PSYCHIATRIC REFERRALS FROM THE POLICE : AN EXAMINATION OF POLICE OFFICERS' ACTION AND INTERACTION WITH PSYCHIATRISTS.

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Abstract

There are two main foci in this research. The first has to do with police officers' management of psychiatric referrals, using their powers under Section 136 of the Mental Health Act, the second with interprofessional relations between the police and psychiatrists. A Section 136 case is defined so as to include all referrals where a mental health disposal is initiated by the police as opposed to a court or other mental health professional.

The research is an attempt to describe police officers involvement with psychiatric referrals and the nature of and reasons behind the decisions they make, and to understand the nature of professional relationships that exist between police officers and psychiatrists in applying this part of the Mental Health Act. The concepts used, and theoretical underpinnings of the research are in the main derived from the sociology of 'mental illness'. Use has been made of the theory of professional dominance to analyse police action and interaction with psychiatrists.

Both quantitative and qualitative methods of data collection and analysis have been used. Primacy has not been given to one or other approach, rather an

attempt has been made to integrate both, so as to present as full a picture as possible of the issues under investigation. Data was primarily collected by means of interviews with police officers from 11 different police stations in the North East Metropolitan Police area. This was supplemented by the use of participant observation at one police station, interviews with psychiatrists at two hospitals and analysis of police documents and administrative records.

The study has been divided into three sections:- preparing for and carrying out the research (Chapters 1-4); the analysis and presentation of findings (Chapters 5-8); discussion and implications of the results and re-examining the theory (Chapter 9-10).

It was rare for officers to initiate referrals themselves, it was mainly as a response to others that they became involved. Officers were generally unaware that they were responding to a mental health emergency prior to arriving at an incident, and decisions to apprehend were made for policing rather than psychiatric reasons. Officers did not always use Section 136 as an authority for arrest where a psychiatric disposal was subsequently

sought. A combination of physical restraint and verbal strategies were used to manage referrals. Officers tended not to treat these differently to other suspects, whilst on the streets, but treated them less punitively than other detainees once at the station. It was found that there was a tendency to exclude other forms of deviancy in identifying mental disorder. Most referrals could have been charged with a criminal offence and officers' reasons for not preferring charges were examined, of which external considerations, (such as the policy of the courts) were found to be important.

Police and psychiatrists generally shared the same perceptions about their client group in terms of the latter's appropriateness to be dealt with by the psychiatric services. With the exception of police ability to diagnose mental disorder, there was agreement about the nature of officer's role in relation to Section 136. Interprofessional contact and perceptions of one another were characterised by distance and indifference. At the hospital, psychiatrists assumed a superordinate role over the police officers. However, police officers exercised considerable autonomy over decision making at the police station which acted to threaten the psychiatrists gatekeeping powers.

Acknowledgements

Many people have helped me in carrying out this research. I would like to thank the subjects of this study, especially the police for their help and co-operation. Thanks are also due to MIND (National Association of Mental Health) who allowed me unlimited access to data and considerable time during my employment with them to concentrate on my own research efforts. In respect of data collection, my colleague at MIND Alison Faulkner was extremely helpful in carrying out interviews in Study B. I would also like to formerly acknowledge the role of Elaine Rassaby in the collection of data in Study A.

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INTRODUCTION

Twenty three years ago in an article entitled 'A Sociology of Psychiatry' Leonard Shatzman and Anselm Strauss advocated the need to extend sociological enquiry beyond the boundaries of the practices of the psychiatric profession and its institutions. Only by studying the public processes relevant to emotional deviance could a fully comprehensive analysis and conceptual sociological framework be established regarding the management and understanding of 'mental illness'. In identifying those agencies which have importance for the understanding of the management of emotional deviance in the public sphere Shatzman and Strauss state that:

> "On the periphery of psychiatry "proper" lies a relatively broad network of quasi-psychiatric persons, often serving as a filtering system. We refer to police, the clergy, teachers, general practitioners, personnel officers, vocational guidance personnel, and so on-people who regularly, intermittently, casually, or formally accept or assign themselves responsibility for ferreting out illness, for treating it, for referring it on to others, or for various combinations of these actions. Questions here have to do with how these people-within or outside of agencies-interpret their own licenses to act. What characteristic judgements do they make about behaviour? What are their conceptual thresholds for recognising mental disturbance? How competent do they think they are in these matters relative to their evaluation of the competence of professional persons or facilities within

> psychiatry? It would appear possible and most fruitful to sort out patterns of comprehension and action among the dozens of occupational and professional classes along the borders of psychiatry (p135 1966).

Since that article was written, the psychiatric profession, its practices and the institutions which it controls have continued to be subjects with which sociologists are concerned (see for example Bean, 1980; Donnelly, 1983; and Scull, 1979). To a lesser extent other mental health occupations, social workers and psychologists have also been the subject of sociological enquiry (Goldie, 1976; Pilgrim, 1987; Ramon, 1985). Yet, in Britain at least, this 'public process' perspective on mental disorder has failed to materialise as a major area of sociological interest or research.

Within this neglected area of study, an important occupational group which has been overlooked is the police. Despite assuming a central position in the maintenance of social order, the management of deviance and their 'social work' role, police handling of mental disorder has drawn little sociological interest. This thesis is concerned with the way in which the police manage mentally disordered people and the contact with

psychiatrists entailed in this management.

In general terms, (more specific comments on the Section will be given later) Section 136 of the Mental Health Act 1983, enpowers the police to remove a person they consider to be mentally disordered and in need of immediate care and control from a public place to a place of safety. Under this legislation, a person may be detained for up to 72 hours for the purposes of being examined by a registered medical practitioner and interviewed by an Approved Social Worker and to allow suitable arrangements to be made for his or her treatment or care. In comparison to the main thrust of mental health legislation, Section 136 is unusual in that it provides for detention from public as opposed to private buildings. Also the section gives a non-mental health professional a legal mandate to initiate compulsory detention on the basis of making a judgement about a person's mental state.

Support for the police's role in dealing with mentally disordered people has been traditionally accepted as appropriate by successive governments and establishment bodies. The Butler Committee

reporting to Parliament in 1975 stated, "we are satisfied that the Section 136 powers of removal to a place of safety are both necessary and generally beneficial" (p133 HMSO, 1975a). Unease expressed by the National Council for Civil Liberties (NCCL) over possible misuse by the police of their powers failed to alter the committee's view. (When the NCCL were asked for evidence of abuses they were unable to produce specific examples.)

Such official endorsement has however failed to prevent increasing challenges being made to the use of police mental health powers. In recent years, considerable disquiet has been expressed from different sources, which at times has been couched in fiercely polemical terms. The black health workers and patients group have referred to the section as the 'mental health sus law'. They claimed that black people were more likely to be detained under the provision than white people (Mercer, 1984), and that the police use it where they would otherwise have no power of arrest. Similarly, feminist groups have, by comparing the proportion of women detained on criminal charges with those admitted under Section 136, claimed the power is one which is used inappropriately and

disproportionately against women (Women and Mental Health, 1984). In 1977 a policy document produced by the British Association of Social Workers considered it a matter of principle that those like the police who are without relevant training and qualifications should not be regarded as competent to diagnose the presence of mental disorder. Support for this position has come from sections of the psychiatric profession. A recent article for example stated that;

> "the prospect of having one's sanity subject to judgement by the police is likely to leave others feeling uneasy ....In no other part of the Mental Health Act, does the responsibility for detaining a person against their wishes fall on an individual without specialist psychiatric training" (p6, Fahy and Bermingham, 1986)".

Perhaps of more significance, was the adoption by the civil liberties campaign led by MIND and the National Council for Civil Liberties of Section 136 as a cause celebre for reform of the 1959 Mental Health Act (Rose, 1986). The focus of attack was that police powers could be used to apprehend and incarcerate a person on the basis of undesirable behaviour which did not constitute a criminal act.

Three factors influenced the decision to undertake

this research. The first was an interest with the public debate about Section 136 outlined above. In particular, how this relatively infrequently used provision had provoked so much vocal antipathy in the absence of any substantial information or research. A second influence was a personal experience as a practising nurse in the 1970's, and especially the memory of ambivalent feelings about the police having the right to 'interfere' in what, according to my professional socialisation, was essentially a health matter. Thirdly, was the influence of and interest in knowledge attained during higher education relating to psychiatry and mental health. It seemed that nowhere else was the social control nature of psychiatry and mental disorder more immediately apparent than in a compulsory power operated by two such powerful occupational groups, the police and psychiatrists.

Initially, it was intended to examine wider issues of psychiatry's involvement in dealing with referrals. However, it was decided on reflection to focus the research on the more manageable issue of police action in relation to Section 136. The thesis is thus, about finding out in what circumstances the police invoke their powers under

this provision, the way in which they deal with and make decisions about the people they detain, and the nature of professional relations between the police and psychiatrists in dealing with this shared client group.

In all, about one hundered and sixty officers have been interviewed and I have attempted to provide on the basis of these accounts, detailed knowledge from which a picture about police practices and interprofessional processes can be built. Qualitative and quantitative research methods have been combined to produce a general picture of an area of everyday life of which relatively little is known. Part of this picture has been derived from quantitative survey data which aims to provide an overall picture of the social processes involved. Another part has used qualitative material to illustrate the micro-processes and interpretations behind events and officers' decisions, in individual cases and interactions with psychiatrists, which go to make up this larger picture. At the same time, the behaviour of officers has been considered against the background of mental health legislation and policy from which their power derives, and the professional position

of psychiatrists to whom the police must necessarily engage with in exercising their mandate. With regard to the latter, additional accounts from psychiatrists interviews have been used.

CHAPTER 1

POLICE POWERS AND MENTAL DISORDER.

Currently, the police have wide ranging discretion and a number of formal and informal means of dealing with mentally disordered people. In encountering a mentally disordered person, the police can take informal action, such as accompanying a person home or issuing a warning, or they can simply take no action at all. If the person has committed an offence (and almost any disruptive behaviour however minor can technically constitute a law infringement (Walker and McCabe 1978)) the police can utilise the criminal justice system by initiating criminal proceedings. Should a person be prosecuted, the courts can impose either a therapeutic sentence under mental health legislation[1] or a penal sentence. Alternatively the person may be remanded to hospital[2].

If a person is recognised as an absconding compulsory patient, the police can detain and return him or her to hospital under Section 18 of the Mental Health Act. Section 138 can be used to retake patients who escape from custody or while

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including a hospital order, Section 37, a restriction order Section 41, an interim hospital order Section 38, and commit to hospital with a view to a restriction order Section 44. Section 35 of the Mental Health Act allows remand to hospital for assessment and Section 36 for treatment.

being taken from one place to another (e.g from a police station to court). Section 135 permits the police to remove from private premises a neglected or ill-treated mentally disordered person on production of a warrant signed by a magistrate on evidence presented by an Approved Social Worker. In exercising such powers, the police are not responsible for initiating the person's apprehension but rather are responding to calls for assistance from other professionals.

Recent police powers of arrest relevant to those suspected of being mentally disordered are embodied under the Police and Criminal Evidence Act 1984. If a person fails to account for his or herself when challenged, and the constable believes that it is necessary to prevent harm to self or others, Part III of the Act allows that person to be lawfully arrested even if no obvious crime appears to have been committed (Cheshire, 1985). Though infrequently used, the police can also use common law to arrest mentally disordered people in instances where a person "seem disposed to do mischief to other persons or to himself" (p109, Hogett, 1979).

Although the police have a number of choices open to them to deal with mentally disordered people, the main statutory power authorising and formalising the arrest and detention of mentally disordered persons is set out under Section 136 of the Mental Health Act 1983. It is the way in which the police implement this particular legislation, as opposed to their wider powers described above, which will be the focus of this thesis.

Section 136 - the general requirements.

Section 136 of the Mental Health Act 1983 (it was also Section 136 under the 1959 Act) is set out under Part X of the Act, entitled Miscellaneous Provisions. The wording of the section is as follows.

(1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in need of immediate care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.

(2) A person removed to a place of safety under this section may be there detained for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an Approved Social Worker and of making any necessary arrangements for his treatment or care.

Briefly, this section is concerned with the following. First, it is a means of dealing with disruptive mentally disordered behaviour in public as opposed to private areas. It also permits the police to detain a person where no offence has been committed.[12]

Second, the term 'immediate' implies urgency. The Butler report cited advice given to police, social workers and hospitals that they should act as soon as possible when someone is detained under the provision (HMSO 1975a). It is doubtful therefore, whether the section would, for instance be being used appropriately where a person's condition or behaviour could await attention by a general practitioner or other mental health professional.

Third, it provides for the apprehension and detention of a person in order to obtain assessments by mental health professionals and to permit further decisions to be made about any necessary treatment or care. At one extreme this could involve the patient being discharged with no

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The Percy Commission recommended prior to the introduction of the 1959 Act that the police "should detain the patient only if his behaviour is such that he is liable to arrest under normal police powers" (para 4.12.). Parliament however rejected this proposal.

further psychiatric intervention or any other action being taken: at the other the person may be compulsorily admitted to hospital under another Section of the mental health act.

Fourth, detention of the person for up to 72 hours is allowed by the Section, although once assessments by the two mental health professionals have been completed and arrangements made, the person should not be detained further, even if this is within the 72 hour period (DHSS 1983). According to the Mental Health Act Commission (1985) the 72 hour period starts from the time of arrival at the first (if there are more than one) places of safety being used.

Fifth, a place of safety is defined under Section 135(6) to include residential accommodation provided by the social services department, a hospital, nursing home, a police station or "any other suitable place the occupier of which is willing temporarily to receive the patient". A variety of different places of safety are used in practice, which include District General Hospital Psychiatric Units, Casualty Departments and 24 hour psychiatric emergency clinics (Rassaby and Rogers,

1986). In the main however, a place of safety is usually either a police station (outside the London area) or a hospital (inside the London area).

The requirements of the three occupational groups.

In addition to the general specifications of Section 136 outlined above, there are a number of points which are specifically relevant to this research. In the main, these relate to the duties of the police and medical practitioner and to a lesser extent those of the Approved Social Worker.

The duties of the police officer.

The section requires the police to make a number of decisions and judgements in exercising their power. The first condition for the police to invoke Section 136 is that the person can only be removed from a 'place to which the public have access'. This appears to exclude the police from being able to detain a person in his or someone else's home or garden, or in other private premises. If a person is considered mentally disordered in these circumstances, the police are instructed to alert an Approved Social Worker or medical practitioner to attend who may take action under Part II of the

act (Metropolitan Police, 1983).

The second condition is that the police must judge whether a person is suffering from mental disorder. For this purpose mental disorder is defined as it appears under Section 1(2) of the Mental Health Act 1983 as; "mental illness, arrested or incomplete developement of mind, psychopathic disorder and any other disorder or disability of mind" (Metropolitan Police 1984). The police are required to make what Bean (1986) has referred to as a "low-level" diagnosis. Similarly, Rassaby and Rogers (1986) state that an exact diagnosis is not required. Rather, an officer has to decide whether or not a person exhibits behaviour suggestive of mental disorder, which implies a preliminary assessment that any layperson is capable of making.

The police cannot invoke the section on the basis of mental disorder alone. Rather a third condition is that there must be some judgement made that the person is in need of immediate care and control and that it is desirable to remove the person for the protection of themselves or other people. There are no formal guidelines as to how officers should interpret these conditions in practice. Like the recognition of mental disorder their decisions

appear to be based on individual discretion and perceptions.

Having removed someone from a public place, in order for the purposes of the provision to be fulfilled, the legislation implies further police responsibilities. The police must arrange for the necessary assessments to be made with the other professionals concerned. The exact responsibilities of the police officer in this regard are ambiguous. Legal opinion given to Westminster social services department in 1984[1] suggested that the police had a duty to notify an Approved Social Worker for every person they detained under Section 136. The Mental Health Act Commission (1985) on the other hand has stated that it is only necessary for the police "to start the ball rolling by contacting one of the two professionals involved". Whilst the police have rights to detain a person for the purposes of assessment, it appears that they have no legal grounds for ensuring that other mental health professionals carry out an assessment, or insisting that a person is accepted for admission or assessment by hospital authorities.

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[1] Cited in correspondence during 1985 between MIND and the Metropolitan Police.

The police must also detain and manage a person until the necessary arrangements have been made with one or both of the two mental health professionals. It has been argued that the power of removal is not exhausted until the person has been accepted by a person at the chosen place of safety (Gostin 1986). This implies that the police have overall responsibility for transportation and ensuring that a hospital receives a detained person, even if other personnel, such as ambulance staff, have been involved.

The statute is not explicit as to whether police have legal responsibilities, along with the other mental health professionals, for the making of "necessary arrangements" for treatment or care. This might include, returning a person home, arranging admission to hostels, or notifying relatives. They do however appear to have responsibility for transporting a person from one place to another if it is necessary to complete an assessment - for example from a casualty department to a psychiatric unit (Rassaby and Rogers, 1986). Technically, the police retain the option to charge a person if a criminal or other offence has been committed but according to a Home Office circular

to the police (HMSOb 1975) this is considered to be unnecessary.

In addition to these legal duties, police forces issue guidelines to their officers. These vary form area to area. Of relevance to this research are two sets of guidelines used by the Metropolitan Police. A code devised in the mid- 1970's by the DHSS for the Metropolitan Police and the four London Regional Health Authorities provided a general structure for the implementation of Section 136. Certain psychiatric hospitals were designated 'responsible' for Section 136 referrals. The code identitified additional 'screening' hospitals with a 24- hour accident and emergency or psychiatric department, to be used in instances where it was not possible to transport patients to the 'responsible' hospital because of distance.

The Metropolitan Police's Standing Orders (1984) provide more specific guidance to police officers. These stipulate that a 'place of safety' should, preferably be a hospital serving the district in which a person is found, and every effort made to remove a person from the police station to this hospital as soon as possible. This should be done

by a police officer "even though the approved social worker is willing to do so". They also instruct police officers to complete documentation (Form 434) which gives brief details of the preceding incident and acknowledges the police use of their powers. The completed form is to be handed to a medical officer who is also to be informed verbally by the escorting officer that the detained person has been apprehended under Section 136 of the Mental Health Act.

The duties of the social worker.

The specification of an Approved Social Worker to carry out a Section 136 assessment, is in line with the need for specialised training of social workers to carry out their functions under the 1983 Mental Health Act. Section 114 states that each local social services authority should appoint a sufficient number of Approved Social Workers to carry out the functions given to them by the Act, and that no one should be endorsed as an Approved Social Worker, without their competence in dealing with mental disorder being approved by the social services authority.

The Butler Committee (HMSO 1975a) specified the

duties of the Mental Welfare Officers (the predecessor of the Approved Social Worker) as, contacting the detained person's relatives and ascertaining a person's past psychiatric history. If admission to hospital is deemed necessary the social worker should indicate which hospital might be most suitable and consider whether other courses of action, other than admission, are appropriate. Such a judgement should, according to the Committee, be made on the basis of "knowing the range of resources available" and being in a position to "assess all the circumstances"(p131). With regard to the social work interview, there appear to be no specifications or guidelines as to how this should be conducted. The duty to 'interview in a suitable manner'[1] in making applications for compulsory admission or guardianship under Section 13 (2) of the Act does not appear to extend to interviews with people detained under a Section 136 order.

The duties of the psychiatrist.

In contrast to the role of the police and Approved Social Worker, there appears to be little

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This requires for example, the social worker to speak with the patient in person Olfsen,R. p46 1984).

available information or legal opinion pertaining to the duties and role of the psychiatrist under Section 136(2). The Butler report specified the role of the social worker but not that of the psychiatrist. The two main legal texts on mental health law mentioned previously (Gostin, 1986; Hoggett, 1984) also have nothing specifically to say about the role of the psychiatrist, or what the medical examination should entail. There is no obligation on the psychiatrist to admit any referral detained under Section 136. Nor are they or other medical practitioners obliged to provide an assessment as this is a matter for professional discretion.

Unlike most of the other compulsory civil procedures, the medical practitioner does not have to be approved under section 12(2) of the Mental Health Act "as having special experience in the diagnosis or treatment of mental disorder". This means that a general practitioner, casualty officer or indeed any other medical practitioner can be called upon to provide an examination. In practice however it is usually a psychiatrist or 'police

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inter-professional relationships are free of definitive guidelines or legal rules. In relation to the theory chosen for this research which is derived from the sociology of professions, (discussed in the next chapter), this implies that professional relationships are primarily defined at the level of individual actors, practices and structural constraints of the organisations within which they work.

Controversies surrounding Section 136

There are both general and more specific legal controversies surrounding the use of Section 136. Some of these overlap. Claims that the Section is used unfairly and disproportionately in relation to women and black people were mentioned in the introduction. There appear to be two types of criticism of police mental health powers. The first attacks the police's role in mental health altogether. This argument centres on the notion that the police lacking expertise and training in mental health matters should not have the power to detain mentally disordered people. The British Assocation of Social Workers, giving evidence to the 1976 DHSS Review of the Mental Health Act, wanted to phase out Section 136 altogether (Thomas,

1986). Yet, it has been pointed out that the police are the only occupational group in a position to deal effectively with mentally disordered individuals in public places. Bean (1986) for example has noted that only the police patrol on a 24 hour basis including areas "where few others would be prepared to go", and that they are invested with powers of arrest which other occupational groups do not have. The second type of criticism is more circumspect - an essentially reformist as opposed to an abolitionist position. It centres around the apparent discrepencies in the use of the Section in different areas of the country (see Table 1.1) (Gostin, 1975). MIND's evidence to the DHSS review advocated that the police should only be empowered to use Section 136 if the behaviour of a person was such that someone would be liable to arrest under other police powers.

A further matter which arises from this position concerns the appropriateness of the existing types of places of safety used to detain people. Home Office advice (HMSO, 1975b) to the police is that, wherever possible, hospitals are to be considered as places of safety in preference to police

stations. This advice is followed in the Metropolitan area but not it seems in other parts of the country, where the police station is the preferred option (Rogers and Rassaby, 1986). However, the use of a hospital as a place of safety has been criticised for its propensity towards the unnecessary admission of patients, whilst questions have been raised as to whether proper after care is provided by non-hospital based places of safety (Rassaby and Rogers, 1987).

The legal ambiguity of Section 136.

In addition to these more general controversies, Section 136 has many legal ambiguities. First, there is confusion over what constitues a "a place to which the public have access". The wording implies a wider definition than that given to a public place in other legislation (Gostin, 1986). It includes shops, public houses and footbal grounds, when open to the public. Whether communal property, such as stairways and balconies is included is less clear. It has for example, been claimed that communal areas are restricted to the landlord, tenants and their visitors and does not therefore constitute "a place to which the public have access" (Carson, 1982). However, it has also

been suggested by reference to legal cases in other areas, that communal property would be considered by the courts as a legitimate place of arrest (Hogett, 1984). Recently, Keown (1986) has implied an even wider definition than this. He has argued, that the phrase ought to be interpreted by reference to Common Law. That is a "place to which the public have access", is any area to which a member if the public can and does have access, whether they are invited by an occupier or are there with his permission, and whether or not access depends on a formality such as signing a visitors book. His interpretation suggests that the police might be able to make an arrest from a private dwelling.

Second, legal opinion is divided over whether it is permissible to use one or more places of safety to detain a person. One point of view is that because the statute is worded in the singular, then the detainee cannot be moved from the place of safety to which he was first taken. Another is that in legislation in general, the singular can be read as plural, unless otherwise stipulated, permitting more than one place of safety to be used[1]. Yet

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[1] Opinion given by MIND's Legal Officer 1986

another view provided by the Mental Health Act Commission (1985) says that "arrangements should be in the best interests of the patient" (i.e. that which is most expedient in obtaining an assessment).

Third, there appears from preliminary discussions with psychiatrists some question over when the 72 hour period starts running, and when it expires. So where the place of safety is designated as a psychiatric hospital, but the person is first detained at the police station for a few hours, what period should be subtracted from the total period ? Linked to this is a second point i.e. whether the 72 hours detention period begins from the time of arrest or from arrival at the place of safety. Despite widespread criticism that the 72 hour period allowed for detention is too long, an amendment to reduce the maximum detention period in the parliamentary debates on the Mental Health Amendment Bill (1982) was defeated. The British Medical Association considered 4 hours to be sufficient yet the National Council for Civil Liberties and MIND suggested 24 hours. Fourth, related to this is the purpose of detertion covered by the provision. It is commonly used in London as

a three day compulsory admission order (Rogers and Faulkner, 1987) yet the section clearly states that the purpose of the section is to provide an assessment - nowhere do the words admission appear. Nor is the purpose of the provision is for the administration of compulsory treatment. Patients detained under Section 136 have the same right to refuse treatment as any other informally detained patient under common law (Section 56(1) of the Mental Health Act) unless they fulfill the criteria for the administration of 'urgent treatment' (S62(1)). Questions have been raised however as to whether this legal safeguard is always recognised in practice by hospitals (Rogers and Faulkner, 1987).

Fifth, it is not clear what should happen if a person is seen by a medical practitioner and Approved Social Worker and no further action is deemed necessary. The police may or may not be acting legally if they continue to detain a person whilst seeking the services of other professionals, who may be more willing to admit the person to hospital than hitherto.

Six, another legal problem relates to the rights

of detained mentally disordered people at the police station. For example, how does a person know when s/he has been detained on a section 136 order? There is no mention of the need for police officers to inform a person that they have been arrested under the provision, or why they are being detained. It appears that some of the provisions of the Police and Criminal Evidence Act 1984 do not apply if the person has been arrested under Section 136, (e.g. the right to contact a solicitor) but do apply if s/he has first been arrested for an offence (HMSO 1985 Part X1). A related issue is the ambiguity surrounding the legal redress a person has against wrongful action/ apprehension by the police officer. Mental health professionals can claim protection from prosecution under Section 139 of the Act[1]. One legal opinion suggests that that the police have, in common with other mental health professionals, immunity from civil and criminal proceedings for any act they carry out in fulfilling their duties, unless, that is, an act was carried out in bad faith or without reasonable care (Thomas, 1986). However, doubt has also been cast on whether this extends to police officers

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[1] The section gives protection for acts done in pursuance of the Act.

who, for example, lure a person from a private place in order to make an arrest under Section 136 (Bean, 1986).

Seven, a further unresolved legal question is whether it is necessary to involve both a medical practitioner and Approved Social Worker. The provision clearly envisages a multidisciplinary assessment by two professionals, but it is open to question (Mental Health Act Commission, 1985) whether it is unlawful for only one of these persons to assess a person detained under a Section 136 order. Related to this is the legal position of the police. Should the police arrest a person under Section 136, but subsequently change their minds and decide to let the person go, are they nevertheless bound to arrange an assessment? There appear to be no legal guidelines on this matter.

Finally, there is the issue of what type of order should be made following the expiry of a Section 136 order. It is unclear whether Section 136 constitutes an emergency, and if so whether an emergency can be said to continue, or whether the emergency is at an end and thus whether it would be legitimate or not to use another emergency power

such as Section 4 of the Act to detain the patient further.

I suggest that there are are two main reasons for the lack of clarity surrounding this section leaving numerous legal loose ends, with the provision being open to differing interpretations. First, unlike Part II of the Mental Health Act which covers compulsory admissions to hospital, there is no statutory requirement for the police or others to complete documents, or formalised procedures laid down as to how the section should be implemented in practice. Additionally, Section 136 has not been the subject of legal rulings by the court. There has been only one case Carter V Commissioner of Police for the Metropolis (1975) and this did not deal with any substantive legal issue concerned with the definition of the section, but was an application for leave to sue the police for wrongful arrest[1].

The issues discussed above provide a legal and social background to the present research. A number of these points, including those relating to the

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Application for leave to bring an action against the Commissioner of police for false imprisonment under Section 141 of the 1959 Act was refused by the judge.

detainees rights are of marginal interest to the main focus of the thesis. Issues which are of more relevance concern the way the police handle mentally disordered people and the interprofessional relations with psychiatrists. These include: the appropriateness and legitimacy of the police having powers of arrest and detention under Section 136; the extent and nature of involvement of the three mental health professionals in providing assessments; the question of 'public place arrest'; and the use and length, of detention at the 'place of safety'.

Psychiatric referrals from the police defined

On the face of things, the Section, as it appears in the Mental Health Act together with the guidelines issued by the Metropolitan Police, provides a clear framework with which to carry out a study. However, the numerous ambiguities surrounding the use of the provision makes a precise legal definition difficult to operationalise. A study by Twigg (1982) for example, indicates that it is not always clear when Section 136 is being used. The Butler Committee also noted from the evidence they had collected

that the police were not always aware of using the Section (para 9.5. HMSO, 1975a).

In the early stages of this research it became apparent that some officers did not recognise their actions as falling within the jurisdication of the Mental Health Act. Some officers for example referred to 'a place of safety order' or 'deeming' or simply made no reference to any formal legal provision. It was not clear whether the latter instances concerned Section 136 or were simply informal police referrals. It was also suspected that officers might occasionally be using the official Form 434, which acknowledges the use of Section 136, even when a person had not been found in a public place or who had initially been arrested for an offence - but later referred to the psychiatric services.

In the light of this, it was considered important to adopt a working definition. Such a definition should incorporate the police use of Section 1361, even though there were no formal documents filled in by the police or by the receiving hospitals. It was also thought important to include the police had use of Form 434 even though the conditions of

arrest and detention may not have been fulfilled in a strict legal sense. This was because the police were treating such instances 'as if' they were Section 136 cases. Therefore in this thesis a wide definition has been adopted. It includes all referrals where a mental health disposal is initiated by the police, as opposed to a court or other mental health profession. Cases excluded from this definition are instances where the police merely assist other professionals in initiating formal and informal mental health procedures (e.g as with Sections 135 and 138 and compulsory admissions under Part II of the Act).

Official statistics and Section 136

The Department of Health and Social Services[1] (DHSS) collect statistics on the number of Section 136 admissions to hospital. These statistics show that the use of Section 136 has risen in the last two decades (848 in 1964, 1,571, in 1976, 1,885 in 1982, 1,956 in 1984) while the number of other compulsory admissions to hospital have fallen (See Table 1.1). This suggests a relatively increased role for the police in the use of their compulsory powers - especially in relation to other mental

[1] Now the Department of Health.

Table 1.1.

Civil compulsory admissions by legal status recorded for 1964-1985

(Calculated from DHSS Mental Health Statistics)

	All formal civil admissions	Under[1] Section 2	3	4	5	135	136	
1964	32,573	10,258	1,748	19,248	46	-	845	(2.6)=
1970	29,883	10,905	1,174	15,926	78	-	1,456	(4.9)
1971	27,447	9,367	978	15,379	92	-	1,369	(4.9)
1972	26,078	8,677	915	14,569	126	-	1,478	(5.6)
1973	24,447	8,012	806	13,683	151	-	1,545	(6.3)
1974	22,472	7,261	735	12,534	178	-	1,542	(6.9)
1975	21,594	7,007	736	11,829	203	8	1,596	(7.3)
1976	20,328	6,713	756	11,057	213	13	1,576	(7.7)
1977	18,912	6,694	793	9,539	244	7	1,497	(7.9)
1978	17,362	6,137	962	8,299	237	9	1,608	(9.3)
1979	16,720	5,847	1,125	7,758	289	10	1,601	(9.6)
1980	17,327	6,116	1,296	7,638	302	14	1,883	(10.9)
1981	17,211	6,008	1,615	7,252	317	19	1,907	(11.0)
1982	16,694	5,861	1,680	6,897	317	30	1,885	(11.3)
1983	15,492	6,000	1,717	5,616	256	31	1,853	(12.0)
1984	14,677	6,855	1,825	3,611	317	68	1,959	(13.3)
1985	15,783	7,758	2,033	3,436	267	136	1,832	(11.6)

[1] Section headings refer to the Mental Health Act 1983 or their equivalent under the 1959 Mental Health Act.
Figures in brackets refer to S136 admissions as a percentage of all formal civil admissions.

Table 1.2.

Section 136 Admissions by Regional Health Authority for 1984

(Calculated from DHSS Mental Health Statistics)

Regional Health Authority	Section 136 Admissions	Percentage Distribution
England	1,956	100.0
Northern	89	4.5
Yorkshire	6	0.3
Trent	22	1.2
East Anglia	19	1.0
North West Thames	476	24.3
North East Thames	569	29.1
South East Thames	369	18.9
South West Thames	345	17.6
Wessex	12	0.6
Oxford	1	0.0
South Western	10	0.5
West Midlands	10	0.5
Mersey	7	0.4
North Western	21	1.1

health professionals who over the same period of time have been using their compulsory detention powers less frequently.

The statistics show substantial regional variations (see Table 1.2), with the four Thames Regional Health Authorities accounting for the vast majority of Section 136 admissions throughout the country, (ninety percent of the 1,956 in 1984 whilst on Merseyside for example there were only 7 such admissions).

The validity of this official data has however been questioned both by the Butler Committee (HMSOa, 1975) and other researchers (George, 1972; Walker and McCabe, 1973). The problem appears to be that the DHSS statistics are a gross underestimate of the total number of times the police invoke their powers. The apparent regional variations are also misleading. It is said that the official figures are not an accurate indicator of the police use of Section 136 because they do not take account of those instances which do not result in admission (Rogers and Faulkner, 1987). These include cases where the police have used their powers under Section 136 but where admission does not follow

assessment; where assessment takes place in a police station and a person is admitted informally or under another section of the Mental Health Act; and where the police remove a person to the station but no assessment follows.

The Home Office does not systematically monitor the police use of this power. Attempts were made to introduce a system of monitoring during the 1982 Mental Health Amendment Bill but to no avail (Hansard, 18 Oct 1982 pp 90-100). Therefore, it seems likely that the discrepency between London and the provinces is in part at least, due to the increased reporting of the use of Section 136. Briefly, in London where hospitals are used as places of safety, Section 136 admissions are recorded on a form at the time when a person is officially admitted to hospital. This form is returned to the DHSS from which Section 136 and other admission figures are calculated. It is suspected that this procedure happens infrequently outside London because the police station is usually used as a place of safety. When this is so, then numbers of people arrested and detained are not collected or collated by the police nor returned to the DHSS or any other government

department. Thus, at the time of embarking on this research, there were no accurate national figures of the prevalance of the police use of Section 136.

Regional variations in practice

That official statistics on Section 136 are probably grossly inaccurate has often been overlooked by those engaged in debate and research on the issue. For example, on the basis of these official figures, Gostin (1975), argued that the Metropolitan police were overusing the section compared to police forces elsewhere, and Rollin (1965) and Kent (1975) that London attracts more disturbed people from all over the country than other regions.

Although, there is considerable uncertainty about the number of times police make referrals in each region, practices adopted locally do appear to differ greatly. This was indicated by, but not elaborated on, in a study by George (1972) which showed that in making referrals only eight police forces said that they used Section 136 as a method of 'first choice' in initiating psychiatric referrals, eight claimed they used it only

occasionally and sixteen that they never used it at all.

Evidence of differing regional practices is also evident from other sources. In Nottingham, the police call on a psychiatrist to attend the station to provide an assessment, with a social worker attending if compulsory admission is deemed necessary (Bean, 1980). A similar procedure exists in the West Midlands, where a police surgeon initially attends the police station (Twigg, 1982). The reverse of this occurs in Gloucestershire, where it is the Approved Social Worker who attends at the request of the police. Only if hospitalisation is considered are medical practitioners called upon[1]. In Liverpool, police adopt a procedure whereby officers send those that they view as mentally disordered straight to a casualty department via the ambulance services. For those where some ambiguity exists over court or hospital disposal, the police take them first to the station to be seen both by more senior officers and a police surgeon. Social workers appear to be involved in some but not all cases depending on the

[1] Information gained from enquiries made to Gloucestershire social services department.

opinion of the police surgeon[1].

Clearly there are large discrepencies in practice between London and elsewhere, although, there are also variations within London itself. Generally the place of safety used is a hospital in London and a police station outside. Why the Metropolitan Police should adopt such a different procedure to the rest of the country is not clear. It may be due in part to a historical legacy (Walker and McCabe, 1973)[2,3]. It has also been suggested that social workers are less involved in police referrals in London (Rogers and Rassaby, 1986).

In relation to the aims of this thesis, the different regional practices raise questions about the roles of the mental health professionals. In London the area in which the research was undertaken, it may be that the police have greater involvement and responsibility for detainees than elsewhere. The Metropolitan police must arrange for

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Information gained by the researcher from a visit to Merseyside police force in 1985.
Prior to the 1959 Act 'police admission' to observation wards under Section 20 of the Lunacy Act 1890 was common in London (Early 1962). Since observation wards were almost exclusively confined to London such practices were not given the opportunity to develop elsewhere.

the detained person to be accepted into the hospital and organise and provide transportation from the police station to the hospital. This means the police spend longer managing a person in their custody. A further question concerns social workers in London: does their low involvement affect the interprofessional relationships between the police and psychiatrists, and if so how?

The police use of Section 136

The police are in frequent contact with people who are mentally disordered. One study has estimated that 3% of all police encounters involve people who show signs of mental disorder (Ekblom and Southgate, 1986). The available data suggests that the police use of Section 136 is more often than the DHSS statistics on compulsory admissions indicates. Twigg (1982) in his Birmingham study of one out of 12 West Midlands police divisions recorded 60 incidents of Section 136 over an eighteen month period, whilst the official statistics for 1982 showed there were 10 Section 136 admisssions for that Regional Health Authority. A Metropolitan Police survey carried out in 1977 recorded 2,452 people apprehended compared to 1,541 Section 136 admissions shown in the four Thames

Regional Health Authorities. Finally, whilst the last available official statistics (1985) show that there were only 9 such admissions in the Mersey Regional Health Authority, data collected by MIND indicated a far greater use of the provision. Over a six month period in 1986, police surgeons reported assessing mental health cases, in which there was no intention of charging on a total of one hundred occasions. Whilst care should be adopted in generalising from these studies, the data does imply that the prevalence of the police use of Section 136 is substantially greater than indicated by official statistics.

The Metropolitan police survey mentioned above, also found that in one year 5270.5 police man hours were spent looking after people at police stations who had been apprehended under Section 136. A total of 28,248 miles were travelled by police in escorting people to hospital, involving 4,309 officers. It was concluded that the increasing financial cost on the police force of dealing with such cases should be met by the DHSS.

Whilst this Metropolitan police survey indicates that the implications of Section 136 for police

work have not entirely escaped the attention of the higher eschelons of the police, it can be argued that overall, it has assumed a marginal position compared to the rest of police work. According to one former police officer:

> "the sober truth is that the law on mental disorder does not figure prominently in police manuals, whilst instruction on the handling of mental patients is minimal" (p6 Elmes, 1972).

The two essential functions of the police have been described in Parsonian terms as 'goal attainment' and 'value maintenance' (Wenninger and Clark, 1967). At a macro-sociological level the police's function in implementing Section 136 can be viewed as compatable with these. Police powers are embedded in legislation and thus, the police can be seen to act as instrumental agents of social control on behalf of the state. In making decisions to remove a person on the basis of non-expert judgement of mental disorder, the police can be viewed as acting as symbolic agents of social control representing established values. However, if the main work of the police is taken to be that of dealing with criminal deviancy on the one hand, and social welfare or 'peace keeping' functions on the other, then in relation to everyday policing,

aspects of the use of Section 136 represent a divergence from the typical occupational practices of police officers.

Section 136 does not come within the remit of criminal law, nor does it fall outside law enforcement altogether, as do those activities defined as police 'social work', e.g. responding to physical health emergencies or returning lost pets (Punch and Naylor, 1978). Rather, as part of mental health legislation, Section 136 involves the police in <u>therapeutic</u> law; an area which is more usually associated with the occupation of medicine. The section requires the police to make a set of decisions based on their recognition of the presence of emotional rather than (or in addition to) criminal deviance. It also requires the organisation of outside professionals to make key decisions about the people they apprehend, the response of whom the police are reliant on to resolve a particular case. This necessitates interaction with the health and social services, as opposed to the criminal justice system, which are structurally and organisationally separate from the police. These, and other aspects of policing involved in implementing Section 136 on the Mental

Health Act, form the main focus of this thesis, the specific aims of which are outlined in the next chapter.

CHAPTER 2

THE AIMS AND THE THEORY

There are three sections to this chapter. In the first, the main aims of the research are outlined. In the second section the theoretical presuppositions are developed, and in the third, a review of the literature relevant to both the aims and theory of the thesis is presented.

Section 1

Aims of the research

The overall aim of the thesis is to understand the nature of the involvement of the police in implementing Section 136 of the Mental Health Act 1983 and the interaction of the police with psychiatrists in dealing with such referrals. Examination of interaction between social workers and the police was excluded from the outset because it was known, that despite a legal obligation, social workers rarely provide assessments to Section 136 cases in London. It was therefore unlikely that social workers would be involved in the incidents examined here[1].

In general terms, the type of research questions that will be asked concern: the circumstances

[1] However, the extent to which social workers provided assessments and implications this had for interaction between police and psychiatrists is included.

precipitating police apprehension of mentally disordered people, the action of officers in managing and processing referrals through to the mental health services; and the type of negotiations and relations that exist between the police and psychiatrists in making arrangements for the assessment of patients. These aims are wide and it is necessary therefore to develop a series of sub-aims. It was recognised that these aims would require expanding as a result of the development of the theoretical presuppositions. These expanded aims are presented later where they are linked to specific objectives and the methodology to be used. These are reproduced in chapter 3. The purpose of including an outline of the main aims here, is in order to demonstrate their relevance to the development of the theoretical presuppositions.

1. <u>To examine the socio - demographic and other background features of the three groups of actors involved when Section 136 is invoked.</u>

<u>Sub- aims</u>:

To examine the socio - demographic characteristics of ;

a) the actors involved in incidents

b) the police officers

c) the assessing psychiatrists

2. To understand the nature of the occupational involvement of the police and the circumstances surrounding the implementation of their powers.

Sub-aims:

To attempt to discover the:

a) circumstances leading to police intervention

b) means by which referrals come to the attention of the police

c) factors influencing police action in apprehending referrals from public places.

d) officers' methods of management used in relation to mentally disordered people.

e) way in which police identify and construe mental disorder.

f) type of officers' decisions taken at the station and the effect of such decisions for the detained referrals.

The above aims are all directed at gaining a general overview of actions by police officers in relation to persons they apprehend in public and remove to the police station.

3.<u>To examine the nature of social and professional relationships between the police and psychiatrists in relation to the use of Section 136.</u>

Sub aims:

a) to identify the occupational strategies utilized by the professions to influence the other profession's decision-making.

b) to examine police/psychiatric negotiations at the station and hospital.

c) to examine how the two professions perceive their shared client group

and

d) each others occupational role and abilities in dealing with such people.

4. <u>To consider the general aims of the thesis - an examination of the way in which the police implement Section 136 of the Mental Health Act and the professional relations between police officers</u>

and psychiatrists, in the light of the information obtained in pursuing sub-aims 1-3.

5. To reconsider the theoretical model of the research taking into consideration the results of the study.

The above aims were derived from three sources: information on hospital case records and police documentation during data collection for a retrospective study of psychiatric referrals made to three different places of safety in the London area (Rogers and Faulkner 1987); discussions with representatives of the police and psychiatric profession in negotiating access for this study; and a review of the literature. (The latter will be outlined after an examination of the theoretical basis of the thesis).

Section 2

Theoretical presuppositions

In attempting to find a suitable theoretical model for research of this nature, one is faced with a plethora of competing theories from which to choose. Furthermore, no one theoretical perspective appeared totally adequate in covering the range of processes related with psychiatric referrals from the police which involves two distinct organisations, actors and practices. For, example, leaving aside the widespread criticism of labelling theory, aspects of such a perspective may be relevant to examining the types of behaviour the police define as mental disorder and differences in rule enforcement. It would however be inadequate to explain the interaction and negotiation with a structurally separate organisation and professional group - psychiatrists. A theory situated within the sociology of law was another option considered[1]. However, the intended focus of the study was on the social action and circumstances surrounding police referrals rather than specific aspects of law enforcement.

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[1] For example Bean (1980) used Lemert's theory of group interaction to examine the way mental health professions carried out compulsory admission procedures under the 1959 Act.

Theories situated within the sociology of the professions were thought to be more adequate in attempting to illuminate the occupational practices of how police respond to and organise their work in relation to mental health referrals on the one hand, and the interprofessional relationships between the police and psychiatrists on the other.

Saks (1983) has outlined three main types of theory within recent sociological approaches to analysing the professions; functionalist (or 'trait'), 'neo-Marxist' and 'neo-Weberian' perspectives. In considering the relevance of these theories to the focus of this study the first two were rejected because of the weaknesses they are deemed to have for empirical research. In Sak's view the functionalist approach is idolotary, purely descriptive and unable to account for the interactive nature of professional processes. The 'neo-Marxist' approach is also of limited value because it tends towards grand theorising and is unable to account for contradictions that cannot be explained purely by reference to the class conflict thesis. Saks is more optimistic about the value and applicability of 'neo-Weberian' approaches as heuristic devices in empirical research.

The 'neo-Weberian' perspective incorporates theories which draw on Weber's notion of social closure with which to analyse occupatical groupings. From this stance, professions are viewed as legally privileged groups which have managed to monopolise, to a considerable degree, social and economic opportunities[1]. One such approach incorporated in this perspective is professional dominance. It is this paradigm as developed by Eliot Freidson which, with some modification, is used for this research.

The theory of professional dominance.

Freidson elaborated professional dominance in relation to the medical profession (1970; 1971). Central to Freidson's concept is autonomy over the technical knowledge and organisation of work which distinguishes the medical profession from other occupational groups. He says the medical profession has, for example, autonomy over diagnosis, selection and treatment of patients and is left unchecked by external authority to develop and define scientifically acceptable practices. The achievement of fully fledged professionalism is viewed as a historical process in which an

[1] The notion of social closure is a process whereby social groups attempt to regulate market conditions in their own favour in the face of competition from external competitors.

occupational group, such as medicine established its status with the aim of securing a monopoly in the supply of its skills and resources. The position of professional dominance can be summarised as having three elements: self regulation over the terms, content and conditions of work, control over other occupations in the division of labour, and control over client groups.

Of most relevance in this study is that part of professional dominance which deals with interprofessional relations. By virtue of their organised autonomy, a dominant profession is not only able to control the content and terms of their own work, it also assumes a superior position in the organisational division of labour in the workplace. Furthermore, it is able to direct the work of supporting occupations in a manner which suits its own interests. These supporting occupations have no reciprocal rights to regulate the dominant profession. Physician control of para-professions is manifested in three main ways. First para-professional training and education is either medically provided and/or sanctioned. Second, para-medical tasks assist but do not replace those of the medical profession. Third, they are carried out at medical practitioners

behest. Freidson summarises the physician's position in the division of labour thus:

> "In the medical organisation the medical profession is dominant. This means that all the work done by other occupations and related to the service of the patient is subject to the order of the physician. The professiona alone is held competent to diagnose illness,treat or direct the treatment of illness and evaluate the service. Without medical authorization little can be done for the patient by paraprofessional workers (p141 1971)."

In his book The Profession of Medicine (1971) Freidson shows how the physician defines the content of practice and training for paramedical and allied professions such as nurses and laboratory technicians (pp 47-71).

