeant, Delton Police Service)

Participants were asked about internal online training they could access for further understanding of mental health, 7 were aware of online training that could be used, 1 was

unaware of any online training they were available and 2 guessed with their views being 'there is normally online training for everything, but I don't know about it'. Some participants mentioned external training such as Michael Brown's website, 'Mental Health Cop, and NCALT which is a training package from the College of Policing which is promoted as internal training. It was reiterated by participants that NCALT was not helpful and reasons for this was because: it was not well-structured, or well-remembered, bland and it seemed more like a compliance tool rather than an educational tool. This was explained by many participants including Officer James, Elliot, Ryan and Andrew.

> THE NCALT Packages don't help even when I do them. I only do them if they are mandatory, but I don't feel I absorb much information from them. it's just looking at a computer screen and flicking through. It's not a good way of learning or teaching quite an important subject. It's because of the delivery it's not very interactive. (Officer James, Sergeant, Eastside Police Service)

> I would imagine there is an NCALT package somewhere because there seems to be a NCALT package for everything these days but not one I'm consciously aware of. (Officer Elliot, Sergeant, Eastside Police Service)

> The NCALT they seem more to be a ticky box exercise for the organization to say they've trained you in mental health so if you do something wrong their covered and it's your fault that's the impression we get from the NCALT training packages. (Officer Ryan, Detective Constable, Sunrise Police Service)

> They are very dry and very bland and computer-based training can come across more often as a compliance tool than an education tool. (Officer Andrew, Special's Sergeant, Delton Police Service)

This led to many participants feeling they had not utilized the training to help them with their job role for attending mental health calls although, two participants thought that they had utilized the training as it had enhanced their knowledge on specific areas.

> Yeah, I have done some e learning but it's really awareness raising and legal responsibilities. It has helped with utilizing my job role. (Officer Charlotte, Superintendent, Boddington Police Service)

> I have utilized it around the changes in the law and around the sections 135 and 136. (Officer Michael, Sergeant, Holton Police Service)

When asked about if they would implement any changes to the training programme, participants went into great depth and passion about what they would do and how they would

implement their ideas. Ideas consisted of: self- reflection to help them deal with mental health calls effectively, feedback system on mental health calls, three- day mental health sessions each year, defensive skills, updates on powers and legislation, training from communication and behavioural specialists, regular yearly training, talks from people who have suffered from a ‘crisis’ and has been involved with the police on calls and training on the main signs and symptoms of mental health illnesses.

> I suppose it would be about understanding the main signs and symptoms of mental health, what to do, what not to do when attending a mental health call, understand their perspective so you don’t escalate the situation, around the law and what they can legally do, what provisions are available and who can help and who else has responsibility for mental health. How to de-escalate things without the support and help that you need and then some scenarios. (Officer Charlotte, Superintendent, Boddington Police Service)

> We need to be far more aware of our powers. It helps with interacting with people so if you don’t have your powers as your knowledge you can’t really do that. I think it needs to be delivered by someone who is a subject matter expert, somebody who has a passion for it and knows it inside out. (Officer Sarah, Police Constable, Eastside Police Service)

Officer James debated that they would not know how to implement mental health training as there are many priorities that the police service face, and it would depend on what was needed to protect and support the public at a certain time. As well, it was noted that police officers do not like training days due to view of internal training being at a poor standard which participants felt would cause problems.

> Well it depends on well there isn’t training on mental health. There’s not training specifically on mental health, so it depends where the police services priorities are. There are loads of priorities and management must balance them and identify where the greatest risks are. (Officer James, Sergeant, Eastside Police Service)

> It’s a day where you could be at home so like anything to say about training is that it is pointless, first aid training we was like ‘oh what can we do’. Some training days I have had missed several trains home because of it and the general frustration from myself and colleagues on that day is with the incident and we don’t want to think about the training. (Officer Jack, Sergeant, Eastside Police Service)

> Generally, because of the standard of training internally it is seen to be quite poor. People don’t enjoy training they don’t particularly look forward to it. (Officer Mark, Sergeant, Eastside Police Service)

This creates a bigger picture around understanding what police officers feel about training and what can be used to change this view on how they feel about training days. This is a restriction on how effective training days can be especially if promoting knowledge about mental health.

Police responding to mental health

Participants accepted that mental health calls had become part of their job due to the increase number they have to attend to. All participants disagreed with the idea that they should be the service that deals with the calls because of the lack of support that they can offer to people who have/ or will be in 'crisis'. Although it was established there has been a positive reaction to the police attending these calls participants still felt that, it should be other agencies and services, that have the skills and knowledge, that attend these calls as they would be more effective than the police service.

> I think it is quite sad we are the best people for the job so yeah that change has become positive overtime the reaction and the reception, should it be like that? I would say probably not (Officer Jack, Sergeant, Eastside Police Service)

> It's not ideal that we deal with mental health calls, but we seem to be the ones that are dealing with it now and not other agencies. (Officer Elliot, Sergeant, Eastside Police Service)

It was further explained how the police were not appropriate for people who were suffering from mental health issues. Apart from the lack of support offered it was further clarified that it was because of: the lack of training received, systems around the law and lack of provisions around areas where they worked in their boroughs. Some officers thought that they 'criminalise mental health and that mistakes will occur as they are not medical professionals. This has also been shown in literature with Borzecki and Worminth (1985).

> Effectively we almost tend to criminalise mental health almost. That we well from my experience I turn up or we turn up in we end up in a situation that might not necessarily be getting out of hand and escalates and it's like well what are we going to do? This person now being aggressive we need to stop them being aggressive from the public and it's like well if we weren't there in the first place maybe they wouldn't be getting aggressive (Officer Ryan, Sergeant, Eastside Police Service)

> Everything that I have tried to emphasise from a policing perspective is if the police are used for mental health, which is not my view of the primary function of the police service, the police service will make mistakes because we are not medical professionals. If police officers were asked to put out a burning building, we would not do it as effectively as fire fighters and that is the same concept with mental health. (Officer James, Sergeant, Eastside Police Service)

Police cuts were also mentioned, and some participants discussed the cuts that their boroughs were facing. Participants explained it was 'frustrating' as without the funding they are unable to make changes that were needed to offer the right support. This was on the idea that they were going to continue to be the service that is supporting mental health issues in the community.

> The time constraints everything the lack of resources we've got now that's starting to take its toll. It is frustrating. (Officer Elliot, Sergeant, Eastside Police Service)

> We don't have the resources available to us to handle mental health and it is starting to affect how we deal with those types of calls. (Officer James, Sergeant, Eastside Police Service)

> Also, with police cuts it is not helpful as it puts more of a strain on us. I understand it's hard for my borough to make the changes needed without the funding available. (Officer Michael, Sergeant, Holton Police Service)

If funding carries on to be cut or not improved then this will impact on police officer's views of providing support to the mentally ill as well as cause frustration due to not being able to provide the right support to people they attend to on mental health calls who are in 'crisis'.

Police and Outside Services

Participants underlined the problems with working with outside agencies and how it caused potential problems for them when they have attended mental health calls. They named: the council, NHS, Government and social services as the main services they felt did not help and caused more problems when involved as well. They also felt that other services such as the ambulance service not knowing their powers complicated options available for people. This was explained by Officers Charlotte, Robert and James.

It can be the comedy phrase. The Friday night 5 o clock call people like social services are going out of their office for their weekend off. We will get calls like 'we haven't had contact with this person' and then trying to get in contact with them for further details can be a frustrating call at times as well. (Officer Charlotte, Superintendent, Boddington Police Service)

It creates further complications when services such as the ambulance staff do not really know their powers and it creates tension as you don't have support it's just you who is trying to help the person having a crisis. (Officer Robert, Police Constable, Eastside Police Service)

My friend who was suffering with mental health issues he was out in a public place and he was suffering from stress, anxiety and depression and we phoned the on call mental health team and the first thing they said was 'call the police' to make an assessment. Now, are the police qualified to make that assessment? And the answer is that we are not. (Officer James, Sergeant, Eastside Police Service)

Participants felt one of the reasons why services were not helpful was due to the lack of External resources such as the limited number of mental health teams and the lack of beds available in mental health suites and provided examples to how this is a common experience for them. Officers also spoke about incidents on the job where they felt medical emergency services are under pressure due to their lack of resources.

There is often a lack of provision or it takes officers a lot of time to get to the places available so that is one frustration but there's frustration around if we do detain someone under 136 the practicality of getting them somewhere safe and with a bed which means sometimes people are left with us for days which is inappropriate. (Officer Charlotte, Superintendent, Boddington Police Service)

A classic example that frustrates me is when you detain someone under Section 136 and they have consumed alcohol. You would take them to a mental health suite and they would be refused to be omitted saying they have to go to A n E to sober up. I would then have to explain under the service agreement he can hold his own body weight, so it is not a medical emergency and the person should be accepted. It comes down to that they are under pressure and have a lack of resources. (Officer James, Sergeant, Eastside Police Service)

Participants felt that this caused the problem of attending more mental health calls and how they were encountering the same people which caused frustration and stress of having to deal with the same person and presenting them with the same outcome due to the lack of resources. They argued that the way forward to is a 'partnership focused drive' for the police service and outside agencies. They put forward ideas such as services needing: procedural changes, opening hours of other services and to have debriefs available for each service.

It can be quite frustration like oh I've got to go to this person again or oh we've got to do this again. (Officer Ryan, Detective Constable, Sunrise Police Service)

There are a handful of repeat callers or you know repeat I don't know victims not the right word but people that you deal with on a regular basis that police officers know. (Officer Sarah, Police Constable, Eastside Police Service)

Services should be geared up like us 24/7. We need to change the provision on the health care that we provide for mental health. (Officer Sarah, Police Constable, Eastside Police Service)

We need more partnership between agencies. I don't know how I would implement it, but it needs to happen. I think everyone would benefit from this and it would be easier for the police service as well. Maybe Debriefs would be a good idea. (Officer Michael, Sergeant, Holton Police Service)

All participants voiced that this had a major impact on some of the emotions they felt when attending mental health calls and felt that if this was sorted this could solve a lot of problems they faced when trying to provide help and support for people who are suffering in 'crisis'.

Support Structures and Processes Available to Police Officers

When asked about support structures and processes available to them if they are affected by what they see on mental health calls, a lot of the police officers named both external and internal ones they knew of. Only one police officer did not know of any structures and processes available to him. These consisted of: MIND blue light programme, their supervisor, occupational health system helpline, CALL4BACKUP, Trauma risk management (TRIM), emergency on-call, counselling, occupational health support, Employee Assistance Network, Christian Police Association, LGBT Association, peer support, debrief sessions, Chaplains and NHS Provisions. Half of the police officers had used one of these structures and processes throughout the years in their police service due to what they have experienced on mental health calls. The consensus of all police officers was that the structures and processes are beneficial to have there for them however, they need to be more expanded and made aware of. This was explained by Officers Jack, Ryan and James.