Once a profession has acquired a position of dominance over other occupations, then the retention of a monopoly over practice and within the division of labour involves the following: maintaining existing boundaries, taking action against encroachment, and surbordinating those with the skills that threaten its own superordinate position. These particular aspects of professional dominance provide the main focus of this thesis. Rather than providing a socio-historical account of the emergence of professional dominance in relation to its more macro-relations with the state, the focus will concentrate on aspects of

interprofessional relations at a micro level. That is, to determine the nature of professional dominance as it relates to the everyday practices of police officers and psychiatrists in dealing with psychiatric referrals. Within this framework, police officers have a subordinate position to that of psychiatrists, the latter being the agents with legal, moral and social responsibility for diagnosing and managing the mentally disordered. They also control the institutions and resources to which the police make referrals.

Unfortunately, Friedson's theory has been subject to only limited empirical examination. Saks (1983) claims that this and similar theories have failed to fulfill their potential. They have led to misattributions about professional power because they have not been sustained by adequate supporting evidence and may not be empirically sustainable. A similar point about the lack of empirical testing is made by Larkin (1979). He advocates specific analyses of the actual processes of relationships between professions in the division of labour. In relation to this criticism a central aim of this thesis is to test Freidson's theory empirically. In doing so it is hoped that more will be learned about professional dominance as it relates, on an

everyday level, to the relationships between the police and psychiatrists.

A further modification of the theory relates to what Larkin (1983) refers to as the 'over-muscular' account of professional dominance (p8). He claims that as a result of specialisation, occupations have promoted reverse dependencies. These have made the medical profession reliant upon other groups for support. Applying this notion to the police it appears that Freidson's analysis requires expansion in order to specify further the conditions of interprofessional relationships between the police and psychiatrists. For example, do psychiatrists expect officers to bring only those mentally disordered people considered 'treatable' by psychiatry? And to what extent are psychiatrists reliant on officers to to manage disruptive patients?

Dingwall (1976) offers criticism of a different type. He argues that:

> "There is a central ambiguity in his work between specifying the objective definition of 'profession' and examining the subjective knowledge of society members. Freidson is not clear whether he wants to study a collectivity by fiat or through the analysis of the work by which members make it real for one another. The strain is usually resolved in favour of the former" (p91).

Dingwall's comment is important for this research. The structural aspects of professional dominance allows an examination to be made of police officers' contact with the mental health services. However, such an approach needs to be complemented by the way in which the actors <u>perceive</u> their own action and the action of others. Thus, some attention needs to be given to certain subjective aspects, i.e. how the police and psychiatrists perceive each others roles and the contact they have with one another.

Finally, one further criticism relevant for the theoretical framework adopted here, is the challenge made by some sociologists to what can be called the 'professionalisation thesis' (see for example Johnson 1972, Parry and Parry 1977). Parry and Parry for example argue that the importance of class and the sexual division of labour in the analysis of occupations has been overlooked by those using approaches derived from professional dominance. The focus of this study however has little in common with the Marxist perspective of Parry and Parry (1977), who analysed the disputes which broke out within the National Health Service in the early 1970's in terms of class conflict. Nonetheless, it seems important to be aware of

issues of class, race and gender in analysing police and psychiatrists interaction.

The social context of police/psychiatric relations.

Having considered the theoretical framework to be used it is necessary to explain why this modified version of Freidson's theory was considered to be the most appropriate. The idea of using professional dominance as a model came from two observations: first concerning the position of psychiatry as a profession in a rapidly changing mental health world, and second the present position of policing as a rapidly professionalising occupation.

The theoretical commitment to deinstitutionalisation (which has underlaid government mental health policy since the 1950's) in the last few years, has now begun to be implemented on a widescale. Most health authorities have detailed plans for hospital closure, and the first large mental hospital closed recently. This shift in policy poses a major problem for British psychiatrists whose position has largely been derived from the institutional base of the asylum

(Scull,1979). In contrast, the community is an area in which psychiatrists have not hitherto had jurisdiction and where other occupations including the police have traditionally operated.

At the same time as psychiatry is facing challenges to its traditional power base from community care policies, the police are laying claim to professional status. A recent document containing a 'code of professional conduct' was circulated to all members of the Metropolitan Police (Newman 1985). In this code a "caring" ethos, (which other professions, including psychiatry, have also made claims to) is evident. For example, it states that one of the officer's professional duties is , "To befriend and assist the citizen by giving sympathetic guidance and comfort to all in distress..." p60.

Preliminary contact with the police also directed the researcher towards adopting Freidson's theory. The police's relationship with psychiatrists in the implementation of Section 136 appeared paradoxical. At the outset of the research police powers were gaining widespread attention. In particular, policing the urban riots in 1982, and the miner's dispute in 1984-5 led to calls for greater police accountability. The nature of coercive policing

received public attention. Yet, in stark contrast, officers' accounts of their role in making psychiatric referrals and their interaction with psychiatrists were at times characterised by diffidence and deference. For example, one Inspector commented that Section 136 bestowed an 'awsome amount of power' since he was not an 'expert' in mental health.

These considerations, when examining the police implementation of Section 136 led to a choice of theory which could examine the nature of professional interaction and power between the two professions.

Professional dominance - police and psychiatrists.

Applying the concept of professional dominance to the focus of this research, it seemed that the police may pose a threat to psychiatric dominance in a number of ways. According to Freidson the attainment and maintenance of professional status rests on three elements:

1. The monopoly of control over a market for services.

2. Close supervision of training and

qualifications.

3. Possession of knowledge and skills publicly regarded as unique and effective.

The police threaten two of the basic factors necessary for psychiatrists to retain their professional status, (1 and 3). Firstly, by having a legal mandate to bring referrals for assessment, the police challenge psychiatrists control over a market for services, i.e. the right to choose who the psychiatrists will see. Secondly, by making decisions regarding whether a person is mentally disordered on the basis of lay judgements, the police may be in a position to challenge psychiatrists' knowledge being unique and effective.

In a more general sense the police also appear to challenge psychiatric professionalism. The maintenance of the autonomy of the psychiatric profession has always been more precarious than other branches of medicine. They have for example had great problems in construing their treatments as effective and have had to resort to other claims to legitimate their position (Goldie 1976, Scull 1979). This is exemplified by 'care in the

community' policies. Police who have jurisdiction in public areas are likely to increase their contact with mentally disordered people as more reside and receive attention in community settings. On the other hand, psychiatrists are attempting to establish themselves in an alien setting outside the traditional power base of the asylum.

The theme of professional dominance is returned to later on in this thesis both in relation to methodology and the results. Before going on to examine the methodological implications of the theory, consideration is given to previous research which has relevance to the theoretical concerns outlined and the methods later adopted.

Section 3

Previous research and related literature

In reviewing the literature relevant to this thesis three areas will be examined: the previous empirical studies on Section 136 and psychiatric referrals from the police; the literature related to policing the mentally disordered, and the related studies and literature which have relevance to the theoretical framework of professional dominance. In addition to the studies specifically on Section 136 there is a wealth of other studies which have relevance to the present research. It is of course impossible to credit all, and attention is focussed on a number of selected studies which are considered to be the most important.

i.Empirical studies of Section 136.

In relation to other areas of mental health, the issue of psychiatric referrals from the police has received little academic attention. Moreover, existing studies tend to be methodologically and theoretically limited. At the outset of the research, 14 British studies on Section 136 or its precursor (Section 20 of the Lunacy Act 1890) were identified. All were conducted retrospectively, and with one exception, George (1972), all used small samples. In five of the studies Section 136 is

dealt with alongside other forms of referral and compulsory admissions[1].

a)Social science research

Whilst there have been a number of studies of Section 136 in the psychiatric literature (discussed below), only three studies (Hitch and Clegg 1980, Twigg 1982, and Walker and McCabe 1973) deal with the issue of police referrals from within the social sciences.

Hitch and Clegg (1980) examined referrals to psychiatric hospital for different ethnic groups. Regarding police referral, they found that New Commonwealth patients were more likely to reach hospital via the police than 'native born' referrals. Police implementation of the section and inter-professional relationships were not however examined. They did however direct attention to the question of whether the police and psychiatrists might vary their use of Section 136 in relation to ethnic groups. Matters of ethnicity were later incorporated into the research design.

Walker and McCabe's (1973) and Twigg's study (1982) had more relevance to the overall aims of the

[1] Only those studies on compulsory admissions where analysis of Section 136 constitutes a major part are included.

thesis. In the latter, Twigg examined 60 incidents of Section 136 in Birmingham. The focus of his study, (apart from providing a literature review) was on the use of psychiatric referral and the outcome of arrest for the patient. Twigg noted in passing how certain influences affected police actions, in particular the way they referred people to different agencies. For example, referrals to hospital were considered difficult to make as hospital staff were thought to be uncooperative. Police surgeons were called to make assessments in preference to social workers because the latter were considered to respond too slowly to police requests. However Twigg dealt with these issues fleetingly. They were drawn from ad hoc conversations with police officers rather than from a systematic analysis of the police handling of individual cases.

Walker and McCabe's study is equally relevant. They examined 53 case studies of the use of Section 136 over a six month period in order to find out in what circumstances police forces would not prosecute mentally disordered offenders. Their research used a questionnaire which was sent to different police forces. The results showed that different practices were used in different areas.

The authors noted that most of the patients could have been arrested for an offence had Section 136 not been used. Moreover, it seemed the police were reluctant to send a person to hospital without medical advice. However, it is unclear how the authors arrived at this conclusion and the reasons for officers' decisions were left unexplored. Nor did Walker and McCabe set out their theoretical position - although a type of legal framework is implied. That they relied on a postal questionnaire also resulted in a poor response rate, which in their own opinion was insufficent to produce " a sample from which to make reliable estimates of the frequency with which different types of situation occur" (p258).

Both the small scale studies by Twigg and Walker and McCabe were exploratory: neither examined in detail how the police implemented Section 136 nor the nature of interprofessional relations between officers and psychiatrists. Nonetheless, they drew attention to some features of police action and noted the use of discretion prior to psychiatric intervention. This proved useful in devising research questions for this research.

b) Medical studies

Those studies on Section 136 which were outside the

area of social science were mainly from medicine. At the time this research began 11 medical studies of psychiatric referrals from the police were identified (Berry and Orwin, 1966; Eilenberg and Whatmore, 1962; George, 1972; Kelleher and Copeland, 1972; Kent, 1972; Ineichen et al, 1984; Rollin, 1969; Sims and Symonds, 1975; Szmukler et al, 1981; Whitehead and Ahmed, 1970). Briefly, these studies were concerned with the following. Berry and Orwin (1966) were interested in finding out the features and admission details of mentally disordered offenders and patients of "no fixed abode". By collecting statistics over one year, Eilenberg and Whatmore (1962) aimed in their study to provide base - line data from which the effects of the introduction of the 1959 Mental Health Act could be evaluated[1]. George's M.D. thesis (1972) focussed on providing a national picture of the type and number of mentally disordered people found on the streets by the police and the pattern of hospitalisation used in response to such referrals. Of the studies, five were comparative, one of which examined the characteristics of formal admissions made by medical practitioners against those made by the police (Kelleher and Copeland, 1972). Kent (1972) surveyed parallel 'police' admissions to two

[1] Data was collected between April 1959 and March 1960.

mental hospitals, one in Sheffield the other in London, in order to compare them across a number of clinical and legal variables. Rollin (1969) and Whitehead and Ahmed (1970) compared the clinical features and offences of prosecuted mentally abnormal offenders against an unprosecuted group. Szmukler et al's study (1981) compared the clinical characteristics of a group of compulsorily detained patients (including those detained under Section 136) with a group of informally admitted patients. A more epidemiological approach was adopted by Sims and Symonds (1975) and Ineichen et al (1984). Both examined the demographic characteristics of a sample of police referrals and the relationship between the numbers of police referrals and areas of the city, (the former in Birmingham and the latter in Bristol).

With the exception of George (1972), all the studies have the disadvantage of being over-reliant on hospital case records[1]. In addition to the general flaws associated with the use of case records, a specific weakness in examining Section 136 is that records only show referrals selected for admission to hospital. Those assessed in

[1] Hakim (1983) notes that information from this source is often not standardised and varies in quantity and detail limiting its value for research purposes.

police stations and subsequently admitted under different Sections of the Mental Health Act, or those initially apprehended by the police and not asessed would not have been included. Moreover none develop an explicit theoretical approach, although from the variables examined a discernable (if implicit) medical perspective, can be identified. Sims and Symonds (1975) however make reference to a sociological theory. They used Durkheims' theory of anomie to explain increased rates of psychotic patients from socially disorganised geographical areas but not in any systematic way.

From these studies two themes predominate: the individual characteristics and clinical management of police referrals; and the efficacy of the police in making referrals to the psychiatric services. In relation to the former, the diagnosis, clinical management and socio-demographic features are examined to a greater or lesser extent.

Overall the studies stress an isolated population from socially disorganised urban areas, a higher proportion of men than women, high numbers of people of no fixed abode, and low levels of GP registration. The majority of police referrals are characterised as having severe mental disorders,

with diagnostic labels of schizophrenia, mania and personality disorders predominating (Eilenberg, and Whatmore, 1962; Rollin, 1965; Whitehead and Ahmed, 1970; Sims and Symonds, 1975; Szmukler et al, 1981). Few referrals were identified as mentally handicapped. Moreover, as a group police referrals are portrayed as 'difficult' to manage and treat. Police referrals were often found to require further compulsory detention or 'certification' (Eilenberg and Whatmore, 1962). A tendency toward premature discharge, absconding and non-compliance with after-care arrangements is a common theme. (See for example Rollin, 1965; Kent, 1971; George, 1972; Sims and Symonds, 1975; Szmukler et al, 1981). Their offences (if they have committed any) are usually found to be minor (Kent 1971, Rollin 1965, Whitehad and Ahmed 1970).

The second theme, that of police efficacy, is dealt with by four studies. Here, the police were considered to be competent referrals agents according to medical criteria. Comparing admissions made by the police and Duly Authorised Officers, Eilenberg and Whatmore (1962) examined the level of behavioural disturbance shown by the subjects, diagnosis of mania and the need for certification after expiry of the three day order. Using these

criteria, they considered that "...police cases directly referred were as justifiable a group as DAO (Duly Authorised Officers) admissions to emergency units" (p100).

A comparison of emergency formal admissions made by the police under Section 136 with those made by general practitioners under Section 29 of the 1959 Act by Kelleher and Copeland (1972) showed the police to be "marginally better" at recognising those in need of psychiatric attention than the medical practitioners. Similarly Whitehead and Ahmed (1970) and George (1972) also showed that police referrals made directly to the psychiatric services were appropriate on the basis that most were 'mentally ill' and had not committed very serious offences.

Relating these studies to the specific aims of the present research, the psychiatric perspective adopted would seem to have only marginal relevance to the sociological approach adopted here. Although all are about Section 136 of the Mental Health Act, they are framed by psychiatric a priori investigator assumptions, and tend to focus on patient characteristics. Only Szmukler (1981) contacted the police directly and this was through

telephone conversations. These were not carried out on a systematic case by case basis. However, despite theoretical and methodological limitations, the empirical findings and the discussion of the results by the different authors were a source of ideas for developing the aims of the thesis. With regard to the latter they pointed to gaps in this area, particularly the need to examine aspects of Section 136 which occur prior to formal psychiatric involvement, as well as the precipitating incidents and behaviour of referrals.

Indirectly the studies also helped promote theory. Studies using a medical framework helped identify issues which revealed the dominant role the psychiatric profession played in defining the terms concerning the management of mental disorder and Section 136. Firstly, because Section 136 patients were portrayed as "difficult" to manage it was thought that this might have importance for examining aspects of professional dominance. Robinson (1976) for example has shown how psychiatrists are able to control the type of patients they see by employing various routines to discourage 'uncontrollable' alchoholic referrals being sent from other agencies. Simalarly, Ramon (1985) and Pilgrim (1987)

have drawn attention to the ambivalence expressed by the psychiatric profession about managing those deemed to be psychopathic. (The latter group are poorly responsive to medical authority and are often perceived as incorrigible and disruptive). Secondly, the way in which police efficacy is evaluated presumes a medical definition of the effectiveness of police action (e.g. diagnosis and need for hospitalisation). The police's own frame of reference, or other measurements of effectiveness, are not considered. Thirdly, the studies provided insight into the way in which psychiatrists perceive their own role and that of the police in relation to mentally disordered people. In particular, there appeared to be an interest in increasing medical input. This is illustrated by Kelleher and Copeland (1972). They state, that their interest in the area "stems from the fact that the police are now the only lay men who can pass judgement on a person's mental state", and aimed to clarify in their study "whether the police are less effective than doctors in recognising mental illness" (p221). Extending medical participation is advocated despite the finding that the police were marginally more effective in making appropriate referrals than their medical colleagues. The authors suggest that

those detained on a Section 136 order should be taken to a casualty department for a psychiatric consultation. They appealed to psychiatric benevolence viz:

> ".....the patient's management and future relationship with the psychiatric services can only benefit from the knowledge that a psychiatrist cared enough to examine him before accepting a layman's decision to compulsorily admit him" (p222).

Similarly, Whitehead and Ahmed (1972) suggest that inappropriate referrals can be prevented if a psychiatric opinion is made available at an earlier point. They too wanted to control police action. They suggested that there should be increasing psychiatric involvement in the training of police officers. They considered for instance, that a knowledge of psychiatry could 'help considerably' in detaining disturbed people in public areas.

Finally, a psychiatric text by Littlewood and Lipsedge (1982) was influential in directing attention to inter-professional relations. Though not based on any empirical research, the authors describe how patients are handed over by police at the hospital. They draw attention to the powerless position of patients, stating that they are usually ignored while matters are dealt with by the

professionals. Littlewood and Lipsedge imply that the subsequent outcome (admission or discharge) is a matter of collusion between the police and psychiatrists.

ii.Studies on policing the mentally disordered.

Since the 1970's a number of studies have been undertaken into British policing. Most however do not consider the issue of policing mentally disordered people, and when they do then only fleetingly. A number of studies however have provided a contemporary analysis of policing within which to locate the present research. Since Section 136 is about the implementation of a legal rule and mental health, studies on police discretion in law enforcement and those on the social welfare aspects of policing were considered to be relevant.

Cain (1973), in her doctoral thesis emphasised the importance of discretion in police work. In examining the interaction between the uniformed constable and individuals it was noted that some illegal acts were ignored; people classified as 'respectable' tended to be treated more leniently than those from 'rough' groups. Chatterton (1975) highlighted discretion in the implementation of the law and the external influences on police

behaviour. He found that law enforcement was a matter of individual negotiation of desirable resolutions in pragmatic terms. However, both studies concentrated on the workings of the criminal law and neither specifically examined police discretion and implementation of Section 136 or non-criminal law in general.(They did nonetheless provide a backdrop against which the police implementation of Section 136 could be compared.)

With regard to the social-welfare aspects of police work, Cain (1973) found that whilst the police were, in terms of their cultural values, orientated toward's crime-fighting, in practical terms this only constituted a minor part of everyday policing. Similarly Punch and Naylor (1978) emphasised police involvement in problems that had little or nothing to do with law enforcement. They found that the public were more likely to call on the police for 'service calls' (health matters, domestic occurences, lost animals etc) than the social services and that the police were regularly involved in performing emergency welfare tasks. Both studies highlighted how the police are often involved in matters that are claimed professionally by others. Neither study examined the relations

between the police and other professions.

The issue of inter-professional relations is partly addressed in Holdaway's ethnomethodolcgical study of police occupational culture (1983). This includes an examination of relations between the police and other agencies. In particular, his study highlighted how doctors and social workers were viewed as 'challengers' to police jurisdiction over suspects and other client groups. Relationships were often characterised by conflict and lack of cooperation. Though not based on empirical research, Brown and Howes (1975) and Thomas (1986) have also drawn attention to a clash of ideologies, mutual misgivings, and frictions when dealing with a shared client group with outside professionals. This research provides a basis for constructing other questions related to police and their relationships with psychiatrists.

Due to the dearth of British studies on policing and mentally disordered people, it was thought necessary (despite the cultural and social differences in policing and mental health systems) to scrutinise recent American studies. Although there is an extensive literature concerned with the issue of policing and mental disorder, three

American studies in particular have direct relevance to the aims and theory of the present research.

Bittner (1967) and Teplin (1984) found that decisions to make referrals to hospital were based on the perceived response of mental health professionals. Bittner's ethnomethodological study found that police decisions to refer cases to hospital were taken reluctantly. They were made only in cases that were serious in a psychiatric sense and a 'serious police problem' (danger to life and property etc). It was suggested that factors such as police perception of lack of expertise in defining psychopathology, the uncertain and tedious process involved in taking someone to hospital (which required interacting with psychiatrists who could place the police's judgement in doubt) contributed to the police's economic use of mental health services.

In Teplin's study (1984), hospitalisation was found to be rarely used as a means of disposal by the police in encountering mentally disordered people because of certain external and internal constraints. These included, the knowledge that mental health referrals were often discouraged by

mental health professionals, that there were few beds avaialable at the hospital to receive people, and the enforcement of strict admission crtieria. Also hospitalisation was not considered a 'good pinch' by the officers' own police department.

A recent study of psychiatric evaluations of police referrals taken to general hospitals (Steadman et al, 1985), suggested that a clash existed between psychiatrists' notions of 'good clinical practice' and the police officers' criteria of arrest. These American studies suggest a closer look is required to see whether similar factors operate in police/psychiatric contact in Britain. Thus, although British policing studies reveal little about the nature of existing police/psychiatric relationships, American research was useful for directing attention to particualr aspects of potential conflict between the two professional groups.

iii. <u>Literature relevant to the theoretical framework of psychiatric dominance.</u>

The studies so far discussed in this section were all a valuable source for indentifying issues relevant to professional dominance and the

implementation of Section 136. In developing a theoretical framework for this research it was also necessary to draw on selected sociological studies which have used professional dominance. Whilst no study has looked at the concept of professional dominance in relation to the police a number of studies from within medical sociology have analysed the medical profession using this theoretical framework.

Central to Scull's (1979) Museums of Madness was the notion of psychiatric dominance. He showed that professional processes accounted for the growth and medical control of ninteenth century asylums. Other sociologists have been more concerned with the position of medicine. Commenting on the state of medicine in the 1970's, both Elston (1976) and Armstrong (1973) argued that there had been a shift in the balance of power away from the medical profession. They attributed this to the nature of state involvement in the NHS and the challenge to the efficacy and efficency of medicine from other health service workers and patients. Though these studies use Freidsons' concept in their work, the authors were more interested in analysing the relationship between the medical profession at a macro-level and the state. They were less concerned

with the interprofessional processes taking place between superordinate and subordinate professions.

Of rather more relevance to this thesis, are studies which have examined the position of medicine in relation to other professions. One such study by Larkin (1979), was concerned with the nature of occupational boundaries between medicine and radiography. Larkin, studied historical records of proceedings which led to the legal establishment of radiography as a profession. He showed that at crucial points in the development of 'sub-professional autonomy' medical interests intervened in a way conducive to the maintenence of control over key activities. From these records Larkin shows how objections by the General Medical Council to the reporting of 'X'-ray plates (because it encroached on the right of the medical profession to diagnose) steered radiography toward a caring as opposed to a curative role. Medical involvement also acted to produce radiography as a sub-profession so that it failed to attain full professional autonomy.

Similar to Larkin's study is the work of Eaton and Webb (1979). They looked at professional dominance as it related to the medical profession and

pharmacists. They examined the strategies used by pharmacists to extend the boundaries of their practice towards traditional medical territory. They also looked at the way in which the medical profession defended its boundaries against such encroachment. They found that pharmarcists (as a group with marginal professional status) extended their work into areas considered undesirable by the medical profession. The adoption of 'dirty work' acted to provide a solution to the obstacles placed in the way of pharmacists claims to full independent professional status by the medical profession: officially delegated work gave increased status to the pharmacists without detracting from their overall subordinate position to the medical profession.

More recently Ovretveit (1986) has analysed medical dominance with regard to physiotherapists at national, district and individual levels. An important finding concerned the nature of authority relationships and jurisdiction which extended over particular areas of work. These characterised the relationship between the two professions. Even though medicial practitioners relied on the specialised assessment provided by the physiotherapists this did not diminish their power

and authority. They retained the right to authorise and remove a patient from treatment.

Other studies found to be relevant are those by Goldie (1974) and Robinson (1976). According to Freidson diagnosis and treatment are dependant partly on 'whats actually wrong', partly on the professional agencies and partly on the referral system in which a patient is located. Robinson examined the handling of alchoholic referrals made to a psychiatric hospital. He analysed hospital case-notes and showed that certain agencies - Alchoholic's Annoymous and social workers for example, were more often deterred by psychiatrists from making future referrals than were probation officers and GP's. Robinson's work focusses on 'the act of referral' which he uses to analyse the nature of the relationship between referring agents and receiving hospital. The focus of this research is also on the process of referral as it applies to mentally disordered people dealt with by the police and psychiatrists.

Goldie's Doctoral thesis (1976) explored the division of labour and interprofessional relations amongst mental health professionals. Starting from

the assumption that the medical profession is in a structuraly dominant position to clinical psychologists and social workers, Goldie showed how 'the dominance of psychiatrists over the treatment of mental illness is sustained and legitimised in daily practice'. Psychiatrists were able to define the terms under which other professions had access to patients by virtue of the "medical mandate". i.e. ideology that serves to sustain the control psychiatrists had over the treatment of mental illness. The majority of psychiatrists sought to legitimise their position by referring to rational factors, such as the need to administer treatments or suggesting a certain naturalness and inevitability about existing arrangements. The diffuseness of their mandate afforded them control over others work. An interesting feature of Goldie's work is his analysis of the position of the subordinate professions and how these at times actively sustained and reinforced their inferior position and disparities in power:

> ....' stability is maintained as much through the way the subordinate define themselves as having an inferior role to play as by the superordinate's use of authority. The occasional use of this authority serves as a reminder of the ultimate differences between them. However, whilst the division of labour may have been imposed by psychiatirsts, it continues to be maintained by the very staff who occupy an inferior position within it " (p134 Goldie, 1977)

The research on Section 136 has common interests with that of Goldie's work. As in the 'Medical Mandate' the focus of interest is on psychiatry. The theroetical aim is to analyse a subordinate occupations relationship to a superordinate professional group and how such a relationship is negotiated through the referral of mentally disordered people found in public places.

Summary

At the beginning of this chapter the aims and theoretical presuppositions of the research were presented. The main aims were to find out the nature of the occupational involvement of the police in implementing Section 136 and the social and professional relationships between police and psychiatrists. These were then developed into a number of sub-aims. In choosing Freidson's concept of professional dominance as a theoretical framework, certain modifications were made in the light of previous criticisms and applicability to this research. The focus here is on the micro aspects of interprofessional contact rather than the socio-historical or macro-state analysis with which professional dominance has often associated. Having examined the present social context within which psychiatry and the police are currently working, one presupposition is that psychiatrists assume a superior position in relation to the police.

In presenting a literature review, a wide range of studies which have covered the areas of Section 136, policing and professional dominance has been scrutinised. The diversity of areas from which

ideas have been drawn has been necessary because of the unusual area of study. On the one hand there are questions relating to the implementation of section 136 by the police and on the other there is the choice of a theory which has generally only been used to analyse the relationships of professional grouping within a health service context. In examining the previous empirical studies on Section 136 there appeared to be only three small scale studies from the social sciences which suggested the need to explore police discretion further. The reliance of the medical studies on the use of case records pointed to the need to include all cases referred under Section 136 and not only those admitted under the section. They also suggested the need to examine police action in apprehending and detaining potential patients prior to psychiatric involvement. Indirectly, the medical studies were useful in developing the theoretical framework of the research. Recent British studies on policing provided little information on the handling of mentally disordered people. However, American studies on the policing of mentally disordered people pointed to potential areas of conflict between psychiatrists and police officers. Finally, the use of professional dominance from studies

undertaken in the field of medical sociology were reviewed and found to be useful in formulating the theoretical approach used to examine police/psychiatrists relations.

In the next chapter, the context of the research is examined followed by the specific aims and methods of the study.

CHAPTER 3.

THE HYPOTHESES AND METHODS

There are three sections in this chapter. (An appendix containing the research schedules is included at the end of the thesis). The first section deals with the connection between this thesis and another research project in order to provide the boundaries of this study. In the second section, the various hypotheses have been outlined together with the appropriate methods; both have been juxtaposed with the aims of the thesis. In the third section, the methods have been elaborated. This is followed by a further discussion of methods and some of the ethical problems involved in the research.

Section 1

The thesis in the context of the MIND research.

Before going on to consider the methodological issues of the research, the circumstances within which this thesis was initiated need to be clarified. The impetus for the thesis was perhaps unusual compared with many other studies in the social sciences. This project was an extension of a larger research study conducted by the national mental health charity and pressure group MIND (National Association for Mental Health). The

research was derived from my employment as a research officer with MIND's legal department (September 1984- July 1987).

Undertaking this research and linking it with another research project had its strengths and weaknesses. On the one hand the MIND project provided an opportunity to pursue my interest. On the other it acted as a constraint as my research had to be consonant with the MIND work with all its strengths and weaknesses. The interrelated nature of the two studies makes it necessary to clarify the parameters of the present thesis. I shall do so by outlining points of convergence and divergence.

There were major similarities between the two studies. They shared the same research topic, both used interviewing as the main method for collecting data and the data collection period largely overlapped. There were, however major differences in the theoretical models used and in the approach of the study, whether in aims, type of analysis or theory.

Aims and objectives of the MIND study.

The MIND research was divided up into three separate studies. The first was a retrospective

case records analysis of 326 referrals made to three different places of safety over a two year period (Rassaby and Rogers, 1987; Rogers and Faulkner, 1987). Two aims were specified. The first was to:

> "examine the procedural variations in Section 136 operating in London.... and how the 'place of safety' chosen for providing assessments affects the way in which the police use Section 136, the nature of any assessment provided by mental health professionals and the disposal following that assessment" (p11, Rogers and Faulkner, 1987).

The second was to examine the past psychiatric history and characteristics of the people referred to the three centres.

The main aim of the second study was to examine "all aspects of police action in exercising their powers under Section 136" (p9, Rassaby et al, 1989). More specifically, this included sub- aims of; examining how the police interpreted and implemented their legal duties and the results of their action; examining the options available to the police in dealing with mentally disordered people and the circumstances in which they chose these options; and examining how the police viewed their role in relation to social services and

hospitals. This second study more closely resembles this thesis than do the other two.

The aims of the third study (Bean et al, 1989) were: to ascertain the individual decisions made by psychiatrists in relation to referrals; to examine the patient 'career' and the care provided for those referrals admitted to hospital; to examine the discharge procedures and management problems posed for staff whilst in hospital; and to examine the views of patients as to how they had been dealt with by the police and psychiatrists. A further aim was to compare patients detained or referred to hospital with those similarly referred to a Distric General Hospital Psychiatric Unit. The final aim was to evaluate Section 136 in the light of the findings of all three studies, i.e. in terms of the police, hospitals and social services.

Assumptions and theory

Overall, the MIND research had no distinct theoretical focus nor did it identify with a specific academic discipline. In general terms it adopted an underlying quasi-legalistic approach in the type of research questions asked. It was motivated by the pragmatic policy issues which were the concern of MIND's legal department and, to a

lesser extent, the policy of the funding body (the now abolished Greater London Council).

The first study assumed an implicit theoretical proposition that organisational factors would account for differences in the outcome for patients rather than their presenting psychopathology (Rogers and Faulkner, 1987). The second study was concerned with the reasons for the apparent disproportionate use of Section 136 in London. For a number of years this had been an issue MIND had wished to investigate (Gostin, 1975). Connected to this was a particular interest in finding out whether the police were following correct legal procedures and were competent enough to deal with mentally disordered people. In the third study (Bean et al, 1989) there was an interest in examining responses made by the psychiatric and social services to patients who had been referred. This was derived from MIND's policy and campaign for community based services. From the findings of the MIND study, it was hoped that alternative 'places of safety' and responses could be proposed which would be more conducive to providing community based services for psychiatric emergencies. The theoretical perspective adopted in this thesis is different. Though issues of social

policy and legal procedures are considered, they are not its main focus. As has been noted earlier, a content analysis of previous literature and observations made about the nature of professional relationships, informed by a sociological interest, led to exploring and developing a modified theory of professional dominance. Professional processes and occupational involvement in Section 136 formed the pivotal focus of this research - these aspects were only fleetingly examined in the MIND research. A further difference was that, whereas the MIND study was concerned with action research, to change practices and promote the proper legal use of Section 136, there was no such direct policy side to this research. Although implications of a policy nature are examined, this research is basically an academic exercise where the emphasis is on developing theory and identifying sociological implications of the subject matter.

Methods.

The findings in the first MIND study were derived from secondary data obtained from scrutinising hospital case records in three different 'places of safety' in areas of London. Data was extracted from the case notes according to a pre- coded structured schedule. None of the data collected in this part of the MIND study has been used here. As mentioned

previously however, the MIND study helped with the construction of some of the research questions.

The methods in the second MIND study involved interviews with the arresting officer, as well as obtaining futher information from police documents and administrative records. The data collected was both qualitative and quantitative. The quantitative data was coded onto a separate schedule and analysed using a statistical package (SPSS.X).

In relation to this thesis, the same semi-structured interview was used to collect data as used in the second MIND study. In addition, police documents and administrative records at one police station were used in this and the MIND study. A substantial amount of the quantitative data collected as part of the MIND study is also used in results chapters 4,5, and 6 of this thesis[1]. However, the qualitative data collected and presented is different. First this type of data was used to a greater extent in the thesis than the MIND study. For this thesis (but not for the MIND study) such data was analysed thematically (Plummer 1983). Additionally, data was collected and used

[1] This relates to the circumstances of the incidents and police handling of mentally disordered people.

which related to police perceptions of mental disorder, their own role and those of psychiatrists and interprofessional relationships to the psychiatrists. This was not analysed in the MIND study.

The way in which the data was interpreted was also different. Whilst in both studies data was used to present a picture of police practices in relation to Section 136, in the thesis it is used in an exploratory manner aimed at developing hypothesis and research questions. That is, the data from this study (Study A) helped in developing a more structured questionnaire for the collection of data which formed the main part of this study (Study B).

The main method used in the third MIND study was structured interviews with the assessing psychiatrists. Other methods included interviews with the referring police officers, a postal questionnaire to the discharging psychiatrists and unstructured interviews with patients. The latter two methods and data were not used at all in this thesis.

The structured interview schedule (Interview C) designed for assessing psychiatrists contained 57 questions[1]. Of these, 32 questions were used in the MIND study but not in the thesis and 14 questions were used in the thesis as well as the MIND study[2]. Seven questions relevant to the thesis were added onto the psychiatrists' interview used in the MIND study to collect data on interprofessional relations.

The 'borrowing' of certain data from the second MIND study police interviews was reciprocated. Interview schedule B (the police interview) was designed specifically from the research questions addressed in this research. The police were only of minor importance in the third MIND research. However, some data collected using Interview B was to supplement the third MIND study[3].

As will be seen later in this chapter, one further methodological difference was that the research for this thesis used direct observation of police

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This is referred to in theis thesis as Interview Schedule C or 'the psychiatrists interview'.
Including questions regarding,the day and time of assessment, (I 1-2), police action (II 1-7), dangerousness IV (1-2), Disposal (1a,) Social Worker assessment (1-2).
Including data on police ratings of dangerousness, severity of mental disorder (V1 1-2, Vii 1),liaison with the hospital (X 1-9)and attitudes of psychiatrists to the police X1 (6-8).

action to address certain research questions, and to cross-validate other data sources, whereas the MIND research did not.

Data collection.

The cases referred to hospital in the third MIND study were used to trace police officers for Interview B. As far as the practical issue of data collection is concerned, the majority of data was collected by myself for both studies. However, two other people were involved at different stages with data collection (acknowledged in the foreword). This required introducing a system of inter-rater reliability into the research design to minimise interviewer bias. This is discussed in greater detail in the next chapter.

Section 2

Aims, hypotheses and methods

The broad aims of the thesis were outlined in chapter 1. In this section they will be translated into hypotheses and linked to the methods. Briefly, it will be remembered that the predominant theme of the thesis is to examine police officers action in relation to the people they detain under Section 136 of the Mental Health Act 1983. Related to this, the aim is to study their contact with psychiatrists.

In aim 1 socio-demographic and other background features of the referrals, police officers and psychiatrists will be examined. In aim 2 attention is directed at police action in relation to those people they apprehend and refer to the psychiatric services. In aim 3 the focus shifts to the nature of professional contact between the police and psychiatrists. In aim 4 the above two aims are brought together in order to examine the influences found in aims 1, 2 and 3. Finally, aim 5 considers the above 4 aims within the theoretical framework of Freidson's professional dominance.

Aim 1:- To examine the background features of the three groups involved when Section 136 is invoked.

<u>Hypothesis 1a:- There will be no marked differences in the background features of the referrals.</u>

Methods:- To establish from police and psychiatrists documents the age, sex, marital status, area of residence, ethnic origin, employment status and past offending careers of the referral population (See appendix A).

<u>Hypothesis 1b:- There will be no marked differences in the background features and service experience of police officers.</u>

Methods:- To establish from interviews the sex, ethnicity, length of service and previous experience of officers dealing with psychiatric referrals. (See Interview B, Questions 1,2,3,4,5,6, Appendix A).

<u>Hypothesis 1c: There will be no marked differences in the background features of the assessing psychiatrists.</u>

Methods- To establish from interviews the professional status, ethnicity and sex of the assessing psychiatrists. (See Interview C Xii, Appendix A).

Aim 2a: To ascertain the nature of the circumstances leading to police intervention.

Hypothesis 2a:- That the circumstances precipitating police intervention will not contain elements other than those specified under the substantive requirements of the Section 136 provision.

Methods:-To extrapolate from police accounts the salient features and characteristics of the circumstances to which the police were called. (See Interview A, items under Part 2)

Aim 2b:- To discover the means by which referrals came to the attention of the police.

Hypothesis 2b:- The main agents of referral will be the police.

Methods:- To establish who the agents of referral were (Interview A Part 1 and Interview B (Int Q II

1,).

Aim 2c:-To ascertain the motivations of the referring agents in initiating psychiatric referral.

<u>Hypothesis 2c:- The primary motivation for initiating referral will be the presence of mental disorder.</u>

Methods:- To establish from officers' accounts the reasons for involving the police in incidents (See Interview A Part 1).

Aim 2d:- To establish the factors influencing police action in apprehending referrals.

<u>Hypothesis 2d:- Prior labelling will not play a primary role in the formation of officers' decisions to make an apprehension.</u>

Methods:- To establish from interviews the extent to which officers were aware of the mental state of referrals prior to attending incidents. (Interview B question II, 3.)

Hypothesis 2e:- There will be no other factor influencing officers' apprehension decisions than the mental state of the referral.

Methods:- To establish through interviews with officers the reasons for arrests in individual cases. To aggregate the replies and show the reasons as a percentage of the total and analyse the reasons thematically. This issue was initially explored in Interview A (part 2) and further developed in Interview schedule B. Questions II 7 and 8 were open questions relating to the reasons for arrest and the likely consequences of no action being taken.

Aim 2e:- To examine the methods of management used by the police in relation to mentally disordered people.

Hypothesis 2f:- Officers will use no other legal means for apprehending referrals and removing them to the police station than Section 136 of the Mental Health Act.

Methods:- From officers' accounts in Interview A (part 2) and Interview B Q II 4, to ascertain the

place of arrest, intentions and authority used by police officers in making an arrest. To aggregate the responses and present them numerically and thematically.

Hypothesis 2g:- Officers will use physical methods only in removing and managing mentally disordered people.

Methods:- To establish, through police accounts and direct observation, the means which were employed to manage mentally disordered people whilst in police custody. In Interview A (part 3) officers were asked in an open-ended way how they managed referrals in during transport and at the station. In Interview B Q's IV (1,2,3,) questions were more specifically aimed at the different stages of arrest and management.

Hypothesis 2h:- Police responses in dealing with Section 136 referrals will be no different to those used to deal with normal suspects.

Methods:- To establish through interviews (Interview B Q's IV,4) and direct observation the way in which officers processed and managed normal suspects in comparison to Section 136 referrals.

Aim 2f:- To examine the way in which officers identify and construe mental disorder.

Hypothesis 2i:- Police identification of mental disorder will not take place at any other time than at the incident attended by officers prior to arrest.

Methods:- To establish through interviews the timing and process by which the police identify the presence of mental disorder (Interview A Part 2). More structured questions were included and systematised in Interview schedule B Q V, 1.

Hypothesis 2j:-Police identification of mental disorder will be based only on behavioural criteria.

Methods:- To establish through interviews the criteria used by officers to identify mental disorder. As in hypothesis 2i above, this was explored from police accounts from Interview Schedule A (parts 1,2,4, and 5) and was developed more systematically in Interview Schedule B (QV, 3). This was directed at eliciting the factors police officers used to identify mental disorder.

It was also directed at ascertaining the influence of other people on police decisions (Q V2 and 4).

Hypothesis 2k:- The police operate with a paradigm of mental disorder based on the medical model of mental illness.

Method:- Through interviews to find out the attributed casues given to mental disorder and the way in which mental disorder is framed and expressed by officers in individual cases. In Interview schedule A part 5, broad questions surrounding the police perception of the nature of mental disorder were asked. The cause of mental disorder was presented in a fixed choice question (Interview B VIII 1 and 2).

Aim 2g: To examine the nature of officers' decisions taken at the station and the effect of such decisions for the detained referrals.

Hypothesis 2l:-The apprehension of a person will not lead to any course of action other than referral to the psychiatric services.

Method:- To establish through interviews the disposal and outcome of people the police refer. To

aggregate the responses and show the psychiatric disposal rate as a percentage of total outcomes. Interview A part 6 and 7 were designed to find out the disposal chosen for individual cases. Since it was recognised that the Section 136 cases in the interviews may be biased in the direction of those individuals sent to hospital another method was also used. The 'persons at station' forms and custody records for all those detained in police custody for a one year period were scrutinised at one station, and from this the disposal of detainees subject to Section 136 were recorded.

Hypothesis 2m:- The police do not have grounds for charging psychiatric referrals with an offence and will not consider other courses of action other than psychiatric referral.

Method:- To ascertain the number, type and seriousness of offences referrals commit and whether officers gave consideration to any other course of action (Interview A part 2, Interview B Q XI a,). To analyse the data as frequencies and to examine decisions thematically.

Hypothesis 2n:- The police's only reason for failing to charge a subject with an offence will be

<u>other than the presence of mental disorder.</u>

Methods:-To find out the reasons why officers do not charge detainees (Interview B X1,1d and qualitative data from police accounts in Interview A).

<u>Hypothesis 2o:- Officers will not take the decision to refer individuals to the psychiatric services without assistance from other professionals.</u>

Methods:- To find out the frequency with which police surgeons and social workers are called upon by the police to provide assessments at the station. Also, the extent to which they respond to police requests to attend will be examined (Interview B Viii questions 3a-4b).

Aim 3a:- To identify the occupational strategies utilised by the professions to influence the other profession's decision making.

<u>Hypothesis 3a:- Police referrals will be automatically accepted for assessment by psychiatrists.</u>

Methods:- To ascertain from interviews (Interview

question B X 2a,b and Interview A part 4), whether referrals were automatically accepted by psychiatrists for assessment.

<u>Hypothesis 3b: Psychiatrists will not attempt to disuade referrals being made to the psychiatric services and the police will not attempt to persuade psychiatrists of the need to accept referrals.</u>

Method:- To identify cases (using Interview schedule A (part 6) which were not readily accepted by psychiatrists and the subsequent means used by the two professions in negotiating an outcome in these cases. Questions relating to this theme were more focussed in Interview B (questions X2 and 5d) and were designed to cover problems or obstacles encountered by officers in obtaining a hospital disposal. Questions X5e and f related to potential psychiatric strategies to prevent a hospital disposal.

Aim 3b:- To examine the nature of police psychiatric negotiations at the hospital in dealing with individual referrals.

<u>Hypothesis 3c:- There will be no difference in the</u>

<u>way that the police and psychiatrists perceive psychiatric referrals.</u>

Methods:- First, data is taken from Interviews B and C to establish the perceptions of the police and psychiatrists in relation to referrals' dangerousness to self and others, and severity of psychiatric condition. This data is aggregated, (responses to questions in Interview B (Q's VI 1 and 2, Q's VII1, and Interview C QII 9, QIV 1 and 2, and VIII 1b). Second, in order to identify and explain differences in ratings, to compare ratings in relation to individual referrals. Third, to examine, using chi-square tests whether there are differences in dangerousness in relation to ethnicity. Fourthly, to establish from Interview C QII (5) psychiatrists' perceptions as to the appropriateness of referral in individual cases and whether there are variations according to the type of referral.

<u>Hypothesis 3d:- Decisions regarding what will happen to referrals will arise out of negotiations between psychiatrists and police officers.</u>

Methods:- i. To find out the number of social workers who were called to make assessments by the

police and psychiatrists (Interview B QX1 3 a and b) and to ascertain the reasons for their non/ involvement (Interview B Q X1 3 a,b, and Interview C V1 1 and 2 and qualitative data from Interview A).

ii. To establish: the characteristics of negotiations from the contact and period of time spent at the hospital by the police (Interview B Q X 5e); the extent to which officers waited for the completion of assessments, exchange of information (Interview C, questions II 2, 3 and 6); and nature of interaction between the two parties. Information from the latter to be derived from direct observation and general comments in Interview B and C.

<u>Hypothesis 3e:- Psychiatrists will make no attempt to discourage the police from making future referrals.</u>

Methods:- To take as indicators of discouragement of referrals: lack of feedback to officers and negative attitudes of psychiatrists to police. To examine whether or not psychiatrists discouraged police from making future referrals. From Interview B (questions 5 and 8) to ascertain how the police

perceived the attitude of the psychiatrists towards them, and the referrals, and whether officers were informed of the outcome of psychiatrists' assessments (questions X 6a and 8).

Aim 3c:- To examine how each of the two professions view the others' competence in dealing with psychiatric referrals.

Hypothesis 3f:- The police do not view the psychiatrist's role in any wider terms than those laid out under the legal requirements of the Mental Health Act.

Methods:- To ascertain from Interview B the police's perceived role and responsibilities of psychiatrists and to present these thematically.

Hypothesis 3g:- The police will consider that psychiatrists are effective in treating and managing psychiatric referrals.

Methods:- To establish from a rating scale the range of efficacy attributed to psychiatrists by police, and to ascertain the reasons for individual officers' ratings (Interview B Q XI 2).

Hypothesis 3h:- Police officers consider that psychiatrists acknowledge police opinion and expertise in dealing with psychiatric referrals.

Methods:- From Interview B, establish the range of perceptions that officers hold, about the value psychiatrists attribute, to police information and opinion (Interview B, questions X1 4 and 5).

Hypothesis 3i:- There will be no differences in psychiatrists or police perceptions as to the ability of officers to diagnose mental disorder and their role in dealing with mentally disordered people.

Method:- To ascertain from officers' and psychiatrists' ratings officers' abilities to recognise mental disorder (Interview B question IX,3 and Interview C QX 1). To aggregate and compare the responses in order to identify any differences in perceptions.

Aim 3d:-To examine the perceived nature of the relationship between psychiatrists and police.