It is nice to know the processes and structures are there, but they need to be made more aware of. (Officer Jack, Sergeant, Eastside Police Service)

TRIM for their incidents are beneficial but they could be expanded to almost have a review of all incidents that officers go to, to see what affects them the most. (Officer Ryan, Detective Constable, Sunrise Police Service)

I think he processes are very good and if the supervisors and organisation are aware then police officers do get looked after. There has been a culture shift, I can't remember the phrase, but it has become 'ok to talk about it'. (Officer James, Sergeant, Eastside Police Service)

Most police officers argued that there are changed that still need to be made to the structures and processes. One police officers felt that the police service has been poor when it comes to internal mental health awareness and this linked with other officers answers who said that: there is a lack of communication and assistance, they need to be more promoted and that some of the services asked too many questions which can impact the amount of police officers who use them. This was outlined by Officers Robert, Elliot and Charlotte.

The processes need to be more communicated and promoted for police officers to get the full effect of the services offered to them. (Officer Robert, Police Constable, Eastside Police Service)

There is a lack of communication, lack of access to professionals to seek assistance and that has a bit of an effect on police officers. (Officer Elliot, Sergeant, Eastside Police Service)

I think there should be more services available for police officers especially ones in emotional roles including front-line police officers. They should be able to have access to these services without too many questions being asked about it. It would be easy for them to be self- referred because of it. (Officer Charlotte, Superintendent, Boddington Police Service)

Another view that police officers had was that the internal and external processes and structures had too much overlap and this needed to be sorted through more effective co-ordination. Officers thought that this would make it more presentable for police officers to understand them which would help. This was explained by Officers Jack and Mark.

It needs to be empathised a bit more or make it a little bit more presentable for officers but yet again it can differ from station to station. (Officer Jack, Sergeant, Eastside Police Service)

External bits and pieces there's probably room for a bit more co-ordination because it seems you've got these groups/charities, so they are receiving external funding but there's quite a lot of overlap with exactly what they do. (Officer Mark, Sergeant, Eastside Police Service)

Discussion

Ten police officers were interviewed about the mental health training they receive in their police services as well as their views and experiences on attending mental health calls. Their views illustrated that they believe they do not receive enough mental health training and should not be the service dealing with mental health calls however, the consensus from the police officers was that they have accepted that attending mental health calls has become part of their job. Staff argued that it should be the medical services that deal with those type of calls due to it being a 'medical emergency', as they would be more effective, and it stopped them from dealing with 'real crime'.

Participants expressed the emotions of: frustration, stress, anxiousness, apprehension and helplessness in attending mental health calls due to majority of the police officers feeling that: they should not be there, it was time consuming and they were not trained well enough to deal sufficiently with the calls to help the person. 'Coping' with mental health calls meant that the officers had to deal with these calls regardless if they wanted to, due to the high volume of calls associated with mental health. When attending the calls, they voiced that they felt they were not effective enough however, it was mentioned there had been positive reaction overtime to the police service arriving on the scene. Most of the police officers agreed that their colleagues experience, in most cases, the same emotions and views as they do as views are normally shared 'across the line' however, this is personal opinion and not all participants agreed with this which, also is on the contrary to the perceived 'canteen culture' that is seen to exist in the police force. There were also other factors mentioned such as knowing of fellow police officers in their service that have dealt with mental health problems in their family, so it is not beneficial for them to attend those types of call. However, this can be argued that they are better prepared to attend those calls as they have first-hand experience

and knowledge on how to potentially handle the mental health issue they are facing. All police officers agreed that the calls were frequent but felt it should not be like this and some vented their frustration due to the barriers that confronted them at the scene. The main barriers were the lack of training they received and their uniform. Some of the police officers explained how they take off their hat and jacket when they arrive on the scene and this seemed to have a really good effect for the people who were in 'crisis'. One officer explained how this should be used by other police officers and how a simple change can help in a 'hectic situation'. They explained how the radio use to be a factor due to noise however the change in system meant they could turn it down and still have their 'lifeline if they needed it'.

There were mixed views on whether they felt they received sufficient training in mental health as they expressed that they received little training on the subject. It was mentioned that the training is delivered briefly in internal training such as Officer Safety Training and Progression Development Days and was around legal procedures, their powers and the law. Most police officers felt that the training was not helpful although it gave a basic understanding of mental health. Most police officers were aware of NCALT, the online training that can offer exercises on mental health and some guessed that online training is available, but they were unaware. All police officers felt NCALT was not helpful and reasons for this consisted of examples such as being bland and a poor interactive tick box exercise that was more seen as a compliance tool than an education tool. External training that was stated was MIND's external seminars and this was described to be useful although, it only offered a certain number of places and officers thought if more people could attend it would be very beneficial. Michael Brown, who is also known as 'mental health cop', was mentioned to be useful for looking at mental health material.

When asked about what they would change to the training programme for mental health, police officers responded thoroughly with what they would implement and most of them

seemed passionate about the changes that needed to be made. The main aspects of training they would implement would be about: their defensive skills such as restraints, getting experts in communications and behaviour specialists to equipped officers on how to deal with people in crisis, understanding main signs and symptoms of mental health and what to do and what not to do on mental health calls, legislation and powers and bringing in people who have received support from police officers to describe their emotions, experiences and what helped them when they were suffering in 'crisis'. For all the classroom-based training they said they would have it every year for a maximum of three days and would want people who were passionate about what they were teaching, and it did not matter if they were in-field or out-field. Some felt that the intranet system should be used more within their services and should have a mental health folder available with videos and e-learning to reinforce and help them with the classroom training. However, police officers indicated that they did not enjoy training as it was an 'extra day' and most of it was delivered by fellow police officers who did not seem to have interest as they were just teaching it for the 'sake of it'. This seemed to impact on how long they would have training for as they understood what their fellow police officers' preferences were when it was for training.