Hypothesis 3j:- Police and psychiatrists will evaluate their relationship in positive terms.

Method:- From the responses to Interview questions B XI 6, and C X6, to ascertain global ratings of psychiatrists and police as to the nature of interprofessional relationships. To examine the descriptions given by police and psychiatrists as to the nature of the relationship and identify themes which may account for the perceived nature of such a relationship (open ended responses from Interview B, questions XI and CX).

Aim 4: To consider the general aims of the thesis - an examination of the way in which the police implement Section 136 of the Mental Health Act and the professional relations between police officers and psychiatrists, in the light of the information obtained in pursuing sub-aims 1-3.

Methods:- To examine and explain the way in which police officers implement Section 136 of the Mental Health Act and the nature of professional relationships existing between psychiatrists and police officers

Aim 5: To reconsider the theoretical model of the research, taking into consideration the results of the study.

No hypothesis or method is developed in respect of these aims which has been included as a basis for the study and is not itself the subject of the research.

Section 3

Methods

Since the research aimed to explore the actions and reasons that officers attributed to issues surrounding Section 136 and their contact with psychiatrists, a methodology was required which would best incorporate the objective and subjective features of police action. The idea that quantitative and qualitative methods in one study are inimical is rejected. Rather the view is taken that both approaches to data collection are necessary to address the research questions previously outlined. Whilst quantitative methods are essential to extend beyond particular individual situations to show more general trends, qualitative methods are essential for revealing certain qualities of events, actions, motives and views which cannot be shown by empirical methods alone. Thus, in the presentation of results there is considerable oscillation between the two approaches. That the subjective aspects of officers' action and interaction with psychiatrists and quantitative indicators of the use of Section 136 were taken as crucial is reflected in the main methods outlined below.

In examining officers' action, (and to a lesser

extent psychiatrists'), an ethnomethodological approach which attempts to understand human action in terms of the definitions and accounts given by the actors themselves has been rejected in favour of a more interpretive approach. In discussing commonsense experience of the world Schutz states:-

> "To a certain extent, sufficient for any practical purposes, I understand their (actors) behaviour if I understand their motives, goals, choices and plans originating in their biographically determined circumstances. Yet only in particular situations, and then only fragmentarily, can I experience the other's motives, goals etc- briefly, the subjective meaning they bestow on their actions is their uniqueness. I can, however experience them in their typicality. In order to do so I construct typical patterns of actor's motives and ends, even of their attitudes and personalities, of which their actual conduct is just an instance of example'(Schutz 1971:496).

Following Schutz, officers' accounts of feelings and actions are to an extent subject to the interpretation and the construction of typologies of action attributed them by the researchers, as are the psychiatrists' comments.

Studies A and B

Two studies were undertaken in this thesis. It was intended at the outset to undertake an all-inclusive study. However, external constraints prevented this from happening. Whilst access to

officers was easily obtained, access to psychiatrists via hospital ethical committees took over one year to obtain. Since both time and resources were limited and there were no assurances that access would be granted by the hospital authorities at all, 'methodological pragmatism' made it necessary to begin data collecting using access to police officers that was already available.

The two studies deal with different aspects of police practice as far as Section 136 is concerned, although there is also considerable overlap on a number of matters. Data collection for Study A took place between January and September 1985[1]. The methods included in Study A were semi- structured interviews with police officers who had dealt with indiviudal referrals and completed the appropriate documents. The focus of Study A was on the circumstances surrounding the incidents to which officers were called, and the way in which they made decisions about dealing with patients prior to contact with the health services. It was also considered to be a preliminary exploratory study from which research questions for the second could

[1] Data collection for studies A and B covered the same period as data collection for Parts II and III of the MIND study.

be developed.

Study B took place between Febuary 1986 and March 1987. The focus here was on matters of interprofessional relations and contact with the health and social services. The methods for Study B included administering a structured interview to police officers and psychiatrists and examining police records. This took place over a one year period at one police station.

In terms of presenting the results, the two studies have been combined under 'issue headings' rather than presented as two distinct studies. The methods used in both studies A and B are described in more detail below. It should also be noted here that between Study A and B a short period of observational work was undertaken with police officers at one police station, in order to observe matters first hand.

The interview method

The interview method was chosen because it was thought to be the most appropriate instrument to collect the quality and type of data required by the research questions. The interview has a number of advantages, since it permits the recording of a

factual type of information and the views of officers to be probed and recorded. Further, as Sellitz et al (1966) note :-

> "The interview is the most appropriate technique for revealing information about complex, emotionally laden subjects or for probing the sentiments that may underlie an expressed opinion" (p244)

Early in the research it became evident that Section 136 would be a sensitive issue to investigate. For example, officers refused to discuss Section 136 at a nationally held conference organised by MIND in 1984. Previous attempts by MIND to gain access to undertake research were rejected because the police were unwilling to participate (Gostin, 1975).

The interview method was seen as appropriate and used here for another reason. Other studies have shown the complexities of police officers' action (e.g Holdaway's ethnographic study 1983), suggesting more indirect methods, such as the postal questionnaire would be unable to reveal the more subtle features of police activity.

As the research was entering an unresearched field it was thought prudent to collect a large amount of descriptive data. This was in order to see more

about the way police carried out their duties, as well as give a chance to examine the context within which police officers worked, and to clarify issues on matters where little was known. Thus, despite the difficulties associated with interviewing, time, resources, problems of access and interviewer biases, the interview method was adopted to form the basis of the study.

Interview A

This interview schedule formed the basis of study A. Interviews took place over a nine month period between January 1985 and September 1985. The interview schedule was designed to collect both factual and subjective data. As far as the former was concerned detailed accounts of the individual circumstances of incidents leading to and involving the police were sought. Subjective data included police opinions and views about the implementation of Section 136 and the relationship between the police and other services.

The type of data to be collected, required flexibility in the mode of questioning. The interviewing technique adopted was influenced by Richardson et al (1965) who advocate the use of the

'non-schedule standardised interview'. The wording, format and ordering of questions were not rigidly set in advance. There was no standardisation as usually achieved by identically worded questions. Instead, the interviewer relied on a list of required information where the task was to enquire into each subject area until she was satisfied that the appropriate material had been obtained.

This method had a number of advantages especially in the early stages of the research. First, detailed questioning was thought to be better than general questions which may have given rise to broad spontaneous generalisations about the incidents and little else. Second, since the interviews usually took place a number of days or sometimes weeks after the actual incident recall was important. Different constructs have different meanings, (e.g violence etc) so that asking for detailed descriptions was thought to be the best way of illuminating the content of statements and ascertaining the actual events relating to particular incidents. Third, the complexity of events and the unknown variety of responses that would be obtained was thought to be best met by flexibility of questioning, and unrestricted

numbers of questions. Fourth, the cooperation and engagement of police officers at this early stage was considered to be crucial. A flexible interviewing method was thought to be most appropriate, permitting unexpected threatening questions to be dealt with effectively, (e.g. by leaving open the option of coming back to such questions at an opportune moment). Finally, this type of interviewing was also useful for the further development of research questions in the second study (Interview B). Richardson et al (1965), claim that this approach allows the full range of material to be related gradually to specific research problems with increased precision. Unanticipated responses provide information for further insights and questions which need to be asked.

Two sorts of information were sought.

a) '<u>Factual' data</u> included behaviour (of police officers and subjects of referral) and events which surrounded the circumstances of the incident and referral to hospital. For example, the schedule included headings on the referring agent, circumstances of the incident, management in

transport and at the station. Such information was later coded onto a schedule and analyses using SPSSX.

b) 'Subjective' data included the attributes assigned by police to the events, subject and psychiatrists and the issues surrounding the use of Section 136. There were no specific headings for these items and the topics were introduced at an opportune moment during the interview.

Interviews were written up as soon as possible afterwards. Lofland (1971) has stated that field notes relating to participant observation should be written up within 24 hours. This method applied throughout. The interview was first recorded in the form of key words and later written up more fully. Moreover, at times it was felt to be important to show an interest in the conversation with the police officer in order to get the maximum 'respondent participation' and to write down notes on certain issues later.

Interview B

Interviews in Study B was carried out over a 13 month period between February 1986 and March 1987. The schedule was developed from experience gained

from using schedule A. Unlike schedule A, Schedule B used a standardised interview. It was felt that enough was now known to be able to standardise certain replies to make them more suited for quantification and hypothesis testing. Two basic kinds of questions guided the interviews. Many questions were of the 'fixed alternative' or closed type requiring specific answers (e.g. place of arrest details of officer's rank and length of service etc). Others were more 'open'(such as questions II 7 and 8) which were designed to obtain more complex or additional information.

In introducing the two interviews, the use of a standard predetermined statement about the aims of the research was rejected. A more personal and unrehearsed introduction that could be varied according to the attitude and receptivity of the respondent was used instead. The interviewer/interviewee relationship is discussed later on in this section.

Interview C

Interview C was designed to elicit information from the assessing psychiatrists as part of Study B. In order to collect data on professional dominance and interprofessional relationships, several closed and

open questions were attached to the psychiatrists' interview being administered as part of the MIND research. A structured standardised schedule was devised following a short piloting period.

Other Methods

Police and psychiatrists documents

In study A, two types of police documents were used. The 'persons at stations' form, and form '434' used by the Metropolitan Police to record where Section 136 has been used were obtained for all cases in which officers were interviewed. These documents contained information recorded by police officers at the time the referrals were being processed. They contained data on the time and place of arrest, and included brief details of the incident and record of officers' observations during detention at the police station. This secondary source of data was used to cross validate the factual information obtained in using Interview A and provide a source of extra information about the arrest and detention of subjects by the police.

Police documents were also used in Study B (see hypothesis 2j). Police records at one police

station[1] for the period 1st January 1985 - 31st December 1985 were scrutinised for any mention of mental disorder in which a minor crime had apparently been committed. Information relating to the type of disposal (e.g. court or hospital) was extracted from the 'person at station' forms or custody records[2] and recorded on a separate schedule. Psychiatrists were also asked to fill in a form for every police referral they were called to assess. This was used for two reasons: as a means of tracing the assessing psychiatrist for interview and obtaining brief details of the referral's background.

Direct observation

Observation was undertaken of general policing activities in one police station's charge room. The aim of this was to establish if the police dealt with mentally disordered people differently to 'normal suspects'. Observation of police activity in the charge room took place over a five week period, three afternoons a week (15 four hour periods), immediately prior to commencing data collection for Study B. In addition, the researcher

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The station making the largest number of referrals in Study A was chosen for this purpose.
The Police and Criminal Evidence Act 1984 came into effect on a trial basis at this station in July 1985, from which time information on detainees was kept in Custody records.

was called out to five cases[1] in order to observe, first hand, police handling, transportation of referrals and contact with psychiatirsts.

The information on the police implementation of Section 136 was obtained from police accounts. In order to check the validity of this data five incidents of police processing psychiatric referrals were observed first hand. This involved attending the station and following the cases through until after the person had been assessed by the psychiatrist at the hospital. Notice was given by telephone/radiopager of potential cases by the custody officer. This part of the observation took place over the same 5 week period and at the same police station mentioned above.

The methods chosen were amended as a result of certain constraints. There were three main external influences affecting the choice of methods. The first was political. The Metropolitan Police had recently given permission for an observational study by the Policy Studies Institute to be carried out on policing. The findings of the study, were presented by the media in a way which did not

[1] The researcher was alerted to these cases by means of a radio-paging system.

reflect the police in a positive light. From conversations with senior officers it seemed they were still ambivalant about further research. It was recognised therefore, that any research would have to be as unobtrusive as possible and sensitive to the scepticism that the police may have had about outside research. Similar considerations were pertinent to researching the psychiatrists. Whilst psychiatrists undertake a lot of research themselves, a scepticism and protectiveness against 'outsiders' was detected early on. The need to be unobtrusive in collecting data was felt to be important in the hospital as well as police settings.

The second factor was to do with section 136 being a rare event in terms of the overall workload of the police. Thus, for example participant observation at one station would not have yielded many cases. Ways of spreading the net more widely needed to be found. A call out system to observe first hand the Section 136 incidents in which the police were involved at a number of stations was also rejected. Their emergency procedures did not permit the police to await the arrival of a researcher.

A third consideration was that the methodology had to fit in with the requirments of the MIND research project - the aims and design of which were not primarily orientated to those of the present thesis. The methodology of the present thesis therefore had to be negotiated and added to these requirements.

Selecting the police officers

Police officers were the target population in this study rather than the potential patients or psychiatrists. It was decided that the officer most closely involved with a particular incident would be interviewed. This was usually the 'arresting officer' in most cases an officer of constable rank. What was needed therefore was access to a sufficent number of police offices dealing with individual cases where they had used their powers under Section 136. These were obtained through arrangements made with the Metropolitan Police. The North East Metropolitan Police Area was chosen as the area within which to conduct the research. This covered 6 police districts containing 53 police stations. The area covered was both urban and provincial and marginally extended into semi-rural Hertfordshire. However, the vast majority of police stations were located in the

densely populated inner city areas.

It was decided to approach senior officers in one of the four Metropolitan Police areas for permission to carry out the research. The Deputy Assistant Commissioner in the North East area was known to be sympathetic to research relating to mental health. For example,in the preceding year, access had been granted to a research project on the interogation by the CID of mentally handicapped people (Tulley and Cahill, 1984).

In the course of the research, two methods were used to contact police officers. Both required their cooperation and sanction. Access to carry out interviews in study A was arranged directly with the police. In study B contact was made indirectly by first ascertaining the name of the officer and police station from which referrals were made from the receiving hospitals.

Access to police officers was arranged with the police headquarters as part of the MIND research. A procedure was agreed which entailed the police stations in the area notifying the central administrative offices by sending documents relating to "all those cases in which police

initiate action under Section 136 Mental Health Act 1983". A memorandum setting out the procedure, introducing the researcher(s) and purpose of the research was sent to all stations in the Area (see Appendix). These documents were then forwarded to MIND and contact made with the officers involved in individual cases of Section 136. Arrangements for interview were made accordingly.

There were two advantages to this method. Firstly, it ensured that a sufficient number of police stations were included in the research to obtain reasonable numbers of police officers. Secondly, the probability of police stations complying with a memorandum signed by the Deputy Assistant Commissioner was far greater than if the researchers had approached each station independently. That the research had been sanctioned in this way also made the research more legitimate to a number of police officers.

There were also a number of disadvantages to this arrangement. First, that the researcher had to rely on police headquarters to ensure police stations sent the relevant documentation. A large number of stations did not respond to the memorandum. It was not clear whether this was because there had been

little use of Section 136 at these stations or simply because the memorandum had got lost under the piles of other memoranda regularly sent from police headquarters. I suspect the latter. During the course of the research, I met a Commander working in the research area who expressed interest in the MIND study, but who knew nothing of the fact that his division (which referred large numbers of Section 136 cases) was supposed to have been included. Obviously, given the priorities and pressures of policing, the central administration could not be expected to spend much time chasing up stations who had not responded.

Although initial agreement was ensured by the memorandum, (few officers overtly refused to be interviewed) another disadvantage was that officers were <u>ordered</u> to 'lend support' to the researcher. This seemed to affect the quality of some interviews. The motivation of officers seemed somewhat lacking in a small minority of cases and consent to be interviewed appeared to be given reluctantly. One officer complained that the research was just another attempt by headquarters to make unnecessary bureaucratic changes.

Study B involved a slightly different procedure. Although the authorisation in the original

memorandum covered both interviews the procedure to contact officers was reversed. Police officers were traced from the hospitals which received referrals. This involved two hospitals in the North East London area used in the MIND study. One was a district general hospital with a psychiatric unit attached and the other was a large Victorian built psychiatric hospital. Notification of police referrals, details of the referring police station and names of officers were sought from the administrative officers of the two hospitals. The officers were then followed up in the same way as they were for Interrview A. Information from this source was also used to contact, and subsequently interview, the psychiatrists who assessed Section 136 patients. Formal permission to interview the assessing psychiatrists had been obtained from the relevant ethical committees and informally from the junior psychiatrists committee.

Relationship between interviewer and interviewees.

As said earlier, the main interviewees in this study were the police. In using interviews as the core method, the need to create an effective relationship with the interviewee was recognised to gain the appropriate quality of data. Cicourel

(1964) argues that one should seek naturalness, frankness, honesty and comprehensiveness in interviews. Sellitz et al (1965) state that "the interviewer's manner should be friendly, courteous, conversational and unbiased".

Certain specific problems relating to interviewing the police were encountered which often made it difficult to follow the prescriptions advocated in methodology textbooks. For example, whether my introduction as a researcher from MIND fitted the criterion of honesty advocated by Cicourel is questionable. Often police officers did not know what MIND was and with an eye to the paternalistic/conservative values of most police officers, I chose to make analogies with MENCAP. That is, I described MIND as a charity that helped mentally ill people. In doing so I played down the radical civil liberties stance of the organisation.

Police scepticism of academic outside research was mentioned earlier and the anti- intellectualism of the police has been noted by Smith and Gray (1983). To counter any inhibiting effect that academic research might pose to officers, a naive stance to

the research issues was adopted[1]. Interviews were conducted as if the interviewer knew little about policing or mentally disordered people - which at the early stages of the research was quite genuine! This deliberate policy of naivety also served another purpose. It avoided the glossing over of topics which had been included in the interviews in order to examine the taken- for- granted assumptions of police practice.

Establishing a relationship with a group of people unused to and defensive about research meant that it was necessary to show an empathy to police culture, and the expectations and demands of their work. Interviews were as far as possible arranged at the convenience of the police, and it was largely left to individual officers to determine their time and place. Except for high ranking officers, police men and women do not have individual offices, and interviews were conducted in a variety of places including police canteens, interview rooms, and the front offices of police stations. Allowing the police to determine the place and time of the interview had disadvantages, of leading to a loss of control over the interview.

It was also important to avoid being mistaken for a social worker as it became apparent that they were regarded negatively by officers.

For example, interviews in the canteen led on more than one occassion to a number of other officers giving their opinions at the request of the officer being interviewed. However, the advantage of allowing officers a degree of control over the interview seemed to outweigh the disadvantages. It made them less defensive and enabled an informal relationship with the interviewer.

In general, contact between the interviewee and interviewer was brief[1]. At times, an initial interview would ensure that the same officer notified headquarters more frequently of subsequent cases, which resulted in further interviews with the same officer. Repeat interviews with one or two officers offered the opportunity of arranging a period of direct observation at the station at which they worked.

Relationships with the psychiatrists were different. Direct refusals to be interviwed were rare. However there were more problems in arranging interviews than with the police. On several occasions arrangements were made and then broken because appointments were forgotten or competing demands on the psychiatrists meant that interviews

[1] Interviews took between 45 minutes -1 hour to complete.

had to be abandoned or rearranged. Moreover, the psychiatrists as a group wanted more control over the content of questions they were asked[1]. So, in general, interviews were of a more formal nature than those with the police. This may have been a result of my links with MIND, which as a pressure group has frequently subjected psychiatry to scrutiny and criticism.

Ethical issues.

The ethical questions involved in this research were undoubetdly not as great as in some other studies undertaken with the police (see for example Holdaway, 1983). However, ethical dilemmas arise for all researchers in the social sciences and this research was no exception.

Perhaps, being unused to research, the officers were not familiar with the ethos that researchers' interventions should be as unobtrusive as possible. They often expected the researcher to offer practical advice about how to handle mentally disordered people, or thought I had the power to take up individual grievances they had with particular hospitals. I tried to deflect from such

[1] For example a request was made by the junior psychiatrists committee that questions about the treatment of patients should not be included.

matters. However, the approach which I adopted, and which implied a lack of knowledge on my part proved to be unacceptable as the police seemed to assume I had a certain degree of expertise about mental health. Nor was it possible to give the sort of explanation that the purpose of research was to observe what was happening rather than changing events. This approach was poorly received. A more successful strategy was to be evasive in ones replies, especially when requested to help in individual cases. At times however it was impossible to avoid discussing 'police problems'. On these occassions 'advice' was kept to a minimum and discussions confined to the legal guidelines of the Mental Health Act.

There was also the ethical dilemma involved in carrying out interviews with police officers about individual referrals. Permission had not been given by patients to gather information from police officers on incidents which were of a very personal nature. Indeed the low response rate of patient interviews for the MIND research indicated that most patients did not wish to divulge such information.

Such problems as existed intensified with the

observational work. In some cases the presence of the researcher had a direct effect on the outcome in particular cases. For example one officer in trying to be helpful, escorted into the charge room a person he thought may have been of interest to me and said " heres one for you, now ask him some questions". Fortunately, the person did not seem unwilling to be interviewed and chatted amicably. This person therefore helped to circumvent an awkward situation arising. A final ethical problem relates to the fact that neither the police officers nor assessing psychiatrists were informed about their participation in this thesis. Both assumed that they were participating in a research project for MIND but not for a Ph.D thesis at the University of Nottingham. A decision was taken early on not to inform participants. It was felt that this would introduce unnecessary confusion and endanger the already precarious access negotiated.

This chapter has outlined the methodology of the study, issues surrounding gaining access to police officers, the relationship between the interviewer and interviewees and ethical issues. In the next chapter the reliability and validity of the study are examined.

CHAPTER 4

RELIABILITY AND VALIDITY

Having considered the methods used in this thesis, it is now necessary to address questions of validity and reliability. Reliability is a prerequisite of validity and refers to the stability and equivalence of a measure (Kahn and Canell, 1968). In the case of interviewing, it refers to whether, if used repeatedly, or by different interviewers, similar results are produced.

A major source of unreliability is distortion which arises from the predispositions of the interviewers. When more than one person was involved in data collection, the study suffered from the problems associated with multiple research workers. For example, difficulties may intrude with different perceptions of research questions, and styles of interviewing. A number of interviewers however had the advantage of providing checks on any distortion of evidence which arises where research is carried out by only one person. As more than one person carried out interviews, inter-rater reliability was essential. Testing for inter-rater reliability was built into the design of interviews A and B, yet modified by two considerations. The first was to maintain the quality of data available, from individual officers. It was noted

for instance, that when two researchers attended interviews the officers were more reticent in their replies. Secondly, resource constraints, such as those of time did not allow the researchers to attend all interviews together. This meant that only a proportion of interviews were attended by two researchers.

The interviews

With regard to interview A, the first four interviews were attended by two researchers to ensure that parameters were set for future interviews (i.e. that similar information was being obtained). Subsequent to this, every 10th interview was attended by the same two interviewers. These were then written up separately and compared for the nature of information recorded. From this exercise it was evident that the researchers adopted different styles of asking questions. However, since this was permitted by the flexible type of interview schedule chosen, in itself, this did not present a major source of unreliability. In general, the same 'factual ' information was recorded and written up by the two researchers. However, there were discrepencies with regard to the subjective data. The researcher conducting reseach for this thesis was more likely to include

greater detail of officers' views and perceptions than the MIND researcher.

A similar procedure was followed for Interview B. That is, the first few interviews were conducted with another person[1], and subsequently double interviews took place at regular intervals. The styles of asking questions had greater concordance than between the researchers in Interview A, and there was general agreement about the nature of information collected.

It was recognised that greater awareness of the issues meant that care had to be taken not to create a halo - effect in later interviews by extrapolating from information gained ealier. Thus, a conscious effort was made towards the end of the data collection period, to ask each question in as much detail as in earlier interviews.

Difficulties associated with biased perceptions are not confined to conducting interviews. They can arise at all stages of the research process: for example in the interpretation of behaviour, and in the analysis of data itself. It was not possible to build inter-rater reliability into other parts of

[1] A different interviewer to that involved in Study A.

the research and it is inevitable that the perceptions of the researcher were a source of unreliability, the effect of which is difficult to evaluate. However, with relevance to the validity as well as the reliability of the study it is recognised that the views, perceptions and values held by the researcher cannot be totally controlled. Moreover, they are essential in directing and formulating the research questions to be asked. The position adopted here is that sociological research cannot be completely value-free and that neutral disinterestedness in research is not achievable. However, honesty about any value preference, by declaring conscious motives is considered a precondition.

In answering Becker's (1973) important question 'whose side are we on', there was at the outset an awareness of a predisposition in favour of the people who were subject to police detention and referral to the psychiatric services. I had worked in hospital settings and had a sociological education which highlighted the deleterious effect of mental health services and controlling aspects of the management of emotional deviance. Thus, I had no taken-for-granted assumptions that the police or psychiatric services were simply there

or caring for those with mental distress. My background assumptions led me to be aware of an empathy with those subject to legal and professional powers. Such assumptions were useful for analysing in more depth matters which, on the face of things, appeared to be commensensical. It also meant that I had to guard against being drawn away from examining aspects which did not fit my world view.

Validity

Validity can be defined as:-

> "..... the extent to which an instrument and the rules for its use measure what they purport to measure" (p 213, Cannell and Kahn, 1954).

There are a number of types of validity used in social science research, many of which have little relevance to the type of study undertaken here. Of most relevance to the present study were, construct, external, concurrent and face validity.

i) The theory

The theory of professional dominance required collecting data on officers' and psychiatrists' opinions and occupational strategies. To examine these topics, direct observation of

police/psychiatric interaction and parallel questions in police and psychiatrists' interviews were used. Overall, it was considered that the interviews, supplemented by observation, did tap the subtle processes of professional interaction, which may have been hidden using other methods.

ii.The population studied

External validity refers to the extent to which results can be generalised beyond the research situation. The absence of previous research into police implemention of Section 136 meant there were no means of comparing the representativeness of the population in Studies A and B. Thus, no random or constant errors could be identified or removed. Nor was it possible to establish whether those officers interviewed were representative of police forces in the UK. Each police force would require investigation in order to obtain a national comparison. Tentative enquiries were made as to the feasability of collecting data from an urban and rural area outside London. However, the difficulties involved, meant that this idea was abandoned. To the extent that the research design allowed a large sample of police officers from the Metropolitan Police Force to be interviewed (100 in Interview A and 61 in Interview B) the research can

be said, with a degree of reasonable certainty, to be representative of police officers currently working in the Metropolitan Police Area, if not of those working in different areas of the country. With regard to the psychiatrists, a number were interviewed on more than once occasion[1]. This meant that there were fewer of them than the police officers, and therefore as a group they were probably less representative.

iii) The interviews

As with all exploratory studies, which tend to use mainly open ended questions, one of the drawbacks of the interview design was that a number of the questions were imprecise and lacked clarity. Questions about the management of the incident and police identification of mental disorder were examples of this. These items were refined in a more systematic way in Interview B.

Interview A

Some of the information using Interview A was found to be peripheral to the main aims of the thesis. This was so with the early interviews. At that time, parameters had not yet been set and some unnecessary information was collected.

[1] Thirty eight psychiatrists were interviewed.

Interview A sought to establish the circumstances surrounding the arrest of Section 136 referrals. Since this information was dependent on police accounts, this data may not be accurate. Attempts were made to cross- validate information given by police officers. At the beginning of the interviews, officers were asked to give a chronological account of the circumstances of the particular incident. They were asked about the incidents again through detailed questioning during the rest of the interview. Any inconsistencies over details were pointed out, and the officer was asked to clarify the circumstances again, or the question was repeated to ensure a more accurate picture. On most occasions the officers were able to recount very clearly the circumstances of incidents. Police documents were used to cross-validate factual information obtained from the interviews. In most instances, such information seemed to correspond closely. However police documents proved inadequate for data on police identification of mental disorder and decisions. Attempts to test validity were made through first hand observation of police processing of cases. It was only possible to attend five such instance and though no glaring discrepencies were found, this form of cross-validation must be considered limited.

Interview B

The experience gained in Interview A meant that in constructing the questions, impreciseness, lack of clarity and irrelevant questions were greatly reduced. For example, in Interview A it was found that officers had difficulties answering questions on the nature of mental disorder. In order to increase the response rate a fixed choice question was included (QVIII,1). Establishing concurrent validity for particular questions was also possible to a greater extent. Psychiatrists' accounts in Interview C, gave indications of how long a person was kept at the station after the police had contacted the psychiatrists to provide an assessment, allowing large discrepencies to be detected.

Several questions considered important at the outset were found to be peripheral - often adding complexity to interviews. Question VIII, 2 ("Does the officer consider the person a typical Section 136 case") was deemed to be of little use because the wording produced responses which were too general. Question II, 6 was designed to ascertain whether the person was forcibly moved into a public place, so that the police could arrest them. This was not answered succinctly by officers - probably

because of its sensitive nature.

A further question found to be imprecise was question X1,6 which appeared in the schedule worded as, " In general how would you best describe the relationship between the police and psychiatrists as compared to the relationships with GP's and others". It appeared to the respondents as if it emphasised the comparative nature of the police's relationship with psychiatrists. Yet, it was intended to produce answers about their relationship in general. So, in some instances, it was necessary to probe further to ascertain general, as well as comparative views of psychiatrists. The problem of clarity was found to be particularly important in respect of Questions X1 1-6 (concerned with how the police perceived psychiatrists). These answers were therefore subject to intensive probing.

The main impression about the validity of Interviews A and B is that the quality varied in respect of individual officers, the circumstances surrounding the interviews and the type of questions asked. There was only one instance in which it was felt that an officer was deliberately involved in misrepresentation. In this case, there

was some evidence from interviews with the psychiatrists and patient, that the officer had acted in an inappropriate manner. When interviewed the officer provided vague and inconsistent information. Apart from this obvious case, it was believed, based on subjective criteria of veracity and tenability, that officers generally were not involved in misrepresentation.

Despite the lack of evidence of overt misrepresentation, the quality of the replies varied according to the type of data collected. Replies to factual questions seemed fairly accurate in that data corresponded closely with information from police documents. Face validity of these type of questions also appeared to be high in that officers replied in a way which was consistent with the questions being asked[1]. The qualitative data were less easy to subject to conventional tests of validity, and the quality of replies varied. Whilst some officers offered well formulated and detailed opinions, others tended towards vagueness and imprecision in their replies.

It should be noted here that two criteria of

For example, no officer objected to a question being asked or questioned the relevance of a particualr line of inquiry.

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validity have been considered relevant to the qualitative data. The first is a conventional notion that qualitative data lends itself to the same methods of validation as quantitative data[1]. The other is the need to elicit the revealing aspects of a certain amount of the qualitative data collected. Plummer (1983) argues that validity of qualitative material requires justification on the basis of quality of the consciousness of the subjects, rather than empirical representativeness. He quotes Blumer in this regard:

> " a half dozen individuals with such knowledge constitutes a far more representative sample than a thousand individuals who may be involved in the action that is being formed but are not knowledgeable about that formation" (Blumer 1979 pxxxiii).

It was evident that certain officers offered greater insights than others about the issues being investigated. Officers with less experience of psychiatric patients appeared less likely to offer formulated opinions than those who had more experience. The latter also tended to offer detailed opinions about psychiatrists[2].

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example by analysing the range of views of officers and comparing with others.

Community 'home beat' officers appeared to have greater contact with mentally disordered people as did officers in stations near to psychiatric hospitals.

we do- so they know all the factors" (C045).

The majority of officers who considered that psychiatrists were not in a position to evaluate all the associated factors of a particular case appeared to do so for three main reasons. Firstly, because psychiatrists are not party to the social circumstances which result in referrals being made. For example, one officer stated that because psychiatrists see the person in a hospital environment they are not in a position to to appreciate the "field situation". Another stated that "they don't always take into account the fact that a person can't look after themselves and have nowhere to go" , (C064) whilst another thought that a person's home situation was often ingnored (C014).

The second reason relates to the absence of a policing ethos on the part of psychiatrists. For instance, a number of officer's (6) claimed that psychiatrists failed to take into account the precipitating disruptive circumstances of the referral. Others referred to the lack of credence given to the control needed to contain patients as illustrated by the following comments;

> "... they [psychiatrists] ignore extreme and indiscriminate violence" (C002);

> " They take no notice of the violence the person presents to others around him in the community. The fact that the

because the research was being conducted by external researchers, who were not medical practitioners, asking questions about issues related to clinical matters. Thus, the data collected was not as detailed as was hoped.

Direct observation

A further method used was observation of police activity. This was included to cross-validate data from the police interviews and to ascertain additional information relating to police activities which the interviews might not have revealed. Inevitably, the presence of the researcher affected police action and thus the validity of data collected. At times, it was apparent that officers made conscious efforts to be on their 'best behaviour'. However, overall no general conspiracy to deceive the researchers was detected. Working in a central London police station, the flow of suspects through the charge room meant that officers were often busy and under pressure from a number of competing demands. This made any special performance for the benefit of an outside researcher unlikely.

Conclusions and comment

The validity of this study should be considered in

relation to all the methods used. The researcher was faced with the wide task of ascertaining the nature of police action as it related to an under-researched area of mental health. For this purpose, a mixture of qualitative and quantitative methods were used. Most reliance has been given to the information obtained in the interviews, especially of the 61 officers in Interview B. Other evidence obtained in the study through psychiatrists' interviews, direct observation and police documents have been used to complement the information obtained in the interviews. The various sources have been used to address the original aims of the research. In some instances (e.g. police documents and observation), the methods were used to cross-validate information obtained from the police interviews. The psychiatrists' interviews have been used to complete a picture of the pertinent issues relating to professional dominance.

Of relevance to the interviews, and to a lesser extent other methods used, validity may have been affected by the timing of the research. The period between the beginning and completion of interviews was 26 months. During this time the Metropolitan Police underwent administrative changes, entailing

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a management reorganisation[1]. As a result, certain procedures were altered including those relating to Section 136. New orders instructed officers to wait for 20 minutes after delivering a person to hospital for assessment. Such changes may have had subtle but important effects on police-psychiatric contact.

Changes in legislation may have also had an impact. Firstly, during the course of the research, officers may have been made more aware of issues relating to Section 136, as an indirect result of the introduction of new mental health legislation. The introduction of the Mental Health Act Commission (under Section 121 of the Act), to review compulsory mental health powers, meant that officers from some stations in the North East Metropolitan area were invited to attend meetings with Commissioners and hospital staff to discuss Section 136. Secondly, the Police and Criminal Evidence Act 1984 became operational during the last 15 months of the research. This involved changes in the documents used to record Section 136 and in the code of practice related to the detention of mentally disordered people. It

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s also resulted in the area being adminstratively divided into two
ller ones.

specified that officers must call a police surgeon if they suspected a detainee to be mentally disordered[1], and the need to call in an "appropriate adult[2]" before permitting a mentally disordered person to be interviewed by the police.

The effect of these changes between 1984-7 on both police practices in implementing Section 136 and attendent police opinions is difficult to ascertain. However, awareness of the issues relating to Section 136 appeared more in evidence at the end of the research period and may have been the result of the combined changes to legislation and procedures and the presence of research being carried out over a fairly long period of time.

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[1] Previous standing orders only specified the need to call a medical practitioner for physical illness.

[2] Lay or professional person external to the police experience of dealing with mental disorder.

A personal view of the research

Whyte (1966) suggests that an understanding of how research is conducted on an everyday basis requires a personal account from the researcher. In some respects doing the research was much easier than might have been expected. This was because of its interconnection with the MIND project. Thus, for example, the maintanence of formal access to the police was guaranteed from the outset. There were also few doubts once the research instruments had been designed, as to the feasability of completing data collection. Nonetheless, there were a number of problems with the day to day process of carrying out the research.

At a formal level, access to officers had been guaranteed by police headquarters, and once engaged on a face to face basis, officers were generally cooperative. However, getting to this stage was sometimes difficult. Considerable time was spent in telephone conversations tracing the individual officers involved in incidents and establishing the basis of authority to carry out the research. No doubt persuasion and endurance in gaining the agreement of subjects is a part of most social science research. In this and the MIND research this was initially difficult. Not only was making

contact often time consuming and involved a substantial amount of travel to different police stations but there was a fear of the unknown. I had never previously been inside a police station and experienced a degree of apprehension about communicating with a group who were imbued with considerable social and cultural power.

Once this initial obstacle had been overcome, the police were generally interested and cooperative respondents. This not only ensured high quality data, but made the task of interviewing a pleasant and interesting one. The ease with which the police engaged in the research contrasted with the psychiatrists, who remained aloof and reserved, and frequently indicated time given over to interviewing was precious[1]. Thus, interviewing psychiatrists was less enjoyable and the data was correspondingly of poorer quality.

That psychiatrists were a more difficult group to work with may have been due to personal factors. They may not have liked me. Structural factors too which are not unrelated to the theoretical interest of this thesis, may also have played their part.

One psychiatrists greeted me by asking me whether I was medically qualified and said that he couldnt waste much time being interviewed.

Neither the police nor psychiatrists have been subject of much research - the latter being more used to conducting research themselves rather than being research subjects. However, in the case of the police, the subject matter appeared to be one which they were not deeply involved in, and therefore were more open to being researched than their psychiatric counterparts.

Sociological textbooks on research stress the effect that the values of the individual investigator brings to the research, and the importance that such values have for the questions that are asked and the way in which data is analysed. Little is said about the effect that conducting research has on the premises and ideology of the researcher. For my own part, exposure to police culture and handling of mentally disordered people involved changes in the way in which police officers and their work were perceived. In one incident a man slashed his wrists and tried to strangle his wife because 'God had told him to' before being placed in police custody, where he wrenched the toilet from the police cell he was occupying. In another incident hospital staff refused to respond to a woman who subsequently mutilated herself and had to be looked

after by the police all night. These were examples which created empathy with both the subjects and the police who had to deal with them.

Some preconceived assumptions about mental disordered people were also challenged. Whilst, in the main, the image held that such people were victims of social deprivation other impressions were created too. Some referrals made other people's lives a misery, like the grandiose manic man who locked his mother out of the house for three nights. Out of desperation she turned to the police. Also there was the dictatorial man who poured a bucket of icy water over his wife and shouted abuse at her as she returned from shopping. Such incidents highlighted the powerless position of relatives and made me realise that inter-personal power is not always loaded against the person considered mentally disordered. The accounts and observation of incidents invoked a number of different emotions; sadness and anger at the inadequecies of responses by services and poverty of the quality of lives both the referral and others were subjected to. During the observational work there was at times fear of violence. Equally humour was invoked by the bizzareness of certain incidents which was

emphasised by the sardonic accounts of the police.

Whilst there were few problems encountered during the collection of data, other aspects of the research were problematic. Conducting the thesis in conjuction with the MIND project was helpful in that it presented the opportunity to carry out this research. Yet, in other respects, it was an inhibiting factor. An obvious difficulty was keeping the two projects separate. The different theoretical and methodological issues underpinning the two studies also caused practical problems. Data collection for example, had to be documented separately, and the two interconnected studies had to be constantly thought of in idiosyncratic ways.

INTRODUCTION TO THE FINDINGS

The findings are placed in five relatively discrete sections summarised as follows:

1.<u>The characteristics of the actors and the incidents</u>[1]. The background features of the three groups of actors, which in (Study B were 91 referrals, 61 police officers and 38 psychiatrists), and the characteristics of the precipitating incidents attended by the police are examined. These are presented in Chapter 5 and relate to aims 1 and 2a.

2.<u>The nature of referral and police action in public places.</u> Data is presented on the referral agents. This is followed by an examination of police apprehension decisions. A description of police management techniques and the presentation of data related to the police identification and construction of mental disorder. These issues are examined in chapter 6 and relate to aim 2 hypothesis 2b - 2 x.

3.<u>Patterns of decision making at the station and negotiations with psychiatrists.</u>

From data collected in studies A and B an

[1] Where information was collected in both Interview A and and Interview B data has been presented for both studies.

examination is made of the process of decision making as it relates to the disposal of referrals and issues relating to the contact and interaction over psychiatrists and police negotiating acceptence of referrals for assessment. This section relates to Aim 2 Hypothesis 2 - 2m and aim 3a and are presented in chapter 7.

4. Police and psychiatrists interaction in hospital settings[1]. The perceptions of the two professional groups in relation to individual referrals is examined, and the nature of professional contact and perceptions of roles and abilities of the two professions hold about one another. These issues are examined in chapter 8 and related to aim 3 hypothesis 3b- 3k.

5. Conclusion and theory re-examined. The various issues examined in chapter 4- 8 are drawn together in the concluding chapters. The last chapter being concerned with the reexamination of the theoretical underpinnings of the research.

Tests of significance

In all the subsequent chapters, use has been made of chi- squared tests to examine sample variables . Chi- squared values (X^2) have been indicated. Where

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Using data from Study B.

the probability of difference has been shown to be less than .05 (i.e. p<.05) it has been assumed that a statistically significant relationship between two factors is present. In all tests where the degree of freedom is 1, (df = 1), and the cell numbers are small the Yates correction has been used. In chapter 8 Pearson's correlation coefficient[1] has been used to assess the degree of linear relationship between psychiatrists' and officers' perceptions of referral characteristics.

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[1] Which measure the linear relationship between variables measured at the interval level. (Matheson et al p351 1978.

CHAPTER 5

THE ACTORS AND THE INCIDENTS

APPENDIX TESTS 5.1.- 5.5.

To put into context the subsequent results in this first chapter, two issues will be examined:-

i. the socio-demographic and other characteristics of the three subject groups involved.

ii. the nature of the incidents which led to the police being called.

The referrals, police and psychiatrists

Aim 1: To examine the background features of the referrals, police officers and psychiatrists.

The purpose of this section is to present data on the background features of the referrals, and the two occupational groups. Whilst in some respects, this data is marginal to the main study it has been included because of the paucity of accurate information available on Section 136 referrals generally. Previous studies and available DHSS statistics have not presented a comprehensive or representative picture of the socio-demogrpahic features of police referrals, nor have they included information on the two professional groups. It is suspected that this lack of information has led to Section 136 becoming one of the most controversial sections of the Mental

Health Act. Therefore, it is hoped that this chapter will provide some of the basic information which has not previously been available. Such information may also be of use to subsequent research by making comparisons possible.

The sources of data available limited the type of information that could be obtained for these purposes. As said earlier, access to patient records was not possible. As a result, important items such as the past psychiatric history of the referrals are missing. Data was collected from psychiatrists and police interviews and documents in studies A and B, and verified where possible by hospital administrative records. With regards to the collection of information on the psychiatrists and police officers themselves, interview questions of a personal nature tended to provoke some hostility from interviewees during the pilot stages. Thus direct questions on background information with regards to police officers was limited to interview questions in Study B about service. With regards to the psychiatrists, this is even less. It is restricted to what could be observed (i.e. sex and ethnicity). An important missing socio-demographic variable for all three groups was social class.

The referrals

Hypothesis 1a:- There will be no marked differences in the background features of the referrals.

Turning first to the type of referral. The age, sex, marital status, ethnic origin, previous criminal record, employment status, and area of residence of the referrals are examined. All referrals in the study were made by the police. In only one instance was a case excluded from analysis. This was where there was evidence that Section 136 had not been used, and where the procedure described by the assessing psychiatrist resembled that of Section 135 of the Mental Health Act.

There were two main populations of referrals. In Study A 100 police officers were interviewed about the same number of referrals and police documents collected. In Study B the police and psychiatrists dealt with 91 referrals[1]. A number of people in both studies were referred on more than one occasion. However, because names were not routinely recorded, as a condition of access. it is not known how many were referred more than once. Therefore, for the purposes of analysis, each incident has

[1] Only 82 of these were eventually referred onto hospital.

been counted as one referral. In Study A referrals were made from 7 police stations to 13 hospitals. The highest number of referrals made to any one hospital was 21, the smallest was 1. The mean number of referrals for each station was 14.2. In Study B, the 91 referrals came from 11 police stations to two places of safety. The largest number of referrals made from one police station was 16, the was smallest 1. The mean number was 8.3. The number made to the hospital with the psychiatric unit was 24, with 68 made to the large psychiatric hospital on the outskirts of London.

a) Age of referrals.

Table 5.1. Age of the referrals

	Study A		Study B		Totals	
	%	(n)	%	(n)	%	(n)
17-25	27.0	(27)	32.0	(29)	30.0	(56)
26-35	32.0	(32)	17.5	(16)	25.0	(48)
36-45	15.0	(15)	15.5	(14)	15.0	(29)
46-55	11.0	(11)	11.0	(10)	11.0	(21)
56-65	6.0	(6)	9.0	(8)	7.5	(14)
66-77	3.0	(3)	3.0	(3)	3.0	(6)
76-88	1.0	(1)	0	(0)	0.5	(1)
86+	1.0	(1)	1.0	(0)	1.0	(2)
Missing	4.0	(4)	11. 0	(10)	7.5	(14)
	100%	(100)	100%	(91)	100%	(191)

The peak age group for the two populations

(totalling 191) referrals was 17-25 years. The youngest referral in each of the populations was 17 years in Study A, and 19 in Study B. The eldest was 86 in Study A and 96 years in Study B. There was little difference in the ages between the two populations. The mean age in Study A was 34.5 years and 30.9 years in Study B, and for both together was 32.7 years.

The population appears young compared to other populations in studies of compulsory admissions to hospital (Bean, 1980; Szmukler, 1981) but similar in age distribution to previous studies of Section 136 (Rogers and Faulkner, 1987; Sims and Symonds, 1976). In this respect, it would seem that the age distribution presented in table 5.1. is more akin to a criminal than a psychiatric population[1].

b).Sex of the referrals

Table 5.2. Sex of the referrals

	Study A	Study B	Totals
	% (n)	% (n)	% (n)
Male	50.0 (50)	50.5 (46)	50.2 (96)
Female	50.0 (50)	49.5 (45)	49.8 (95)
	100% (100)	100% (91)	100% (191)

[1] Young people are highly represented in offender populations and in contacts with the police for public order and criminal matters (Smith and Gray 1982, Southgate and Ekblom 1984).

The proportion of males and females in Table 5.2 is different from some studies on Section 136. A slightly higher proportion of men to women were shown in the studies by Rogers and Faulkner (1987) and Simms and Symonds (1976), whereas in this study the ratio between males and females is remarkably alike. However, it is a similar ratio to the study by Szmukler (1981) who found a ratio of 1 male:1 female. Compared to psychiatric populations generally women in the study are under-represented. (DHSS figures for 1984 show that 58.6% of informal admissions and 59.1% of compulsory civil admissions were women).

Speculating on this data, it may be that Section 136 tends to reflect behaviour which is a threat to public order. It may be more common for the behaviour of mentally disturbed men to include outwardly displayed aggression, which attracts the attention of the public and police. Women are also, in general, greater users of health and social services (partly as a result of childcare and domestic responsibilities) and so may be more likely in a psychiatric emergency to find their way to hospital via these other agencies.

c) Marital status of the referrals

Table 5.3 Marital status of the referrals

	Study B	
	%	(n)
Married/cohabitating	13.5	(12)
Single	51.5	(47)
Separated/divorced	10.5	(9)
Widowed	1.5	(1)
Missing	24.5	(22)
	100%	(91)

Table 5.3 shows that with regard to the population in Interview B the majority 47 or 51.5% of the Section 136 referrals were single with comparatively few, 12 or 13.5% living with a spouse or cohabitee at the time of referral. The large number of single referrals is greater than for other psychiatric populations which show a higher number of married or cohabitating patients (Bean, (1980; Szmukler, 1981). Whilst some of the medical literature suggests that being single makes a person more prone to mental illness than those who are married, it is also possible that this comparatively high number of single referrals may be related to a person's social network. Previous research shows that a partner is the most likely people to refer to other agencies concerned with emergency psychiatry, when signs of mental disorder become threatening or where danger is involved

(Clausen and Yarrow, 1955; Horwitz, 1980). The same detection and referral opportunities are not as likely to be available to single people. Mad behaviour may, as a result, more frequently erupt in public places and involve the police.

d) Ethnic origin of the referrals.