Police officers were reluctant that mental health calls was now a part of their job with the increased number of calls they were receiving as some expressed they heard figures around 40% or one call relating to mental health every shift. However, they still felt they were the worst people to be dealing with mental health issues and this was for several reasons. There was a discrepancy between how the police felt they did on mental health calls in comparison to people who were in crisis. It was commented on how different police officers felt there has been a positive reaction to them arriving however, it was explained that the consensus was they offered a lack of support to people who were in crisis. The lack of training, systems around the law and the lack of provision in their boroughs were highlighted as well from

police officers across different services. One police officer felt they criminalised the mentally ill due to the lack of support they can give and how this was not appropriate. Police cuts were also mentioned and how this has impacted on how they support the mentally ill. They expressed with the less funding their boroughs received it meant they could not make the changes possible to help provide the support that people need, if they are suffering from a mental health issue. Some participants tried to emphasise from a policing perspective that if the police service is continued to be used to support people who are in 'crisis' that mistakes will be made as they are not medical professionals. However, it can be argued that police officers may have too high expectations on what they can achieve when attending a mental health call. Professionals such as psychologists who treat mental health patients do not expect a 'cure' in one or a few sessions. It can be a long term process to help support the individual who is suffering from a mental health problem. So, police officers may be putting more pressure on themselves in thinking there are failing someone because they are not providing a resolution for the individual.

Police officers emphasised their frustration with outside services when trying to contact them or when they were involved with the call. They outlined it caused potential problems for the person in crisis and they were not effective enough together. The council, NHS, Government and social services were named from different police officers as the agencies they felt were at fault. It was also outlined reasons why services were not helpful due to: the lack of external resources from outside services, the lack of mental health teams and the lack of mental health suites available. Police officers gave their examples to how this affected them on the calls with them getting frustrated as they attended the same people on different shifts. It was even mentioned how Sergeants have been called to help conflicting situations that occur in mental health suites due to, police officers and mental health staff not understanding intoxication issues surrounding mental health. Further examples included

mental health teams directing issues to the nearest police service to ‘make the assessment’. Participants felt that the way forward to become more effective was for a more ‘partnership focused’ drive between the police service and the outside agencies. They included ideas around services needing procedural changes to help them become more effective during mental health calls such a feedback sheets or information available for reoccurring people. Opening hours was mentioned that they need to be geared up 24/7 like the police service to make things easier for each service. Debriefing was talked about and police officers thought this could have an impact on how it can help the services interlock and become more effective. One police officer spoke about the Helicopter Emergency Medical Services (HEMS) and how they are trained for debriefs should be implemented in the police service to help bring them and other police services together. This was because, it was detailed and everyone was involved with decision making and they were checked to see if they were feeling ok after the situation had been dealt with. This was highlighted to be very important as the debriefing helped analyse how to deal with the same situation more effectively next time it occurred.

Most participants (9 out of 10) knew of external and internal support structures and processes that can be offered to police officers if they were affected by mental health calls. The participants were able to name a substantial amount of internal and external programmes which were available to them. Five out of the ten officers had used one of the structures and processes available to them and each of them felt they were helpful and some spoke of how they found it easier to talk about the situation which affected them. The other four police officers did not feel they needed to use it as they felt they have ‘coped’ with what they have seen when attending mental health calls, but they appreciated and thought it was beneficial to have them in case they needed to use them. The officers that had not used the services or processes were more prone to see changes than the officers who had used them. It was

emphasised that they felt the police service was ineffective with internal mental health awareness and they need to make these structures: more presentable, more co-ordinated and have less overlap surrounding the internal and external support offered. Some gave examples to how they need to offer services without too many questions being asked and they need to be extended such as counselling. Some officers said how they sessions were limited at six and if this doesn't help the person they can go on the NHS Provisions which has a waiting list. This led to the person leaving the police service due to the trauma not being helped. Another idea was that there should be the introduction of a psychiatrist in every police station that should be on-call for police officers if they need support.

There are issues around the study regarding generalisability/reliability/validity of the findings as the number of participants is low and only six participants belonged to one police service with the others all represented to different police services. It was noted on the complications of getting participants and how social media was used to be the most effective way and this has been documented in other studies (Andrews, 2012; Adair, 2015). Even when the participants were happy with the interview the time constraints on their job made it hard for a suitable time and day to conduct the interview. The themes offered in this study are representable and supported from the data itself using thematic analysis (Braun and Clarke, 2006). The use of thematic analysis allowed the views of each individual participant to be acknowledged and allowed for the discovery of themes and sub themes from all ten interviews. NVivo can have drawbacks which have been stated by Ishak and Bakar (2012). 'NVivo is just another set of tools that will assist a researcher in undertaking an analysis of qualitative data. However, regardless of the type of software being used, the researcher has to dutifully make sense of all the data him or herself, without damaging the context of the phenomenon being studied. Inevitably, the software cannot replace the wisdom that the researcher brings into the research because at the back of every researcher's mind lies his or

her life history that will influence the way he or she sees and interpret the world' (Ishak and Bakar, 2012, P102). This led to the reading of transcriptions repetitively also known as the 'bottom up approach' (Braun and Clarke, 2006). Overall, this study can act as a basis for further studies. Research should be continued further into what training is provided for police officers for mental health on a larger scale. Furthermore, showing police officers views on attending mental health calls would be beneficial or a larger scale to see how police officers feel from different services in the service and understanding their views further to why this is.

The findings of the study were expected due to the academic literature proving there is a problem, but nothing has been done to help police officers and, the constant monitoring of the situation on social media and newspapers showing the condition has got worse over recent years. The findings from the study links directly to other literature in mental health and policing such as: police officers not seeing mental health as real crime (Bittner 1967; Dunn and Fahy, 1987), accepting mental health is a part of their job (Corlett, 2013; Pettitt et al., 2013) and feeling they 'criminalise the mentally ill' (Borzecki and Worminth, 1985). Assessing the research question, it can be analysed that police officers want to receive more training in mental health and are not happy with the current mental health training in place. When asked about what training they would implement, if they could for mental health, nine out of the ten officers were very passionate about the changes they would make. For all these officers, they spent the most time answering this question out of all the questions on the interview schedule and did not need prompting around duration of the training and how long it should be for. It was unusual that one officer did not offer any training suggestions due to the many priorities they felt faced the police service, but scrutinised the current training calling it 'very bland' and 'poor'. Furthermore, when asked around support structures and processes if they are affected by what they see on mental health calls, one police officer was not aware of any. This can be a cause for concern if this is on a bigger scale as, all police

officers should be aware of at least one support structure or process they can contact if they feel they need to. Overall, it can be argued that police officers do want more sufficient training in mental health

Conclusion

This study has addressed the need for more policing research on the mental health training police officers receive and their views on supporting individuals who are suffering from mental health issues (McLean and Marshall, 2010). Although the study had a low volume of participants the results reiterates most of the same ideas from literature that is already available for mental health and policing. This can suggest that the same problems are occurring for the police service when they are attending mental health calls and not a lot has been changed to help them.

The findings from the study in line with literature such as: police officers do not see mental health as real crime and see it as time consuming to attend these calls (Bittner, 1967; Dunn and Fahy, 1987). Police officers explained the training they receive for mental health was very basic and poor and so was their online training. Only one police officer felt that his training he received was 'immensely good', but this was because he had just joined a new police service. This made them feel out of depth when attending mental health calls (Cummings and Jones, 2010) and some felt they were failing individuals who were suffering from a mental health problem as they could not help them enough (Fry et al., 2002; Cummins, 2007). Most of the police officers expressed in detail what they would add to the mental health training program and how external training needs to be more promoted as it can be a very useful tool for police officers to have. One of the main frustrations for the police service was working with outside services due to the lack of resources they offered, and it was the consensus that this needs to change. However, they have accepted that it is a part of their job which in line with other recent literature (Corlett, 2013; Pettitt et al., 2013) and that there has been a more positive reaction to them turning up to the calls. Some felt that they still 'criminalise the mentally ill' (Borzecki and Worminth, 1985). To conclude, it can be

argued that mental health training is still needed for police officers in England and Wales due to the findings of this report (Edmundson and Cummings, 2014; Thomas and Watson, 2017). However, this may be a difficult task as it has already been shown that it is hard to distinguish what models of training are beneficial for police officer's (Parker et al, 2018) but it is certain that changes need to be made. The thesis summarizes that, mental health training is still needed for police officers in England and Wales

Recommendations

The recommendations from the findings consist of: more effective mental health training for police officers, better organisational structural skills and better working relationships between agencies which have been mentioned before in other studies (Cummins, 2007).

(1) Police officers need more effective mental health training. Training should include regular yearly training which consists of what police officers felt they needed to learn more about, to have a better understanding of mental health such as: updates on powers and legislation, defensive skills, three-day mental health sessions each year, training from communication and behavioural specialists etc.

(2) Organisational structural skills need to be improved to make police officers more engaged with training as most described training as boring and a pointless day. Training should be provided by someone who is passionate and has a good understanding of mental health illnesses. This would change the view of how training is seen and provide police officers with a better understanding of mental health issues.

(3) Police services need to be improved so police officers feel that they are being listened to by their organization. The introduction of ratings sheets for training sessions to identify what could be improved and provide feedback would be beneficial.

(4) The College of Policing must improve NCALT training they use for e-learning of police officers as it has been called not well-structured or well- remembered, bland and more of a compliance tool than an educational tool.

(5) There is a need for better working relationships between agencies as the information provided on calls help police officers a lot. This could be accomplished with the changing of opening times or staff working overnight to help relationships being

stronger and working together to, help individuals that are suffering from a mental health problem. Information would be produced quicker and there would be less tension because of this and would help in the effectiveness of the support giving to the people who are suffering from a mental health illness.

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Appendices (1-4)

Appendix 1: Interview Schedule

Interview Schedule

The aim of the interviews is to collect data from Police Officers about the mental health training you receive and is available for your job and how you feel this affects you during your job when attending mental health calls. This will provide us with detailed information of views in this area which affects their job and to develop further studies and recommendations if possible. It is very important that you do not name co-workers so we can maintain anonymity. If you do mention co-workers or clients you will be asked to stop and any details you have mentioned will not be used. Due to time constraints we may have to move on from certain subjects to get through all the questions.

Interview questions (prompts are provided under each question).

1. How long have you been serving in the police force? What is your rank? Age? What is your sex?

2. When attending a mental health call, what emotions do you feel?
A) What emotions did you feel when you first attended calls? Have they changed now?
B) Can you provide specific examples?
C) Are there emotions that colleagues experience that you do not? Can you give some examples? Why do you think they experience different emotions?

3. What type of experiences have you had when attending a mental health call?
A) How have people reacted to your presence?
B) What impact do you feel this has on your job?