Table 5.4. Ethnic Origin of the referrals

	Study A		Study B		Totals	
	%	(n)	%	(n)	%	(n)
Afro-Caribbean	41.0	(41)	36.5	(33)	38.7	(74)
Asian	2.0	(2)	4.5	(4)	3.1	(6)
Greek/Cypriot/ Turkish	2.0	(2)	2.0	(2)	2.1	(4)
Arabic	1.0	(1)	0.0	(0)	0.5	(1)
White	51.0	(51)	52.0	(47)	51.3	(98)
Missing	3.0	(3)	5.5	(5)	4.1	(8)
	100%	(100)	100%	(91)	100%	(191)

The ethnic origin of the referrals is presented in table 5.3. The majority of referrals were white, (98 or 51%). There was also a high number of Afro-Caribbean referrals (74 or 39%). Compared with the population generally, as indicated by the local census data and other studies of psychiatric populations (e.g. Hitch and Clegg, 1980), Afro-Caribbean referrals were over-represented. In contrast, the Asian and White referrals were under-represented (the local ward census classifies 19% of the population as Afro-Caribbean, 6.9% Asian

and 73.4% White).

The Afro-Caribbean group were found to be significantly[1] younger than the other referrals (X^2 = 4.6653, d.f.= 1, p <.0308). Seventy two percent (or 23) were aged below 35 compared to 45% (or 22) of the rest of the referrals (see test 5.1). There were no such differences regarding other socio-demographic variables of employment, marital status and gender (see tests 5.2, 5.3.and 5.4).

There are a number of possible reasons which could account for the high proportion of Afro-Caribbean referrals. From a psychiatric view point (e.g. Copeland, 1987) it has been suggested that the type of pathology presented by young black men may account for greater referral from law and order agencies. However, such claims about higher rates of psychosis /schizophrenia amongst this group have only been based on research examining clinical populations, rather than epidemiological research which deals with base rates in the general population.

The disproportionate number of Afro-Caribbean referrals in the study may simply reflect the

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[1] Tests are included in an Appendix at the end of chapter 5.

higher rate of contact between black people and the police generally. Afro-Caribbeans are over-represented in criminal statistics for certain 'street' crimes, and one recent study shows a greater likelihood of 'negative' contact (e.g being stopped and searched) with the police than white groups (Smith and Gray, 1981). With regards to the policing in the geographical area covered by the research, one locality in particular made a greater number of Afro-Caribbean than White referrals[1]. Intensive policing took place because the local force considered that most of the trouble on their patch was attributable to young black people. Therefore it may have been that the increased opportunities for reporting by members of the public, and contact in the streets between black people and the police, together contributed to the high proportion of Afro-Caribbean referrals.

Differences in help seeking of Afro-Caribbean people may mean that they are less likely than White or Asian people to use other agencies dealing with emergency psychiatry. Ineichen et al (1984) have suggested that alienation and distrust may be a reason for low take-up of primary health care services by ethnic minority groups.

Nine out of fifteen referrals made.

Another factor which may be of relevance is the 'outdoor' culture, of young Afro-Caribbeans. If a greater part of Afro-Caribbean social life takes place on the streets, then mad behaviour is more likely to be detected and dealt with by the police, than is the case with white people, who tend to have an 'indoor' culture. Finally, emotional disorder amongst young black people by police and the public maybe construed as more threatening and thus in need of being dealt with by the psychiatric services via the police.

e)Criminal history

Table 5.5 Criminal history

	Study A	
	%	(n)
Criminal record	30.0	(30)
No criminal record	30.0	(30)
Missing	40.0	(40)
	100%	(100)

Table 5.5 presents the number of referrals in Study A, who were recorded on charge sheets, or 'person at station' forms, as having a past criminal history as identified by local officers from computers at police headquarters. Of those where the presence or absence of a Criminal Record

Offence (CRO) number was recorded, 30 or 50% were found to have been convicted for a previous criminal offence. This data suggests that a large number of the referrals are 'doubly deviant', i.e. labelled as both criminally and psychiatrically deviant. Thus, Section 136 is only one means of disposal used by the police for the same population. The use of the courts on one occasion does not preclude the use of a psychiatric disposal on another.

g) The employment status of the referrals

Table 5.6 Employment status

	Study A		Study B		Totals	
	%	(n)	%	(n)	%	(n)
Employed	7.0	(7)	9.0	(8)	8.5	(15)
Unemployed	65.0	(65)	51.5	(47)	58.5	(112)
Retired	3.0	(3)	6.5	(6)	4.5	(9)
Houseworker	0.0	(0)	1.0	(1)	0.5	(1)
Other (e.g student)	0.0	(0)	5.5	(5)	2.5	(5)
Missing	25.0	(25)	26.4	(24)	25.5	(49)
	100%	(100)	100%	(91)	100%	(191)

The table on employment status shows that the majority of referrals were unemployed. Of those where employment status was known, 65 in Study A were unemployed and 47 in Study B. Compared with official statistics, these proportions are far in excess of national and regional unemployment

figures. (The 1986 figures for Greater London show a 9.30% unemployment rate.) They also appear high in relation to another study of referrals made under the civil compulsory powers of the Mental Health Act (Social services research group 1986).

h) Area of residence.

Table 5.7. Area of residence

	Study A	
	%	(n)
Local	69.0	(69)
Not local	9.0	(9)
No fixed abode	9.0	(9)
Not known	13.0	(13)
	100%	(100)

The data presented in Table 5.7. shows that the overwhelming majority of people had local addresses. Only a small proportion were resident outside the local community. Compared with previous studies of Section 136 cases[1], the number of people (9%) of 'no fixed abode' is relatively small. The reasons for the lower number of homeless referrals in this study is not clear. Unlike Szmukler's and Rogers and Faulkner's research (1981;1987) the area from which police referrals was made did not

[1] Sims and Symonds (1975) found 20% of their police referrals sample to be homeless, Szmukler (1981) 56%, and Rogers and Faulkner (1987) 17.2%.

contain a mainline railway station where homeless people tend to congregate. This may, in part, explain the lower rate. It is also possible that previous studies might have overestimated the numbers of homeless people in their samples because they relied on hospital case records. From my field work with the police, sometimes officers recorded a person whose home was not in the immediate catchment area as being of 'no fixed abode'. This may have been a strategy for persuading the hospital to accept them for assessment.

That the majority of referrals came from the local area contrasts with previous claims in the psychiatric literature that a large number of Section 136 referrals come from outside London (Kent, 1969; Rollin, 1965). That only a small number of people either came from outside the locality or were homeless, points to stability in the referrals' social existence. This contrasts with previous psychiatric thinking. Hitherto, justifications about failing to provide support or deliver treatment to this group have been made on the assumption that these patients are transient and geographically dislocated[1]. For this group of referrals, lack of earlier intervention, whether

[1] Rollin (1965) for example asserted that London attracts 'chronic psychotics' from all over the United Kingdom.

from psychiatric or social services, cannot be attributed to any lack of social stability.

In summary the typical Section 136 referral is: young (aged below 35), single' living in the locality of the referring police station, as likely to be male as female, only slightly more likely to be white than black, and equally likely to have a criminal record as not have one. This suggests that null hypothesis 1a should be rejected.

The police

Hypothesis 1b:- There will be no marked differences in the background features and service experience of police officers

In this section the sex, ethnicity, length of service and previous experience in dealing with Section 136 of officers Interviewed in Study B is presented. 61 officers were interviewed at 7 police stations. The largest number interviewed at one station was 17, the smallest was 1.

a) Sex of the police officers

Table 5.8 Sex of the police officers

	Study B	
	%	(n)
Male	88.5	(54)
Female	11.5	(7)
	100%	(61)

It can be seen from Table 5.8 that the overwhelming majority, 54 or 88.5% of the officers interviewed were male, and only 7 or 11.5% were women. This contrasts with the gender distribution of the referrals, which are divided almost equally between men and women (see table 5.8). It is however, similar to the sex ratio of officers in the Metropolitan Police as a whole, 90% of whom are male (Jones, 1984). The data here suggests that Section 136 is not police work which is based upon any particular sexual division of labour.

b)The ethnic origin of the officers.

Table 5.9 Ethnic origin of the officers

	Study B	
	%	(n)
White	95.0	(58)
Afro-Caribbean	1.5	(1)
Missing	3.5	(2)
	100%	(61)

Data presented in table 5.9 shows that all but one of the officers were white. This contrasts with the ethnic breakdown of the referrals which included a high proportion of Afro-Caribbeans.

c)Officers Rank

Table 5.10 Rank of the officers

	Study B	
	%	(n)
Inspector	3.3	(2)
Sergeant	11.5	(7)
Constable	85.2	(52)
	100%	(61)

Table 5.10 shows that officers were mainly of constable rank. Officers of a higher rank had responsibility for officially referring a person to the psychiatric services, by filling in the appropriate documents. Instances where they were involved in the apprehension, management and transportion of referrals were exceptional. These included the following examples. A CID inspector whilst taking a statement about a crime, became aware of a women's disturbed mental state and referred her under Section 136 (C015). In another case (064), an inspector was involved in apprehending a referral because the social services

department specifically asked for someone of his rank to use Section 136. The woman had already been deemed by them to require psychiatric attention.

d) Previous experience.

Table 5.11. Length of service

	Study B	
	%	(n)
0-5 years	49.0	(30)
6-10 years	26.0	(16)
11-15 years	5.0	(3)
16-20 years	10.0	(6)
21+ years	6.5	(4)
Missing	3.5	(2)
	100%	(61)

Table 5.12

Number of times Section 136 invoked in the past.

	Study B	
	%	(n)
None	3.5	(2)
1-5	23.5	(14)
6-10	21.5	(13)
11-15	8.0	(5)
16-20	6.5	(4)
21+	34.5	(21)
Missing	3.0	(2)
	100%	(61)

Table 5.11 shows that the largest group of officers (30 or 49.0%) had served five or less years in the

police force with only 13 (or 21%) who had been police officers for 11 or more years. Similarly, the largest group of officers (21 or 34.5%) had invoked their powers more than 21 times during their employment with the force. Only 2 officers had previously never used the power. Perhaps, not surpringly, significant differences were found between the number of previous times police had used their powers under Section 136 and length of service (X^2= 9.2722, d.f. = 1, p <.0023)[1]. Of the officers who had dealt with more than 11 incidents of Section 136, 21 or 37% had 6 or more years service experience, compared with 8 or 14% who had less experience. This latter group included a community police officer. He attributed his considerable involvement to a change in policy of the local psychiatric unit towards early discharge. This had involved him in more cases and a generally higher rate of contact with psychiatric patients in the community. Another officer, who prior to joining the police force, had worked in a mental hospital, attributed his high use of Section 136 to a personal interest in mental health. This meant that he actively sought to become involved in such cases.

The null hypothesis (1b) should be accepted in so

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[1] See Test 5.5 in the Appendix.

far as the overwhelming majority of officers were male, white, and of constable rank. There were however greater variations in the officers length of service and experience of dealing with psychiatric referrals.

The psychiatrists

Hypothesis 1c:- There will be no marked differences in the background features of the assessing psychiatrists.

a) Rank

Thirty eight psychiatrists who dealt with 81 referrals were interviewed in Study B. These were generally of junior status. 34 were Senior House Officers who had opted to specialise in psychiatry on a six monthly rotation system, and whose only previous training had been 9 weeks as medical students. Of the remaining 4, one was a general practitioner who was gaining three months experience in psychiatry, whilst the other three were senior registrars. Of these 34 psychiatrists, 13 worked at the psychiatric unit in the District General Hospital and 25 worked in the large psychiatric hospital on the outskirts of London.

b) Sex and ethnic background of the psychiatrists

Table 5.13 Sex of the psychiatrists.

	Study B					
	Psych Unit		Psych Hosp		Totals	
	%	(n)	%	(n)	%	(n)
Male	61.5	(8)	60	(15)	60.5	(23)
Female	38.5	(5)	40	(10)	39.5	(15)
	100%	(13)	100%	(25)	100%	(38)

Table 5.14 Ethnic origin of the psychiatrists

	Study B					
	Psych Unit		Psych Hospital		Totals	
	%	(n)	%	(n)	%	(n)
White	92.5	(12)	36	(9)	55.5	(21)
Asian	0	(0)	56	(14)	37.5	(14)
Chinese	7.5	(1)	4	(1)	5.0	(2)
Afro-Caribb		(0)	4	(1)	2.5	(1)
	100%	(13)	100%	(25)	100%	(38)

Data presented in Table 5.13 shows that 60.5% or 23 of the psychiatrists were men and 15 or 39.5% were women. The majority, (55.5% or 21) were White, but there was also a high proportion of psychiatrists who were Asian (37.5%). If a large proportion of women and ethnic minority medical practitioners in a speciality are taken as indications of the marginal status of a discipline, then these data tend to confirm the marginality and low status of

psychiatry within medicine. Furthermore, with regard to ethnicity, all the Asian psychiatrists worked at the large psychiatric hospital comprising 56% or 14 of the number interviewed. It is possible to speculate that this ethnic breakdown reflects the relative lower status of the Victorian institution compared to the newer and medically assimilated psychiatric unit.

The higher numbers of female psychiatrists and those of Asian origin allows hypothesis 1c to be rejected.

<u>Hypothesis 2a: That the circumstances leading to and police involvement will not contain elements other than those specified under the substantive requirements of the Section 136 provision.</u>

This hypothesis is concerned with the characteristics of incidents which precipitated the arrival of the police. This was one of the main foci of Study A (see Interview A schedule part 2). A psychiatric crisis refers here to the substantive requirements of the Section 136 provision as the presence of:

<u>i. Mental disorder</u>. This was operationalised in interviews to refer to odd behaviour and appearence

identified by police officers and does not refer to any formal notion of mental illness that may be ascribed by a psychiatrist.

ii. Indications of 'danger to self or other people'[1] was operationalised to include self-harm (or suicide attempts), and threat of or actual violence to others.

The incidents

a) Characteristics of the incidents

Table 5.15 Features of the incident

	Study A	
	%	(n)
Odd behaviour	75	(75)
Threat of or actual violence towards property	37	(37)
Odd appearence	35	(35)
Threat of or actual violence to people[2]	34	(34)
Threat of or actual self injury	8	(8)
Threat of or attempted suicide	7	(7)

Table 5.15 shows the features of the incidents precipitating police involvement. The 'odd behaviour' of the referrals was identified by police officers as a distinguishing feature of the incidents in 75% (or 75) cases. Included in this

[1] "In the interests of that person or for the protection of other persons" has been interpretted as meaning a danger to self or others.

[2] Excluding violence to police officers.

category were a range of behaviours from the mildly eccentric to the more bizarre. The former included such behaviours as talking in an incoherent manner to someone who was not present (007), "laughing to himself" (031), alternatively dancing in the middle of a zebra crossing and lying down in the street (037). More extreme examples included a man who spat on the floor and then licked it up (012) and a woman who forced her way into a stranger's house and urinated in the sitting room (020).

Odd appearence[1] was a feature in 35% (or 35) of the incidents. These included a man found wearing a kaftan over several layers of clothing, including a jumpsuit and several bandages tied around his abdomen and carrying a blue rubber duck (017), and a woman dressed oddly in that she was wearing layers of clothing with skirts on top of trousers, jumpers and jackets. (042).

Threat of or actual damage to property was referred to in 37% of incidents. In the main, threats of or actual damage caused to property tended to be of a minor nature[2]. Smashing windows was a common form of actual damage to property,

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[1] This category did not include dirty clothing or a scruffy appearence alone.

[2] Although this does not mean that they were viewed as a major threat by the referral agents.

(005,006,007,011,021,027,030). Other minor damage included breaking milk bottles (028) and causing damage to the paintwork of a front door (017). Though, in the overwhelming majority of cases, damage to property was minor, two instances involved damage of a serious nature. The subject in one (049) caused hundreds of pounds worth of damage by systematically smashing the windscreens of several cars. Similarly, in another (038) damage to property was extensive because it had involved the subject burning down a derelict property owned by a housing trust.

Threat of or actual violence to other people, was identified as being present in 34% of incidents. Actual violence was a more common occurence than the threat of violence. The former was present in 20% (or 20) cases, the latter occured in 14% (or 14) incidents. Threats ranged from the minor to the more extreme, and included both a man throwing an empty aerosal can at a woman in the street which missed (031), and a man holding a knife to a woman's throat (028). Incidents of actual violence to other people never resulted in serious injury. Although violence which could be considered to be of a serious nature included a man who tried to strangle his wife (071) and another who picked up children in a sweet shop and shook them violently

(032).

Finally, physical injury to self and /or attempted suicide featured in 15% (or 15 incidents). This included a woman who slashed her wrists (036), and someome who had tried to jump in front of a train (005).

b) The relationship of psychiatric to social aspects of the incidents.

Forty six percent of incidents constituted full psychiatric emergencies, according to the criteria outlined under hypothesis 2a above, in the sense that there was both an element of dangerousness (violence to self, others or property) and the presence of odd behaviour and or appearence. In 39% odd behaviour and or appearence was noted without any indications of violence to self, others or property. In 10% of incidents there was no evidence from accounts, of odd behaviour or appearence. In 2% no indications of either violence or mental disorder were given. In 3% there was no information on the incidents by the police officer interviewed. Thus, a slightly greater number of incidents did not contain elements of a psychiatric crisis. But overwhelmingly, the incidents involved either dangerous behaviour or odd behaviour).

Overall, analysis of the behaviours show that in the overwhelming majority of instances, psychiatric crises were social crises too. As well as the actual events (e.g threat of and actual violence) which constituted the incident additional elements could be identified. These show how the social context of behaviour, which extended beyond the immediate impact of the referrals behaviour on others, was relevant.

There were a number of incidents in which there was some doubt whether if they had occurred at a different time of day, they would still have provoked someone into alerting the police. For example, a man had broken a stairwell window and was creating a 'disturbance' outside on the landing at 6am in the morning (011). Or again, a man was banging on his sister's door, shouting and screaming at 7.30 am on Sunday (014).

Another feature appeared to be the weather. For instance, 022 was a case involving an elderly woman scantily dressed in a dressing gown and slippers, sitting on a bench early in the morning on a bitterly cold snowy day. Had this occurred on a summers day the incident may not have been regarded as severe.

A further characteristic not immediately available in Table 5.15 is that a number of incidents were not isolated events of disruptive behaviour. They were a series of interrelated events or a culmination of a number of more minor occurences[1]. It was evident that in a number of cases, events were ongoing, lasting a matter of hours. For example, several calls had been made to the police throughout the day about a man making a nuisance of himself. These included him being abusive to a passerby, "running riot" on a farm and attacking the farm hands, entering a house by unpicking the tiles on a roof and entering and urinating in the corner of a room (019). In another, a woman had been noticed hanging around the railway station acting oddly for several hours before the police were called to an incident in which she threw a spade through a minicab firms window (007).

In most of the incidents social disruption was of an extreme nature. In a few incidents the transgression of more subtle social norms appeared to be important. In one case (010) a woman was at a motel. She was not ordering food but talked constantly to the men and was sexually provocative. Her hands and face were filthy and she smelled. She

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Since information available on the circumstances of incidents varied between officers it is not possible to assess how many involved an ongoing crises

was childish, laughing and giggling. When asked to leave by the owner she refused and the police were called.

It appears from this example that the behaviour had to be seen in context, in this case of a hotel. The fact that she was "filthy", sexually provocative, and not ordering food was considered socially inappropriate. Similarly, in case 077 the man was infatuated and "fixated" with a woman and was constantly ringing her up and pestering her family by calling round with flowers. This involved no threat of actual violence but his behaviour was still interpreted as an extreme social nuisance.

The data allows the null hypothesis 2a, to be rejected. Almost half the incidents did fulfill the criteria as specified under Section 136, yet it was evident that the impact of the behaviour in its particular social context were major features surrounding police involvement.

There is nothing new about the finding that psychiatric crises involve major social disruption. As Bean (1980) points out;

> " ....not all social emergencies are psychiatric ones, but virtually all psychiatric emergencies are simultaneously social emergencies. Deviance from, or a threat to social

> norms appears as a prerequisite for admission to hospital, and particularly so if that behaviour is highly visible and immediately socially disruptive" (p81).

Overall social disruption was an integral feature of the incidents, but generalising further about the nature of the incidents is more difficult. The symbolic interactionist W.I.Thomas's statement that " social situations never spontaneously repeat themselves, every situation is more or less new, for everyone includes new human activities differently combined" (p856,Gonos, 1977) provides an appropriate caution regarding the nature of incidents in this study. Whilst it was possible to collect data which could be codified and analysed empirically, the situations as described by respondents appeared highly idyonsyncratic. That is, it is difficult to say with certainty whether or not in different contexts, involving different sets of actors, an individual's behaviour would have been construed as needing police intervention. One characteristic which however does require comment is that nearly all the incidents occurred in public. This meant the high visibility and extreme bizareness of events could not be hidden behind closed doors or disguised or contained by close family members. It may have been that a great deal of the behaviour would have been perplexing

and upsetting enough to have led to calls for psychiatric services whatever the context. However, there were some behaviours which would not in themselves have led to such a course of action had they not happened in public. In other instances, the effect of behaviour would have been more uncertain had it taken place elsewhere, for example sexual inappropriateness and nudity. Thus, whilst the incidents in this study shared in common with other psychiatric emergencies social disruption, this was higly dependent on the context of it taking place in public.

A further consideration is that behaviour in a public place may trigger variable responses from different audiences. Some, but not others, may contact the police when faced with disruptive behaviour. Who the referral agents were and why they contacted the police is examined in the next chapter.

Summary of results

This chapter has been concerned with describing the background features of the three groups of people involved in psychiatric referrals from the police and describing the features of the incidents. The aim here has been to provide background information for further analysis in subsequent chapters. The main conclusions from this chapter are as follows:

1. The police referrals tended to be young, single and living in the vicinity of the police station to which they were referred. There were approximately equal numbers of men and women. Those with a previous criminal record were a similar number to those without. Whilst the majority of referrals were White, Afro-Caribbeans were found to be over-represented compared to their numbers in the general population.

In terms of age, sex, marital status, and criminal record there were little or no marked differences with other studies on Section 136. Differences were however noted in relation to area of residence and levels of homelessness. There were smaller numbers of people of 'no fixed abode' and few who came from outside the locality in which they lived.

2. The police involved in making referrals came

from seven police stations, were overwhelmingly white, male and of constable rank, and had some previous experience in using Section 136. Almost a half of the officers had been in the force for five or less years.

3.The psychiatrists were usually of Senior House Officer rank. The majority were male but with a high proportion of women and Asian psychiatrists. A larger number of the psychiatrists were situated in the psychiatric hosptial than in the District General Hospital Psychiatric Unit.

4. Of the circumstances of incidents resulting in police referral, nearly half contained both elements of a psychiatric emergency as defined by the substantive requirments of the Section 136 provision. Analysis of the content of the circumstances themselves showed that an individual's behaviour caused major disruption and that the social context of the incidents appeared as a factor in whether the police were alerted.

Appendix to chapter 5

Test 5.1

Ethnic origin by age of detainee

	Up to 35 yrs	Over 35 yrs	Total
Afro-Caribbean	23	9	32
Other	22	27	49
Total	45	36	81

$\chi^2 = 4.6653$ d.f. = 1 $p < .0308$.

Test 5.2.

Marital status by Ethnic origin

	Married/Cohabiting	Single	Totals
Afro-Caribbean	4	18	22
Other	6	36	42
Totals	10	54	64

$\chi^2 = .06022$ d.f = 1 $p < .8717$

Test 5.3.

Ethnic origin by employment status

	Employed	Unemployed	Houseworker	Other	Total
Afro-Caribb	5	19	0	3	27
Other	3	27	1	8	39
Totals	8	46	1	11	66

$X^2 = 6.1457$ d.f.= 3, $p < .1284$

Test 5.4. Ethnic origin by sex

	Male	Female	Total
Afro-Caribb	20	13	33
Other	24	29	53
Totals	44	29	86

$X^2 = 1.3470$, d.f.= 1, $p < .2458$

Test 5.5. Length of service by number of S136 cases dealt with in the past.

S136 case / Service	0-10	11+	Total
0-5 years	20	8	28
6+ years	8	21	29
Totals	28	29	57

$\chi^2 = 9.2722$ d.f.= 1, $p < .0023$

CHAPTER 6

FROM PUBLIC TO POLICE JURISDICTION

APPENDIX TESTS 6.1.- 6.9

In the last chapter the types of crises which led to police involvement were described. In this chapter four themes will be examined: the means by which referrals came to the attention of the police; police decision making in apprehending referrals; the use of law and methods of police management; and police recognition of mental disorder.

a)How the referrals came to the attention of the police.

Hypothesis 2b:- The main agents of psychiatric referral will be the police.

Hypothesis 2C:- The primary motivation for initiating referral will be the presence of mental disorder.

Table 6.1. Referral agents

	Study A		Study B	
	%	(n)	%	(n)
Police initiated	9	(9)	8.0	(5)
Self referral	3	(3)	5.0	(3)
Relatives	13	(13)	6.5	(4)
Neighbours	15	(15)	21.0	(13)
Hospital/ statutory agency	7	(7)	6.5	(4)
Stranger/Passerby	42	(42)	49.5	(30)
Missing/Unknown	11	(11)	3.5	(2)
	100%	(100)	100%	(61)

Table 6.1 provides data on the people who called the police in Study A and B. Three main points can be made. Firstly, it was rare for the police to initiate contact with a potential referral. In only 9% (or 9) of cases in Study A and in 8% (or 5) in Study B was this so. In most cases members of the public called on the police for assistance. Secondly, members of the public who made referrals rarely knew the person they were referring. In only 28% of cases in Study A and 27.5% in Study B were neighbours or relatives involved in making a referral.

It may be remembered from the results in the last chapter that Afro-Caribbean people were found to be over-represented compared to their numbers in the locality. There was also an indication that they (in Study B) were less often referred by relatives or neighbours and slightly more frequently referred by passersby than were the other referrals. Only 3 out of 20 were referred by neighbours or relatives compared to 14 out of 36 of the rest. This may suggest that the labelling by strangers may be partly responsible for their relative over-representation.

Thirdly, it can be seen from table 6.1 that a small number of people in both studies referred themselves to the police or were referred by a statutory agency. The former group did not appear to have entered a

sick or patient role, in that none sought out police assistance explicitly for a mental health problem. One person (009) approached a police officer in the street to complain that his medical records had appeared on the TV and wanted the police to take him to hospital to stop this happening again.

Additionally, police appeared to be mainly called by statutory agencies (social services, health centres etc) when a person's behaviour fell outside the type of problem that these agencies were prepared to deal with. Examples included a man who attended a doctors' surgery and threatened a general practitioner with a knife (023) and the local social services office who called the police when someone demanding shelter refused to leave (C034). Thus, it appeared that other public agencies called on the police when the type of deviance encountered was perceived to fall outside their own areas of management. It was found in Study B that all four of the referrals made by statutory agencies were male. Whilst generalisations cannot be made from such small numbers, it may be that male psychiatric emergencies are viewed by such agencies as particularly problematic because of the large numbers of women working in the health and social services, who may be unable to contain threats of or actual violence.

Table 6.2 presents data on how the agents of referral made contact with the police in Study B.

Table 6.2. How the referring agent made contact with the police.

	Study B	
	%	(n)
Police on patrol	8.0	(5)
Telephone call to station	74.0	(45)
Attendance at station	8.0	(5)
More than one of the above	5.0	(3)
Missing	5.0	(3)
	100%	(61)

It can be seen that apprehension from direct on- the- scene encounters or requests was rare. In only 5 instances did officers come across incidents in the street or were made aware of them by requests from others. The most common means of contacting the police was by telephone (in 74% or 45 instances), either to the local station or through the central emergency services (999). In a small number of instances (3), attendance at the station was the means by which police were alerted.

Table 6.3. Referring agents reference to mental disorder

	Study A	
	%	(n)
Reference to mental state of the referral	29	(29)
Reference to violence threats of violence	38	(38)

The data presented in Table 6.3. shows that 29% of referring agents made some reference to the presence of mental disorder on making initial contact with the police. Thirty eight percent (or 38) referred to some threat of or actual violence to property or person, whilst in 35% (or 35) cases the message was not known or the information required was not applicable[1]. A further 3% (or 3) referred to both. It appears from the above table, that referring agents were more often concerned with the threat of violence than they were with a persons' mental state when contacting the police.

In the 29% (or 29) of cases where a persons' mental state featured as part of a message alerting the police to an incident, descriptions tended to be of a general nature. Examples included: "disturbance by mental female in flat above" (018); "a man gone berserk with hammer" (016); "male mental spraying parked vehicles" (31). Exceptionally, details of a person's mental state were more specific. In one case (021) the message received was, "renewed disturbance from Thursday. Mentally disturbed male from flat below who becomes calm when police arrive but goes berserk when they leave".

This category included instances where there was no referral agent and "self- referrals".

It was generally the case that messages and communications to the police were framed in terms of a variety of public order occurrences, which made no indication of a person's mental state. These included the following examples; female screaming for police (006); someone obstructing the traffic (009); a person causing a disturbance on the landing (011); attempted carbreaking (012); house breaking (017); female scantily dressed on seat (022); assault by father on his son (024); next door neighbour smashing windows (029); a man attempting to leave a shop without paying (086).

Since, the majority of mentally disordered people were referred on to the police by other parties, the null hypothesis that the police will be the main referring agents is rejected. Compared with other research into policing encounters, levels of public initiated contact with the police were much higher[1]. That so many of these members of the public were strangers to the referrals, perhaps, is not surprising. As was shown in the previous chapter, a high proportion of the referrals were single, suggesting that the opportunity for significant others to refer a person to the police is likely to be small. Strangers who are unfamiliar with a

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[1] Ekblom and Southgate (1986) found that policing encounters were initiated directly by the police in 37% of instances.

referral may also be less tolerant than friends or relatives of deviant behaviour, which may more readily be construed as a threat requiring police intervention.

From the data presented above it is reasonable to argue that hypothesis 2c should also be rejected. A substantial minority of the referal agents made some reference to a person's mental state. However, in a greater number of cases a concern with actual or threats of violence, and a range of public order disturbances, were more evident. This does not mean that where it was not mentioned, the presence of mental disorder was not detected, only that of greater importance was the threat of violence, rather than its underlying causes.

b) Police decision making in apprehending referrals.

Although members of the public tended to initiate referrals, once the police were made aware of an incident, their actions became central. That does not mean that the public played no further part in influencing police behaviour, only that the next course of events became a matter of police rather than public discretion.

Hypothesis 2d: Prior labelling will not play a primary role in the formation of the police officer's decision to make an apprehension.

Hypothesis 2e: Officers reasons for apprehension will be primarily influenced by the mental state of the referral.

Of relevance to this hypothesis are:

i) the reasons police gave for removing a person and likely consequences had the police taken not involved (Q11,7 and 8).

and

ii) Police accounts and descriptions from interview A of the influences impinging on police in particular incidents.

Table 6.4. Officers awareness of mental disorder prior to incident.

	Study B	
	%	(n)
Yes	26.0	(16)
No	64.0	(39)
Dont'Know.	10.0	(6)
	100%	(61)

Table 6.4 table shows that in just over a quarter of cases officers were aware, prior to attending an incident, that they would be required to deal with a

person who was mentally disordered. In 64% (or 39) instances officers said that they had no advance warning that the incident involved anything other than a public disorder, or criminal, matter. It appears that in most instances officers did not have the necessary information to label a person as mentally disordered prior to attending incidents. This means that decisions were generally made according to the immediate circumstances they encountered.

From the data it is difficult to assess the overall impact that the lack of prior cues had on subsequent police action. However, there were indications that at times it led to the police over-reacting. One example of this was given by one officer interviewed. He claimed that on receiving a message that there was a disturbance on a nearby 'sink' estate, he contacted all the officers in the surrounding area (including the 'Special Response Unit[1]') and instructed them to respond to the incident. Fifty police officers arrived on the scene, the person concerned was handcuffed and taken away amid angry bystanders who accused the police officers present of unnecessary harassment. The interviewee admitted that, in retrospect, it had been a mistake to send so many officers, but

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[1] Previously called the Special Patrol Group

stated that he had been responding to a message which had made no mention of the nature of the disturbance.

Table 6.5. Reasons for apprehension.

	%	(n)
Psychiatric condition of the referral	11.0	(6)
Person's own safety.	36.5	(20)
Protection of the public/ law and Order reasons	45.5	(25)
Unformulated reasons[1]	7.0	(4)
	100%	(55)[2]

For the purposes of analysis, factors related to the apprehension of referrals have been subsumed under four headings - threats to public order, threat of proliferation, contingencies and social resources and ad hoc factors.

i.Threats to public order

Table 6.5. gives data on the primary reasons given by police officers for the apprehension of referrals. It seems it was rare to remove a person for explicitly psychiatric reasons. In the overwhelming majority 82% (or 45) of incidents "policing" problems were identified as the main reason for arrest, i.e. threats to public order, danger to health, life or

[1] e.g. "something had to be done.
[2] Six officers did not give a reason.

property in public places. It was not usually enough for someone to be showing signs of emotional distress for police officers to intervene. This is illustrated by one case (088) in which officers took a decision not to arrest a man who was lying on the ground, naked shouting at passersby. He was thought to be suffering from "harmless delusions only", and he was returned to his home. However when the police were involved later that day, when the same man was found fighting, the police arrested him and took him to the station.

It can be seen from data presented in table 6.5 that "policing reasons" given for apprehending a person were split almost equally between apprehension for "protection of the public/ law and order" and the "safety or interests of the person". The latter 'social work' element was illustrated by a comment made by one police officer about an elderly woman who had been picked up on a cold day after a tussle with a bus conductor: "If we hadn't have brought her in she would have just ended up as another statistic" (003).

Only the primary reason for detention, as taken from police accounts, has been included. However, it needs to be mentioned that at times police accounts presented contradictory versions of the reasons for

arresting a person. A number of officers stated that threat to public order was uppermost in their minds but simultaneously glossed over this and spoke in paternalistic terms, as illustrated by these two officers' replies: "she was in a state of undress- likely to cause a breach of the peace so we removed her in the interests of her safety" (W514); "she had caused criminal damage to council property and therefore needed care and control"(C014). This perhaps reflects something of the complexity and contradictory elements and attitudes towards care and control when dealing with mentally disordered people in public places.

ii.<u>Threat of proliferation.</u>

Another important factor in officers' decision making was the likelihood of existing troubles continuing. Of the 55 officers who were asked what the likely consequence would have been had they not made an arrest, 89% (or 49) gave the continuation of a disturbance as the likely outcome, and 11% (or 6) the unpredictability of what might occur had they left the situation as it was.

At times proliferation of an incident was seen only in terms of its nuisance value for officers. For example, according to one officer attending one

incident (032) the police would have been called again because "someone would have found her and called us". On other occasions, more altruistic motives could be identified. In one such incident, an elderly man had stripped the wires bare in his flat, flooded it with water and wrenched the main gas pipe from out of the floor. Had the police not intervened, the man or another person would have probably died (C015).

These examples and data presented in table 6.4. show that in addition to the immediate elements of an occurrence being taken into consideration, so too was the likelihood of further trouble. In this respect, officers were 'hedging' their bets and can be said to have made decisions, not only on the basis of what had actually occurred, but what <u>might</u> occur in the future.

iii <u>Contingencies.</u>

From the analysis of qualitative data in Interviews A and B, in deciding whether or not to arrest someone, resources and options available to officers on the street were influential. Two factors of particular importance, were the effectiveness of informal courses of action tried by officers and the influence of other people associated directly or indirectly with the incidents.

Whilst the likelihood of further trouble occurring appeared a dominant factor in arresting a person, at times the reverse happened. Officers were willing to give referrals the 'benefit of the doubt' as shown by a number of instances in which informal ways of resolving a situation were tried. Two examples illustrate this point. First, a woman was involved in an incident in a newsagents in which the police decided to accompany her home as she was not thought to be "bad enough" to be taken to the station. However, on arrival at her flat, she was found to have lost her key. The police tried, but were unable to break in. At this point it was decided to remove the woman to the station (045). In another incident, the police put the subject in a car with the intention of taking her home. However, when it became apparent that she had forgotten her address the officers took her to the station instead (034). Non-intervention was another informal course of action used to avoid an arrest being made. This is shown by the following two incidents. The police were questioning a shopkeeper who had called them because of a dispute about payment with a man who was standing in the middle of the shop posturing threateningly with fists in the air. When the police turned round the man had left the shop, so they dismissed the problem and decided to take no further

immediate action. Five minutes later they were called to a similar disturbance in another shop. The man left the shop again in a similar manner. This time, the police decided to follow him. The man walked down the street brandishing a piece of wood. It was only after the police had observed another incident, which involved him knocking on the door of a stranger's house engaging him in a bizarre conversation, they made an arrest (C009).

In a situation in which a man attended the police station and appeared very angry and agitated, the police sergeant decided to use delaying tactics and left him in the room on the pretext that he was making enquiries. It was hoped that the man would get fed up and leave of his own accord. When he showed no signs of calming down and kept on following the sergeant around. He was told to leave the station. On refusing he was arrested (073). It can be seen from the above incidents that the failure of these informal strategies led ultimately to a person being taken into police custody.

The police were also influenced by home circumstances and the availability of relatives to look after a person. A woman found shouting and screaming outside her house which had broken windows, was covered in excrement, and had no water, gas or

electricity supply. The house was considered unfit for human habitation by the officers and was cited as a reason for her apprehension (029). Another subject said she was expecting relatives, who did not turn up. She was taken along with her 11 yr old son to the station. (020)

In addition to calling on the police for help, members of the public were often present when the police attended the incidents. At times such people were important in police decisions. Sometimes their expectations were influential. In case 012 a man had made a citizens arrest on a 17 yr old youth whom he believed was trying to break into his car. The police gave as the reason for arrest that the complainant wished to see some affirmative action.

On other occasions, pressures on officers to take action was more explicit. In case 039 a number of people had crowded together and collectively approached the officers saying that they were frightened because the woman had a carving knife, that she made a lot of noise and that similar incidents had been occurring for years. Sometimes however the police were influenced <u>not</u> to apprehend a person. In one incident (030) the police were called to a "serious disturbance" by neighbours. The police were disuaded from apprehending the subject because

the "father was reluctant for the police to get involved".

In other incidents it was not so much direct pressure by a third party but officers' <u>interpretations</u> of the consequences of a particular situation, which influenced their decisions. Thus in case 049, a woman who had broken some car windows was arrested because the officer thought that "she might have been "pummelled" by the angry motorists". Additional problems arose where old people or children were implicated. A woman was arrested because her mental state was thought by officers to be adversely affecting her 11 year old son (020). In another incident, which involved nothing more serious than a woman swearing and shouting, the police detained her when they were told that an 8 year old child was asleep upstairs and terrified of the person's behaviour. In relation to the vulnerability of the elderly, a person (C46) was arrested after shouting, screaming and banging on doors because the elderly person with whom he shared a house appeared to the police to be in bad health. Similarly, a decision to apprehend in another case was made partly because the subject (who was elderly) lived with another elderly confused lady.

iv. Ad hoc reasons

It was possible to identify influences that on the face of it, bore little or no connection to the circumstances of the incidents. The idiosyncratic preferences of individual officers were examples of this and seemed important in a few incidents. During the observation period, which involved observing officers action in the charge room, someone who would otherwise have been detained on Section 136 was not, because the officer "was feeling generous that day". Idiosyncracies could of course work in the opposite direction. In case 012 a mentally handicapped youth was detained in order to "teach him a lesson". Occasionally structural considerations were important. Take for example the wider politics of community/police relations. In relation to one case (012), the officer talked of bad relations between the police and local community, and felt that to take no action would have reinforced the view that the police fail to do anything when called. Public opinion and force policy were also important in the case of (C45). A woman arrested late at night was considered vulnerable to sexual attack. The officer claimed that his decision had been influenced by an increase in sexual offences in the locality and newly issued police guidelines on the detection of rape.

Data presented at the beginning of this chapter

showed that officers' prior awareness of incidents as ones involving mental disorder were rare. Thus, hypothesis 2d should be accepted. Returning to hypothesis 2e (that officers reasons for arrest will be primarily influenced by the mental state of the referral) the data presented above suggests that the null hypothesis should be rejected. Only a small minority of officers give the primary reason for arrest as the persons' mental state. Factors relating to policing were important. Within these paternalistic demands, concern for the welfare of the individual carried almost equal weight to law and order reasons. However, they were not mutually exclusive. Analysis of police accounts showed some officers held contradictory perceptions of their reasons for apprehensions. Not only were the events at the incident important, but in making an arrest most officers took into consideration what <u>might</u> happen. For example, the effectiveness of informal police strategies (including non-intervention) and home circumstances, which involved other people, influenced some officers.

<u>c. The use of law and police management</u>

Having looked at the rules underlying police decisions to make arrests, the focus in this section will switch to exploring the management strategies used to apprehend and detain referrals. Included

under this heading, is the type of law enforcement and management strategy officers deployed in dealing with psychiatric referrals.

Hypothesis 2f:- Officers will use no other legal means apart from Section 136 of the Mental Health Act to apprehend and remove referrals to the police station.

Table 6.6. Place of arrest

	Study A		Study B	
	%	(n)	%	(n)
Public premises	64.0	(64)	83.5	(51)
Private premises	21.0	(21)	11.5	(7)
Uncertain/Missing	15.0	(15)	5.0	(3)
	100%	(100)	100%	(61)

Sixty four per cent of the apprehensions in study A and 83.5% (or 51) in study B were made from public premises[1]. These included arrests made from the street, in shops, motels, cafes, from underground and railway platforms and from the front desk of police stations. In just over one fifth of cases in study A, and one seventh in study B, individuals were arrested from private premises in contravention to the law. Of these cases some were arrested from the person's own home, others from someone else's home or garden. One

[1] This included places such as communal balconies and stairwells over which there is some legal debate as to whether they fall within the meaning of a place to which the public have access.

arrest was made from a derelict property, one from a bus garage's staff canteen and another from sports ground's dressing room.

Since most arrests were made from public places, it can be seen that officers were, by and large, acting within the remit of their legal mandate. Reasons for not arresting a person from a public place were mixed. In 2 instances officers (both of whom were junior) claimed that they were unaware of the legal requirement to arrest someone from a public place. In another instance the officer was aware of the public place requirement but he thought the alternative procedures were ineffective. This was a case in which neighbours informed the officer that the social services department had been called several times and had not responded. The officer believed that by using Section 136 he could avoid using an Approved Social Worker or psychiatrist, especially as the incident took place in the middle of the night (034). In another instance, where an officer intervened to remove someone about to throw themselves off a council flat balcony, the situation was such that if the 'public place' requirement had been adhered to death would have ensued. The third and main reason why officers made arrests from private premise relates to the <u>intention</u> of officers at the time of arrest, i.e. police officers used other legal grounds

as the authority with which to make an arrest. This is discussed in relation to the data presented in Table 6.7 below.

Table 6.7. Officer's intention on arrest.

	Study A.	
	%	(n)
Charge with an offence	23	(23)
Take to a psychiatric hospital	38	(38)
Take to station without any clear intention	19	(19)
Missing	9	(9)
	100	(100)

Data presented in table 6.7. shows that in a minority of cases,(38% or 38 of cases) did the officer use Section 136 (or at least intend to take the person to a psychiatric hospital) as the legal power with which to make an arrest. In 23% or 23 of cases officers used their more general powers to apprehend an individual. In 19% or 19 of instances the police appeared to have arrested a person without using any formal power. That is, at the time of arrest, the officer had not clearly formulated the legal or other grounds for making an arrest.

Data from police accounts suggests a number of reasons why officers used Section 136 so infrequently. In a proportion of cases, Section 136 was not used beacause officers did not initially

attribute the cause of trouble to the mental health of the referral. At times, mental disorder was recognised, but arrest for a criminal offence was thought to be more appropriate. The subject of 078 for example, was recognised as "nutty" at the incident but he was arrested for threatening behaviour.

In six of the incidents in which officers arrested a person for an alleged offence there was, nonetheless, an implicit intention to send the person for a psychiatric assessment, ususally because the circumstances did not fit the necessary requirements of Section 136. For example, the subject in incident 001 was arrested for carrying an offensive weapon about on private premises. Similarly, (in 054) a man was arrested for criminal damage.

Legal requirements and latent signs of mental disorder were not the only reasons for choosing a particular means of removing someone to the station. Simple expediency sometimes determined the use of one rather than another power of arrest. The constable in case 007 arrested a woman for criminal damage as a means of getting her to the station. However, she did not at any time expect charges to be pressed. Likewise, in another situation (065) which involved a great deal of disturbance and violence from both the

referral and the referrals relatives, the officer did not consciously use any specific legal power. His primary concern was to remove the subject from the incident in order to bring the situation to an end. Similarly, in another incident (074) no specified power was cited as having been used to make an arrest. Here the officers had to deal with a person who was " very violent, hitting out punching and kicking. It took four PC's to bring him to the van". Even when there was no emergency, police sometimes showed a preference for criminal legislation to deal with a person. For example, a young man in one incident (075) was thought to be mentally disordered, yet was still arrested for attempted burglary.

From these data it can be seen that the null hypothesis 2f should be rejected. Police officers used Section 136 as an authority for apprehension in a minority of cases only. In the main, other formal and informal powers were used. Put another way, it seemed that at the time of arrest pragmatism and expediency determined the type of law enforcement used rather than a rational appraisal of whether a set of circumstances warranted the the use of Section 136.

Hypothesis 2g:- Officers will use physical means[1] alone in removing and managing mentally disordered people.

Hypothesis 1f: Police responses and methods of dealing with Section 136 referrals in custody are no different to those used to deal with normal suspects.

Table 6.8 Transport

	Study A		Study B	
	%	(n)	%	(n)
Panda	27.0	(27)	20.0	(12)
Van	37.0	(37)	51.0	(38)
Foot	4.0	(4)	1.5	(1)
Area Car	1.0	(1)	13.0	(8)
Missing	31.0	(31)	15.0	(9)
	100%	(100)	100%	(61)

Table 6.8. shows the type of transport used by the police employed to remove their subjects from the situations in which they were found. It is suggested that the mode of transport symbolises the type of incident the officers regarded themselves as dealing with. The use of a van was preferred according to the responses. Vans are used most frequently when dealing with someone who requires restraint. Panda cars which are mainly employed to transport officers from one

[1] Physical management refers to removal, transportation physical restraint, use of handcuffs and cells.

destination to another, and not for transporting detainees, were used slightly less. Removal by area car or accompanying a person by foot occurred rarely.

Transporting people to the station served an administrative purpose i.e. it was necessary for an Inspector to assess a person's mental state in order to sanction referral for psychiatric assessment. It also served another function in that it tended to bring closure to a crisis. Thus, one of the main ways in which officers can be said to have controlled and managed referrals was to remove subjects from the situations in which they were found. In doing this, officers were able to establish boundaries of control and to resolve the complexity of situations which are more easily done within the confines of the police station than on the streets. This was clearly illustrated by one P.C's comments (075).