4. What aspects of the training you have received on mental health help you when attending calls?
A) How do you feel this training has helped you when attending a mental health call? Examples?
B) Are you aware of any online training? Do you feel you have utilized it to help you with your job role?
C) Are there any aspects you feel that don't benefit you? Why? Can you provide specific examples?

5. What training have you received in relation to responding to mental health calls?

A) How do you feel about the current training programme you receive for mental health?
B) How long is the training you receive? is this yearly? Are there optional classes?
C) Do you feel the training helps when attending mental health calls?
D) Is there anything you would change to the training programme?

6. Are there support structures and processes that can be offered to police officers if they are affected by mental health calls?
A) Have you used these structures/ processes?
B) Do you feel you have needed to but haven't? if so, why didn't you?
C) Do you feel that the support structures and processes available are beneficial?
D) Would you like to see any changes in these structures? If so what and why?

7. Is there anything we haven't covered or that you would like to tell us before we finish?

Thank the participants for their time, say you will email them a debriefing sheet and remind them of research team contact details for any queries

Appendix 2: Ethics Submission

For Research Office Use
Checklist No:
Date Received:

PROPORTIONATE ETHICAL REVIEW

ETHICS REVIEW CHECKLIST

*Your application **must** comprise the following documents (please tick the boxes below to indicate that they are attached):*

Ethics Review Checklist	X
Consent Form(s)	X
Participant Information Sheet(s)	X
Risk Assessment Form	X

Copies of any documents to be used in the study:

Questionnaire	
Introductory letter(s)	
Data Collection Instruments	
Interview Questions	X
Focus Group Guidelines	

Other (please give details)

Canterbury Christ Church University

For Research Office Use
Checklist No:
Date Received:

PROPORTIONATE ETHICAL REVIEW

ETHICS REVIEW CHECKLIST

Sections A and B of this checklist must be completed for every research or knowledge transfer project that involves human or animal[1] participants. These sections serve as a toolkit that will identify whether a full application for ethics approval needs to be submitted.

If the toolkit shows that there is **no need for a full ethical review**, Sections D, E and F should be completed and the checklist emailed to red.resgov@canterbury.ac.uk as described in Section C.

If the toolkit shows that **a full application is required**, this checklist should be set aside and an ***Application for Faculty Research Ethics Committee Approval Form*** - or an appropriate external application form - should be completed and submitted. **There is no need to complete both documents.**

Before completing this checklist, please refer to *Ethics Policy for Research Involving Human Participants* and the *Code of Practice for the Use of Sentient Animals in Research and Teaching* on the University Research website.

The principal researcher/project leader (or, where the principal researcher/project leader is a student, their supervisor) is responsible for exercising appropriate professional judgement in this review.

N.B. This checklist must be completed – and any resulting follow-up action taken - before potential participants are approached to take part in any study.

Type of Project - please mark (x) as appropriate			
Research	X	Knowledge Exchange	

Section A: Applicant Details

A1. Name of applicant:	Danny Holloway
A2. Status (please underline):	Postgraduate Student / Staff Member
A3. Email address:	Dh359@canterbury.ac.uk
A4. Contact address:	5 Clement Close Canterbury, Kent CT1 1HW
A5. Telephone number	07835052560

1 Sentient animals, generally all vertebrates and certain invertebrates such as cephalopods and crustaceans

Section B: Ethics Checklist

Please answer each question by marking (X) in the appropriate box:

	Question	Yes	No
1.	Does the study involve participants who are particularly vulnerable or unable to give informed consent (e.g. children, people with learning disabilities), or in unequal relationships (e.g. people in prison, your own staff or students)?		X
2.	Will the study require the co-operation of a gatekeeper for initial access to any vulnerable groups or individuals to be recruited (e.g. students at school, members of self-help groups, residents of nursing home)?		X
3.	Will it be necessary for participants to take part in the study without usual informed consent procedures having been implemented in advance (e.g. covert observation, certain ethnographic studies)?		X
4.	Will the study use deliberate deception (this does ***not*** include randomly assigning participants to groups in an experimental design)?		X
5.	Will the study involve discussion of, or collection of information on, topics of a sensitive nature (e.g. sexual activity, drug use) personal to the participants?		X
6.	Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to human or animal participants?		X
7.	Does the study involve invasive or intrusive procedures such as blood taking or muscle biopsy from human or animal participants?		X
8.	Is physiological stress, pain, or more than mild discomfort to humans or animals likely to result from the study?		X
9.	Could the study induce psychological stress or anxiety or cause harm or negative consequences in humans (including the researcher) or animals beyond the risks encountered in normal life?		X
10.	Will the study involve **interaction** with animals? (If you are simply observing them - e.g. in a zoo or in their natural habitat - without having any contact at all, you can answer "No")		X
11.	Will the study involve prolonged or repetitive testing?		X
12.	Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?		X
13.	Is the study a survey that involves University-wide recruitment of students from Canterbury Christ Church University?		X
14.	Will the study involve recruitment of adult participants (aged 16 and over) who are unable to make decisions for themselves, i.e. lack capacity, and come under the jurisdiction of the Mental Capacity Act (2005)?		X
15.	Will the study involve recruitment of participants (**excluding staff**) through the **NHS**?		X

Now please assess outcomes and actions by referring to Section C ➲

Section C: How to Proceed

C1. If you have answered '**NO**' to ***all*** the questions in Section B, you should complete Sections D–F as appropriate and email the completed checklist to red.resgov@canterbury.ac.uk. **That is all you need to do**. **Once your application is assessed and if it is given approval you will receive a letter confirming compliance with University Research Governance procedures.**