> "We look very bad in front of the public when there's three coppers trying to restrain a mental person, they are very violent and we have to use physical restraint-it makes it difficult to do if a whole load of people are staring and making comments about what you're doing. When we get a violent one we try to get them away to the station as soon as we can and sort things out from there."

At times the mere act of removing a person from the situation bought about the end of a psychiatric emergency. For example, a man who had created "a scene of devastation" in his flat and was reported to

have been very violent at the incident itself "sat quietly in the detention room, and was reported by the police officers to be O.K. once he was taken away from the scene" (080).

Table 6.9. Use of handcuffs

	Study A		Study B	
	%	(n)	%	(n)
Yes	14.0	(14)	18.0	(11)
No	64.0	(64)	82.0	(50)
Dont/know	22.0	(22)	0.0	(0)
	100%	(100)	100%	(100)

Physical restraint

	Study A		Study B	
	%	(n)	%	(n)
Yes	24.0	(24)	38.0	(23)
No	50.0	(50)	60.5	(37)
Dont Know	26.0	(26)	1.6	(1)
	100%	(100)	100%	(61)

It can be seen that physical restraint of some sort was used as a means of management in just under half the cases in Interview A and just over in Interview B. The use of handcuffs was relatively infrequent, 14% in interview A and 18% in Interview B. However, there were significant differences between men and women with handcuffs being used, exclusively in relation to men (X^2= 11.4976, d.f.= 1, p<.0001, see test 6.1). There appeared to be no major difference

across age and ethnicity (see Tests 6.2. 6.3). Physical restraint was employed in 24% of instances in Interview A and in 38% of cases in Interview B. Again there were significant differences in the use of physical restraint between men and women (X^2= 4.5124, d.f.= 1, p< .0337, test 6.4) but no differences in relation to either ethnic origin or age.

Most frequently, officers described physical management as a coercive means of taking people to the station. Occasionally, physical means of management was not overtly coercive in nature. For example, the officer in case C029 put his arms round a woman to console her, another officer mopped up the spittle from a referrals mouth (W518) and yet another wrapped a blanket around a naked woman (W508). The use of physical restraint was not the only way in which the police dealt with psychiatric referrals. Other methods were also used. In response to an open question (IV,2) in Interview B:"how did you deal with the person prior to arrival at the station?", of the officers who made a response 51% (or 31 officers) identified some form of verbal communication as the main method of management used. "Talking" as a management strategy took on a number of forms. It was used to cajole, coax or persuade a person to come along to the station.

Table 6.10. Management prior to arrival at station

	Study B	
	%	(n)
Verbal strategies	51.0	(31)
Handcuffs/physical restraint	21.0	(13)
Non-coercive physical management	5.0	(3)
Missing	23.0	(15)
	100%	(61)

A number of officers said that they used 'talking' as a means of management. The value of 'talk' as a strategy for calming a person and securing their agreement was clearly expressed by the responses;

> "I talked to him all the time, I've dealt with a lot of mental patients and if you talk to them it relaxes them- if they get upset about something your saying, you change the subject. That way everything stays calm". (C029)

> " I just talked him into it.....The more you talk to them,the more they come around. He said the music upset him so I told him there was no music at the station. (C059)

Officers used a variety of 'talking' styles in their attempts to control and manage situations. Humouring was mentioned by six officers. This included playing along with the subject's fantasies in a humourous way (C003) and C006). Another coaxed his subject into the back of the van by saying "your chariot awaits you" (C025). Others were more directive; "she was told that she was being taken to the station in order to

get her some help" (C036); "we told her what we were going to do with her and that we thought that she needed help (C032).

Officers' verbal skills are an important aspect in their training and great value is attributed by supervisory officers of probationers in developing such expertise (Fielding 1985). Similarly, the data presented here suggests that officers' abilities to deal effectively with referrals, whilst maintaining equilibrium, was dependent in part on their verbal skills.

Observation of police methods of management of normal suspects in the charge room showed that officers routinely lock up suspects in cells. The exception to this general rule is juveniles who are placed in the detention room. Though the detention rooms of police stations do not differ markedly from cells, they are regarded by officers as being less custodial.

Table 6.11 The use of cells

	Study A		Study B	
	%	(n)	%	(n)
Yes	36.0	(36)	44.0	(27)
No	34.0	(34)	46.0	(28)
Dont Know	30.0	(30)	10.0	(6)
	100%	(100)	100%	(61)

Table 6.11 shows the number and percentage of

referrals who were placed in cells whilst in police custody. In less than half the cases, in both interview A and B, were psychiatric referrals kept in police cells. However, there were sex and age differences in the use of cells (see Tests 6.7-6.9). Men were more frequently placed in cells than women - differences were significant (X^2 = 3.9088, d.f.=1 p<.0469) as were those aged below 35 (X^2=3.0561, d.f.= 1 p< .0561). Presumably, this was because women and older people were regarded as less threatening. There were no significant differences in relation to Afro-Caribbean versus the other referrals. The comparative low useage of cells indicates that officers generally took a less punitive attitude to mentally disordered referrals than others. This less punitive attitude was evident in some officers' comments as indicated by the following examples.

> "normally he would have been placed in a cell, but this would have made him feel worse" (C015).

> "He was not treated as a prisoner he was sat down in the charge room to chat to the sergeant rather than in the cell" (W14).

Officers were asked whether or not they dealt with psychiatric referrals any differently from other suspects (BQIV, 4).The responses to this question are presented in table 6.14.

Table 6.12 Police management in custody

	Study B	
	%	(n)
Treated differently	54.0	(33)
Treated the same.	23.0	(14)
Uncertain/missing	23.0	(14)
	100%	(61)

It can be seen from this table that of the majority who responded, most said that they treated Section 136 referrals differently to ordinary suspects. Those officers who said they treated the psychiatric referrals the same tended to draw on notions of equality or 'normalisation' to justify their stance. One officer stated;

> "You have to treat everyone the same; PACE[1] doesn't apply but I still dealt with her the same way I would anyone else" (C065).

A more sardonic version came from one officer dealing with case C042 who stated ; "I treat all my prisoners with great consideration and care".

There were a number of ways in which mentally disordered referrals were considered to have been treated differently. Adopting a kindly or sympathetic attitude was the most frequently mentioned difference, i.e. with 11 out of thirty three officers. For example one officer stated "I

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[1] Police and Criminal Evidence Act 1984.

treat them differently-talk to them and mollycoddle them a bit more"(C016) whilst another said "I was more tolerant with her. You take more from someone like that, you have to understand the state they're in and make allowances"(C030). A further ten officers mentioned that they were more inclined to observe closely mentally disordered detainees. In addition they offered refreshments and cigarettes. These together with other privileges, distinguished officers' dealings with mentally disordered people from other suspects. For example, two officers allowed relatives to stay with the person, and a further two referrals were not strip searched as was customary for offenders.

Returning to hypothesis 2e, from the data presented, it can be seen that physical methods of management were central to officers' ability to manage and control the people they were dealing with. Removing a person to the station was a pre-requisite for establishing the necessary conditions to deal with matters on their own terms and territory. Physical restraint, and to a lesser extent handcuffs, were also used in moving and constraining people. In addition to these physical methods, a variety of verbal strategies were used by officers to gain compliance. This suggests that the null hypothesis should be rejected.

Also Hypothesis 2f should be rejected on the basis of data presented above. The latter showed that officers claimed they dealt with Section 136 referrals detained in custody differently to other suspects. Section 136 referrals were less frequently placed in cells than other suspects. Also, officers reported that they treated the former differently, in that they adopted a softer or more kindly attitude towards them.

Briefly, in summary, this section has highlighted some police management strategies. Most arrests were made from public places with a minority being made from private areas. The police did not rely on Section 136 of the Mental Health Act to arrest referrals but used other powers considered expedient in a particular situation. Police officers used a combination of physical methods and verbal strategies as methods to manage effectively and contain people whilst in police custody. Police officers reported that they treated mentally disordered people in custody differently from other suspects.

d) <u>Police identification and construction of mental disorder</u>

In a study concerned with psychiatric referrals from the police, their recognition of mental disorder is

obviously a key element, although as it has been shown, perhaps not as important as might be first assumed. It was shown earlier that psychiatric disorder was not always the dominant consideration in officers' reasons for making arrests. Nonetheless, police identification of mental disorder provides the rationale for legal and practical police action.

In examining how police recognised mental disorder, data was used derived from responses to questions in Interview B. This included: when officers became aware that referrals were mentally disordered (QV1); the criteria and influences which contributed to police identification of mental disorder (QV3(a-g), 4(a,b); and the degree of agreement between officers that mental disorder was present (QV.2). Qualitative data is also used from police accounts in Interview A and B.

<u>Hypothesis 2i:- Police identification of mental disorder will not take place at any other time than at the incident attended by officers prior to arrest</u>.

Table 6.13 Police identification of mental disorder

	Study B	
	%	(n)
At the incident	87.0	(53)
During transport	6.5	(4)
On arrival at the station	3.5	(2)
Sometime later whilst in custody	1.5	(1)
Missing	1.5	(1)
	100%	(61)

The data presented in table 6.13. shows that police officers generally identified mental disorder early on in their direct contact with a referral. In 87% (or 53) cases police said they identified mental disorder at the incident itself, that is before an arrest was made. It was less frequently reported that mental disorder was recognised at a later stage, i.e. during transport or whilst at the station.

Further aspects of this process, are evident from police accounts. Although the vast majority of officers claimed that they had identified mental disorder before removing the person to the station, identification was not always immediate. About 11% said they had not recognised mental disorder until after the person had been taken into custody, and a number of other officers said that recognition at the incident itself was not always immediate. This appears to bear out one of the findings under hypothesis 2f. (Officers sometimes failed to use

Section 136 as a mandate for arrest because they had not construed the situation as one involving a mental health problem).

Any delay in making a positive identification was it seems due to a lack of abnormal or atypical behaviour. In case 011 officers only thought the man they had arrested for breaking a window was "more than a bit weird" when he started "ranting and raving about his nuclear reactor in the back of the van". Also, certain forms of grossly atypical behaviour were not immediately seen as representing mental disorder. An example of this was incident 014. Mr S was found banging on his sisters' door shouting and screaming early on Sunday. The constable tried to talk to him but could not make sense of his replies. It was only sometime later, when transporting the man to the station, that the officer started to think that the man was mentally disordered.

Why should such delays occur? It seemed that delays were because officers tended to view atypical behaviour as part of their usual duties. Or put another way, there was a tendency to exclude other forms of deviance. For example, in the case of C032 a teenage girl was found by an officer to be in a distressed state. She was alternatively laughing histrionically and crying, and she was half naked.

The officer first thought she might have run away from home after a row with her parents because "that would have been the most likely reason for a girl of her age being upset. We get a lot of trouble with youngsters running away from home". When she was found not to answer questions coherently, the officer thought she might have something to do with the teenage drug project, which was run in the locality. However, he saw no evidence of needle marks. It was only after rejecting these two likely options that he thought that the girl might be mentally disturbed in some way. Another case involved an inarticulate woman found half naked, covered in blood. She was initially thought to be have been a rape victim (C30). Only after this had been excluded did the WPC begin to think of the woman as potentially mentally disordered. In another incident, a woman was trying to break her door down with a dustbin and was subsequently restrained by police officers. She was thought to be drunk or on drugs before a neighbour mentioned the possibility of mental disorder (W17). Finally, a man wandering around in a dazed state was only considered mentally disordered after the police officer had assured himself that he had not suffered from a heart attack and was not a victim of a crime. The police it seemed were often faced with a lack of information, yet were under pressure to act quickly. It is suggested these factors may account

for a lack of initial recognition of mental disorder. A good example of this was incident 013. Here, the police stopped a youth who was chasing three others down the street with a piece of timber. As the panda car drew up, the youth threw the wood at the car. The policewoman asked him what the problem was and he grabbed her by the lapels. The other officer intervened and, after a struggle, handcuffed him and took him to the station.

It seems that, in relation to hypothesis 2i, the data presented in table 6.13 shows that police officers generally make a diagnosis prior to removing someone to the station. Thus, the null hypothesis should be accepted. Nonetheless, qualitative data suggests that police identification of mental disorder is a complex process. At times it involves other forms of deviance being considered and excluded.

<u>Hypothesis 2j:- Police identification of mental disorder will be based only on behavioural critirea.</u>

There are three considerations here. The first concerns theose attributes and presenting behaviour of the referrals. The second relates to the influence of other people. The third is to do with the collegiate consensus of officers.

a) The influence of the referrals behaviour.

Table 6.14 Characteristics identified as mental disorder.

	Study B			
	Yes		No	
	%	(n)	%	(n)
Strange/bizarre Speech	67.0	(41)	33.0	(20)
Odd appearance	8.0	(5)	92.0	(56)
Odd behaviour	43.0	(26)	57.0	(35)
Violence	20.0	(12)	80.0	(49)
Self injury	1.5	(0)	98.5	(60)
Living conditions	3.0	(2)	97.0	(59)

Table 6.14. shows the characteristics deemed to be signs of mental disorder. The most commonly identified feature was a person's speech, which was taken as an indication of mental disorder by 67% (or 41) of officers. Oddity of behaviour was also commonly cited - mentioned by 43% (or 26) officers. Violence was identified by 20% (or 12) officers. Bizarre appearance and self-injury were items that were least mentioned. In two cases the results of a person's actions (i.e. the state of their house) rather than presenting behaviour, were viewed as signs of their mental state.

Officers usually took a combination of more than one of the above cues. It was usually the person's whole demeanor that gave the impression of madness, illustrated by the following quotes:

"had that glazed look in her eyes, laughing fits and kept on gabbling "you'll be sorry" and "I'm as good as the queen". She talked past you rather than too you (067)".

" Not rational, screaming and shouting. His whole manner and way of behaving was not normal. Could tell by his facial expression, especially the eyes" (C057).

"He was so aggressive. Thoroughly abusive, his speech was totally pointless and he had delusions-he thought he was Abraham Lincoln, God and that sort of stuff" (C058).

"Drinking out of a baby's bottle, rocking back and forth, the way she didn't speak; non-communication" (C060).

"Talking about non-comprehensible things, seeing things which weren't there, cursing people who werent there, saying people owed her money. Garbage really". (C064)

Mental disorder as defined by the Mental Health Act covers both "mental handicap" and "mental illness". Police made a distinction between these categories. For example Case 002 was identified as mentally handicapped on the basis that she was "childlike and clung to the WPC".

Past knowledge or information about how a particular individual behaved appeared relevant. One example of this relates to people known in police culture as "local loonies", who are generally well known as previous psychiatric patients. In regard to these

people, officers expect a certain degree of presenting psychopathology and use previous knowledge about a person's demeanor as a yard stick in their ascriptions of the severity of mental disorder. One referral (009), Ms A often called into the police station having been the subject of regular complaints from neighbours. Her reaction to police was described in generally positive terms, "she's usually good to us". In the present incident she was found holding up the traffic and swearing. When approached she was abusive and ran inside slamming the door. One of the reasons given for apprehending her was that she "was not her usual nice mad self", and was thought to be suffering from more than "harmless delusions".

Mental disorder was also measured against behaviour of other groups which the police have contact with. The following quotes illustrate this.

> "usually villains try to disguise their appearance if being watched to evade being caught. He didn't take off his hat or anything-it was an unusual thing to do, not the actions of a sane man." (C050)

> "The content of her speech was irrelevant to making an enquiry at the police station"(C045).

> ....."the criminal damage was unprovoked she had no reason to be angry and she wasn't a 16 year old yobo.....People usually assault you because they dont want to be arrested but she continued to assault us even after arrest." (007)

"he had no idea that looking into cars and fiddling with the handles usualy means you are going to steal the car." (012)

"There was a lack of understanding of the seriousness of what he had done." (C015)

b) The influence of others.

Table 6.15. Mental disorder mentioned by others[1].

	Study B					
	Yes		No		Missing	
	%	(n)	%	(n)	%	(n)
Referral	15.0	(9)	83.5	(51)	1.5	(1)
Relatives	20.0	(12)	78.5	(48)	1.5	(1)
Police Surgeon	15.0	(9)	83.5	(51)	1.5	(1)
Social Worker	1.5	(1)	95.0	(58)	3.5	(2)
Police Records	16.5	(10)	80.0	(49)	3.5	(2)
Other Officers	20.0	(12)	78.5	(48)	1.5	(1)
Hosptial	11.5	(7)	82.0	(50)	6.5	(4)
Other(passerbys GP's etc)	18.0	(11)	78.5	(48)	3.5	(2)

Table 6.15 shows that in 74% or 41 out of the 61 cases, officers received cues of mental disorder from other sources. In 20% (or 12) of cases this was provided by other officers working at the police station and in 16.5% (or 10) cases from police records. Relatives frequently provided information, so did divisional surgeons. The referrals made reference to their own mental disorder in 15% (or 9) instances.

Of course the type of information received varied.

[1] Total for rows = (61) or 100%.

For example, police physicians were more likely to give information in terms of a medical diagnosis. Information about a person's mental state from relatives tended to be more general, giving as important, items such as previous admissions to hospital and incidents. Referrals tended to mention medication and the names of hospitals that they had previously attended.

Table 6.16 Influence of others on the recognition of mental disorder.

	Study B.	
	%	(n)
No influence	34.5	(21)
Confirmed police decision	18.0	(11)
Main basis for diagnosis	10.0	(6)
Missing	37.5	(23)
	100%	(61)

Data presented in Table 6.16 is on the effect other sources of information had on police. It can be seen that 21 officers claimed that others' cues about a person's mental state had no effect on their judgement. Conversely, in just under a third of instances (29%), police officers said that external cues influenced their decisions, whilst in 10% (or 6 instances) they formed the main basis for their diagnosis.

These data may be linked to the findings under

hypothesis 2i, which showed that officers were sometimes slow to view atypical behaviour as mental disorder. It seems that in addition, they did not rely on their own judgements and/or the odd behaviour of the referrals but used information from other people.

Not all external cues carried the same influence. Often they differed according to the source or group that made the suggestion. Referrals own information carried the least influence, in only 2 cases did their admission of mental disorder affect officers perceptions'. In neither case did they form the main basis of the police officer's decision. Surprisingly, colleagues had little influence. In 7 out of 10 instances, they were ignored effectively[1]. Mention of mental disorder on police records was also ignored in 5 out of 9 instances. Relatives and neighbours opinions carried more weight. Officers were influenced in approximatley half such cases. The group it seemed, who carried the most weight, were the police surgeons. Here, in 7 out of 9 instances an officer's opinion was influenced.

The reasons why colleagues were not influential is not clear from the data. Perhaps there was an element of competiveness or rivalry about the management of a

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[1] This does not refer to officers attending incidents together which is discussed in the next page.

referral and that as a result other colleagues opinions were not considered. That relatives and neighbours opinions carried more weight may have been due to the judgement that people who have most contact with referrals, are likely to know something about their mental health. How does one account for the influence of the police surgeons? Perhaps they were, perceived as having a degree of expertise in medical, and therefore mental health, problems. Accordingly, their opinion was, in relative terms, rated highly.

The recognition of mental disorder was rarely something that was dependent on one officer's opinion. It was usual for two officers to attend incidents, and Inspectors nearly always made an evaluation of a person's mental state when they had been brought to the station.

Table 6.17 Level of agreement between officers.

	%	(n)
Conflict of opinion	10.0	(6)
Agreement about mental disorder	85.0	(52)
Missing/uncertain	5.0	(3)
	100%	(61)

That data presented in Table 6.17. above refers to the level of agreement between officers in Study B, as to whether a person was mentally disordered. It is

evident that there was a high level of collegiate agreement. In only 10% of cases was there disagreement. An example of this was where one officer thought that a man was "high as a kite", due to smoking cannabis, whilst the Inspector thought he was mentally disordered (C047).

The degree of diagnostic consensus amongst officers in this study is greater than psychiatrists making generic diagnoses[1]. It may have been that this was due to the limited type of diagnosis that is expected, compared to the more sophisticated procedures employed by psychiatrists. Perhaps too, the police like other lay people, are able to recognise mental disorder on a commonsense basis.

The data presented above suggests that the null hypothesis (2j) is rejected, i.e. that police identification of mental disorder will be based on behavioural criteria alone. Other factors were also found to be important. Where individuals were known to officers, past, as well as present, behaviour was taken into consideration, as was information from other people. The opinion of neighbours, relatives and divisional surgeons carried the most weight. Finally, officers were found to be in agreement with one another about the presence of mental disorder.

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[1] Busfield (1986) includes a review of this literature.

Hypothesis 2k:- The police operate with a paradigm of mental disorder based on the medical model of mental illness.

In Interview B, police officers were asked what they believed the cause of mental disorder to be. This was subsequently coded into the categories presented in table 6.18.

Table 6.18 Causation of mental disorder

	Study B	
	%	(n)
Psychological(family,personality, relational)	23.0	(14)
Social (city living /unemployemnt etc)	10.0	(6)
Medical (disease of the mind etc)	23.0	(14)
Drug/ alchohol related	6.5	(4)
More than one of the above	21.0	(15)
Uncertain/missing	16.0	(9)
	100%	(61)

The two most commonly attributed causes were evenly distributed between psychological and medical. The former category included such causes as "she had a bad childhood", and "problems with the boyfriend"(509). Medical causes were usually given a genetic basis, "she was like it from birth", or physiological degeneration, as with "senile" or "old age" or more traditional medical labels such as "schizophrenia" or mental "depression". Social causes

were thought to be responsible in only 10% of instances. These included "living around here" "Mrs Thatcher's policies", "her [the referral's] general habitat". Drugs were thought to have been responsible in 6.5% of cases and alchohol in 1.6%. Almost as often (in 21%) officers gave a combination of medical, social, psychological factors as the cause. "It was her surroundings, depression and a deep rooted sadness" (C031), "a combination of drink and mental depression (C010)", "medical problems in the past, and living alone with no family support" (C021).

From police accounts in Interview A, this "eclectic" or multi-factoral explanation appeared to be more pronounced[1]. A number of examples show this;

> "She was suffering for religious mania caused by stress which affected her nerves together with not having slept for a long time"(103).

> "Mixed up nutter hooked on football hooliganism"(104).

> "Deep and traumatic depression which resulted from a severe accident some years before which left her badly scarred. This was exacerbated by the fact that she had no job and thought that the world was against her, that was the

[1] The results may not accurately reflect the number of officers adhering to this explanation. The fixed choice mode of question did not encourage elaboration.

reason she wanted to commit suicide".

"The man is physically a freak, he was born like it, he is very short with a high pitched voice - basically very intelligent. I think that it was his unfortunate physical disabilities and disadvantages coupled with the fact that his wife recently left him that made him go potty,- an inferiority complex I suppose. (092)

In addition, the police spoke of "triggering" mechanisms, which were thought to be important. Examples included: a man who's underlying condition was said to have been exacerbated by "his family breaking up-his wife and child left him" (C058); death of a spouse (C027); a row with a boyfriend (C035); rape (W515).

Violence was a further feature identified by officers as a sign of mental disorder. As was shown in the previous chapter, many of the incidents contained elements of threat of or actual violence. However, at times the extent and nature of attributed violence was exaggerated. The subject of 080 was described as "struggling like a madman, he had the strength of ten men".

The extent to which officers associated mental disorder with violence was evident from replies given to another question in Interview B. This was an open ended question which was phrased, "Was this a typical

Section 136 case"? It elicited responses in which 18 out of 54 made reference to the presence or absence of violence as a distinguishing feature, as the following quotes suggest;

> "The only common factor between them is that they are a danger to themselves or others" (057).

> "..had all the symptoms you would associate with a good Section 136-ranting and violence" (C043).

> "They are either very violent or very quiet and then change quickly" (C058).

> "They vary such a lot-some violent some Doreens" (C065).

Descriptions of violence was also used to describe extreme mental disorder;

> "He's more than a nutter he's a psychopath. Talk to him one moment and the next thing he will have his hands around your throat" (032).

> "He was not a schizophrenic - no violence he wouldn't have pulled a knife on you". (043)

Further distinctions were made. The difference between mental handicap and mental illness was one as shown by these officer's comments;

> "it was not a case of being mentally ill more a case of mentally thick" (012);

> "she was slow and retarded rather than mad" (022);

> "he was simple rather than disturbed"(075).

Differences between psychosis and neurosis was a further distinction. Typical mental disorder dealt with by the police was deemed to fall within the former category; "not paranoid or talking about different colours and voices, she was more hysterical really" (C20); "geriatric and psychiatric, not the seeing martians variety" (053).

Classification according to the administrative and legal rules for dealing with mentally disordered people was also mentioned. One officer stated;

> "there are three sorts of nutters those who are not too bad and go before the court, those who are really mad and certifiable, and those who fall in between and go before the court for psychiatric reports" (017).

The issue of intelligibility - or lack of it was seen by some as central. This was summed up in one comment made;

> "There are so many variations. I've had all different sorts, violent ones, broken down ones, they vary so much but all of them have this in common, they are not really with us not in the same world" (C039).

Returning to the question of whether the police operated with a paradigm of mental disorder based on the medical model of mental illness, the data presented above suggests a more complex picture. In

these circumstances Hypothesis 2k should not be accepted. Rather than a predominance of medically conceptulised views of emotional deviance, an even distribution between psychological and medical explanations amongst officers were identified. In addition to these factors, the suddeness of an event (emotional or social) was thought in many cases to bring out a predisposition towards mental disorder. Violence was also commonly viewed as an indication of mental disorder.

Discussion and summary.

In few instances were officers the initiators of the referral. This finding contrasts starkly with Bittners' American study (1967), in which it was found that 50% of emergency psychiatric apprehensions arose from on- the- scene encounters. This discrepancy may be a reflection of cultural differences in policing practices, in that American officer's may spend a greater amount of time patrolling the streets.

A factor which may account for Afro-Caribbean people being over-represented (see chapter 5), was suggested by the data on referring agents. This showed that Afro-Caribbean referrals were less likely to be brought to the attention of the police by their relatives and more likely to be referred

by people they did not know than was the case with the other referrals. This fits the notion suggested by Horwitz (1980) that the greater the social (which includes cultural) distance between groups the more likely it is that a person will be labelled as mentally disordered.

Although, only a small number of referrals were intitiated by statutory agencies, the fact that any at all were made is worth noting. It indicates that psychiatric referral processes can not be seen as a unilinear pathway from the community to psychiatric professionals. Rather, it is sometimes a matter of "passing the buck" between various health and welfare professional groups in an attempt to get rid of people who are regarded as difficult to deal with.

It was found that nearly two-thirds of officers had no prior warning of the type of incident that they were being asked to attend. Officers generally formulated what was going on and make decisions on the basis of what they saw and discovered at the incident itself. (There were some indications that occasionally, the lack of information led to an inapprorpraite response). In this respect police officers appear to be at a disadvantage in dealing with mentally disordered people compared to other mental health professionals. The latter frequently

have access to information from case notes and other sources and carry out their work in circumstances which are more contained and less uncertain.

One finding was, that the reasons for making an arrest were related to threats to public order. This suggests that officers view their contact with mentally disordered people within a wider conceptual scheme of law enforcement and control (Fielding 1987). However, within this overall framework a paternalistic/ social work element was strongly expressed. This perhaps, indicates the complex and contradictory elements of care and control involved in this type of police work.

The data illuminated a number of decision rules invoked by police officers. Decisions were found not only to be made on the basis of what officers were confronted with, but what they perceived might occur if no police action was taken. In this regard officers can be said to have been trying to avoid type 2 errors (Scheff 1978). That is, in the face of uncertainty, officers operated the principle that 'when in doubt arrest'.

Other less frequent decisions made were of a "if in doubt wait and see" or "when in doubt try something

else" type. With regard to the latter it was only when various strategies failed that officers used their powers of arrest. Similarly, where the former rule was followed it was usually when the "wait and see" strategy did not work. In formulating arrest decisions officers were also influenced by the views of others closely involved. The impact that a partiuclar situation might have on individuals - especially if they happened to be children or elderly people was also taken into consideration.

In section three the finding that most arrests were made from public places showed that generally officers were acting within their prescribed legal remit under the Mental Health Act. Nonetheless, a substantial minority contravened the law. This was for a number of reasons including; lack of knowledge about the legal requirements; the emergency nature of the incident; perceived inadequcies of other civil compulsory detention procedures; and the interpretation of events as constituting criminal activitites. Related to this latter point was a further finding, which was the comparatively low use of Section 136 as an authority for making an arrest. This may suggest that some officers did not view Section 136 as an authority for arrest, the Mental Health Act rarely being a part of their everyday dealings with citizens. However, this was not the

only reason. Officers failed to see many instances as appropriate under Section 136. The cause of trouble was not always immediately attributed to a person's mental state or officers used a form of law enforcement to suit the circumstances they were faced with. Thus, there appeared to be a lack of fit between the prescribed legal requirements under Section 136 and the situations that officers were expected to deal with.

The methods of management used to remove people to the police station appeared to be no different to the practices used by officers in other disruptive situations. However, once at the station, differences in the way officers dealt with mentally disordered people compared to other suspects were apparent. This was shown by the limited use of cells, greater observation and adopting a more caring attitude. Thus, officers seemed to assume a dual role in their dealings with mentally disordered people. Whilst officers operated in conditions of uncertainty in public, their role was one in which maintaining public order assumed the greatest importance regardless of who was creating disruption. However, once at the station when matters were more contained, officers could afford to adopt a different, less punitive more paternalistic role.

The importance of the social context within which ascriptions of insanity were made was demonstrated by data presented in section 4. In addition to behavioural cues there was some evidence that officers recognised mental disorder as part of a process in which other forms of deviance were first excluded. Incidents often required immediate action, which sometimes delayed a judgement being made about the categorisation of deviance. A further contributing factor to officers formulation of a situation were other peoples opinions about the mental state of the subject concerned. In this regard police surgeons had most influence, reflecting perhaps, the influence of medical authority.

There was no clear overall medical, social or psychological paradigm within which officers viewed mental disorder. This may suggest that in contrast to other mental health professionals, officers in this study did not use professional knowledge. They held the same views as other lay people including cultural stereotypes about mental disorder. Police accounts however showed officers made distinctions between various types of mental disorder, (e.g. between mental handicap and mental illness and between psychosis and neurosis).

Summary of the main results presented in chapter 6.

In this chapter the results of the study in relation to police decisions at the time of arrest, management strategies and the recognition and construction of mental disorder have been presented.

1) In the first section the results showed that it was generally members of the public who involved the police. Officers in studies A and B initiated referrals in less than 10% of instances.

2) The motivation for initiating a referral was most frequently the threat of or actual violence (as indicated by 38% of referral agents compared to 29% who made reference to a persons mental state in study A).

3) In study A, in 26% of instances, officers were aware of a persons mental state prior to attending an incident.

4) Officers decisions to arrest were made principally for "policing" rather than psychiatric reasons. (In only 11% of instances did officers arrest a person primarily because of their psychiatric

condition). In just under 40% of instances the police gave reasons which were related to the protection of other people or law and order. In a further 36.5% of instances policing such reasons related to a persons own safety.

5) The threat of proliferation was also found to be a major reason for officers deciding to make an arrest.

6) Police acccounts showed that some officers tried to use other informal means of dealing with a referral before resorting to arrest. Other people closely involved in the incident at times affected police officers descions to arrest

7) In the second section the management strategies of officers were examined. It was shown that officers were not reliant on Section 136 of the Mental Health Act as a mandate (with which to apprehend psychiatric referrals which they used in 38%) of instances. Sometimes, officers had other intentions and used alternative means to remove people to the station. In managing referrals, officers used a combination of physical means (handcuffs and physcial restraint) and verbal strategies to deal with people.

9) At the station officers tended to treat

psychiatric referrals differently from other detainees. Cells were used less frequently than ususal. 54% of officers said that they treated mentally disordered people in custody differently from other detainees. The ways in which officers reported that they treated such people differently included, increased observation and adopting a less punitive attitude.

10) The majority of police officers (87% in Interview B) identified mental disorder whilst at the incident. Strange speech and odd behaviour were the items most frequently cited (in 67% and 43% of instances respectively). In 28% of instances in Study B officers recognition of mental disorder were influenced by other people. The process of identifying mental disorder was one in which other forms of deviance were first considered and excluded. Mental disorder was sometimes masked beacuse of the speed with which incidents happened and officers were required to act.

Officers were found not to have one dominant framework through which they viewed the causation of mental disorder. The variations in single causes cited, and the large minority who referred to multiple causes suggests that officers were operating with a lay rather than a professional ideology.

Appendix for Chapter 6

Test 6.1. Use of handcuffs by sex

	Male	Female
Yes	11	0
No	19	31
Totals	30	31

$X^2 = 11.49761$, d.f. = 1, $p < .001$

Test 6.2. Use of handcuffs by age

	Up to 35 yrs	35-60 yrs
Yes	8	3
No	21	29
Totals	29	32

$X^2 = 2.229255$ df= 1 $p < .1300$

Test 6.3. Use of handcuffs by ethnic origin

	Afro-Caribbean	Other
Yes	5	6
No	17	31
Totals	22	37

X^2 =.08591 df= 1 p < 0.954

Test 6.4. Physical restraint by sex

	Male	Female
Yes	16	7
No	14	23
Totals	30	30

X^2= 4.5124 df= 1 p <.0337

Test 6.5. Physical restraint by ethnic origin

	Afro-Caribbean	Other
Yes	10	13
No	11	24
Totals	21	37

$X^2 = .42877$ df= 1 p< .5126

Test 6.6. Physical restraint by age

	Up to 35 yrs	35 to 60 yrs
Yes	13	10
No	16	21
Totals	29	31

$X^2 = .54028$ df =1 p= <.4623

Test 6.7. Placed in cell by sex

	Male	Female
Yes	18	9
No	11	17
Totals	29	26

$X^2 = 3.9088$ df =1 p< .0469

Test 6.8. Placed in cell by age

	Up to 35 yrs	35-60yrs
Yes	16	11
No	9	19
Totals	25	30

$X^2 = 3.0561$ df =1 p< .0681

Test 6.9. Placed in cell by ethnic origin

	Afro-Caribbean	Other
Yes	12	14
No	9	19
Totals	25	30

$X^2 = .0158$ df = 1 $p < .904$

CHAPTER 7

POLICE DECISIONS AT THE STATION

PRELIMINARY CONTACT WITH PSYCHIATRISTS

The topics examined in the last chapter concerned police decisions made in public, their management of referrals and their definitions and identification of mental disorder. The foci of this chapter are police decisions regarding the disposal of referrals and the preliminary interaction which took place between psychiatrists, hospital and police officers. It will be remembered from the first chapter that according to the Metropolitan Police's standing orders, a person who has been apprehended must first be brought to the police station. This allows an Inspector to see the person and make a decision made about whether to refer to a psychiatrist.

a) Police disposal decisions - court or hospital?

i. Disposal outcome

There is substantial evidence that police officers operate with a great deal of discretion when making decisions to charge, (Cain, 1979; Holdaway, 1983; Newman 1985). Likewise, the way in which Section 136 is legally formulated implies a substantial degree of police discretion. Aspects of such flexibility have already been discussed in relation to officers activities in dealing with public incidents. In this section, particular attention is given to examining police discretion as it relates to the disposal of referrals. In order to do this, it is necessary to

ascertain the effect police action had for the people who were apprehended.

Hypotheses 21:- The apprehension of a person will not lead to any course of action other than referral to the psychiatric services.

Table 7.1 Final disposal

	Study A	
	%	(n)
Taken to a psychiatric facility	89.0	(89)
Other	9.0	(9)
Missing	2.0	(2)
	100%	(100)

From table 7.1 it can be seen that in study A the overwhelming majority, 89% (or 89) referrals were taken to a psychiatric hospital. Examples of people not sent to hospital included: the referral who was assessed by the night duty social worker at the police station and returned home to the care of relatives (001); the woman who was refused an assessment by the hospital and was instead found temporary accommodation in an old peoples home (002); and a man who was simply released from the station after a few hours (012).

It was recognised that the data presented in table

7.1 was likely to be an underestimate of the number of times that officers chose to take someone to a psychiatric hospital. Since it was the police authorities which selected out cases for the study, on the basis of the use of Section 136, it is probable that instances which resulted in a court or other disposal might have been selected out. Since the purpose of aim 2g was to examine the types of decisions taken by officers at the station, a more accurate picture of disposals was required. The custody records at the station making most referrals to the psychiatric hospital in Study B were examined over a period of one year.

Table. 7.2 Disposal at one police station for one year

	%	(n)
Section 136	52.0	(42)
Informal Referral	5.0	(4)
Released	19.0	(15)
Charged	3.0	(2)
Cautioned	6.0	(5)
Returned absconder	11.0	(9)
Other.	4.0	(3)
	(100)	(80)

From the data presented in Table 7.2. it can be seen that in common with the data presented in Table 7.1 the majority of referrals were taken to a psychiatric hospital. In fifty two percent (or 42) of cases

police used Section 136 as an authority for doing so and in 5.5% (or 4) people were referred on to hospital 'informally'. In a further 11% of instances police simply returned an absconding patient. It can also be seen that another form of disposal was used to deal with a substantial minority of cases considerd to be mentally disordered. The most common method was to release a person without any further action being taken. This occurred in 19% (or 15) of cases. In six percent (or 5) incidents the person was cautioned. In only 2 cases did police officers charge an individual with an offence. The population identified from police documents as mentally disordered was likely to include instances where psychiatric referral was never intended [1]. Therefore these results should be interpreted with caution. Nonetheless, the data suggests that officers make a variety of decisions relating to the mentally disordered people they apprehend who have not committed major crimes.

The data presented above suggest that officers did not generally deal with mentally disordered people in a routine fashion but were discriminating in their decisions. Hypothesis 21 should therefore be rejected.

A wide definition to include all cases where mental disorder was mentioned excluding those where a serious offence had been committed (e.g rape,murder).

ii. Police decisions

Table 7.3. Time referrals spent at station

Study B

	%	(n)
0-1 hours	39.5	(24)
1-2 hours	23.0	(14)
2-3 hours	8.0	(5)
3-4 hours	1.5	(1)
4+ hours	5.0	(3)
Missing	23.0	(14)
	100%	(61)

Data presented in Table 7.3. shows the length of time that referrals were detained at the police station. The majority stayed for 2 hours or less, with about 40% remaining less than one hour. Rarely, (in 3 instances) was a person detained for 4 hours or longer. This data suggests that, in general terms, officers' decision making was not a lengthy process. However, in relative terms to the speed with which the officers had to act in removing someone from a public place (as indicated by the findings in chapter 5), the time given over to making decisions at the police station was far greater.

Hypothesis 2m:- The police do not have grounds for charging psychiatric referrals with an offence._

Table 7.4 Commission of an offence

	Study A		Study B	
	%	(n)	%	(n)
Yes	56.0	(56)	52.5	(32)
No	20.0	(20)	37.5	(23)
Missing	24.0	(24)	10.0	(6)
	100%	(100)	100%	(61)

Table 7.5. Type of offence committed

	Study A		Study B	
	%	(n)	%	(n)
Breach of the peace	30.0	(17)	34.5	(11)
Criminal damage	30.0	(17)	22.5	(7)
Threatening behav/language	12.5	(7)	3.0	(1)
Assault	9.0	(5)	19.0	(6)
Trespass	5.5	(3)	9.0	(3)
Theft	0.0	(0)	9.0	(3)
Intent to supply drugs	0.0	(0)	3.0	(1)
Offensive Weapon	5.5	(3)	0.0	(0)
Arson	2.0	(1)	0.0	(0)
Sex Offence	2.0	(1)	0.0	(0)
Other/not known	3.5	(2)	0.0	(0)
	100%	(56)	100%	(32)

Table 7.6 Officers' ratings of seriousness of charge

	Study B	
	%	(n)
Very Serious	3.0	(1)
Moderately Serious	22.0	(7)
Not Serious	63.0	(20)
Uncertain	3.0	(1)
Missing	9.0	(3)
	100%	(32)

It can be seen from Table 7.4 that in 20% (or 20

cases) in Study A, and 38% (23) cases in Study B officers considered that charges could not have been pressed. Examples include, a young girl found hitchhiking in the early hours of the morning (C036) who was apprehended on the grounds that she was vulnerable to assault; a man found running up and down the road with a garden rake (C057); and the subject of C046 who had caused considerable damage to his flat but because it was his own property, no charge for criminal damage could have been made.

It can also be seen from Table 7.4 that the majority of officers (56% in Study A and 52.5% of intances in Study B) were of the opinion that charges could have been preferred had they so wished. Table 7.5 shows the likely charges that could have been brought against the apprehended referrals who were considered to have committed an offence, and officers' ratings of the considered seriousness of the charges. Breach of the peace was the most common likely charge, (for which there is no custodial sentence) followed by criminal damage, assault and threatening behaviour. It can further be seen from table 7.6., that in only 1 case (or 3%) did the officer consider the charge to be serious. This was where there was a suspicion that the person concerned was supplying drugs to school children (C044). Sixty-two percent (or 20) officers considered the offence to be "not serious"

whilst 22% (or 7) thought that the offence was moderately serious. This confirms that the population that officers deal with are 'doubly deviant', in that their behaviour can be considered to be both indicative of mental disorder and minor offending.

Table 7.7 Consideration of alternative action

	Study B	
	%	(n)
Yes	47.0	(15)
No	53.0	(17)
	100%	(32)

In relation to those people considered to have committed offences it can be seen from table 7.6 that, a slightly greater number of officers (17) did not give consideration to other courses of action (15). Of those that considered an alternative disposal, five of the officers considered sending someone to court. Another gave someone the option of leaving - which they refused (C025). Two officers tried to take someone home without success, in one case the women had lost her keys and in another no relative was at home. In another instance, calling a Social Worker and a Psychiatrist to assess a person for admission under Section 2 of the Mental Health Act was considered but rejected.

On the basis of these data Hypothesis 2m should be

rejected in part. Officers generally had grounds for charging detainees with an offence though the offences would mainly have been of a minor nature. A number of officers contemplated using other measures before opting for a psychiatric disposal. However, the majority did not consider other courses of action.

To understand further officers' motives in seeking a Section 136 disposal, it is necessary to examine the reasons officers gave for failing to press charges.

Hypotheses 2n: The police's only reason for failing to charge a subject with an offence will be the presence of mental disorder.

This hypothesis involves an open question in Study B "What was the primary reason why the officer did not press charges". The responses are presented in table 7.6. Qualitative data from police accounts is also presented thematically under four headings._

Table 7.8 Reasons for not pressing charges

Study B

	%	(n)
Mental State	43.0	(14)
Unsuited for courts	28.0	(9)
Offence too minor/ Not enough evidence	22.0	(7)
Previous S136 disposal	6.0	(2)
	100%	(32)

It can be seen from this table that the most common

reason given for not pressing charges was the mental state of the referral. This was cited in 43% (or 20) of the thirty two cases. The second most common reason (in 9 instances) was that the person was more suitably dealt with by the court. In 7 instances the offence was deemed too minor to be worth pressing charges or there were not the necessary requirements to do so. Finally, in 2 instances a previous mental health disposal was given as the reason for not pressing charges.

a) <u>The influence of the referral's mental state</u>

Evaluations made about a person's mental state were related to judgements of the intent or motivation to commit an offence. A police officer dealing with one woman for example, did not send her to court because "she was unaware of what she was doing" (C037). The officer in another instance (085) thought that the man he had arrested should not be charged because "he was not in control over what he was doing". Whilst another officer thought, "it was a waste of time to charge, youv'e got to know what youve done and she didn't have a guilty mind" (087). Likewise another person was not charged because "he was not capable of criminal intent" (C031), in case C003 the officer said he "would have sent him to court if he was in control of his actions-but he wasn't". These examples suggest that officers used a sort of "insanity

defence" when they decided whether a person was responsible for their own actions.

As well as considering the motives, or rather the lack of them, for a particular crime, a further aspect was evaluation of the behaviour which could be attributed to mental disorder, viz: that considered to be criminal. The following two examples illustrate that where the seriousness of mental disorder is weighed against a particular act of criminality, a court disposal is only sought if the latter is considered to outweigh the former.

> "Would have been charged if he had been in control of his actions, but he wasn't-with Section 136 your'e not; it means your condition is too serious to be sent via the courts". (C003)

> "would only take a mental person to court if there is doubt about it - people in the grey area"

The opposite process occurred where a referral's criminality was seen as outweighing his mental condition (069). This was a case where Section 136 was only used after being charged with an offence and the person had made a court appearence[1]. Similarly, a man was arrested for shoplifting from Woolworths. On arrival at the police station he was agitated. The

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[1] The magistrate ordered the police to take the person to a psychiatric facility because he was considered unfit to plead.

custody officer remarked (to me) "thats almost one for you" suggesting he had thought of using Section 136. The man was subsequently charged with theft and bailed. When asked why he had not used Section 136, the officer replied that he thought that the man was probably suffering from mental disorder but he was not considered ill enough to be sent to hospital. He also said that if the police sent everyone like that to hospital, the courts would have little to do!

That officers' perceptions of mentally disordered people as 'disarmers' was also relevant. According to Holdaway (1983) 'disarmers' are people who, by prompting sympathy, weaken or neutralise the traditional 'crime fighting' role of the police. The subject in incident 050 was not perceived by the officer in criminal terms. He remarked "she was a lovely person and I would have been upset if she had been charged". A moral judgement appealing to a sense of fairness was apparent from the officers in cases 035 and 028 respectively who stated; "the people who get charged with Breach of the Peace are nasty-not the June Jones's[1]". "It would have been unfair to charge. Prison would have done him no good at all." Similarly, charging a mentally disordered person was thought to be too harsh by the officer involved (in case 048). He said, "to have charged him would have

[1] Pseudonym.

been like hitting a nail with a sledge hammer".

b) <u>The anticipated reaction and perception of the courts.</u>

The court's anticipated reaction to both the officer and referral was also identified from police accounts. A number of officers particularly sought to avoid personal criticism by magistrates and the courts;

> "We would have been criticised by magistrates for bringing someone mentally disordered before the court (009).

> "We would all have looked daft if he'd gone to court, there would have been a complaint for bringing charges against such a bloke, especially if he got in the witness box and started yelling about his nuclear reactor"(011).

> "Courts don't like you bringing people like that to court (C042).

> "If he had been charged with breach of the peace the court would have thrown it out or asked for medical reports"(084).

In another case the officer was concerned about the reaction of the magistrates because the subject "would have played up in court"(085).

Most of the comments about disapproving magistrates appeared to come from one police station. It may have been that the attitude of the court used by the station, contributed to its high number of

psychiatric referrals. As one sergeant from the station explained;

> "Remand for psychiatric reports is rarely used in court X compared to the station I used to work in. In this court they don't believe the officers and thats why we deem a lot more". (022)

In addition to officers being influenced in their decision making by the presumed reaction of the court, the officers' own perception of the appropriate role of the court were relevant. That the person may nonetheless have ended up with a psychiatric disposal was one such consideration. One officer (059) thought it likely that the same result would have been achieved if a person was sent to court. "If he had been charged he would have been remanded for psychiatric reports".