[*Master's students should retain copies of the form and letter; the letter should be bound into their research report or dissertation. Work that is submitted without this document will be returned un-assessed.*]

C2. If you have answered **'YES'** to ***any*** of the questions in Section B, you will need to describe more fully how you plan to deal with the ethical issues raised by your project. This does not mean that you cannot do the study, only that your proposal will need to be approved by a Research Ethics Committee. **Depending upon which questions you answered 'YES' to, you should proceed as follows**

(a) If you answered '**YES**' to any of ***questions 1 – 12 ONLY*** (i.e. not questions 13,14 or 15), DO NOT complete this form, you will have to submit an application to your Faculty Research Ethics Committee (FREC) using your Faculty's version of the ***Application for Faculty Research Ethics Committee Approval Form***. This should be submitted as directed on the form. The *Application for Faculty Research Ethics Committee Approval Form* can be obtained from the Research Ethics pages of the Research and Enterprise Development Centre on the University web site.

(b) If you answered '**YES**' to ***question 13*** you have two options:

(i) If you answered '**YES**' to ***question 13 ONLY*** you must send copies of this checklist to the Student Survey Unit. Subject to their approval you may then proceed as at C1 above.

(ii) If you answered '**YES**' to ***question 13 PLUS any other of questions 1 – 12***, you must proceed as at C2(b)(i) above and then submit an application to your Faculty Research Ethics Committee (FREC) as at C2(a).

(c) If you answered '**YES**' to ***question 14*** you do not need to submit an application to your Faculty Research Ethics Committee. ***INSTEAD***, you **must** submit an application to the appropriate external NHS or Social Care Research Ethics Committee [see C2(d) below].

(d) If you answered '**YES**' to ***question 15*** you do not need to submit an application to your Faculty Research Ethics Committee. ***INSTEAD***, you must submit an application to the appropriate external NHS or Social Care Research Ethics Committee (REC), *after* your proposal has received a satisfactory Peer Review (see *Research Governance Handbook*). Applications to an NHS or Social Care REC must be signed by the appropriate Faculty Director of Research or other authorised Faculty signatory before they are submitted.

IMPORTANT

Please note that it is your responsibility in the conduct of your study to follow the policies and procedures set out in the University's Research Ethics website, and any relevant academic or professional guidelines. This includes providing appropriate information sheets and consent forms, and ensuring confidentiality in the storage and use of data. Any significant change in the question, design or conduct over the course of the study should

be notified to the **Faculty and/or other Research Ethics Committee** that received your original proposal. Depending on the nature of the changes, a new application for ethics approval may be required.

Section D: Project Details

D1. Project title:	Do police officers receive sufficient training in mental health?
D2. Start date of fieldwork	May 2018
D3. End date of fieldwork	September 2018
D4. Lay summary (max 300 words *which **must** include a brief description of the methodology to be used for gathering your data*)	Literature that is available in the United Kingdom shows that police officers are becoming the forefront of 'care in the community' however, they are not receiving appropriate training to assist when attending a mental health call. Furthermore, there is little known about UK police officers' views on working with people suffering from mental health problems. My research will look at collecting data to assess the question of 'Do police officers receive sufficient training in mental health? Interviews will be conducted to collect the data. I will look at interviewing students on the policing programme at Canterbury Christ Church University. I will recruit the participants by attending policing lecture weekends' and talking to the student to promote my study and by blackboard. I will aim to interview around 15- 20 students to understand their views by asking them semi structured interview questions around their mental health training that is available for their job. Questions will consider demographics such as age, rank and length of service in the police force. This will be to look for any correlations from these demographics if any appear after the transcription of the interviews. It will be taken into consideration that participants may want to be interviewed either: in person, by telephone or skype. For these different types of interviews that could be possibly conducted a confidential space will be used to ensure confidentially and validity of the participants' in the research.

Section E1: For Students Only

E1. Module name and number or course and Department:	PRHMS [PLG] RES
E2. Name of Supervisor or module Leader	**Supervisors:** Kristina Massey Dr Steve Tong **Module Leader:** Dr Daniel Donoghue
E3. Email address of Supervisor or Module leader	**Supervisors:** Kristina.massey@canterbury.ac.uk Steve.tong@canterbury.ac.uk **Module Leader:**

	Dan.donoghue@canterbury.ac.uk
E4. Contact address:	N Holmes Rd, Canterbury, Kent CT1 1QU

Section E2: For Supervisors

Please tick the appropriate boxes. The study should not begin until all boxes are ticked:

The student has read the relevant documentation relating to the University's Research Governance, available on the University web pages at: https://cccu.canterbury.ac.uk/research-and-enterprise-development-centre/research-governance-and-ethics/research-governance-and-ethics.aspx	☐
The topic merits further investigation	☐
The student has the skills to carry out the study	☐
The participant information sheet or leaflet is appropriate	☐
The procedures for recruitment and obtaining informed consent are appropriate	☐
If a Disclosure & Barring Service (DBS) check is required, this has been carried out	☐

Comments from supervisor:

Section F: Declaration

- I certify that the information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
- I certify that a risk assessment for this study has been carried out in compliance with the University's Health and Safety policy.
- I certify that any required Disclosure & Barring Service (DBS) check has been carried out.
- I undertake to carry out this project under the terms specified in the Canterbury Christ Church
- University Research Governance Handbook.
- I undertake to inform the relevant Faculty Research Ethics Committee of any significant change in the question, design or conduct of the study over the course of the study. I understand that such changes may require a new application for ethics approval.
- I undertake to inform the RKE Co-ordinator at red.resgov@canterbury.ac.uk in the Research and Enterprise Development Centre when the proposed study has been completed.
- I am aware of my responsibility to comply with the requirements of the law and appropriate University guidelines relating to the security and confidentiality of participant or other personal data.
- I understand that project records/data may be subject to inspection for audit purposes if required in future and that project records should be kept securely for five years or other specified period.
- I understand that the personal data about me contained in this application will be held by the Research and Enterprise Development Centre and that this will be managed according to the principles established in the Data Protection Act.