Another reason mentioned was the efficacy of a court disposal. One officer expected that had the person he had detained under Section 136 been sent to court the magistrates or judge would have eventually sent him to hospital- but only after he had been let out on bail for six weeks. In another case the officer thought that the court would have sent the person to hospital under a different section of the Mental Health Act. A Section 136 disposal was considered as having the same effect but entailing a lot less trouble (023). In other cases officers did not

consider dealing with mentally disordered people as part of the courts remit;

> "Its pointless to prosecute the mentally ill,only if they've committed serious offences do they go through the court. They should deal with punishment not care" (W505).
> "He needed medical attention, the police have more experience than courts in deciding whether a person should go to hospital (C001).

The nature of the offence which had been committed was also important in terms of the expectations of the courts. The decision to 'deem' rather than charge was made by one officer (017), because the subject was thought unlikey to receive a custodial sentence. Similarly, in view of the minimal damage caused by the subject of one incident, charges of arson were dropped (038).

At times it seemed, that irrespective of the mental state of the subject, if an offence was minor no charges were made. For example, a constable claimed that although a person could have been charged with breach of the peace, it was not his normal policy to charge for such a minor offence (056). Similarly, another officer said (in relation to a person having committed a breach of the peace) that he would not have charged <u>anyone</u> with such a petty offence but would have cautioned the person and then released them (065.)

For those cases, where officers did not choose to press charges because the offences were of a minor nature, and where a psychiatric disposal was sought, subjects faced the prospect of custody for up to 72 hours. Other non- mentally disordered persons arrested for similar offences would not it seems have been detained.

d)<u>The absence of practical criteria</u>

On some occasions, officers did not charge a person with an offence because the necessary practical and/or technical requirements were absent. In C035 no victim was involved "so there was no question of compensation". In 064 the police could not find the alleged victim. In 071 the wife of a subject was not prepared to press charges, nor was the son of the referral in 024. In C045 the police had difficulty in formulating a precise charge, and in C015 it was thought unlikely that the local authority would have taken action against the subject who had damaged Council property - partly because of his mental state but partly also because he was elderly. In another case (044) the police would have preferred to caution the detainee rather than using Section 136. However, because the person was required to admit to the offence he had committed, but was unable to do so, the police were unable to take this course of action. In a further incident (087) an officer said that it

would have been practically impossible to charge the person he had arrested because "he was out of his head".

Finally, a past course of action sometimes affected an officer's decision. For example, an officer decided on a psychiatric disposal after dicovering that the person had previously been dealt with under Section 136 (W511). Similarly, C045 used S136 because "that was what was used the last time". Thus, knowledge of a subject's psychiatric career created precedents for the police officers.

e) Perceptions of the hospital

The sample in studies A and B only included those referred to the psychiatric services under Section 136. Therefore there were no cases ihcluded in which officers made a decision to send people to court in preference to hospital. Nonetheless, there were indications of dissatisfaction and reactions to hospitals which officers said might influence their decisions on future occasions. For example, one officer was reluctant to take a referral to hospital because "no one there knows what to do with her", yet also felt that the court was not the appropriate place for someone so disturbed (092). Another officer said that because the hospital were so reluctant to take the person and were so "uncaring" he would

"think twice" before referring another person again (011). Finally, there was the cumbersome procedure adopted by one psychiatric service, which required the transportation of a person twelve miles to a casualty department and another twelve back to the local district general hospital psychiatric unit if admission was required. This prompted one inspector to say that in future he would encourage psychiatric cases to be taken before the court instead of to hospital (C024).

The restrictions of the research design meant that it was not possible to evaluate the degree to which the policies and perceptions of different hospitals were taken into account in officers' decision making. Nonetheless ad hoc comments revealed a number of views which may have had indirect bearing on the making of decisions. District General Hospital psychiatric units (DGHPU's) were in particular regarded with suspicion. For example, one constable admitted to not using a local psychiatric unit on the grounds that "they have insufficient 'security'" (006). Similarly, an officer stated that "the local hospital has problems taking violent patients so I use another". Another officer thought that the large psychiatric hospital used as a place of safety in Study B was a more appropriate place to send someone than the District General Hospital psychiatric unit.

The former it was thought was more specialised in dealing with mental health problems than the latter (001). However, another officer expressed reservations about the appropriateness of the same large hospital; "its a terrrible place, very depressing. I wouldn't want to send anyone to a place like that if it wasn't absolutely necessary - it scares me silly" (015).

Returning to Hypothesis 2n, in summary the data presented above shows that the person's mental state was a major reason for not charging a referral with an offence. Some officers operated a form of presumed insanity defence, which included as a principle in deciding not to charge, a balance between mental disorder and criminality. Where mental disorder was perceived as being more severe than an alleged offence, Section 136 was the preferred course of action. These findings suggest that the null hypothesis should be accepted. However it is also important to note that mental disorder was not the only reason given for not charging a referral. Officers also took into account other factors. They were influenced by: their perceptions and expectations of the courts towards themselves and mentally disordered defendants; the seriousness of an offence; the practicalities of preferring charges; and the type of disposal that had been used

previously. The perception of the type of hospital available for receiving referrals was also an influential factor at times.

Involvement of other professionals in disposal decisions.

Hypothesis 2o:- Officers will not take the decision to refer individuals to the psychiatric services without the assistance of other professionals.

Table 7.9. Professional assessment at the police station

	Study B			
	Yes		No	
	%	(n)	%	(n)
Social worker assessment	0	(0)	100	(61)
Visit by a police surgeon	36	(22)	64	(61)

It has been seen in the previous chapter how others such as neighbours, relatives and police surgeons influenced officers' opinions as to whether a person was mentally disordered. Table 7.9 presents data on the the involvement of professionals other than the police in attending to a person whilst detained at the station. It can be seen that social workers were not involved at all with section 136 cases at any of the stations. Police surgeons were more frequent visitors and attended in 36% (or 22) instances. The

main point that can be made from this table is that decisions were taken unilaterally by the police. (Where another person was involved this was an employee of the police so technically control remained firmly in their hands).

The reason for police surgeons being more frequently involved in attending police stations than social workers may have been due to opportunity. During the period of observation, police surgeons were called frequently to attend to prisoners. They would sometimes carry out a number of examinations or administer medication during a visit. On occasion when a person was detained under Section 136 no special effort was made to contact a police surgeon. But when one visited to check on the progress of another detainee the custody officer as an afterthought said "whilst your here could you have a look at this one". A further reason for greater police surgeon involvement may be related to the role they played as mediators between the police officers and psychiatrists. This is discussed in more detail in the second part of this chapter.

The main reason why social workers were not involved in decisions made at the police station is simply that they were not asked. In only two instances did officers actively request a social worker's presence.

The more interesting question is why officers did not call social services departments. From the qualitative data the most frequent reason for this appeared to be that officers were unaware that social workers needed to be involved in Section 136 cases as indicated by this officers remark; "It wasn't necessary we can 'deem' straight away. No need to call a social worker she was found on the street not on private premises (C030)." Other reasons show an inbuilt scepticism about social workers based on officers past experience. Firstly, social workers were not expected to respond appropriately even when officers recognised a duty to call them and their involvement was seen as an impediment to dealing with a person effectively and efficiently. These three comments are illustative of this;

> "For the welfare of the person, to go to hospital was the simplest and quickest solution. Have you ever tried getting in a soical worker at that time of the morning? (C036).

> "Calling the social workers would have meant the person staying longer at the station and thats not a suitable place for such a person to be in (C025)".

> "Nine times out of ten you can't get hold of them. He was going to the hospital so there was no need. Might have if we'd considered sending him back home, but the hospital can deal with these cases o.k. on their own (C035)".

Secondly, some officers saw themselves as performing

social work tasks as well as, or better, than social workers themselves as indicated by the following comments;

> "Something which is often ignored or forgotten is that the police are as much social workers as the traditional social workers (C061)."

> "An experienced police officer is more capable than the average social worker of being aware of someone who is mentally ill (C053)".

> "Social worker...everyone mentions social workers! I don't know about social workers - this is about commonsense really and its us who's got that not them. (C055)"

Finally, was the generally low opinion that officers held of social workers.(Derogatory remarks about social workers arose frequently and sponteneously during interviews). In particular a difference in approach and politics was mentioned. "Social workers are offhand, left [wing] and hate the police (010)"; "they're uncaring and unconcerned about people like this (015)"; "they don't do anything when they do move off their arses to come - theyr'e always on strike in this area anyway" (C032).

The findings that social workers did not attend the station at all, and police surgeons attended in less than half the cases suggests that the officers generally made decisions independently of other professions. Based on this data, the null hypothesis

(2m) that officers will not take the decision to refer individuals to the psychiatric services without the assistance of other professionals should be rejected.

Section 2.

Interaction with the hospital and psychiatrists.

In the last section it was seen what factors were involved in officers' decisions to refer an individual to the psychiatric services. In this section the polices' interaction with psychiatrists is examined in relation to the way arrangements were made for receiving detainees from police custody. Officers' first point of contact and negotiation with psychiatrists is in arranging assessments over the telephone from the police station.

Hypotheses 3a: Police Referrals will be automatically accepted for assessment by psychiatrists.

Hypotheses 3b. Psychiatrists will not attempt to dissuade referrals being made to the psychiatric services and officers will not seek to persuade psychiatrists of the need to accept referrals.

Table 7.10 Problems in gaining an assessment.

	Study A		Study B	
	%	(n)	%	(n)
Yes	27.0	(27)	13.0	(8)
No	44.0	(41)	54.0	(33)
Missing	22.0	(21)	33.0	(20)
	100%	(92)[1]	100%	(61)

[1] 8 out of the 100 cases were released without attempts being made to refer to the hospital.

It appears from Table 7.10 that whilst the majority of officers in study A did not experience problems in obtaining a psychiatric assessment a substantial minority, 27% (or 27) encountered difficulties in persuading the psychiatrist to provide an assessment for the detained referral. The data presented in this table also suggests that difficulties in obtaining an assessment were not as frequent in study B as in A. It is likely that the lower percentage (13%) in study B may be due to a halo effect[1] and that the results in study A are a more accurate reflection of the rate of difficulties encountered in obtaining an assessment. The main point is that the number of problems encountered was quite considerable when considered in the context of Section 136 providing a legal mandate for gaining a psychiatric assessment.

The police and psychiatrists have various means which they can use to facilitate or impede a referral. Ascertaining the different occupational strategies used by the police and psychiatrists presents a validity problem. Because accounts of encounters between the two professional groups often contain partial information, evaluating their accuracy was difficult. For example, it was not possible to confirm the psychiatrist was "too busy" to see a

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[1] It may be remembered that both the police and hospital administration had noted improved communication and reduction in problems as a result of the research.

referral whether this claim was accurate (W505). Was the psychiatrist indeed too busy or was he using this as a means of detering a referral being made? In another case (C058) a psychiatrist kept police waiting for a considerable time at reception, and then, when he arrived, went off somewhere else almost immediately, without telling police where he was going or when he would return. Was he hoping that the police would become bored or disgruntled and leave with the referral? (C058). Whatever the truth, the main issue is one of the former presenting an obstacle to the latter which has to be overcome, if the referral is to be accepted for assessment.

The nature of the strategies used by psychiatrists in preventing police referrals being accepted will be examined first. Police officers counter strategies will be examined subsequently. The data is presented in this order because it is assumed the police in negotiating the acceptence of a referral are in a less powerful structural position than the psychiatrists.

Table 7.11 Nature of problem encountered

	Study A		Study B	
	%	(n)	%	(n)
Catchment area dispute	28.0	(7)	43.0	(3)
Inadequate/inappropriate facilities	24.0	(6)	12.5	(1)
Untreatable/"black listed" patient	48.0	(12)	43.0	(3)
Other	23.0	(2)	12.5	(1)
	100%	(25)	100%	(7)

Table 7.11 shows the nature of the problems encountered by police officers interviewed. A number of points can be made about this table. Firstly in 28% (or 7 cases) in study A, and 3 cases in study B, the claim by psychiatrists that the patient came from the wrong catchment area was used as a strategy to refuse the acceptence of a referral[1]. Each police station is assigned a designated hospital(s) where referrals are taken within a geographical area. However, as table 7.11 indicates, even though police stations were trying to make contact with designated hospitals, catchment area disputes were evident. In one case, the psychiatrist claimed that though a person was found in the vicinity of the police station of which their hospital was the designated one for accepting referrals, the person was not a local. On another occasion, though the psychiatrist accepted that the person was resident within the

[1] Unlike physical emergencies, loose catchment areas are used for hospitals accepting emergency psychiatric referrals from a particular vicinity.

hospital's catchment area, a request for initial assessment was refused because the referral had recently been an inpatient at another hospital.

Six (or 24%) problems encountered in study A, and 1 in study B were to do with inadequate or inappropriate facilities. In 5 cases problems over facilities for violent patients were given as a rationale for trying to disuade a referral being made, and in 2 the unavailability of beds was specified. Since the police in instigating Section 136 were requesting a psychiaric assessment and not admission, the issue of approprite facilities with regard to the acceptence of a referral was logically irrelevant. It may be possible that a number of psychiatrists misinterpreted the Section 136 provision as being for admission rather than assessment (Rogers and Faulkner, 1987). Whether by default, or not, psychiatrists nevertheless at times used admission criteria to prevent officers bringing a referral to hospital for assessment. Moreover, the strategy was not confined to psychiatrists working in DGHPU's. Five out of the 6 psychiatrists in study A were operating from a large psychiatric hospital where, given deinstitionalisation policies, there is unlikely to be a bed shortage.

A further 12 incidents from study A and 3 in study B,

concerned the claims made by psychiatrists that referrals should be refused because they were disruptive or difficult, or their psychiatric condition was "untreatable". For example, the officer in (017) who contacted the local hospital was told by the duty psychiatrist that the subject the police had detained was a "black listed patient" and there was a policy that he should not be admitted. The psychiatrists rights of definition and use of diagnosis, as a means of choosing to accept or refuse a person for assessment is most clearly illustrated by one subject who was referred twice to the psychiatric services during the study period. On the first of these the referral was admitted after being assessed. At the time of assessment, and on the discharge form, the patient was diagnosed as suffering from "schizophrenia". The same patient was involved in an incident soon after. According to the police account, the assessing psychiatrist refused to provide an assessment on the grounds that the referral was suffering from a personality disorder and therefore should not be reassessed because he was considered to have an untreatable condition (C003).

A more blatant assertion of a psychiatrist's professional right to decide on the acceptence of a referral was noted in the following interaction (074). The psychiatrist refused to accept a patient

without a prior medical opinion. The Inspector said to him that it was in the power of the police to invoke Section 136 proceedings and not the divisional surgeon. The psychiatrist then questioned the right of the officer to decide who is mentally ill and stated, "its up to doctors to decide and not the police".

The remaining 3 cases in Study A and B were as follows. In one, the psychiatrists simply refused to accept the referral with no explanation offered. Checking the legality of police action occurred in another. The officer concerned reported that on the telephone the psychiatrists, "Questioned us about where we picked hom up from - was it in a public place". Finally, the failure to locate a person's hospital records (because it was at night) was given as a reason for why the police should not bring someone for assessment.

Police counter-strategies

A number of counter-strategies could be identified, which officers used to get a referral seen or dealt with. These to some extent mirror the strategies of the psychiatrists. One tactic used by officers was to provide false information. One officer stated that when psychiatrists would not accept a person for assessment, " We say they're no fixed abode so that

they take them" (070). Another registered the woman on the form 434 as being of 'no fixed abode' and stated that "if the hospital had known her address they would not have accepted her" (004). At other times, officers refused access to assessment simply tried another hospital (004).

A further strategy for avoiding obstacles being presented by psychiatirsts was "dumping" of referrals. This involved the police simply bringing the referral direct to the hospital. When this was used police usually got away with it. In one case where the subject was a well-known"black listed" patient, the police officers did not ring to inform the psychiatrists that the patients was being taken to hospital. Neither did they request an assessment be made. They simply took him to the reception of the hospital and asked the receptionist to call the psychiatrist to see him. The police then left before the psychiatrist arrived (C024). On another occasion, where no prior contact was made, the police delivered the referral to a ward, where it was known the referral had previously been an inpatient, and left without making contact with the psychiatrists (C039).

At times police officers simply confronted the psychiatrists with what can be called 'counter experience'. Consider 074: appealing to common sense

and length of experience, the Inspector replied to challenges to his diagnostic authority, that he had enough experience from years of policing and could tell as well as anyone else who was mentally disordered. However, confrontation of this type was rarely mentioned during interviews. It was usually through the delegated authority of police surgeons that issues around diagnosis were taken on by the police.

The most frequently used and effective strategy for gaining the compliance of psychiatrists was by seeking other medical authority. The police have access to their own medical experts in the form of police or "divisional surgeons". These are general practitioners who are employed by the police force on a case by case basis. There is no mention in police standing orders of the need to call a police surgeon in the cases of mental disorder. One assessment by a police surgeon however lasted only a short time, it took three minutes and involved little "examination". Four questions were asked, and there was no equivalent of the Mental State Examination or other examination that might be expected from a psychiatrist. The diagnosis, given on the form was that the subject "was obviously disturbed". Police

documents[1] also suggested that police surgeons' examinations generally took no more than a few minutes.

Table 7.12. Police surgeon's assessments

	Study A		Study B	
	%	(n)	%	(n)
Yes	37.0	(37)	36.0	(22)
No	57.0	(57)	51.0	(31)
Missing	6.0	(6)	13.0	(8)
	100%	(100)	100%	(61)

Table 7.13. Purpose of calling police surgeon.

	Study B	
	%	(n)
Opinion re mental disorder	45.5	(10)
Physical injury	9.0	(2)
Other	45.5	(10)
	100%	(22)

Tables 7.12 and 7.13 shows the number of cases to which a police surgeon were called and gave the purpose for calling upon them. It can be seen from this table that the numbers of incidents in which officers interviewed in studies A and B are remarkably similar. It can also be seen, that with regards to study B, the most frequent reason given

[1] Officers fill in a form everytime a police surgeon makes a visit stating the time of arrival and departure.

for calling a divisional surgeon was to decide whether the person was mentally ill. For example, in one case (W515), the police surgeon was asked to visit the referral in order to "advise on his mental state". In another (C036), that officers believed the referral was mentally disordered was given as a reason for not calling in the police surgeon. It could be argued that any doubt officers had about a diagnosis was the reason that divisional surgeons were called. However, this reason is unlikely to be the only one. Data presented in the next chapter shows officers to have high levels of confidence in their abilities to diagnose mental disorder. Moreover, at times officers were sceptical of the ability of police surgeons to make superior judgements. For example, the constables in (058) and (C042) commented, that in calling the police surgeon for such cases,"the police surgeon nearly always confirms officers' actions in deeming" and "they aren't trained for this sort of thing".

A more likely reason is that a police surgeon's knowledge and legitimacy in making medical diagnoses of mental disorder are needed by the police in order to give them greater negotiatiang rights with psychiatrists in the acceptence of a referral for assessment. Yet, the police surgeon was useful at times in relation to administrative work at the

station and in negotiating access to psychiatrists for assessments. With regards to the former, adherence to station rules and procedures was a reason given for calling on the services of the police surgeon to certify that the person was "fit to be detained" (W517), (C010), (C016). In relation to negotiations with hospital psychiatrists, authority to fulfill the formal administrative requirements was also deemed to be important. This is implied by the officer in (C035) who stated;

> "We're not experts in mental conditions by law, you need an expert to say whether a person is or isn't.
>
> It's like if a person is dead you know they are but you have to have a doctor to write out a death certificate."

The police surgeons acted as mediators between psychiatrists and police. The officer in (086) asked the police surgeon to write a letter to the hospital. "It was useful as it acted as a personal communication between doctor and doctor and could help to get the man admitted". Another officer commented that the divisional surgeon "smoothed the way with the hospital" (C042). Whilst in (030) the police surgeon was called because of "recent difficulties" with the hospital and because the psychiatrists "are reluctant to take the word of the officers".

Indications that police surgeon visits were imbued with authority in negotiating access was also confirmed by a number of the psychiatrists[1]. In one case (C016), the psychiatrists commented that there was no need for the officers to stay until an asessment was complete because the woman had been seen by the police surgeon. In another (C025), the psychiatrist commented that if the person had not been seen by the police surgeon she would probably have been more thorough in her examination. The assessing psychiatrist in (C065) thought the police surgeon should have seen the referral prior to being sent as; "it might be very distressing to be brought to a psychiatric hospital if your'e not ill".

Though, in the main, the divisional surgeon was used as a strategy to increase the police's power in negotiations, occasionally the tables were turned and psychiatrists attempted to use the police surgeons in their negotations with officers. An example of this was case 012. When the police contacted the psychiatrists to ask for an assessment the psychiatrist told the police that they should get a police surgeon to see the person before sending them on to the hospital. (C012).

On the basis of the data presented above hypothesis

[1] Gleaned from comments made in Interview C.

3a and 3b should be rejected. Whilst the majority of referrals were accepted automatically for assessment by a psychiatrist, in a substantial minority of cases officers encountered difficulties. It was found that psychiatrists use catchment area criteria, assertions regarding an individual's 'treatability' or acceptability, and the availability of beds and other resources to deter police making referrals to them. It was also found that police deploy certain occupational strategies of their own in countering, or pre-empting, obstacles or difficulties put in their way by psychiatrists. This mainly included the use of police surgeons' authority.

Discussion and summary

The finding that over a period of one year at one police station that police officers chose other alternatives to using Section 136 as a disposal option, indicates that police officers are discriminating in their decisions. Thus, at times referrals with similar statuses are subject to different types of justice. The majority of cases were sent to a psychiatric facility, only a couple of individuals were charged, but a larger number were released without any further action being taken. Thus a small group may have been seen to 'escape' the possibility of both detention in hospital or action

by the court[1].

That the majority of referrals were found to have committed offences for which they could have been charged is important. It suggests that Section 136 is being used more or less in a manner recommended by the Percy Commission (which preceded the 1959 Mental Health Act) but which was subsequently rejected by Parliament. (The Commission recommended that officers should only use Section 136 when a person has committed an offence). Additionally, officers did not appear to use Section 136 routinely as an alternative form of detention when there were no grounds for making a charge, as has previously been claimed (see chapter 1).

The type of decisions made at the station differed from those made on the street. As findings presented in the last chapter showed, (e.g. the low use of Section 136 as a mandate for arrest and delays in the recognition of mental disorder presented) reasons for making an arrest were not clerly formulated. In contrast, things were clearer once at the station. Ambiguity was reduced and officers' decisions centred on a suitable disposal.

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although it may be counter argued that such people were also being denied the 'benefits' of treatment.

Officers provided a number of reasons for not pressing charges (where this was a possibility), the most frequent one being a person's mental state. Officers appeared to operate a form of insanity defence in which a persons perceived responsibility for his/or her actions was considered. In deciding not to charge a person one externality which was important was the perceived reaction and policies of the court. One station in particular appeared to make greater use of Section 136 becuase of the perceived negative attitude of the court towards mentally disordered defendents. It is also possible to speculate that, given certain views held about District General Hospital Psychiatric Units in particular, at other times the reverse might also have been occuring; i.e. that some people who might otherwise be referred for psychiatric assessment may be processed through the criminal justice system instead.

The impression gained was that police officers were generally more in control of their decision making than when they were previously dealing with matters in public. Some suggestion of this was given by the finding that police officers tended to make unilateral decisions about what to do with a person independently of social workers and, to a lesser extent, of divisional surgeons. The reasons for the

non-involvement of social workers seemed to be related on the one hand to a lack of information as to the social workers role in Section 136 cases, and on the other, to professional rivalry and the perception that social workers would impede rather than facilitate matters. Thomas (1986) has noted the negative way the police generally view social workers. An indication of this in this study was that officers were outspoken in their comments. Perhaps this signifies the threat social workers pose to the officers professional autonomy in dealing with mentally disordered people.

The second section of the chapter examined the interaction that took place between psychiatrists and police officers in arranging assessments and reception of patients. In the majority of instances, making such arrangements appeared to present no difficulty. However, there were a substantial minority of instances in which officers encountered problems from psychiatrists. Given that all, apart from one person, were eventually accepted for assessment psychiatrists cannot be regarded as having acted against the rules of the Section 136 provision. Nonetheless, by being obstructive they can be viewed as acting aganist the spirit of the Act, even if their attempts failed. Despite the ambiguity surrounding the duties of the psychiatrists in

relation to the provision (as outlined in chapter 1), that a psychiatric assessment is required is clearly stipulated.

The most common type of strategy used by psychiatrists in attempting to disuade the police sending a person for assessment was to 'blacklist' a patient (usually on the basis of perceived disruptive behaviour) usually adding that his condition was untreatable. Other literature has drawn attention to the value of applying the label of personality disorder in psychiatry (Ramon, 1986; Pilgrim, 1987)[1]. Here, a label of personality disorder or being 'difficult to manage' appeared to be used as a justification for not providing psychiatric attention. A lack of beds or other inpatient faciltities was also used as strategy to try and prevent referrals being made. A request for assessment does not in itself implicate the use of a bed. Even if admitted the necessary arrangements exist between hospitals in the NHS for patients to be accepted. Similarly, with regards to catchment area criteria (also a strategy employed in attempting to deflect a referral from being made) there is no legal or formal obligation to prevent any medical practitioner in their discretion to accept any

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allowing claims to be made for certain types of patient to be sent to or to remain in special hospitals.

patient they wish.

Perhaps what is surprising is that none of these strategies resulted in a different course of action being taken by the police. All the referrals that the police had decided should be seen by a psychiatrists were eventually accepted for assessment. A lack of tenacity on the part of psychiatrists may have been partly responsible- perhaps because they recognised a legal duty to cooperate. However, it is also likely that their lack of success was due to the way in which which officers deployed counter strategies. Qualitative data highlighted the verbal skills of officers in talking round psychiatrists and outmanoeuvering them. Co-opted medical authority in the form of police surgeons was also used as an addendum to such verbal tactics. Thus, although a substantial minority of psychiatrists attempted to control matters at a distance, whilst at the station officers appeared to have the resources to ensure that they remained in control of proceeedings.

Summary.

The main findings in this chapter were as follows:

1. The police are discriminatory in their decisions to use Section 136 as a disposal for mentally disordered people that they apprehend. In study A it was found that 9% (or 9) arrests did not result in referral to hospital. The custody records at one station using the psychiatric hospital in study B showed that in 48% of arrests where mental disorder was mentioned (and no serious crime had been committed) a disposal other than Section 136 was used by the police.

2. Most referrals detained under Section 136 could have technically been charged with an offence; 80% (or 80) in study A and 62% (or 38) in Study B but that charges would have been for mainly minor offences.

3. Police officers gave a number of reasons for not pressing charges, the most frequently cited was a person's mental state (in 43% (or 14) applicable cases in Study B. The policies and expectations of the courts were identified as a reason for not charging in 8 instances, technical or practical difficulties in preferring charges in 7 cases and the type of disposal previously used in a further 2. Qualitative data showed that officer's perceptions

of psychiatric facilities were also thought to be important in their decision making. District General Hospital Psychiatric Units were in some instances perceived as less appropriate than large mental hospitals.

4. Officers did not generally involve other professionals in making a decision regarding the course of action in individual cases. In Study B in only 22 instances did police surgeons visit a potential psychiatric patient, whilst social workers did not attend at all.

5. In the second part of the chapter, it was shown that in a substantial minority of cases (27% or 27 in study A and 13% or 8 in Study B) police encountered obstacles in obtaining a psychiatric assessment. Different occupational strategies used by the police and countered by psychiatrists were then examined. The former included the use of catchment area criteria, inappropritae or insufficent facilities, and 'untreatability' criterea. The police in turn used a number of counter-strategies which included using verbal skills and referring to their own experience and knowledge in attempting to persuade psychiatrists to accept referrals. Police surgeons' medical authority was also used by the officers.

In the last chapter, an examination was made of police negotiations with the hospital and psychiatric staff about assessment arrangements. This chapter will focus on three main topics. The first two are to do with the officers' and psychiatrists' handling of individual referrals; the way in which the two professionals perceived referrals; and the type of interaction that took place between the psychiatrists at the hospital. The third is how each of the two occupational groups perceived the others' dealings with mentally disordered people and their appropriate professional roles.

Other studies on interprofessional relationships in the health field suggest that differences, conflict and boundary disputes can in part, be attributed to ways the professionals view a shared client group.(See for example Huntington, 1982; Goldie, 1976; Pilgrim, 1986). Likewise, to understand the interaction that took place between the psychiatrists and police, it is important to examine differences and similarities in their perceptions of referrals. In doing so, certain differences that exist between the police's and other mental health professionals' interaction with psychiatrists need to be noted. It was shown in Chapter 6 that officers possessed an eclectic view of mental disorder. Unlike psychologists and social workers, the officers in this study did not lay claim to or construct a coherent alternative body of knowledge with which to challenge the

medical model within psychiatry. A further difference is that, working outside the health service, the police do not share the same division of labour as other mental health workers, which psychiatrists tend to determine and dominate.

The hospital context

In order to provide a context within which professional contact took place, data is presented on the places of safety to which referrals were taken and the day and time of assessment (Study B).

Table 8.1. Place of safety.

	%	(n)
Claybury	68.0	(56)
Whittington	32.0	(26)
	100%	(82)

Table 8.2 Day of assessment

	%	(n)
Weekday	64.5	(53)
Weekend	35.5	(29)
	100%	(82)

Table 8.3 Time of assessment

	%	(n)
9am - 17.00 hours	39.0	(32)
5+pm -23.59 hours	34.0	(28)
Midnight - 8.59am	26.0	(21)
Missing	1.0	(1)
	100%	(82)

Data presented in Table 8.1. shows that referrals were not evenly distributed between the two psychiatric facilities. The large psychiatric hospital (Claybury) received more than twice the number than the District General Hospital Psychiatric Unit, (Whittington). At the latter place, assessments and contact with the police took place in the Casualty Department. At the former, the designated place for assessment was an office on the ground floor in the main reception area of the hospital.

From Tables 8.2 and 8.3 it can be seen that, proportionately, more referrals were assessed at the weekends than on weekdays and/or 'out of hours' -i.e. between 5pm and 9am. Even so, for an emergency mental health power used by a non-mental health professional, the numbers are not all that high[1]. Sixty -five percent (or 53) referrals were made on a weekday, and 39% (or 32) during the normal working day when others, i.e. social and health services, are more readily available.

Police and psychiatrists perception of referrals

Hypotheses 3c:-There will be no differences in the way in which police and psychiatrists will perceive referrals.

This hypothesis involves an examination of the extent of

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[1] A common belief on the part of mental health professionals is that police referrals generally take place outside of normal working hours.

agreement about the referrals' psychiatric condition, dangerousness to themselves and others, and the perceived appropriateness of the referral for psychiatric attention.

Table 8.4. Outcome of psychiatrists' assessment.

	%	(n)
Referral Admitted	87.0	(71)
Referral discharged	12.0	(10)
Decision pending	1.0	(1)
	100%	(81)

Table 8.5. Diagnosis

	%	(n)
Schizophrenia	20.0	(16)
Unspecified psychosis	12.5	(10)
Personality disorder	12.5	(10)
Paranoid state	10.0	(8)
Hypomania	8.5.	(7)
Mental handicap	1.0	(1)
Acute confusional state	2.5	(2)
Unspecified mental disorder	6.0	(5)
Uncertain whether physical/ mental disorder	3.5	(3)
Not mentally disordered	5.0	(4)
Missing	18.5	(15)
	100%	(81)

Table 8.4. and 8.5. present data on the outcome of psychiatrists assessment and the type of diagnosis attributed to patients. It can be seen that all but 12% (or 10) were admitted to hospital. On only two occassions did psychiatrists make any 'aftercare' arrangements for those discharged - one referred a patient onto the

Community Psychiatric Nurse, and another notified the G.P that he was sending the patient concerned home[1]. However, of these 6 were treated before discharge. In all cases this took the form of medication. Of those 71 patients admitted, a small number were admitted informally (13.4% or 11), 2.5% (or 2) were admitted under Section 2[2] and 2.5% (or 2) were held under Section 4[3]. The largest group of patients (60% or49) were admitted under Section 136. This finding confirms previous research (Rogers and Faulkner, 1987) that Section 136 is being used as a short term admission order rather than for assessment as envisaged by the Mental Health Act.

Table 8.5 presents data showing the diagnosis made by the assessing psychiatrist. In common with previous studies, the most frequent diagnosis was schizophrenia or an unspecified psychosis. None of the patients were deemed to be depressed. One minor difference compared to other studies, is that a slightly greater number of patients received a diagnosis of personality disorder[4]. The interesting point about this group of patients is that 6 out of the 10 who were not admitted had been diagnosed in this way. Thus, it may have been that the psychiatrist

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There was a certain irony in this case, since it was the G.P who had called on the police to remove the subject from her surgery because she would not leave without seeing a doctor.
twenty - eight day observation order.
Medical practitioner's or registered mental nurse's 24 hour holding power.
Rogers and Faulkner (1987) found that 6% of patients were labelled as personality disorders.

viewed this type of mental disorder as 'untreatable' and therefore unsuitable for admission. Alternatively, this diagnosis may have been used when the psychiatrist did not wish to admit certain patients.

It is assumed that in taking the referrals to hospital the police accepted that the patients to some degree suffered from mental disorder. To a large extent police perceptions about mental disorder were confirmed. This is clear from table 8.4. where it shown that in the ovewhelming majority of cases the referrals were also deemed by the assessing psychiatrists to be suffering from some form of mental disorder. A further point not shown in the above table is that a large group of the psychiatrists (41.5% or 34) also thought that the mental condition of these referrals was more severe than was usual. Only 17% (or 14) were considered to be "less severely ill".

Table 8.6.

Psychiatrists' and police ratings of the referrals level of danger to self

	Psychiatrists		Police	
	%	(n)	%	(n)
Serious	21.0	(17)	29.0	(18)
Moderate	16.0	(13)	15.0	(9)
A little	19.5	(16)	28.0	(17)
Not at all	41.0	(34)	16.5	(10)
Uncertain	2.5	(4)	10.0	(6)
Missing	0	(0)	1.5	(1)
	100%	(82)	100%	(61)

Table 8.7

Psychiatrists' and police ratings of the referrals level of danger to others

	Psychiatrists		Police	
	%	(n)	%	(n)
Serious	16.0	(13)	23.0	(14)
Moderate	21.0	(17)	18.0	(11)
A little	14.0	(12)	16.5	(10)
Not at all	45.0	(37)	36.0	(22)
Uncertain	4.0	(3)	5.0	(3)
Missing	0.0	(0)	1.5	(1)
	100%	(82)	100%	(61)

Table 8.8 Police and psychiatrists' ratings of ability of referrals functioning was impaired

	Psychiatrists		Police	
	%	(n)	%	(n)
Serious	39.0	(32)	44.5	(27)
Moderate	10.0	(8)	16.5	(10)
A little	19.5	(16)	3.0	(2)
Not at all	20.7	(17)	28.0	(17)
Uncertain	5.0	(4)	6.5	(4)
Missing	6.0	(5)	1.5	(1)
	100%	(81)	100%	(61)

It can be seen from the data presented in the above tables that there appears to have been agreement between officers and psychiatrists over the degree to which referrals were thought dangerous to themselves and/or others. There was slightly less agreement over the extent to which a person was thought to be 'functioning' by psychiatrists and able to 'care for themselves' by police officers. However, this data has two major drawbacks. Firstly, there are a different number of psychiatrists and police officers (21 more of the former than the

latter). Secondly, the data is an aggregate of all the referrals, which prevents individual comparisons being made. That is, it does not enable a comparison to be made of the ratings made by psychiatrists and police of the same referral. A more accurate picture of the extent of agreement or disagreement is given by comparing psychiatrists' and police officer's ratings of individual referrals along these three dimensions.

Table 8.9 Comparison of ratings between psychiatrists and police

	Psychiatric Condition		Danger to others		Danger to self	
	Psychs' Ratings	Police Ratings	Psychs' Ratings	Police Ratings	Psych's Ratings	Police Ratings
Serious	14	22	11	11	11	14
Moderate	6	10	9	9	9	8
Mild	14	2	7	9	7	14
None	10	13	23	18	22	10
Could not rate	6	3	0	3	1	4
Total	50	50	50	50	50	50

In terms of psychiatric condition[12] there is a positive but low correlation between the psychiatrists' ratings and the ratings of the police officers (r= + 0.34). For danger to self there is a remarkedly similar positive correlation (r = +0.36). For dangerousness to others a

[12] Because of differences in professional terminology about mental disorder, the questions on ratings of psychiatric condition were worded differently for the two professions. In police interviews, the term "ability to care for self" was used and in the psychiatrists "impairment of functioning.

very high positive correlation (r = + 0.993). There was substantial disagreement between officers and psychiatrists ratings over the extent of a person's psychiatric condition. In only 11 out of 50 instances did psychiatrists and police make a similar rating. Of the 39 instances of disagreement, the police officers rated the psychiatric condition to be worse in 24 instances and the psychiatrists in 15.

Table 8.9 shows that there was also considerable disagreement between psychiatrists and police over dangerousness to self ratings. Again, in only 11 out of 50 instances was there agreement between the psychiatrists and the police. In 25 instances out of the 39 the police rated the referral as a greater danger to self than did the psychiatrist, with psychiatrists rating higher than the police in the remaining 14 instances. In contrast, there was substantial agreement over the ratings of 'danger to others'. In the majority of instances, (27 out of 50) police and psychiatrists ratings agreed and in 23 instances there was disagreement. The latter was also more evenly distributed, with 12 officers rating dangerousness at a higher level than the police, and the psychiatrists doing so in 11 cases.

The interesting question from this data is why there should be substantial disagreement between psychiatrists

and police regarding dangerousness to self and psychiatric condition, but considerable agreement over dangerousness to others. It may have been that the psychiatrists' greater experience of mental disorder led them to assess 'dangerousness to self' lower. Alternatively, the tendency for the police to rate referrals condition as worse and dangerousness to self higher than the psychiatrists may have been because the police saw the patients in a different setting. That is, the police often saw a person's living conditions, heard accounts from neighbours and relatives and saw the patient prior to 'cleaning them up' at the station, whereas the psychiatrists did not.

Nonetheless, there was considerable agreement over ratings of dangerousness to others between the psychiatrists and the police. In previous studies (Bean, 1980; Scheff, 1966) it has been suggested that psychiatrists may overdramatize the extent of dangerousness. In this study it may have been that police and psychiatrists equally "overdramatised" the extent of dangerousness.(It was shown in chapter 7 that some officers tended to exaggerate the extent of potential threat that mentally disordered referrals posed.) The high level of agreement may be due to a greater shared frame of reference concerning their role as controlling

agents, than for example between psychiatrists and social workers. Alternatively, the referrals may have demonstrated such obvious signs of violence that there was less room for disagreement.

Because of the claims regarding social control and the use of police powers in relation to black people, whether the police and psychiatrists rate Afro-Caribbean people differently to the other referrrals was thought to be worthy of further scrutiny. This was examined using the concept of 'dangerousness to self' and 'other' data on ratings. In examining police officers' ratings of the two groups (Tests 8.1-8.4. in the appendix) it was found that there were significant differences, with officers rating a greater number of the Afro-Caribbean group as presenting less of a 'danger to self' than the other referrals (X^2= 5.150, d.f= 1 p =<.0202). Police ratings regarding dangerousness to others were similar for both groups (X^2= 0.103, d.f = 1, n.s.) Thus officers were not discriminating against black people, in so far as they did not view mental distress amongst Afro-Caribbeans as posing more of a threat in terms of dangerousness to others. They may however, have viewed mental disorder in this group as being less intro-punitive as indicated by the comparison of dangerousness to self ratings.

The psychiatrists ratings were slightly different. The proportions rated as being a serious or moderate danger

to themselves were similar for both groups (X^2= 0.063, d.f.= 1 n.s). However there were significant differences in ratings of 'danger to others' with psychiatrists more frequently rating the Afro-Caribbean group as a serious or moderate danger to others (X^2= 4.864 d.f = 1 p <.0256). Thus, it appears that psychiatrists viewed mental disorder as presenting a danger to oneself whether the person was Afro-Caribbean or not. However, compared with the police, they over-emphasised the threat of dangerousness to others that black people presented in relation to other referrals. Perhaps they did this because of less exposure to and experience of dealing with dangerous behaviour than the police officers.

Table 8.10

Appropriateness of referral according to assessing psychiatrist

	%	(n)
Referral aproppriate	83.0	(68)
Referral inapproapriate	8.5	(7)
Missing	8.5	(7)
	100%	(82)

The psychiatrists were also asked whether they considered that the police had made an appropriate referral. It can be seen from Table 8.10 that the overwhelming majority of psychiatrists (83% or 68) thought that the referrals made by the police were appropriate, with only a small minority (8.5% or 7) disagreeing. Of the latter, three cases were deemed inappropriate because the person was

not thought to be actively "ill" by the assessing psychiatrist, whilst the other two were thought to be inappropriate only in the sense that the police had referred them to the wrong hospital. Thus according to the psychiatrists, the referrals the police made were deemed to be appropriate for the psychiatric services.

The data presented above shows a somewhat complex picture. On the one hand, the overwhelming majority of referrals brought by the police were considered to be mentally disordered and few were discharged. Examining aggregate data, there appeared to be considerable agreement between psychiatrists and police officers over the perceived dangerousness and mental condition of the referrals. However, in examining data in relation to individual referrals, differences emerged. There was considerable agreement over ratings of dangerousness to others but less agreement between psychiatrists and police ratings of 'dangerousness to self' and psychiatric condition. (Additionally, police officers were found to view Afro-Caribbean referrals as less likely to a threat to themselves than other referrals but similar in terms of the danger they posed to other people. The reverse was found to be the case of psychiatrists ratings). Yet, these differences did not seem to affect the general way referrals were perceived. The majority of psychiatrists still considered the referrals appropriate to be dealt with by the psychiatric services. This suggests the null

hypothesis should still be rejected.

Hypothesis 3e:- decisions regarding what will happen to a referral will arise out of negotiations between psychiatrists and the police.

Four items were examined under this hypothesis: the involvement of social workers at the hospital, contact and time spent at the hospital by the police; whether the police waited for the psychiatrists to complete assessments and if they did the purpose for doing so; the nature of information exchange; and interaction between the two parties at the hospital.

i. Social work intervention

There are two possible points with Section 136 cases in which social workers can provide an assessment - at the police station, or the hospital. It was seen in the last chapter that social workers did not assess any of the referrals whilst they were detained at the police station.

Table 8.11 Social worker assessment at the hospital.

	%	(n)
Assessment by social worker	15.0	(12)
Not assessed by a social worker	84.0	(69)
Missing	1.0	(1)
	100%	(82)

Data presented in table 8.12 above shows that social

workers were not rountinely involved in providing assessments at the two hospitals i.e. they did so in only 14.6% (or 12) instances. Eight out of these 12 social work assessments took place at the District General Hospital Psychiatric Unit site, others at the large psychiatric hospital. Of the twelve cases, assessing psychiatrists who had also seen the patients, considered that social workers only had an ongoing role in the further management of the people they had asseessed in three instances.

In common with the findings in chapter 7 where it was shown that officers rarely alerted social workers about referrals they detained, the main reason for the low involvement of social workers appeared to be that psychiatrists did not request their attendance. In 79% (or 65) instances no attempts were made to contact a social worker. In four instances social services were contacted but they did not agree to attend or failed to arrive at the hospital for some other reason.
A variety of reasons were given by psychiatrists for not contacting a social worker. In ten instances psychiatrists stated that there was no requirement for a social worker to be involved or that social workers were only required if a further section under Part II of the Mental Health Act was being considered. (This incidentally is legally incorrect). A further seven stated that they thought that it was the responsibility

of the police to involve the social worker at the police station and five claimed that there was little point calling a social worker because the local social services department was unresponsive to such requests.

In the main psychiatrists indicated that social workers were not called because they were considered superfluous to proceedings, as indicated by the following comments. "I only call them if it is purely or mostly a social problem (C013)"; "It might have been useful in the future but not at the time C025". "No social worker could have held a conversation with her, she wasn't well enough (C014)". " A social worker wasn't needed as it was an assessment to see if the person was mentally ill and needed admission. In any case they couldnt have done anything at that time of day. Social workers can't do much until the drugs have worn off W507."

These comments indicated little recognition of the more equal role envisaged for the social worker under the Mental Health Act. Clearly, the psychiatrists preferred to adopt a marginal definition of social workers role: that is marginal to the main business of doctoring, the diagnosis and management of mental disorder. Whatever the reason for the low-involvement of social workers in proceedings, the greatest importance as far as professional dominance and interaction is concerned is that where there should have been negotiation between

three professional groups this was rarely so.

ii. Contact and time spent by officers at the hospital.

Table 8.12. Police contact with duty psychiatrist

	%	(n)
Met psychiatrist	54.0	(33)
No contact with psychiatrist	28.0	(17)
Missing	18.0	(11)
	100%	(61)

Table 8.13 Time officers spent at the hospital

	%	(n)
0-10 minutes	26.0	(16)
11-30 minutes	29.5	(18)
31-60 minutes	10.0	(6)
1+-2 hours	3.5	(2)
2+-4 hours	1.5	(1)
4+-8 hours	1.5	(1)
Missing/NA	28.0	(17)
	100%	61

Table 8.12 presents data on the extent of contact between police and psychiatrists at the two places of safety. Table 8.13 shows the length of time officers spent at the hospital. It can be seen from the former table that 28% or 17 officers had no contact at all with the duty psychiatrist on arriving at the hospital. Instead, these officers handed over the referral to the receptionist and left before a psychiatrist came to see the patient. Data presented in Table 8.13 shows that most (56% or 34) officers remained at the hospital for 30 or less minutes, whilst a small number (2) remained for two hours or more.

Two main points can be made here. Firstly, there appears to have been a reluctance on the part of some officers to make contact with or engage with psychiatrists. This meant that contact in a number of instances was avoided and negotiations circumvented from the outset. Secondly, the short length of time spent at the hospital by most officers suggests that where contact was made with psychiatrists, negotiations were generally of a brief and cursory nature.

iii. Waiting.

An important point of negotiation between psychiatrists an officers was whether the police waited until after the psychiatrist had completed the assessment.

Table 8.14 Police waiting

	%	(n)
Police waited until assessment complete	41.5	(34)
Police did not wait until assessment complete	53.5	(44)
Missing	5.0	(4)
	100%	(82)

Table 8.14 shows that in 41.5% of instances psychiatrists reported that officers had waited until the completion of their assessment. It also appeared, from psychiatrists' comments, that the point at which officers left the hosptial was generally decided by them deferring to medical authority. For example, one psychiatrist (C044)

told the policeman to leave as she believed that he had upset the patient and she wished to "calm the situation down". In case C043 the police wanted to leave straight away- but stayed at the behest of the psychiatrist. In another instance (C054), the police asked to go and permission to do so was granted, and in another (C067) the psychiatrists informed the officer that he could leave after 20 minutes.

There were exceptions to this general rule. Occasionally, the psychiatrist left the decision to the discretion of the police, as did the one who asked the police, " are you staying or leaving" (C066). At other times officers did not defer to the psychiatrists' wishes. In one instance (521) police remained, even though they had been told they could leave, because the wished to accompany the patient to the ward. In another, the police refused to wait stating that he was too busy to do so (514).