As the Principal Investigator for this study, I confirm that this application has been shared with all other members of the study team	(please tick) X

Principal Investigator	Supervisor or module leader (as appropriate)
Name: Danny Holloway Date: 17/04/2018	Name: Date:

Section G: Submission

This form should be sent as an attachment to a covering email, to red.resgov@canterbury.ac.uk

Appendix 3: Ethics Approval

27 April 2018 Ref: 17/SAS/59C

Mr Danny Holloway
c/o School of Law Criminal Justice and Computing
Faculty of Social & Applied Sciences

Dear Danny,

Confirmation of ethics compliance for your study - *Do police officers receive sufficient training in mental health?*

I have received your Ethics Review Checklist and appropriate supporting documentation for proportionate review of the above project. Your application complies fully with the requirements for proportionate ethical review, as set out in this University's Research Ethics and Governance Procedures.

In confirming compliance for your study, I must remind you that it is your responsibility to follow, as appropriate, the policies and procedures set out in the *Research Governance Framework* (http://www.canterbury.ac.uk/research-and-consultancy/governance-and-ethics/governance-and-ethics.aspx) and any relevant academic or professional guidelines. This includes providing, if appropriate, information sheets and consent forms, and ensuring confidentiality in the storage and use of data.

Any significant change in the question, design or conduct of the study over its course should be notified via email to red.resgov@canterbury.ac.uk and may require a new application for ethics approval.

It is a condition of compliance that you **must** inform me once your research has completed.

Wishing you every success with your research.

Yours sincerely,

Tracy

Tracy Crine
Contracts & Compliance Manager
Email: red.resgov@canterbury.ac.uk

CC Ms Kristina Massey
Dr Steve Tong
Dr Daniel Donoghue

Research & Enterprise Integrity & Development Office

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Professor Rama Thirunamachandran, Vice Chancellor and Principal

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Appendix 4: Consent Form

CONSENT FORM

Title of Project: Do police officers receive sufficient training in mental health?

Name of Researcher: Danny Holloway

Contact details:

Address:	N Holmes Rd Canterbury, Kent CT1 1QU
Tel:	07835052560
Email:	Dh359@canterbury.ac.uk

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
3. I understand that any personal information that I provide to the researchers will be kept strictly confidential ☐
4. I agree to be audio recorded for the study ☐
5. I agree to take part in the above study ☐

____________________ Name of Participant	____________ Date	________________ Signature
____________________ Name of Person taking consent (if different from researcher)	____________ Date	________________ Signature
Danny Holloway Researcher	17/06/2018 Date	DHolloway Signature

Copies: 1 for participant
1 for researcher

Canterbury Christ Church University

DO POLICE OFFICERS RECEIVE SUFFICIENT TRAINING IN MENTAL HEALTH?

PARTICIPANT INFORMATION SHEET

A research study is being conducted at Canterbury Christ Church University (CCCU) by Danny Holloway from the School of Social and Applied Sciences.

Background

Since the 21st Century mental health overtime has seen to become an increasing police matter for the police force throughout England and Wales. It has been suggested that police officers are not receiving enough training to deal with the increasing calls directed to mental health in society. This research is aimed at speaking to police officers about their experiences and their training they receive on mental health.

What will you be required to do?

Participants in this study will be required to answer questions by interviews on their training in mental health they receive.

To participate in this research you must:

- Be a serving police officer.

Procedures

Participants in this study will be required to be interviewed between 45 – 60 minutes on their views on mental health training they receive as a police officer. The interview will be recorded and transcribed for analysis.

Feedback

Once the analysis is complete a summary report and/or a copy of the dissertation (this will be made available to participants) will be finalised.

Confidentiality

All data and personal information will be stored securely within CCCU premises in accordance with the Data Protection Act 1998 and the University's own data protection requirements. Data can by only accessed by the researcher Danny Holloway, Supervisors Kristina Massey and Dr Steve Tong and the possibility of an external examiner. After completion of the study, all data will be made anonymous (i.e. all personal information associated with the data will be removed) and the data will be held on to for 5 years. It is important to remember that anything disclosed that is illegal will be reported in accordance to the College of Policing Codes of Ethics 2014.

Risks that have been identified with the study are confidentiality and anonymity. These will be discussed at the start of each interview with the participant. On completion of study all data will be made anonymous (personal information will be removed) and participants will be able to choose an alias in which they will be referred to throughout the interview. If

phone calls are used they will be conducted in a controlled environment where only the researcher is present to ensure confidentiality of the information provided.

Dissemination of results

The results will be used to provide statistics in my dissertation and will be used to also provide a summary report for participants if they would like to receive one.

Deciding whether to participate

If you have any questions or concerns about the nature, procedures or requirements for participation do not hesitate to contact me. Should you decide to participate, you will be free to withdraw at any time without having to give a reason.

Any questions?

Please contact either:

Danny Holloway from the School of Social and Applied Sciences via email
dh359@canterbury.ac.uk

Kristina Massey from the School of Law, Criminal Justice and Computing via email
Kristina.Massey@canterbury.ac.uk

Dr Steve Tong from the School of Law, Criminal Justice and Computing via email
steve.tong@canterbury.ac.uk.