There were important reasons, at least for the psychiatrists, behind the requests. Only 5% (4) psychiatrists felt that in general, the police should not remain at the hospital until the completion of the assessment. (see question IX,5). Two main reasons were given. Firstly, psychiatrists depended on officers to restrain violent patients or help them give medication. In other words to carry out the coercive aspect of admitting unwilling patients. For example, the reason why

officers (W518) were asked to stay was because the patient was "stroppy, aggressive and agitated", and in another (518) because the patient's unpredictability meant that the police's assistance would be required in admitting the patient to the ward.

The second reason for wanting officers to remain, was that it gave psychiatrists more autonomy. By waiting, the police in effect were leaving it open for psychiatrists to reject the referral i.e. by returning responsibility back on to the police, as indicated by these comments:

> " The police should wait until the doctor has made a decision, because they have to take the patient away if they're not suitable" (C043).

> "They should stay in case a person is not admitted. If the patient is discharged it's their responsibility to take them back."(C064)

Even when psychiatrists had decided to admit a person, the police were sometimes asked to wait until there was an assurance that the patient could be dealt with appropriately. For example (W508 and W511), a decision to admit had already been made but, as there was a shortage of beds, officers were asked to wait until vacancies became available.

On the whole, officers appeared to accept the need to wait, at least for a short period in so far as it meant

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obeying force policy[1]. A constable, reluctant to agree, consulted his sergeant, who informed him that he had to stay to comply with force rules (W503). Nonetheless, officers appeared to comply only for a certain period of time, after which, they were likely to leave whether a psychiarist wanted them to stay or not.

> "We waited 15 minutes for the Doctor and a further 15 minutes in case we were needed; we told them them then that we were going" (C023).

> "I waited for the doctor to give the man three injections whilst he was in handcuffs. The doctor asked it we would wait for the injections to take effect, but that would have been 2 hours so I said 'no'" (C022).

The following comment indicates that at times waiting is not always unconditional but is dependent on some form of recipricocity from the psychiatrist;

> " Waited for the doctor- waited to see what he was going to do. He didn't tell us so we left" (C033).

iv) Information exchange.

Table 8.15 Information provided by police

	%	(n)
Provided information	81.5	(67)
Did not provide information	16.0	(13)
Missing	2.5	(2)
	100%	(82)

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[1] Local force guidlines state that officers can be expected to wait for twenty minutes.

Table 8.16 Police made aware of results of assessment

	%	(n)
Made aware of assessment results	47.5	(39)
Not made aware of assessment results	43.0	(35)
Missing	9.5	(8)
	100%	(82)

It can be seen from Table 8.15 that officers provided information in the vast majority of cases. Nearly eighty-two percent (or 67) of the psychiatrists said that information had been provided by the police compared to the 16% (or 13) who claimed that the police had not done so. Overall, the type of information provided was of a general nature, usually limited to the events precipitating the person's arrest.

Table 8.16 presents the responses to question Int C, II,6 ("Were the police made aware of the results of your assessment?") In contrast to the high rate of information provided by the police, psychiatrists did not reciprocate by giving details of their assessments. Just under half (43% or 35 instances) of the psychiatrists said that the police were not made aware of such results. Of those that were, only four were informed directly; in three instances by the psychiatrist and one by the Nursing Officer. In the remaining 35 instances, psychiatrists did not give details of the assessment. It was somehow assumed that officers knew the outcome, if only they did not have to take the person home or because they

accompanied the patient to a ward. Such presumption was shown by one psychiatrist's comment (C032) "I assumed the police knew he had been admitted,it was not necessary for me to tell them directly".

The data presented above, which show that the psychiatrists rarely felt the need to inform officers directly of the outcome of an assessment, resemble previous findings on the conveyance of information by psychiatrists (Bean 1980)[1].

iv. Police psychiatrists interaction

In more general terms too, meetings appear to have been characterised by officers adopting a subordinate position to that of the psychiatrists. Although some officers automatically gave information, more frequently they appeared to take their cues from the psychiatrists. One officer stated (C015) " no information was asked for so none was given". During the small number of psychiatrist/police interactions observed directly by the researcher, it appeared that the psychiatrists attempted to take charge. The following research notes illustrate the nature of the meetings between psychiatrists and the police when handing over referrals.

> The receptionist contacted the doctor who told her to tell the police to take him to Ward 2. The police took him to the

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[1] Bean's study showed that a minority of psychiatrists informed patients of decisions to admit or their legal status under the Mental Health Act 1959 (p139-140).

ward and was met at the door by the psychiatrist. His attitude was casual and he wore nothing to identify him as a doctor. He said nothing to the officers and greeted the man who asked the psychiatrist how he was. The officers waited in the office whilst the psychiatrist interviewed the man. Ten minutes later the nurse came out and told the police that they could leave.

On arrival the officers reported to reception,who contacted the psychiatrist. On arrival the WPC handed over the form (434) to the psychiatrist who did not ask the WPC any questions but told her to wait outside. Towards the end of the assessment the psychiatrist called the WPC into the interviewing room and asked her for information about the woman's GP and social services arrangements. Having replied the psychiatrist asked the WPC to leave the room and continued his assessment. On completion of the interview the psychiatrist instructed the WPC to take the woman home and inform the social services that the woman needed help in relation to her children and said that he had decided not to admit the woman, but gave no reason for his decision.

During one interview, the officer (C052) summed up the nature of contact in the following way;

> "He (the psychiatrist) was like a magistrate and we were down here somewhere (pointing to the floor). It was us who had to account for our actions, we were on trial. I always had it in the back of my mind will he take the bloke, is he going to believe us or will we have to take him back to the station?."

One exception to this general picture relates to a 'borderline' case where the decision to admit or discharge was not clear. The psychiatrist was unsure whether the young man was mentally disordered and needed

admission. He expressed this uncertainty to the police officers who had brought him to the hospital;

> "It was the police who influenced me to admit him. He (the officer) looked me straight in the eye and said I wouldn't like to be the one responsible if he went out tonight and murdered someone. I thought what would happen if he did do something? I am the one who is 100% responsible. The court would say the police did tell you he was violent how could you justify sending him away on a 20 minute assessment?.....I admitted him to be sure - you could say to protect my own skin, to avoid an error" (C049).

This example can be viewed as an exception contrasting with the officers' generally passive stance towards psychiatrists. Perhaps the difference could be explained because the assessing psychiatrist in this case was new to the job. He had only been working at the hospital for a week and said he had informed the police that he had never dealt with a police referral before.

Officers at times expressed resentment over the psychiatrist's power to make an independent decision, "we don't send them for no reason" (C064). However, just as officers generally accepted psychiatrist's authority in waiting until the completion of their assessment, they also tended to accept the decisions made by psychiatrists as to what should happen to the referrals. That is, in none of the cases discharged in Study B was an attempt made to take the person to another hospital, or to charge the person with an offence, as far as it was possible to

ascertain from the information available[1].

In summary, the data presented and discussed above suggests that decisions regarding what should happen to the patient did not usually arise out of negotiations between the officers and psychiatrists. Some officers preempted negotiations taking place by leaving before the psychiatrists arrived. For the majority of officers who stayed, the police acted as subordinates to the psychiatrists, who generally made unilateral decisions. The police were there to facilitate the psychiatrists decision rather than being party to it, by providing information and acting as a potential source of transport, in case a referral was subsequently not admitted. It would seem therefore, that the null hypothesis should be rejected.

Discouraging future referrals.

The maintanence of psychiatrists' dominance relies, in part, on their powers of gate-keeping. This entails control over access and the amount and type of contact they have with such referrals. Thus, the extent to which officers are encouraged or discouraged from making future referrals is an important issue for assessing the nature of professional dominance between psychiatrists and the police.

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[1] It was only possible to get such information in 6 out of the 10 instances from interviews with police officers.

Hypothesis 3e:- Psychiatrists will make no attempt to discourage the police from making future referrals.

Of relevance to this hypothesis are two questions. The first is whether officers were explicitly discouraged by being rebuked or deterred by the negative attitudes of the assessing psychiatrists. The second is whether the police were implicitly discouraged from making further referrals. This can be ascertained from police interview questions on whether the officer knew the outcome of the assessment.

Table 8.17. Attitude of psychiatrists to officers and referrals

	Psychs'attitude to the officers		Psychs attitude to the referrals	
	%	(n)	%	(n)
Positive	15.0	(9)	31.0	(19)
Indifferent	23.0	(14)	26.0	(16)
Negative	29.5	(18)	1.5	(1)
Uncertain	6.5	(4)	13.1	(8)
Missing	26.0	(16)	27.5	(17)
	100%	(61)	100%	(61)

Table 8.17 presents the police officers ratings of the attitude of psychiatrists to themselves and the referrals that they made during contact at the hospital. It appears, that psychiatrists were significantly more likely to adopt a negative or uncertain attitude towards officers than the referrals who were brought to the

nospital (X^2 8.910, df=1 p=< 0.0145 See Test 8.5). Psychiatrists adopted a negative attitude to officers in 29.5% (or 18) cases compared to 1.5 (or 1) instance to the police referral. Although the possibility remains that the officers may have exaggerated the extent to which psychiatrists adopted a negative attitude towards them, nonetheless the data suggests that it was the police as a source of referral, rather than the referrals, who were the target of a discouraging attitude on the part of psychiatrists.

Further evidence that the police were an unpopular source of referral shows in the frequent criticism of police behaviour, (in 30.5% or 25 of the cases). At times criticism was made about how the police dealt with the referral, as can be seen from the following comment: "did not handle in the best way, ...was provocative young and inexperienced. He'd said to the referral 'you can come along the hard way or quietly'" (C049). Sometimes it was the procedures used to which the psychiatrists objected. One psychiatrist complained about a delay at the station for several hours (C044); another whether the correct documents were being used "they didnt know if it was section 136 or not- they had the wrong form with them" (W524); or the failure to wait as indicated by another psychiatrists who accused a police officer of "dumping" the patient (C043).

It was shown earlier that few psychiatrists claimed that the police were told the outcome of their assessments. This was also borne out by the police interviews.

Table 8.18 Police awareness of psychiatrists decisions

	%	(n)
No	69.0	(42)
Yes, waited at hospital	13.0	(8)
Yes, informed by psychiatrist	3.5	(2)
Yes, informed by others	1.5	(1)
Yes, repeated incident	1.5	(1)
Yes, other	5.0	(3)
Missing	5.0	(3)
	100%	(61)

From table 8.18 it can be seen that in the vast majority of instances, (69% or 42) police officers were not aware of what had happened to the referrals after they had been assessed. In only 15 cases officers claimed they were made aware of the outcome of the assessment. The most common means by which officers found out was by waiting at the hospital. In only 3.5% of (or 2) instances were officers directly informed of assessment decisions[1].

Compared to a study of referrals to psychiatric hospitals from other sources, the psychiatrists in this study appeared to discourage referrals very frequently. A study

[1] Psychiatrists claimed that they informed officer slightly more frequently than this see Table 8.13. but in overall terms the differences are small.

using the same criteria[1], was conducted by Robinson (1976), in which "alchoholics" were referred to psychiatrists from a variety of sources (e.g social services, probation officers, GP's). The latter were implicitly discouraged from making future referrals in 40% of instances. Whether officers construed the lack of feedback as a clear strategy for deferring, discouraging, or pre-empting future referrals is not altogether clear. However, police comments suggest a lack of feedback led to dissatisfaction. Officers sometimes mentioned that they found it difficult to understand why there was regular feedback from hospitals over physical illness but not with mental health cases (C016, C017).

There may be a number of reasons why psychiatrists so readily discouraged further referrals. From this data two explanations seem most likely. Firstly, discouraging referrals relates to the extent to which psychiatrists are able to control the situation. Unlike GP's, for example, the police as referring agents could not accept medical responsibility for the referrals which they made. There was only a slender chance that the police would return someone home (hence the eagerness of psychiatrists for police officers to wait until the completion of their assessment). As it may be remembered, the majority of referrals were considered suitable for admission (82%)

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[1] Psychiatrists failure to correspond with, or notify referral agents of the outcome of the referrals that they had made was assumed to be a means of discouraging further referrals .

and the overwhelming majority were considered to be seriously "mentally ill". Thus, according to conventional medical criteria, referrals made by the police were appropriate. Clearly then, the psychiatrists ability to control the type of psychiatric patients they "treat" would be undermined if this source of referral from the police continued to expand unchecked.

Secondly, further difficulties may have been raised by the non-medical frame of reference[1] and expectations of police officers. These may have encouraged psychiatrists to make future referrals more difficult. Of the 15 officers who knew the outcome of the psychiatrists assessment, 8 were either 'dissatisfied' or 'very dissatisfied' with the outcome of the psychiatrists assessment. Certainly, some officers' expectations of a successful outcome were not limited to the provision of a psychiatric assessment, they extended to a type of treatment and care they thought hospitals ought to provide. A number of officers (8) in response to the question "What should the psychiatric services have provided?" cited the need for admission or a period of observation. Some officers expected psychiatrists to use their custodial powers, by sectioning (C040) or by the use of locked wards or secure enviroments (C050). Other expectations included: the provision of

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[1] Freidson (1970) and others have noted the preference of the medical practitioners to limit referrals being made by and to members of their own profession.

medication/"treatment" (C027); that the hosptial make contact with social services to provide accommodation for the referral (C060); the relief of overburdened relatives (C053) and arrangements for the referral to be "looked after" (C026). The clearly formulated and high expectations that officers had of the type of provision for referrals is further illustrated by the following two quotations;

> "The psychiatric services should have provided, immediate treatment with drugs to calm her down, and support on discharge- a community hostel and continuing follow-up and supervision in a suitable environment".(C003)

> "They should have kept her in for a while for observation purposes at least. It's not enough to release her after asking a few questions" (C064).

The nature of officer's perceptions and expectations of psychiatrists are in marked contrast to the GP's making psychiatric referrals. In Robinson's study, GP's conformed more to the expected norms of the medical profession by generally confining themselves to requesting psychiatrists to assess on a "please see and advise" basis (p143 1976).

The perceived negative attitude of the psychiatrists to the police, compared to the patients, the criticism levelled against the police and the failure to inform officers directly of the outcome of the assessment, all suggest attempts were made by the psychiatrists to

discourage the police making future referrals. The reasons for this may have been related to the need for psychiatrists to control the number of referrals they accept from the police, together with the clash with a non-medical frame of reference and high expectations officers had about what psychiatrists could provide. On the basis of this data the null hypothesis should be rejected.

General views of police psychiatric interaction.

Professional interaction in relation to the individual referrals made during the study period was examined in the first part of this chapter. In this second section the aim is to describe some of the general perceptions that the two professional groups had about each other and one another.

i. Police officers views of psychiatrists.

Hypothesis 3f:-The police do not view the psychiatrists role in any wider terms than those laid out under the legal requirments of the Mental Health Act.

Hypothesis 3g: The police consider that psychiatrists are effective in managing psychiatric patients.

This first hypothesis relates to data obtained from a

question in which officers were asked "Who has major responsibility for dealing with the mentally disordered?" and (BXi,7) qualitative data obtained from an open ended question (BXi,1) where they were asked to describe what they thought the "job" of a psychiatrist entailed.

Table 8.19.

Officers view as to who has primary resposbility for mentally disordered people

	%	(n)
Family	3.0	(2)
Social services	15.0	(9)
Psychiatric services	36.0	(22)
Joint Psychiatric and social services	8.0	(5)
Other combination	20.0	(12)
Uncertain/missing	18.0	(11)
	100%	(61)

It can be seen from table 8.19 that the psychiatric services were seen by officers to have the primary responsibility for dealing with mentally disordered people (in 36% or (22) instances). In contrast, the social services were deemed to have overall responsibility in only 15.0% or 9 instances, the "family" was cited by 2 officers, whilst 8% (or 5) officers thought that the psychiatric and social services had joint overall responsibility. Not one officer thought that the police should have the major responsibility for mentally disordered people. Thus, this data suggests, that the police perceived psychiatrists as holding major responsibility for mentally disordered people. Officers

it appeared, made no legitimate claims to this area.

Descriptions of the nature of the psychiatrists task revealed much about how psychiatry was perceived. A number of officers (10) confined their description of the psychiatrists role to the legal requirements in the Section 136 provision as in the following examples;

> "To assess and treat accordingly" (W501)
>
> "To assess and if need be administer medical or psychiatric attention" (W509)
>
> Assess whether patients are in need of further care and control and to take steps to provide it " (C014).
>
> " They should see and assess to see if they should be kept for 72 hours or released immediately after some treatment" (C043).

Although many officers perceived the psychiatrists' role as confined to the provisions of Section 136, others held different views. Some attributed considerable skills, knowledge and benevolence to psychiatrists work. Others expressed in non-specific terms the view that psychiatrists had considerable diagnostic and curative powers. For example one officer (C001) summarised his view of the psychiatrists job as, "to asses the mental stability of the patient, find the causes try to remedy them and bring them back to normal". This was often mixed with awe and perceived mystique. For example, one officer stated that psychiatrists were there "to make these people better - [psychiatry is] a science which we know

nothing about"(C028). Others referred to the psychiatrist's role in terms of their professional mandate or training, as did the officers who described the psychiatrists job as providing " a professional opinion as to whether people are mentally ill" (C060) and "to provide a professional opinion and decision because they have had the training (W523)". The dominant position of psychiatrists in relation to other mental health professionals was also occasionally recognised as one officer stated;

> "Psychiatrists act as the middle man between patient and the public they are the PR men and mediators. The also make links with the social services and nurses. They have a coordinating role."

Even others held a different view. One theme which was noticeable was the portrayal of psychiatrists as psychoanalysts or psychotherapists. This is illustrated by the following quotes :

> "To deal with peoples mental problems. The impression from what I've seen on the TV its the old black couch, talking to people, finding out what the problem is" (C050)

> " People go to them if they're under stress.They find out the reasons theyre unhappy and talk them through it" (C045).

> "They sit down, listen to peoples problems, analyse why they have problems and find a cure". (C052)

> "To analyse the problems of the mind and decide on treatment to return the person to a degree of the accepted norm" (C053)

Psychoanalysis is not the dominant method used by British psychiatrists whose emphasis remains largely on medical interventions, such as drugs and ECT (Ramon 1985). The psychiatrists in this study appeared to be no different from their counterparts. Only one psychiatrist mentioned that he preferred to work in a psychodynamically orientated way (W24). The most common form of treatment used were the major tranquillisers (Bean et al, 1989). Moreover, since officers' contact with psychiatrists is mainly dealing with psychiatric emergencies (and therefore the more overtly controlling end of psychiatry) it was on the face of it, suprising that a substantial number of police officers held such views. It may have been that the lack of indepth contact with psychiatrists meant that officers did not develop their beliefs so much from their direct contact with psychiatrists, as from the media and other lay sources.

ii. Efficacy of psychiatrists.

It is now necessary to ascertain how effective officers thought psychiatrists were in dealing with mentally disordered people.

Table 8.20 Efficacy of psychiatrists

	%	(n)
Effective	16.5	(10)
Ineffective	28.0	(17)
Uncertain	49.0	(30)
Missing	6.6	(4)
	100%	(61)

Table 8.20. presents data on the ratings of officers as to the effectiveness of psychiatrists in managing and treating psychiatric patients (see question XI,2). The main point to be made about this table is that few officers (16.5% or 10) viewed psychiatrists as effective in their dealings with mentally disordered people. Twenty eight percent (or 17) officers said psychiatrists were "ineffective", and a further 49% (or 30) were "uncertain" about whether psychiatrists were effective when dealing with mentally disordered people.

The small number of officers who viewed psychiatrists as effective tended to do so in terms of their ease of relationships. For example, one officer said: "psychiatrists are very effective. I've never experienced any difficulties (W509)"; "they're generally very good - especially with the violent ones (C024)", "there is never any delay" (C026).

The officers who rated psychiatrists as ineffective did so on a number of counts. First there was the problem of recidivism i.e. with patients previously referred and the perceived ability of psychiatrists to resolve a situation for the police.

> "People keep coming back to us- the success rate can't be high. No one I've met has said 'I used to be a nutter but I'm all right now' (C036)"

> "They [psychiatrists] don't have any

effect- the police would not be called to so many cases if they were effective (C030)"

"Most [patients] are back out in 2hours with nothing having been provided- they don't want to know about people who give us real problems (C015)"

The absence of a social- welfare orientation was another item that was associated with the ineffectiveness of psychiatry. Then there was a lack of concern for the patient's welfare as illustrated by the following quotes: "They release them to the same situation, they don't investigate their domestic background which is 99% of why they're there (C005)". "Theyr'e not concerned about a persons welfare- they simply put them back on the street (C029)". In contrast to this, exceptionally, the failure for patients to return to the community was also noted (see C006 below). Finally, the knowledge and methods used by psychiatrists were also a reason for officers perceptions of their ineffectiveness.

"How effective is treatment?- not very. Treatment stops and the person goes back to the state they were in before." (W518)

"Its not their fault, they don't get enough back-up resources nor enough time. The reason they'r e ineffective is because its not like dealing with a broken leg. Psychiatrists don't know what they're really dealing with. They try a series of drugs and electric shocks but they don't really know what it does and in the end it's hit or miss whether it actually does the person any good (C003)"

Finally, and contrary to the general view held by officers that psychiatrists did not keep people in hospital for long enough, one officer perceived the lengthy periods of time patients spent in hospital as indicative of psychiatry's ineffectiveness;

> "The area is a very complex one and psychiatrists simply don't seem to know much about it. That's why patients never tend to come out of hospital once they're there (C006)".

It seemed that the large number of officers who said they were uncertain about whether psychiatrists were effective or not (see table 8.20), was partly a result of officers reluctance to make such judgements because of their limited contact with psychiatry. This was reinforced by the view that police officers were socially inferior in position and knowledge to psychiatrists. Comments expressing this view included the following: " I don't have any real knowledge of their work to say "(W511); "In twewnty-five years on the job I have had little contact with psychiatrists so I am not in a position to say how effective they are (C032)"; "I've never had much to do with them so I can't criticise them (C016)", "I'm unsure because we get no feedback about people (C017)".

A second reason for the high number of uncertain ratings was related to perceptions of the effectiveness of psychiatry in some areas compared with their

ineffectiveness in others. As one officer stated "they're sometimes successful but sometimes they're completely wrong (C043)". The ambivalence evident in the "uncertain" ratings about efficacy related to the type of patients psychiatrists deal with. In particular, psychiatrists were thought to be ineffective with psychotic patients, but effective with those deemed to be "neurotic".

> "It depends whether they're curable or not- whether a person is suffering from an illness. There are two categories an illness, for example schizophrenia and emotional reaction such as depression. They're not OK with an illness but they are with depression." (C044)

> "In some areas they're more successful than others. With nervous depression or exhaustions they have fairly good success. We don't get called to too many nervous breakdowns. The other illnesses require a degree of after treatment and care and its here that psychiatrists fail (C053)"

> "They can deal with crises like Section 136 but not long term mental disorder." (C013)

> "They're al right for breakdowns but not good for bad cases." (C004)

Returning to hypothesis 3g and 3h. From the data presented, it has been seen that officers viewed the psychiatric services as having the primary role to play in dealing with mentally disordered patients. From the analysis of officers accounts, it is also clear that, to

an extent, officers restricted their view of describing the job of a psychiatrists to generalised perceptions of the legal remit set out for the profession, under the Section 136 provision. Where officers viewed it in wider terms, they tended to hold the psychiatrists role in high but distant esteem, attributing them with considerable curative and professional powers. Another feature of police perceptions was the image of psychiatrists as having a psychoanalytical orientation, similar to that portrayed in the media. Thus whilst the null hypotheses should for the most part be accepted, there were additional features of officers views which suggested that, in addition to their contact with psychiatry in their role as officers some of their views were formulated according to lay perspectivesof psychiatry.

In relation to Hypothesis 3h it seems that, overall, officers expectations of the role psychiatrists were supposed to have, i.e. considerable professional power in dealing with mentally disordered people, did not match with the effectiveness with which psychiatrists were deemed to carry out their roles. The data presented above suggests that the null hypotheses should be rejected since a smaller number of officers considered psychiatrists to be effective than ineffective. However, the largest number of officers chose to rate the efficacy of psychiatrists as "uncertain". This was mainly due to their discrimination in particular areas. Also, it was

because social distance, and perceptions of their own lack of expertise in psychiatric knowledge, made officers reluctant to judge another group of professionals.

Hypothesis 3h: Police officers consider that psychiatrists acknowledge police opinion and expertise in dealing with psychiatric referrals.

Table 8.21 How much notice psychiatrists were considered to take of police views,

	%	(n)
No notice	16.5	(10)
Minimum notice	29.0	(18)
Some notice	23.0	(14)
A lot of notice	10.0	(6)
Uncertain	21.5	(13)
	100%	(61)

Data presented in table 8.21 shows that the largest group of officers (45.5% or 28) considered that psychiatrists generally took little or no notice of police opinion when dealing with Section 136 cases. Twenty three per cent (or 14) officers believed psychiatrists took "some notice" of their opinions, whilst 10% (or 6) perceived psychiatrists as taking a "lot of notice".

This data suggests that, overall, police considered psychiatrists did not view officers opinions about psychiatric matters as valid. Some officers accepted such a view as legitimate, clearly preferring to maintain

professional boundaries. That psychiatrists ignored the police was accepted as a necessary element to officers work. This was demonstrated by the comments made by two officers:

> "I don't see why they should take any notice - it would be like telling us how to arrest someone, they know their own job and we should'nt interfere. (C045)

> " They take notice of the initial circumstances, but will take the rest of what we say with a pinch of salt. But it works both ways - when there's a prisoner in hospital- then we take their view with a pinch of salt." (W518)

Another officer thought that were a psychiatrist to take notice of what the police said it would undermine the perceived objective/scientific basis of medical opinion - "Presumably they don't take a lot of notice of us because a professional diagnosis should be based on their own observation and not what we say" (C059). Other officers however did not share this view.Some did so on the basis of judgements about 'good practice'. For instance one officer commented, "I like to think that they base quite a lot on what we say because it's all part of the case - taking it from all angles"(C060).

In general, it appeared that officers resented what they perceived as the superior attitude of psychiatrists and the little value given to their knowledge regarding the referral's mental state and actions. Such a view was forcibly expressed by a community officer who dealt with

mentally disordered people in the locality on a regular basis;

> 'There's very little communication between us - they ignore you when you go in, They're just sitting there writing notes they don't acknowledge youre presence. They just talk to the patient, say he's got X or say to the nurse 'open a file on him' without asking us our opinion. They treat you like you're thick. I'm no clinical psychologist but I've got enough grey matter to tell him what the incident was about and how they behaved but they ignore you -often walk past you and you're left standing there like a right lemon." (C050)

Others compared the weight given to the opinion of the police with other parties involved in Section 136. One officer stated "the police view is ignored, they only look at it from the patient's view" (C025), whilst another commented that psychiatrists "don't ask police what happened or ask our opinion. The doctor asks more from the receptionist than us" (C029).

From the data, 41% (or 25) officers considered that psychiatrists did not take into account all relevant factors when making their assessments. The few officers who thought otherwise appeared to do so on the basis of assumptions about the professional status and knowledge of the psychiatrists. One officer thought that they took all factors into account because psychiatrists code of professional ethics demanded it (C059), whilst another stated that "they have more training and expertise than

we do- so they know all the factors" (C045).

The majority of officers who considered that psychiatrists were not in a position to evaluate all the associated factors of a particular case appeared to do so for three main reasons. Firstly, because psychiatrists are not party to the social circumstances which result in referrals being made. For example, one officer stated that because psychiatrists see the person in a hospital environment they are not in a position to to appreciate the "field situation". Another stated that "they don't always take into account the fact that a person can't look after themselves and have nowhere to go" , (C064) whilst another thought that a person's home situation was often ingnored (C014).

The second reason relates to the absence of a policing ethos on the part of psychiatrists. For instance, a number of officer's (6) claimed that psychiatrists failed to take into account the precipitating disruptive circumstances of the referral. Others referred to the lack of credence given to the control needed to contain patients as illustrated by the following comments;

> "... they [psychiatrists] ignore extreme and indiscriminate violence" (C002);

> " They take no notice of the violence the person presents to others around him in the community. The fact that the

police are called time and time again to a 'nutter' to deal with violent incidents and disturbances and that we respond to calls from the public simply does not register" (C015).

> "They don't take into account what happens on the street- they are usually calm by the time the doctors see them" (W503).

The third reason concerns what were perceived to be certain idiosyncratic ways in which the profession of psychiatry operated. One respondent spoke of the "rules" that meant that psychiatrists could only see one side of things (C013) another officer thought that the isolated institutional base within which psychiatrists operated explained why certain factors were not taken into account;

> " Psychiatrists are very cut off from the outside world stuck out there in the hospital so they can't tell when someone might be pulling the wool over their eyes. Some are not as bad as they appear when they are at the hospital and the psychiatrist hasnt got a clue whats gone on out there" (C032).

The lack of time psychiatrists spent with referrals was another example. One officer claimed that their lack of interest and heavy workload meant that they didn't take into account patients as individuals (W506). Another stated that "psychiatirsts who speak to someone for less than one hour a day can't tell their mental state" (C030).

The data presented above suggests that the null hypothesis 3h should be rejected. Most officers thought that psychiatrists gave scant regard to their opinion about individual cases. Whilst some officers accepted this as a legitimate means of maintaining professional boundaries, in general officers thought of it as an unacceptable practice. Furthermore, the majority of officers considered that psychiatrists failed to take all the relevant factors into account when making their assessments, in particular the circumstances of the precipitating incident, a wider community perspective , and management of potentially violent or dangerous behaviour.

Police and psychiatrists views of each others roles.

i) Police ability to recognise mental disorder.

There were indications in the results presented under the last hypothesis that officers suspected psychiatrists of not recognising their skills and role in handling mentally disordered people. The two hypotheses under this heading will explore further how legitimate each of the two professions perceived the officers' role to be.

Hypothesis 3i: There will be no differences in psychiatrists or police perceptions as to the ability of officers to diagnose mental disorder and their role in dealing with mentally disordered people.

Questions relating to officers ability to recognise mental disorder in relation to Section 136 referrals were incorporated in Interviews B and C (see qs IX,3 and qs X,1 respectively). Table 8.22 presents the psychiatrists and police officers ratings from these questions.

Table 8.22

Police and psychiatrists ratings of police diagnostic abilities

	Police ratings of police diagnoses		Psychs' ratings of police diagnosis	
	%	(n)	%	(n)
Very able	51.0	(31)	2.5	(1)
Able	34.5	(21)	58.0	(22)
Minimaly Capable	8.0	(5)	13.0	(5)
Incapable	0	(0)	2.5	(1)
No rating made	6.5	(4)	0	(0)
	100%	(61)	100%	(38)

$\chi^2 = 24.92$, d.f.= 4 $p < 0.001$.

It can be seen that police officers considered themselves to be more effective at recognising mental disorder than did the psychiatrists. Whereas 51% (or 31) officers rated themselves as "very capable" at recognising mental disorder only 2.5% (or 1) psychiatrist did. Whilst a similar percentage of officers and psychiatrists thought the police were "capable" of recognising mental disorder, a substantial number of psychiatrists were uncertain as

to whether the police were capable of doing so.

Differences between officers and psychiatrists were significant (X^2= 24.92, d.f.= 4, p<.001).

The reason why a large number of officers considered themselves so competent in recognising mental disorder was because the task of diagnosis was considered to be a relatively simple matter: either because of their own professional expertise or because recognising mental disorder was not considered to be difficult anyway. So one officer stated that "anyone could recognise it" (C029), whilst another said "It's easy to decide who's whacky and whip them up to the hospital" (C030). However, other officers thought it was the job of policing which had provided them with the necessary skills. Some officers referred to their 'commmon sense' experience attained from so much contact with the public, as one officer commented;

> " We deal with these sort of people every day. The number of people we deal with, we will come across more people who are mentally ill that anyone else except the psychiatrists. We get a lot of experience, so are able to classify accurately and quickly"(C036).

> "The vast majority of people are able to recognise that people are suffering from mental disorder, but they do not have the procedures to deal with them" (C042).

It is not immediately apparent from the data why so many psychiatrists were uncertain about officers abilities[1].

1. The majority of psychiatrist gave vague replies when asked why they thought officers lacked ability in this area.

It may have been that they felt they had little knowledge of officers ability in general. This is possible given that the psychiatrists were of a junior rank. Alternatively, it may have been that they acknowledged the police as efficient diagnosticians but that they were reluctant to express this view to the researcher. Maybe they wanted to protect the view that they possessed unique and professional skills of diagnosis that the police did not. Certainly diagnosis was viewed with some professional jealousy by the assessing psychiatrists, who tended to be grudging in acknowledging the accuracy of police abilities to recognise mental disorder.

Some were disparaging about the ability to make "lay" rather than "proper" diagnosis. This was despite the fact that the criteria used by both the professions to recognise mental disorder was similar. One psychiatrist who rated the police as "capable" of recognising mental disorder commented;

> "We give them the benefit of the doubt, they are not really sure of what the illness the patient is suffering from, some try and use medical terms , for example by saying 'hes not psychotic', but I don't think they know really". (W522)

Other psychiatrists tended to doubt the police's abilities to make finer distinctions considered to be involved in making a professional medical diagnosis;

> "Mental disorder as I see it has definite symptoms- not just behaving strangely on

the street; they just slap on a S136. They can recognise someone is mad, but is he psychiatrically ill?. Can they pin a specific problem on them? My definition [of mental disorder] is clear cut and specific." (C063)

"Many patients they bring in tend to be behaviourally disturbed while outside but they're not necessarily psychiatrically ill" (C066).

Another accepted, with some reservations, that the police should have a legal mandate to decide on the presence or absence of mental disorder but seemed to state a contradictory position about the skills needed to make a diagnosis;

"I'm surprised that they have the power at all given that they have no training in mentalhealth. They vary, are as good as any lay person -anyone can recognise it [mental disorder]" (C043).

ii.) <u>Police appropriateness to deal with Section 136 cases</u>

Despite significant differences in the perception of officers' abilities to diagnose mental disorder there were similar perceptions regarding the appropriateness of the police in general to handle mentally disordered people found in the street.

Table 8.23

Appropriateness to deal with psychiatric cases

	Police rating		Psychiatric Rating	
	%	(n)	%	(n)
Appropriate	83.5	(51)	92.0	(35)
Inappropriate	10.0	(6)	8.0	(3)
Missing	6.5	(4)	0	(0)
	100%	(61)	100%	(38)

χ^2 = 0921, d.f.=1, p< .832

It can be seen from Table 8.23. that a very high percentage of both the police and psychiatrists thought it appropriate for officers to deal with mentallly disordered people. A small number of police officers (10% or 6) thought it inappropriate that they should be so involved but no psychiatrist thought it inappropriate. However, 8% (or 3) were uncertain.

Both the psychiatrists and police gave similar reasons as to why they thought it appropriate for officers to have such powers. Both considered it necessary and inevitable. According to one officer "you've got to deal with them once on the street and they're causing a disturbance (C018)" or as another simply stated "who else is there?" (C041). Psychiatrists made similar comments; "I can't see anyone else doing in (C053)", and "its the police who are called in so they have to take some action" (C064).

Likewise, the views of the two professions regarding the limits to officers' role were similar. Psychiatrists tended to see the polices' role as restricted to providing transport and obtaining a "proper" medical assessment;

> "The role of the police is to get a person as quickly as possible to a medical centre so that they can be correctly assessed by a person who is capable of deciding whats wrong with a person" (W522).

The police also appeared not to want to expand their role. Indeed although they thought it appropriate that they should deal with psychiatric emergencies found in public places, it was a role which was reluctantly undertaken. As one officer stated "I'd like to answer 'no' [to the question]- it takes up a lot of work time but it's one of those things no one else will deal with" (W509). Another officer stated "Its necessary rather than appropriate because you can't ignore it- it's part of police work but not a major part " (C004). Additionally officers did not appear to want greater powers or involvement with this client group. One officer for example thought it desirable to have a more circumscribed role vis a vis psychiatrists than they alreay had;

> " The police should be the front line but psychiatrists should come to the station and do more of the preliminary work, for example find out about the incident and discuss it with the relatives."

Thus, although it appeared from data presented earlier in this chapter that officers sought a less unequal position

in their interactions with psychiatrists, this did not extend to a need for greater participation in this type of work. In other words, officers did not seek to challenge the boundaries of the profession of psychiatry.

Returning to hypotheses 3i, the data presented above suggests that the null hypothese should be partly rejected only. Dealing first with the police's ability to recognise mental disorder the data shown above suggests that the overwhelming number of officers tended to view themselves as accurate diagnosticians. However, psychiatrists did not concur with this view. A large number of psychiatrists were uncertain about officers abilities, and psychiatrists comments too suggested doubts about officers skills in this area. Whilst the two professions differed over the perceived abilities of officers diagnostic skills, they broadly agreed about the 'appropriateness' of officers to deal with mentally disordered people and the limits or boundaries of their roles.

iii. The nature of police psychiatric relationships

The final issue to be examined in this section is the way in which psychiatrists and police officers viewed their overall relationship in dealing with Section 136 cases.

Hypothesis 3j:- police and psychiatrists will evaluate their relationship in positive terms.

The hypothesis relates to two questions in the police and psychiatrists interviews respectively (BXI6,and CX6).

Table 8.24 Relationship between psychiatrists and police

	Police ratings			Psych's ratings	
	%	(n)		%	(n)
better than with other doctors	1.5	(1)	Good	29.0	(11)
Same	28.0	(17)	Indifferent	23.6	(9)
Worse	20.0	(12)	Poor	13.0	(5)
Uncertain	39.5	(24)	Uncertain	26.5	(10)
Missing	11.5	(7)	Missing	8.0	(3)
	100%	(61)		100%	(38)

It can be seen from this table (8.19) that the largest group of officers rated their relationship with psychiatrists as "uncertain". The second largest group of officers (27.9% or 17) considered their relationship with psychiatrists to be no different to that of other medical practitioners whilst 19.7% or 12 officers considered their relationship to be "worse". Only one officer considered the relationship with psychiatrists to be "better" than with other medical practitioners.

It can be seen from table 8.24 that 11 psychiatrists viewed their relationship with officers as

"good". A further 40% or 14 rated their relationship as "indifferent" or "poor", whilst a further 12% or 10 were "uncertain."

These empirical ratings provide limited information about police and psychiatrists evaluation of their mutual relationship. The qualitative data reveals more. Particularly noticeable was indifference and veiled hostility on both sides. As with officers' opinions about how much notice psychiatrists took of police accounts, officers mentioned the aloofness of psychiatrists. "There's no hostility or resentment-just indifference"(C026) as one officer put it. Another, when asked to describe the relationship between the police and psychiatrists stated "There isnt one " (C030), yet another described the relationship as "purely professional - with no personal contact" (C052). Some officers viewed this distance in negative terms, one rated the relationship between psychiatrists and police as "worse" on the basis that the police see less of the psychiatrists than other doctors. However, the opposit e view was expressed by another officer who adopted a respectful attitude.

> "I have more respect for psychiatrists than casualty doctors or GP's, they are more dedicated than casualty officers who spend a lot ot time drinking with us and who are less concerned about their job. Psychiatrists have a bloody hard job and are more dedicated tha your run of the

mill doctor" (C035).

The unequal relationship between psychiatrists and police was also mentioned. As one officer stated "psychiatrists do not give police the credence they deserve. Alot of ground is lost because there is no close working relationship" (W508).

Psychiatrists were not very forthcoming about their views regarding their relationship with the police and generally appeared uninterested in commenting,(only 12 psychiatrists responded to prompts from the researcher in relationship to this question). However, from the comments made by psychiatrists indifference about the two profession's relationship appeared to be shared by them. "Its usually a fairly formal working relationship " (C037); "I wouldn't describe it as cordial or hostile either" (C058);"A superficial relationship only" (W507). One or two psychiatrists viewed the relationship as an uneasy one - " often it is a frustrating time for both (W512)" as one put it.

Certainly the unequal relationship mentioned by some officers was also evident as illustrated by these two quotes;

> "I dont have much to do with them; it would be better it they were better educated and we were able to converse with them about medical things better "

(W522).

"We try and get on. Police try harder than psychiatrists because the psychiatrists don't have to try" (C032).

From the data presented above, the overall mutual attitude between police and psychiatrist can be described as one of indifference or lack of interest. However, it can be also be argued that a range of more subtle attitudes were masked, including aloofness and hostility. It was seen earlier for example how some officers tried to avoid meeting psychiatrists, or the way psychiatrists sometimes ignored the officers presence. Perhaps the reason for expressing their relationship in generally indifferent terms rather than open hostility, is beacuse of their time limited contact with one another. Consequently, the absence of any further professional interaction over the treatment and care of patients means that overt conflict is not given time to emerge.

Another function that this indifferent attitude may serve is that it visibly acts to keep entirely separate the role of the police from that of the psychiatrist. The wish to keep separate roles may be related to the differences in the two groups: frame of reference; professional imagery they wished to promote; and control the wished to retain over certain areas of work. With regard to the latter, it was shown earlier how the making of future referrals was discouraged. With regard to the

different frame of reference and professional imagery, responses to question xi,4, and comments made in passing during the course of interviews, seemed to suggest that

police involvement with mentally disordered people directly threatened certain images about the nature of managing emotional deviance held by psychiatrists. This manifested itself in comments regarding the appropriate handling of referrals. In particular, psychiatrists expressed disagreement over the use of overtly controlling or repressive aspects of police management of psychiatric emergencies. This is illustrated by the following comments;

> "I don't like the use of handcuffs, they're for prisoners not patients. I think medication given by the police surgeon is preferrable, and failing this they should use straightjackets" (C058).

> "I don't think that they handle referrals well, its a combination of them being frightened and exager.ating the violence and craziness. They are very distanct from them [the patients], they never stand talking to them- and they dont get close to them. They make people more vulnerable and frightened and they use handcuffs unnessarily" (C057).

Mental health law was also an area where the psychiatrists had different and specific expectations. "They use Section 136 as a matter of course even when the person is willing to come they don't understand the concept of informality (C20)". Similarly, the type of patient that the police were expected to bring did not fit one or two psychiatrists expectation: "personality

disorders and borderline cases should not be brought to psychiatric hosptials but should be deal with in other ways by the police" (C013).

As far as the police were concerned it was shown earlier how they had high expectations ofpsychiatrists curative and caring powers and were critical when psychiatrists failed to provide what seemed necessary.

> "Often the psychiatrist will say the person is too insane and 'we don't have the facilities to deal with such people especially the more violent ones'. It seems silly to say we'll deal with them when they're less insane because they're job is supposed to be about curing insanity"(C050)

In summarising the views both characterised their relationship in somewhat distant and indifferent terms. This suggests that the null hypotheses (31) which states that the police and psychiatrists will evaluate their relationship in positive terms should be rejected.

Discussion and summary

This chapter consisted of two sections. In the first, the way in which the two professional groups perceived the patients and the interaction that took place around their reception and acceptence at the hospital were examined. In the second, issues related to the two professional groups perceptions of the others abilities, professional

roles, and potential areas of conflict in dealing with referrals more generally were also examined. Both were concerned with the nature of professional dominance existing between the parties. Many of these aspects have already been discussed in relation to the specific findings presented above and these and other areas will be expanded upon in the next chapter. Thus, (to avoid repetition) it is only necessary to present a brief discussion of the findings here.

The findings at the beginning of this chapter showed that police officers took referrals to the hospitals for assessment at all times of the day, during the weekdays, and at the weekends (although proportionately such referrals were more frequent at weekends and out of hours'). The police then were not merely plugging a gap in services, but were providing a supplementary emergency psychiatric service to other mental health professionals.

There were few differences in the way in which officers and psychiatrists perceived referrals. For the referral population as a whole there was agreement over the extent of dangerousness to other people and mental state. Most psychiatrists deemed that the police had acted appropriately in making a referral, most were considered in need of admission and of those that were not only 2 were not given treatment. There was apparent diagreement over the severity of psychiatric condition and

dangerousness to self with police officers, more frequently than the psychiatrists, perceiving a person to be unable to look after themsleves and more of a threat to themselves. Apart from this aspect, there appeared to be little differentiation overall between the psychiatrists and officers perceptions.

Consensus of opinion over the referrals did not lead, as might have been expected, to any joint decision making over what should happen to individual patients. Police adopted a passive and subordinate role and were not involved in psychiatrist's decisions. They merely waited until psychiatirsts had completed their asessements. Even the decision to wait was arrived at largely at the behest of the psychiatrists. The police acted to provide a fall back for psychiatrists if they did not wish to admit a patients. There were however limits to the passive position adopted by officers. Generally officers would wait for a specific time after which they would leave irrespective of any requests or being made. There was evidence too that psychiatrists did not treat officers in the same way as they might have other referral agents or mental health workers working inside the hospital. Very few informed officers of their decision, the basis for making it or provided them with any other feedback.

In addition to excluding officers from decision making (which may on legal grounds be justified on the basis that

the police do not constitute a mental health profession), another feature of psychiatric dominance was the failure of the majority of assessing psychiatrists to inform social workers of the need to carry out such assessments. This had the effect of simplifying the way referrals were handled, since social workers might have challenged psychiatric authority.

A final point with regards to the results in the first section of Chapter 8 is the finding that psychiatrists tried to discourage the making of future referrals by adopting an attitude that was perceived as negative by the officers. Also they provided little post - hoc information about referrals. This suggests that even though police referrals were generally considered in need of psychiatric attention, the psychiatrists were attempting to maintain a strict control over the numbers of referrals that police officers might make.

Part two appeared to confirm and elaborate this picture. Despite officers holding considerable doubts about the efficacy of psychiatrists, the majority considered psychiatrists should have the primary responsibility for dealing with mentally disordered people. None thought the police should have such responsibility. In other words police officers were not attempting to encroach on psychiatrists' jurisdiction.

As far as the officers' role was concerned, there appeared to be general agreement as to the need for police to intervene with mentally disordered people found in public places. Similarly, there was little disagreement as to the limits of officers' role. Both were inclined to view it as restricted to detaining, providing transport and seeking a speedy medical assessment. However, whereas the police deemed themselves to be competent in recognising the presence of mental disorder psychiatrists were more uncertain about the police's abilities despite indications that officers were generally making appropriate referrals. This failure to acknowledge police diagnostic abilities suggests that psychiatrists were anxious to protect an area of work that they considered to have a justified monopoly over.

This acceptence of polices role' and disinclination of police to encroach on psychiatrists territory did not, as one might expect, appear to lead to harmonious relationships between the two occupational groups. Officers were generally of the opinion that psychiatrists took little or no notice of their point of view and differences and antagonisms were particularly prominent. The police reported 'superior' attitudes on the part of psychiatrists, which may well have reflected class and educational differences. The different environments in which each of the two professional groups worked (the police in the community, psychiatrists in hospitals)

might also have been important. Disapproval from psychiatrists about the use of police coercive control was also an area of conflict. In relation to professional dominance such antagonism can be seen as an ideological threat. i.e. as a means of exposing or demystification the nature of emergency psychiatry. Such an image is unlikely to fit that of care and compassion the psychiatrists might have preferred to promote.

Further evidence for the limited contact and distance of police psychiatric relationships was found. It included the following. Firstly, officers perceptions of these psychiatrists was more akin to lay perceptions (e.g. viewing them as psychoanlytically orientated) than an occupational group that had substantial first- hand contact with psychiatry. Secondly, suggestions that psychiatrists and police officers found difficulty in evaluating their mutual relationship (substantial numbers of both psychiatrists and police rated their overall realtionship as 'uncertain'). Thirdly, the nature of their relationship was described as characterised by indifference, aloofness and distance.

In the next two chapters the elements of professioanl dominance and interaction described above will be examined further. They will be discussed in relation to the findings of the previous chapters and the theoretical presuppositions identified at the outset of this thesis.

Summary of the main findings.

1. Sixty- four percent (or 53) of the referrals were made to the hospital on weekdays and the majority (60% or 49) were made during the hours of 5pm and 9am.

2. Few referrals were discharged after being asessed by the psychiatrist with 87% (or 71) being admitted to hospital. The most common diagnosis given to patients was shcizophrenia or other psychotic condition. No patient was considered to be suffering from depression.

3. Police and psychiatrists were found to hold different perceptions as to the severity of individual referrals psychiatric condition and the degree to which referrals posed a danger to themselves. The police rated referrals as having worse psychiatric conditions and of being of greater danger to themselves than the psychiatrists. There was however, considerable agreement over how dangerous referrals were pecieved to be a 'danger to others'. Psychiatrists perceived Afro-caribbean referrals to be a greater danger to themselves than did the police officers. The overwhelming majority (83%) of psychiatrists considered that it was appropriate for the referrals to have been sent to the psychiatric services.

4. Social workers rarely provided assessments for referrals (in 15% or 12 instances). In 79% of instances

this was because the psychiatrist failed to inform social of the need to do so.

5. A minority of officers (28% or 17) had no contact whatsover with a psychiatrists. The majority of officers (55% or 34) remained at the hospital for 30 minutes or less indicating that contact with psychiatrists was of a brief and cursory nature.

6. According to the psychiatrists interviewed, just over half (53%) of officers did not wait unitl the completion of their assessment.

7. The majority of officers (67%) appear to have provided psychiatrists with information about the referral and incident on arrival at the hospital. This was not reciprocated by the psychiatrists to the same extent. Only 43% (35) of psychiatrists claimed that officers were made aware of the results of their assessements and rarely did psychiatrists communicate this directly to the police.

4. Psychiatrists were more negative in their attitudes towards officers than psychiatrists (differences were statistically significant), indicating that the police as a source of referral rather than the referrals themselves were the provoked psychiatric objection.

General views of police psychiatrists interaction

1. The largest number of officers (38% or 22) identitifed the psychiatric services as having primary responsibility for dealing with mentally disorerd people. Not one police officer thought it was the responsibility of the police.

2. Only 16.5% (or 10) officers viewed psychiatrists as effective in dealing with mentally disordered people. In particualr doubts were expressed over psychiatrists to cure mental disorder. According to qualative data most officers perceived the role of psychiatrists in terms of the Section 136 legislation. There was atendency to hold psychiatrists in high but distant esteem. A sub- group of officers described psychiatrists as psychotheraputically orientated which appeared incongruent with the way in which police were likely to have seen psychiatrists deal with referrals.

3. Only 24.5% (or 15) officers perceieved psychiatrists as taking a lot of notice of officers views and opinions indealing with mentally disordered people.

4. There were statistically significant differences in perceptions about police officers ability to diagnose mental disorder between the two professions. The police considered themselves more able to do so than the psychiatrists. There was however considerable agreement

regarding the appropriateness of officers to retain a legal manadate to apprehend mentally disordered people from public places (83.5% (or 51) officers and 92% (or 35) psychaitrists). This appeared to be based on the notion that there was no feasable alternative to the present arrangements.

8. Few officers or psychiatrists viewed their mutual relationship in positive terms. Twenty four officers (39%) and 10 (or 26.5%) psychiatrists rated the type of relationship existing between the two occupations as 'uncertain'. The relationship was described in terms of distance and indifference.

Test 8.1. OFFICERS RATINGS 'DANGER TO SELF' AND ETHNICITY

	Afro- Caribbean	Other	Total
Serious/moderate danger	7	19	26
A little or no danger	14	10	24
Total	21	29	30

$X^2 = 5.15$ df = 1 $p < 0.2012$

Test 8.2 OFFICERS RATINGS OF DANGEROUSNESS TO OTHERS AND ETHNICITY.

	Afro-Caribbeans	Others	Total
Serious/moderate danger	9	12	21
A little/no danger	11	17	28
Total	21	29	50

$X^2 = 0.10$ d.f. = 1 $p < 0.9953$

Test 8.3. PSYCHIATRISTS RATINGS OF DANGER TO SELF AND ETHNCITY.

	Afro-Caribbean	Other	Total
Serious/moderate danger	11	16	27
A little/no danger	10	13	22
Total	21	29	50

$X^2 = 0.063$ d.f. = 1 $p < .9997$

Test 8.4. PSYCHIATRISTS RATINGS OF DANGER TO OTHERS AND ETHNICITY

	Afro- Caribbean	Others	Total
Serious/moderate danger	13	10	27
A little/not at all	8	19	23
Total	21	29	50

$X^2 = 4.86$ d.f.= 1 $p < .0256$

Test 8.5 PSYCHAITRISTS ATTITUDES TOWARDS POLICE AND REFERRALS

	Officers	Referrals	Total
Positive/ Indifferent	23	35	58
Negative/ Uncertain	22	9	31
Totals	45	44	89

$\chi^2 = 7.05$ d.f. = 1 $p < .0086$

CHAPTER 9

THE PROCESS AND PROFESSIONALISATION OF PSYCHIATRIC REFERRALS FROM THE POLICE.

In order to provide a framework for examining the implications of the thesis presented in this and the final chapter, a core assumption will operate that: referrals under Section 136 of the Act are subjected to an increasing funnel of professionalisation and management. This assumption has three components. First, there is the prepatient phase, prior to psychiatric intervention in which the public and the potential patient are the relevant actors. Second, there is the phase where police intervene and interact with the public to process the referral. The third is when police and psychiatrists interact in order to complete the referral process and arrrive at a decision regarding the fate of a referral. Having examined these three component phases, the implications of this thesis for mental health law and social policy will then be explored. In chapter 10 the implications for the theory of professional dominance will be examined.

a) <u>The pre -patient phase</u>

i)<u>The public</u>

The starting point of this thesis was the lack of sociological knowledge and analysis regarding the phase prior to the formal intervention of the psychiatric services. Previous studies have shown

the importance of the lay area in initiating a person's contact with the psychiatric system. Mechanic (1962) for example, stated that 'the person defined as mentally ill is brought into hospital primarily as the result of lay decisions' (p74). In his work on the family and mental hospitalisation, Goffman (1961) showed how a sense of betrayal was experienced by patients after they had been lured or coerced into the mental hospital by close relatives. Other studies have emphasised the role of laypeople in initiating the patient career. With few exceptions however, this type of enquiry has remained on a fairly abstract level. This study provides some specific data to add to this.

In this study, there were a number of implications concerning the involvement of the public, rather than the police, in initiating the process of referral. Firstly, the data shows some of the reasons why people are referred to the psychiatric services. In particular, the findings presented in chapters 5 and 6 on the circumstances of the incidents and the reasons for alerting the police, shows that people do not enter into the referral system primarily because they are ill. Rather it was that a person's behaviour affects others. Data

related to hypothesis 2c showed that the primary reason for the public making contact with the police was because of violence or threat of violence. Extreme and bizarre incidents precipitating police involvement indicated that the referral agents were generally tolerant, up to, and until, the appearance of a threat of violence or major social disruption. Thus, individuals did not contact the police simply on the basis of 'residual rule breaking' as defined by Scheff (1966). Only when the breaking of residual rules was accompanied by disruption and violence were the police called. Secondly, the particular <u>context</u> within which behaviour leading to police involvement took place was important too. The public nature of incidents described in relation to hypothesis 2a meant that untoward behaviour was amplified, and thus likely to attract more attention, than if it had taken place in private.

Thirdly, the dominating feature was the immediate threat to <u>public</u> rather than domestic order. There was usually no direct personal relationship between the potential patient and the referral agent (as indicated by data presented in relation to Hypothesis 2b). Thus the usual reasons which involve civil referral were absent. The primary

fear of violence was the salient characteristic for initiating referral. There was for example no fear on the part of relatives of the patient becoming 'lost[1]' to them, or opportunity on the part of the referrals of feeling 'betrayed[2]' by their significant others.

An important difference associated with this relates to the selection of Afro-Caribbeans who were shown (according to data relating to hypothesis 1a) to be over-reprepresented in Section 136 referrals. Two types of explanation for this were offered in chapter 5 :those that attribute overrepresentation to the individual characteristics of young black people[3]; and those that seek an explanation at the level of the formal agents (i.e.police and psychiatrists) involved in the referral process[4]. It seems a third type of explanation may be offered, that is, the role played by the public in setting the agenda for subsequent police action. (It may be remembered

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Scott (1973) showed that relatives whom referred schizophrenics to psychiatrists feared the patient becoming 'lost' to them more than outward signs of violence.

this refers to a person close to the patient colluding with the psychiatric services which subsequently gives rise to patients feeling resentment or betrayal (Goffman, 1961).

This includes psychiatric and cultural explanations, that black people are iller than whites or more likely to express emotional deviance in public because of a preference for street culture This has tended to place the emphasis on police and psychiatrists labelling and racial prejudice (Littlewood and Lipsedge 1984).

that Afro-Caribbean people were less frequently referred by their relatives or neighbours and more frequently by strangers than were the other referrals). This implies what Reiner (1986) terms "transmitted discrimination", which entails the police acting as a 'conveyor belt for community prejudices' due to public perceptions of black people's deviant behaviour constituting a threat to law and order. So, racial biases on the part of the public can be said to have shaped the decisions to contact officers regarding Section 136 referrals. A similar argument can be made for the over representation of men to women referrals (see chapter 5). That is, male referrals may well have displayed more overt aggressive behaviour than females. It is also likely that, as a group the men were more likely to be perceived by the public as a greater threat warranting the intervention of the police.

Further differences, relating to characteristics of referrals in terms of gender and ethnicity were noted at different points in the thesis. For example, results in chapter 6 indicated that there was signficantly less use by the police of physical restraint. The use of handcuffs and cells in relation to female compared to male referrals

indicates that women were viewed as less threatening and treated in a less punitive way than men. (This casts doubt on the validity of claims made from feminist groups outlined in chapter 1 about the discriminatory treatment of women whilst detained by the police).

ii) The referrals

At the outset, when designing the research, a decision was made that it would not be possible to examine the effect on referrals of action taken by professionals or the referral's perspectives. However it is important to note a number of points about the position of such referrals. First, the assumption that they took on a passive role were in some respects found to be exagerated. In regard to the incidents leading to the use of compulsion, referrals' behaviour was by no means passive. However, after this initial phase it seemed that the detainee became, or were seen as more passive. Behaviour, opinion, and civil rights appeared to have little impact on proceedings generally. Detainees were not consulted about their position, and were rarely asked for information about themselves. From observations made, and accounts given, it appears that they were not informed about the terms or conditions of their compulsory

detention, whether by the police at the station, or on arrival by the psychiatrist at the hospital. In this regard, comparison with the position of patients in other settings where an outcome is negotitiated (albeit within an asymmetrical power relationship) seem largely inappropriate. Here decisions were a matter for the police and psychiatrists.

b)Police action.

i.The context of police action

Data relating to police action in dealing with psychiatric referrals was presented in relation to hypothesis 2d - 2m in chapters 6 and 7. A number of points revealed by the data, need to be made about the context of police action.

The first relates to the extent of officers' previous experience. It was shown that most officers had dealt with Section 136 cases in the past. (Out of officers interviewed in Study B, only two had never previously used Section 136.) However, overall, the extent of their experience was not enough to warrrant the use of Section 136 being seen as constituting a large element of everyday policing.

The comparative rarity with which officers were involved with Section 136 may help provide an explanation of the data on police action shown in chapters 6,7 and 8: the reasons why the Mental Health Act was not always used as a point of reference for an authority in making an arrest; that officers tended to exclude other forms of deviance before arriving at a positive identification of mental disorder; and views of mental disorder and psychiatrists, which in a number of respects did not differ from lay views generally. These results reflect that in dealing with psychiatric emergencies in public places, the officers, main references were to policing norms and means of dealing with events.

Second, the role played by the referral agents is also important in conceptualising and analysing the subsequent actions taken by the officers. It has been mentioned earlier that police referrals were generally initiated by outside persons or agencies. Thus, the police officers acted as the second rather than the first link in the chain of events. This finding suggests that the analogy which has been made been made between the use of Section 136 and the now abolished 'sus' laws (Mercer 1983) is inappropriate. The latter was nearly always police

initiated (Demuth 1980), whereas the cases in this study were not. So, theoretical presuppositions used by some commentators who have adopted a 'top-down' model of social control (e.g. Bunyon 1977) with which to analyse police activities appear severely limited when applied to the issue of policing the mentally disordered. Social control <u>from below</u> was a more important element in setting the scene for subsequent police action about mental disorder.

Third, there is the manner in which police decisions were made. For the purposes of analysis, it has been necessary to present the results in a way which has shown police action as operating a unified process with clear cut boundaries (e.g. police called to incident, followed by the use of Section 136, identification of mental disorder, management before and after arrrival at the station etc). What has been difficult to convey overall is the speed, the confusion and the ambiguity surrounding events. It was shown in relation to findings on police management and identification of mental disorder whilst in public (chapter 6) that there were few definitive judgements made to identify the point at which a person became a 'psychiatric referral'.

ii.Action in public

Officers' action and decisions took place in three areas; on the streets, at the police station and at the hospital. In the first of these, decisions were being made in an 'open system'. (One in which there was little organisational backup in staff or resources and where the police had to form opinions as to what was going on, and make decisions in an ad-hoc manner, drawing on information from individuals who were there by chance.

Police explanations for apprehending a potential patient for psychiatric reasons were rare: policing reasons (e.g.threats to law and order) were common. In addition to the circumstances of the incident itself, data relating to the arrests showed that a main feature of officers' decisions was whether an incident was likely to continue if no action was taken. In this respect, officers were making judgements which were aimed at avoiding type 2 errors (Scheff 1978). In this study, it is difficult to criticise the cautiousness of the officers in this regard (as for example Scheff (1978) has done in relation to medical practitioners' tendency to overdiagnose). The double uncertainty of the context in which officers were forced to make such decisions, and the

unpredictable behaviour demonstrated by the subjects, who were subsequently arrested, gave officers little room to wait and see what <u>might</u> have occurred had they not intervened.

Overall, there appeared to be little distinction made between the nature of police response made towards Section 136 referrals and to criminal deviance generally. This was shown in findings related to hypothesis 2d - 2g. Only a minority of officers in Study A were aware of the presence of mental disorder prior to attending the incident. They also tended to treat psychiatric referrals in a similar manner to others who pose a threat to public order (e.g in using physical restraint and removing someone to the station). Thus, in contrast to other areas of police work[1] dealing with mentally disordered people in public did not appear to constitute a specialism.

Data relating to the apprehensions made also suggested that there was a similarity with other areas of policing, in that the use, or possession of the legal powers, of arrest were less important than might be commonly assumed. Only a minority of

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Holdaway (1984) notes how specialisation within the police has ocurred in a number of areas; e.g. Police specialists in traffic management, computerisation, community relations etc.

officers used Section 136 explicitly as a legal mandate to make an arrest and a substantial minority were not made from public places. This use of other legal and ad hoc means of apprehension tends to confirm Bittner's claim that police capabilitiy of maintaining order is the diffuse capacity for decisive action; "a solution of an unknown problem arrived at by unknown means" (Bittner 1974,p35).

iii. Decisions at the police station

As with other studies on policing[1], officers in this study appeared to have limited control over what happened. The nature of incidents such incidents demanded immediate action. Things were different once at the police station. A referral's passage through the police station was made according to a series of practical judgements regarding the courses of action to be taken. The police station was the place where the accuracy of initial judgements was confirmed. It was only here that an undifferentiated 'problem' became a clearly defined mental health case requiring psychiatric attention.

In Holdaway's study (1983) for example one of the main features of urban officers culture and work centred around the station where space and time were found to be most effectively managed.

There were other such indicators too. Data presented in relation to hypothesis 2g showed how one of the main police management strategies was to transport referrals to the station in order to be able to establish boundaries of control. Additionally, and in contrast to police handling of referrals on the street officers in the station clearly distinguished treatment of mentally disordered people from other prisoners. The mentally disordered people were treated less punitively. This was shown too by the data collected on the use of cells. It was also at the station that police officers had most power in influencing negotiations with psychiatrists. This aspect is discussed later on in this chapter.

Data presented in relation to hypothesis 2j showed that few mentally disordered people arrested over the period of a year at one police station actually resulted in a court appearance. Clearly then the police have the potential to exercise extensive 'gatekeeping' powers, such as whether a person enters the criminal justice or psychiatric system. These powers were explored in chapter 6 where it was shown that, the overwhelming majority of those apprehended had committed offences for which they could have been charged. This qualified them for

entrance into both the criminal justice and mental health system. Just under a half of officers in study B considered alternative disposals to psychiatric referral. In this respect, the perceived seriousness of mental disorder was found to be important - if, for example, a persons mental condition was thought to outweigh the seriousness of offence then police tended to use a psychiatric disposal in preference to the criminal justice system. This gatekeeping potential places officers in a strategically important position, with regards to the formation of social policy, which will be returned to at the end of this chapter.

Other studies on policing have tended to stress the influence of rank and intrapolice organisational factors on decision making (e.g Cain, 1974; Holdaway, 1983). Though such factors may have also been present in this study, influences from outside appeared more important. The findings in relation to hypothesis 2e showed that police actions in public were in a number of instances subject to external contingencies. These included the availability of relatives to look after a person, the living conditions to which a person could be returned and the perceived, and actual, response of others closely involved in incidents or related to

the referrals.

Influences at the station (as shown by data presented in chapter 7) were different. Here the importance of relatives receded, and more formal institutions and personnel took on greater significance. The divisional surgeon and the policy of the local courts and psychiatric services together were perceived as important. This data suggest the existence of a dialectical relationship between police decision making and external institutions. It is likely, that where hospitals are perceived as cooperative, the police may be more prone to refer a detainee to the health service, than where a hospital adopts a negative attitude. Similarly, where courts act punitively towards officers who bring mentally disordered people before them, this may encourage increased referral to the health service.

One implication here for the use of the provision is that police action should not be viewed, as divorced from its immediate context and influences. These include institutions such as the courts and health service. From this study, social resources available to indviduals at the time of arrest and the functioning of these other organisations had

implications. They affect whether an individual is arrested, enter hospital as a patient, or the penal system (or psychiatric system) via the courts as a mentally disordered offender.

A final aspect to consider in this section is officers' identification and construction of mental disorder. It will be remembered from chapter 1 that claims made by those wishing to reform or abolish Section 136 centered around suggestions that the police are not competent diagnosticians of mental disorder. There appeared to be little evidence to support this view. The findings in chapter 6 indicate that far from setting themselves up as 'street corner psychiatrists' the police were not generally over-keen to label someone as mentally disordered, preferring first to exclude other more obvious forms of deviancy. Officers also appeared to be able to distinguish between 'mental illness' and 'mental handicap' both of which are incorporated under the legal definition of mental disorder. Compared with other studies on Section 136 (e.g. Kelleher and Copeland, 1972; Rogers and Faulkner, 1987) there was high rate of inter- rater reliability between police officers' and psychiatrists' opinions. Only 6 of the 82 referrals brought to hospital were considered not to be

mentally disordered by the psychiatrists. There was also apparent agreement over the type of disorder. The overall descriptions of behaviour as unintelligible, odd, funny or bizarre suggests that officers recognised most referrals as 'psychotic' rather than 'neurotic'. The predominance of psychosis was confirmed in the type of diagnostic labels given to the patients by the psychiatrists.

One aspect of this, which may separate the police from other mental health professionals, was the extent of contact and information available to them. In general, officers had only limited contact with referrals and were forced to make judgements on the basis of a snapshot picture of behaviour in fraught circumstances. Whilst it may be the case that this characterises all psychiatric emergencies, psychiatrists, nurses and social workers tend to have far more knowledge of an individual from previous contact. (Bean et al (1989) for example showed that psychiatrists relied extensively on previous hospital case notes in their decisions about Section 136 referrals). This limited contact may also explain why officers views were more akin to those of lay people than professionals. (Officers for example portrayed mentally disordered peole as excessively violent

and data relating to hypothesis 2k showed that no distinctive professional paradigm[1] was found to characterise their views of mental disorder.

One final aspect of interest, was the extent to which officers took notice of other peoples' opinions (e.g. relatives, neighbours police surgeons). It was shown in chapter 6 that a substantial number either confirmed their own decisions or used these sources as the main basis for diagnosis. In this respect, there was some suggestion that officers differed from the psychiatrists who were found to take little notice of officers' opinions. The interesting question of how far this distinguishes police officers from other professionals such as social workers awaits further research.

c)<u>Interprofessional relationships</u>

i.<u>The exclusion of social workers.</u>

The professional relationships between police and psychiatrists were the focus of chapter 7 and 8 and Hypothesis 3a- 3m. If in this study, Section 136 had been implemented according to the legal remit of the Act, relationships between <u>three</u> groups of

[1] akin for example to the medical model of mental illness in psychiatry.

professionals would be under scrutiny. In the event, social workers were rarely called, by police officers to attend the station, or by psychiatrists to provide an assessment at the hospital. The main reason for this exclusion was found to be an apparent lack of knowledge about the Section 136 provision. A further reason relates to the more general interprofessional relationships existing between social workers and police officers and social workers and psychiatrists. Not only were social workers not viewed as being helpful or necessary, but they were seen as an impediment to the referral process. Two question arise from this data. The first is why were social workers viewed in this way? Part of the reason may be to do with the perceived lack of resources social workers had at their disposal. Perhaps any alternative that social workers might have offered, (e.g. a home visit, access to emergency accommodation etc) was not considered suitable. That is, it may not have been seen as an alternative to admission or containment offered by the psychiatrist who had access to hospital beds. It is also likely that the role of social workers in acting as a check on the need for compulsory detention, as well as their perceived more liberal values, also played a part in provoking a negative attitude from the other two

professions.

The second question is how was it possible for psychiatrists and police to exclude social workers so easily? There is little evidence to suggest that social workers are excluded from other compulsory mental health processes or from juvenile court proceedings. A possible reason for this relates to the inadequte policing of Section 136 use by the Mental Health Act Commission and the courts. This has allowed psychiatrists and the police to proceed virtually unchecked. Whatever the reasons, the absence of social workers acted to simplify matters, as far as the police officers and psychiatrists were concerned. Referrals were a matter of negotiation between the police and psychiatrists, without the additional complication of the intrusion of an additional set of arrangements, assessments, and professional rivalries that social workers would have undoubtedly introduced.

ii) Professional territory.

A further influence on professional interaction was the territorial base of the two professions. It was evident from the results in chapter 5 and 6 that the police were most powerful in directing events

and their relationship with psychiatrists when managing matters within the confines of the police station. In contrast, psychiatrists gained much of their professional authority from the territorial base of the hospital. This was best seen when the police handed over the referrals for assessment.

Examining first the nature of inter-professional relationships at the station, then the most pertinent issue concerns the relatively high rate of dispute over the acceptance of referrals for assessment. It was shown in chapter 7 that it is not unusual for psychiatrists to employ various strategies to disuade an officer from bringing a referral for assessment, even though, unlike other medical referrals, police have the legal power to do so. The strategies used to prevent a referral being made and the counter-strategies used by police officers were the subject of Hypothesis 3d. These centered around the traditional areas over which psychiatrists have control: access to resources, (beds, secure faciltities etc); hospital catchment areas; and diagnosis, with certain categories or individual patients being excluded from the outset.

Yet, despite these attempts, officers were able to

exert counter-strategies. Thus, officers were by no means ineffective in countermanipulating psychiatrists' attempts to refuse a referral. As shown in chapter 7, the most effective strategy entailed using the police surgeon. Despite police surgeons providing little of practical or technical assistance (the police did not consider them to have particular expertise in mental health and their examinations at least in this study were cursory and expensive) they served a useful purpose. Officers used the police surgeons' status as medical practitioners to increase their own power in exerting influence over psychiatrists.

The importance for psychiatrists in attempting to control referrals being made before they had left the station may have been related to a need to exercise their own gatekeeping powers as early as possible, when they were perceived as having the maximum effect. However, the psychiatrists were, at this stage of the proceedings, far from being in a dominant position over the police.

Having already arrived at a decision as to whether a person was suitable to be sent to hospital, prior to contacting the psychiatrist the officers exercised considerable autonomy. As far as the

police were concerned, such decisions were not reversable or open to negotiation. Officers exercised additional power in choosing whether to contact and discuss a referral with the psychiatrist prior to transporting the referral to the hospital. After contact had been established police still retained a degree of control over decision making. In the event of an objection to a referral being made, the police had the ultimate resource to ignore it by simply taking referrals and 'dumping' them at the hospital.

These power relationships were reversed once inside the hospital. Judgements and decisions there became a medical and not a police matter. Just as officers made decisions independently of the psychiatrist at the station, so the police were ignored at the hospital. As was shown in chapter 8, officers adopted a subordinate role to the psychiatrists, with the former tending to do things at the behest of the latter. There was also, according to the findings related to hypothesis 3c, an absence of negotiation about what should happen to referrals, with psychiatrists making autonomous decisions. Medical authority also appeared to be accepted beyond the confines of the hospital. Police officers made no attempt to challenge decisions

taken by psychiatrists, even after a person had been refused admission.

iii.Professional relations and the division of labour

The lack of active involvement on the part of the police in decisions at the hospital differ from other descriptions of psychiatric dominance in which subordinate professionals play a more active role (Goldie, 1974; Huntington, 1981; Hughes, 1988)[1]. Associated with the passive role of the police officers vis a vis the psychiatrists was an impersonal, indifferent and distant relationship between the two professions. This was shown by their lack of communication in their individual dealings over referrals and their general opinions about one another. Whilst there was little open hostility, there was also no pretence at harmonious relationships either.

A number of explanations may be offered for the nature of relationships between police officers and psychiatrists. One is that, in adopting such a passive, non-communicative role, police officers

[1] Hughes (1988) for example showed that casualty nurses formulated and articulated ideas regarding diagnosis and matters that should be checked by casualty officers.

knew of, and were simply strictly obeying, the 'rule of law' under the Mental Health Act, which gives the medical practitioner responsibility for decision making. However, this is unlikely to be the only explanation, since officers in this study often knew little about mental health law. Also, other studies have shown officers not to be so respectful of the legal duties of other professionals not to challenge them[1].

It may have been that differences in occupational culture and socialisation, and in social class and education between psychiatrists and police, contributed to the way in which officers and psychiatrists interacted. Certainly, these factors could be identified from a number of officers and psychiatrists' accounts. Gender may also have been relevant,(40% of the psychiatrists in this study were women compared to 11.5% of police officers[2]). It is possible for example that officers resented women being in powerful positions. However, whilst occasionally such views were detectable from police accounts, overall there appeared to be no differences in whether the psychiatrists were male or female.

Holdaway (1983) showed how officers frequently challenged the authority of lawyers in relation to criminal matters. in Interview B.

The most likely explanation is that that there may have beeen little functional necessity for either profession to engage in personal niceties, positive cooperation or communication. Decisions made by the two professions were made separately and autonomously. Unlike the interdependency in a hospital division of labour, there were clear demarcation lines between the institutions where decisions were made, first by the police at the station, and subsequently by the psychiatrists at the hospital. The necessity for direct contact between the two professions was further limited by high levels of agreement over the perception of the referrals, as mentally disordered and in need of hospitalisation, and the roles each of the two professionas should assume in implementing Section 136.

In some respects, the officers' passivity can be seen as serving a function in reinforcing the clear demarcations lines between police and medical work. This was indicated by data in chapter 7 where it was shown that although there were objections to the way officers were treated by psychiatrists, a number of officers also saw this as an acceptable, and even necessary, as long as each of the

professions kept within their own occupational boundaries.

A final issue examined under this section is the threat posed by the police to professional dominance. The clear demarcation on the part of the police between matters criminal and medical, together with the findings in relation to Hypothesis 3f, also suggest that police officers have little or no interest in seeking to incorporate aspects of psychiatrists remit into their work. Nonetheless, it was evident that the police in this study did challenge aspects of medical dominance, especially on matters relating to psychiatrists' gatekeeping powers. Psychiatrists had no power over the categorisation of detainees (i.e. deciding who should and should not be referred). This was performed by the police officers at the station. They also appeared to have little room for manoeuvre over the referrals that were brought by the police, since most, according to their own evaluation, appeared to be appropriate and to warrant admission. Thus the only feasible area that they did have control over was in relation to prospective police activity. This was shown by the findings relating to hypothesis 3f, i.e. that psychiatrists attempted to discourage

future referrals being made by adopting a generally negative attitude to police officers, and rarely providing direct feedback on the outcome of their assessments.

The process of Section 136 has so far been analysed in terms of police officers' action and interaction with psychiatrists. The remainder of the chapter is concerned to examine some of the findings and their implications for mental health policy generally.

d) Implications for mental health policy generally.

Though not the main focus of this study, a number of findings had implications for contemporary mental health policy and legislation. Mental health policy is used here in a wide sense, as being related to legislation on the one hand and the wider mental health services policy on the other.

i. Section 136 and mental health legislation.

Social policy considerations need to take into account the criticisms levelled against the use of the provision at the outset of this research. It may be remembered that one position adopted was that Section 136 should be abolished because the police, who are not trained in these matters, detain someone on the basis of their judgements

about a persons' mental state. A second position, advocated by MIND, centres on tightening the definitions of existing legal criteria to ensure that sufficient constraints are placed on police officers to prevent abuse. In this study, there is, for different reasons, little support for either of these positions.

Dealing first with the question of the ability of police officers to diagnose mentally disordered people. The high rate of agreement between psychiatrists and the police, over levels of dangerousness and presence of mental disorder, implies that as far as current psychiatric standards are concerned the police were acting appropriately.

An evaluation of the second position involves the consideration of more complex issues. On the face of it some of the findings seem to lend support to the notion that officers use the law inappropriately. For example, data presented in Chapter 6 showed a substantial number of referrals were not arrested from a public place (21% in Study A and 11.5% in Study B) and that police officers did not generally view section 136 as an authority for arrest (in only 38% of instances in study A)

but as a means of disposal. Yet, it is open to question whether the law is the most relevant basis for making evaluations of the effectiveness or appropriateness of police action. A more pertinent question seems to be whether there is empirical validation for the premise of law in the first place.

As far as the results of this study are concerned, the legal criteria on which the implementation of Section 136 (1) are based show a simplistic and inaccurate view of social reality as determinants of police action. An evaluation of Section 136 as a socially constructed process may be more appropriate for evaluating its operation. It has already been mentioned that police action did not generally follow a set of ordered steps, in which mental disorder was recognised and Section 136 of the Mental Health Act ipso facto applied.

In chapter 5 and 6 it was shown how a Section 136 case frequently began as an undifferentiated problem which only gradually, became defined as one means, selected from others, of bringing about a pragmatic conclusion to a particular public order dilemma. Given the circumstances in which officers became involved and made on-the-spot decisions, it

is difficult to see how officers could have acted any differently. Officers were called to deal with disruptive situations requiring expediency. They had little prior knowledge that a person may have been mentally disordered. So, decisions were made in conditions of uncertainty, and against the background of officers's comparatively rare experience of dealing with such disruption.

The tightening up or changing of legal procedures may have more relevance to the improved efficacy of Section 136 (2) which relates to police action, and assessments of other professionals and the terms and conditions surrounding the detention of referrals. (Once a degree of containment had been brought to an emergency situation in bringing someone to the station more ordered decision making appears to be more feasible). Stricter and clearer guidelines regarding aspects of Section 136 could make the provision work more efficiently, and in the spirit indicated by mental health legislation. These might include a high court ruling or directions from the Mental Health Act Commission as to whether it is legal to use one or more places of safety for detaining a person. The procedures in this study, whereby a person was detained both at a police station and the hospital, raise the question

of the legality of moving a person from one venue to another. Secondly, it might also assist if, the designation of responsibility on either the police and/or psychiatrists to notify local social services departments of the detention of a referral, so that social workers are in a position to provide an assessment.

More generally, the legal enforcement of the need to provide routine social worker assessments would end the monopoly over the disposal of referrals. As things now stand, it is concentrated in the hands of the psychiatrists and police. Social worker involvement could act as an added safeguard against wrongful compulsory detention.

With regards to patients rights, this study also higlighted the need to correct the routine use of Section 136 as a form of compulsory detention. The findings in chapter chapter 8, showed that the majority of referrals were admitted to hospital under Section 136, even though it is a section which should only be used as a means of assessment. There also appear to be insufficient grounds for retaining the 72 hour rule. The making of arrangements with the hospital to accept a referral was not normally a lengthy matter. Usually it

involved only a short period of detention at the police station.

Cohen (cited in Bean 1980) has argued that clear cut rules and procedures are required if law is to be implemented properly. However, an equally fundamental requirement is that there should be effective control over the use of such legislation. There is some doubt as to whether such control existed in relation to Section 136 cases in this study. The work of the Mental Health Act Commission is primarily directed towards monitoring the proper application of the Mental Health Act. Given Commissioners would have had access to similar information, it is perhaps surprising that glaring inadequacies, such as the misuse of Section 136 as an admission order and absence of social work assessments, were not identified and action taken[1]. From examining questions of legal relevance to this study, two main criticism's of legalism, as they relate to Section 136, can be added to other recent critiques (Bean, 1980,1986; Rose, 1986)[2,3]. That is, there appears to be an irreconcilable misfit

Evidence from other sources is emerging which suggests a lack of effective policing of the MHA by the Commission. (Bean and Mounser 1989, Pilgrim & Rogers 1988).
It has been claimed that mental health legislation provides insufficent checks on clinical autonomy to ensure patients rights, and that legalism depolitisises the debate over how psychiatry is organised

between prescribed legal measures and social reality. Also there are signs of inadequate policing to ensure the appropriate use of the section.

ii. Implications for service provision

The discussion in the preceding section revealed something of the limitations of legalism as a dominant approach to addressing issues relating to section 136. Arguably, the non-legal aspects are however of greater importance. Two such aspects indicated by the study are the choice of the appropriate place of safety and the service response to acute psychiatric emergencies.

Changing from using a hospital as a place of safety to a police station requires no legislative changes. The wide definition under Section 135 (6) of the Act allows a variety of venues to be used. Given the future direction of mental health policy, the use of a police station for assessment rather than a hospital setting might be preferrable. The imminent closure of many large psychiatric hospitals in London implies that other venues need to be found. The police station appears to be an obvious choice for containing highly disruptive

behaviour which needs to be contained[1]. District General Hospital Psychiatric units, which appear to be emerging to replace the larger Victorian hospitals, have the disadvantage that they cater for physically ill and often frail people and are not designed specifically for mentally disordered people (Baruch and Treacher, 1979). Some officers indicated that the use of DGHPU might prevent them from using Section 136. Newly established Community Mental Health Centres also might not provide a suitable environment for such psychiatric emergencies because of the need to provide for a range of activities and groups of people within a confined space (Goldie et al, 1989).

Of wider concern is the apparent limited availability of responses to psychiatric emergencies. Intervention was overwhelmingly of one type - admission to hospital when distress became disruptive. There was little sign of alternative community crises intervention, which may have been more effective in some instances. The results in chapter 8 showed that officers felt that psychiatrists failed to pay adequate attention to the circumstances surrounding the external context

[1] Although it is recognised that relationships between the police and some ethnic groups will not always make the police station the most suitable place.

within which acute crises arose. Moreover, some of the accounts of events leading up to incidents suggested that other community services, such as GP's or social services, had not responded when called upon by relatives or neighbours prior to them contacting the police. Thus there appears to be a need for planning and provision of mental health services in the areas studied which provide a wide range of responses (evaluated for their effectiveness) towards psychiatric emergencies which takes into consideration the social context within which crises arise.

Summary of the findings.

Chapter 5.

1. In chapter five basic social demographic data of the referrals, police and psychiatrists were considered. Data from studies A and B showed that in terms of age the police referrals tended to be young (just over half were aged below 35). Most lived near the police station to whom they were referred. A sub- group of referrals were found to be homeless. There were approximately equal numbers of men to women and those who had a previous criminal record to those that did not. Additionally, the majority of referrals were white, but Afro-Caribbean people were found to be over-represented compared to their numbers in the general population.

2. The police officers involved in making referrals came from seven different police stations, were almost exclusively white, male and of constable rank. Almost a half of the officers had been employed in the police force for five years or less. Most were found to have had previous experience of dealing with psychiatric emergencies but this was comparatively rare in relation to other areas of police work.

3. The psychiatrists who received referrals from

the police in study B were predominanately junior in rank, and most were male but with a relatively high proportion of women. A substantial minority of psychiatrists were of Asian origin. A larger number of the psychiatrists worked in the large psychiatric hospital than in the District General Hospital Psychiatric Unit.

4. Of the incidents resulting in a person being referred to the police, nearly half contained both elements of a psychiatric emergency as defined by the substantive requirements of the Section 136 provision. Analysis of the content of the circumstances showed that an individual's behaviour caused major social disruption. In addition, the social context of the incidents taking place in public (and thus were highly visible) was as a factor in whether the police were called.

Chapter 6.

In chapter six the main findings related to describing the decisions police officers made at the time of arrest, the management strategies they used in dealing with mentally disordered people and the way in which they recognised and construed the presence of mental disorder.

5. It was rare for officers to initiate a referral.

It was mostly as a response to others that the police intervened. Most referring agents' primary concern in alerting the police appeared to be the threat of violence and public disruption, although nearly a third mentioned the referrals mental state on making contact with the police.

6. Officers were generally unaware that they were responding to a mental health emergency before arriving at the incident. Decisions to apprehend were made for 'police' reasons (e.g. the maintenance of public order) rather than psychiatric ones. The likely proliferation or continuation of a disruptive situation was also a major influence on police arrest decisions. A small number of officers operated the opposite strategy of giving the 'benefit of the doubt' or attempting to use informal means as an alternative to arrest. Officers were also influenced by others closely involved in incidents.

7. Police officers were found to be generally acting within their legal remit, in that most arrests were made from public places. However, there were indications of a low use of Section 136, as an authority for arrest, suggesting that many officers were not acting in a way prescribed by the Mental Health Act. The use of other powers was

largely found to be a result of pragmatism and the need for expediency in handling the type of incident and factors surrounding the labelling of mental disorder by officers.

8. Police used physical restraint and verbal strategies to manage mentally disordered people. Whilst on the streets, methods of management appeared to be no different to the practices used by officers in other disruptive situations. However, once at the station, officers treated psychiatric referrals differently from other detainees. For example, cells were used less frequently and officers adopted a more benevolent attitude than usual and allowed greater 'privileges'.

9. Although, in the majority of instances, police identified mental disorder at the time of the incident, it was found that there is a tendency to exclude other forms of deviancy and possibilities before a positive identification of mental disorder is made. Mental disorder was identitifed primarily on the basis of unintelligible behaviour and speech, and officers were influenced in their formulations by members of the public and police surgeons. No one dominant or 'professionalised' conceptualisation was found of causation. Rather

officers drew upon social, psychological and common sense explanations in an ad hoc way, which was more akin to lay perceptions of mental disorder.

Chapter 7.

The main findings of chapter seven were related to police decisions made at the station about hospital versus a court disposal and police negotiations with hospitals and psychiatrists over the reception of detainees.

10. There were indications that the police are discriminatory in their decisions to use Section 136 as a disposal for the mentally disordered people they apprehend. Over a one year period, 48% of the arrests at one station involving mental disorder and minor crime did not result in the use of Section 136.

11. Most referrals apprehended had committed an offence for which they could have been charged, albeit for mainly minor offences. Police officers offered a number of reasons for not pressing charges. These included; the mental state of the referral; perceptions and expectations of the courts and local hospital; and the practical difficulties of preferring charges.

12. Whilst at the station officers did not generally involve other professionals in making decisions. When they did, police surgeons were the most likely to be called. Social workers were very rarely called upon to provide an assessment. They were also infrequently called upon by the assessing psychiatrists to attend to referrals at the hospital, which may be suggestive of a preference on the part of both professions to exclude social workers from this area of mental health.

13. In making arrangements with psychiatrists, a substantial minority of officers encountered a number of obstacles organisising the acceptance of a detainee. A number of different occupational strategies used by the psychiatrists and police were then examined. The former included the use of catchment area criteria, claims of inappropriate or insufficient facilities, and the 'treatability' of individuals, to disuade referrals being made. The police in turn used a number of counter-strategies to encourage acceptance of referrals. The most important of which was the cooption of the medical authority of police surgeons.

Chapter 8

In chapter eight the results examined pertained to the perceptions the two professions held about the

referrals, the type of interaction that took place between the psychiatrists and the police on arrival at the hospital, and the wider views that they held about each other.

14. There were low positive correlations between the two professions over psychiatric condition and dangerousness to self of the referrals, but high positive correlations over the perceived 'dangerousness to others'. Additionally, in the overwhelming majority of instances, psychiatrists viewed the referrals the police had made as appropriate to be dealt with by the psychiatric services.

15. A number of officers left before meeting the psychiatrists and most remained at the hospital for 30 minutes or less indicating that contact with the psychiatrists was of a brief and cursory nature. That police officers adopted a subordinate and psychiatrists a superordinate role in interactions was included in these findings:

i. Whether police waited until the completion of the assessment generally relied on psychiatrists' discretion.

ii. The majority of officers provided the

psychiatrists with information on arrival at the hospital but this was not generally reciprocated. In only a small minority of instances did psychiatrists directly inform the police of the outcome of their assessments.

iii. The police accepted the psychiatrists' decision as final.

The psychiatrists also tended to discourage the making of future referrals. This was done explicitly by adopting a negative attitude towards the officers, and failing to provide direct feedback about what happened to patients subsequently. It was suggested that the importance of restricting future referrals was connected to the need for psychiatrists to maintain their gatekeeping powers and ideological legitimacy over the treatment and care of patients.

The following results are to do with the overall and perceptions of the two professions evaluation of each others role.

16. The largest number of officers identified the psychiatric services as having the legitimate primary responsibility for dealing with mentally disordered people. None thought it was the

responsibility of the police. Officers viewed the role of psychiatrists in terms of the legal remit defined under Section 136 of the Mental Health Act and in treatment and care in generalised terms. A sub-group described them as psychotherapeutically orientated, which appeared incongruent with the way in which psychiatrists actually dealt with police referrals. Few officers viewed psychiatrists as effective in carrying out their prescribed role. Most were unable to make a definitive positive or negative rating because they were reticent over making judgements about another professions area of expertise and because they viewed psychiatrists in some areas of mental health as being effective and some as ineffective.

17. There were significant differences in perceptions as to the police's ability to recognise mental disorder. Officers considered themselves to be more able at doing so than the psychiatrists. There was however, considerable agreement as to the appropriateness of the police to deal with mentally disordered people found in public places. This appeared to be based on the view that there was no feasible alternative to the present arrangements.

18.Few officers or psychiatrists viewed their mutual relationship positively. Most described it

as indifferent and distant. It was suggested that this dominant attitude may mask conflicts over ideology, areas of expertise and professional imagery.

Traditionally, the use of Section 136 has been discussed and evaluated in terms of the legal dimensions of police action. Throughout this study due regard has been given to the importance of these aspects, but such a reading of the issue of police involvement in psychiatric referrals is as it stands, unacceptable. Not only have the particular nature of incidents and their social context been found to be pertinent in understanding the operation of Section 136, but also of importance is that officers' decision making should not be considered as if it takes place in isolation. Rather it needs to be seen in relation to the immediate externalitites influencing decisions, the rest of police work, and inter-professional relationships. For example, discouraging future referrals is likely to influence how frequently officers use Section 136. Police action is therefore more appropriately viewed as part of a wider system or 'feed back' loop which is influenced by the courts, hospitals and professional interests.

CHAPTER 10

THEORY RE-EXAMINED AND FUTURE RESEARCH

The theoretical perspective of professional dominance, outlined in chapter 2 provided the main analytical basis of the approach in this study. Throughout, professional dominance has been found to be a useful model for analysing the relations between the two professional groups. However, there has been a recognition that the theoretical presuppositions of the research were not adequate to account for all aspects and the theoretical model, as espoused by Freidson, requires reexamination and development.

The theory developed in the early stages of the research was at an abstract level, although elements provided the source for part of the methodological approach. Moreover, because so little was known sociologically about the proposed area of research, the use of a predictive formal theoretical framework, which has been used in some ares of sociological investigation, was deliberately rejected. It was expected that because of the exploratory nature of the research, new theoretical presuppositions would emerge. These could form the basis of future investigation. Professional dominance was therefore viewed more as a set of sensitising concepts to guide the study. This would then direct attention towards the

actions and interactions of the two professional groups involved.

An assessment of professional dominance

The application of professional dominance to this study had a number of advantages. The first was that it focussed attention away from aspects of law enforcement which have dominated the debate surrounding Section 136. In this way the theory helped the researcher focus on the more subtle processes involved in accounting for police action and interaction with psychiatrists in dealing with referrals.

The second advantage relates to the first, in that the theory proved to be a valuable heuristic devise. It was not too abstract so as to be impractical, yet was sophisticated enough to provide a fairly indepth analysis of the subject matter. In particular, it proved useful in revealing the tentativeness and subtle conflict inherant in police/psychiatric negotiations. For example, in chapter 8, the results showed psychiatrists adopted a negative attitude to police officers and did not provide them with feedback on the outcome of their assessments. The concept of professional gatekeeping was important in

explaining these findings.

Thirdly, the theory appeared to be a plausible one during the research as well as the outset, enabling a commitment to it from the researcher. At no time was it considered that an alternative theory would have been a more appropriate one to deal with the focus of the study. It revealed the nature of contact police had with psychiatrists. It enabled other aspects of police officers' action to be analysed as well, (e.g. management strategies and factors which affected police autonomy such as the courts).

There were also limitations to the application of the theory. Professional dominance was adopted to meet the requirements of the main issues of the thesis. However, the perspective has been accepted as limited, given the parameters of the research. The different organisations, contexts and sets of actors meant one theoretical model was inadequate to deal with all that was involved in the issue of psychiatric referrals from the police. Also, the empirical questions in examining two professions in separate organisations meant that it was not always possible to forge theoretical links between them. (For example, accounting for the constraints on

officers' dealings with public order crises compared to the different situation within which psychiatrists assessed patients in a hospital setting).

In retrospect, Freidson's model was more appropriate to the findings where psychiatrists interacted with police officers than the early part where the police were operating in public areas. Although Freidson's theory has been used to examine macro processes, in this research it was directed towards examining what may be termed 'middle range' phenomena. Thus, the weakness in the approach has been that little consideration has been given to events operating outside the immediate practices and relationships of the police and psychiatrists.

Questions in the interview schedules and other methods reflected three main interests. First,to examine police officers actions and circumstances surrounding the apprehension and processing of referrals. Second, to examine the negotiation between the police and psychiatrists over the acceptance of referrals and third, to examine the attitudes and assumptions that the two professionals held about one another. An assessment and elaboration of professional dominance as it

related to this study will be discussed, in accordance with these three interests, using the concept of professional autonomy and the relationship of the subordinate to superordinate profession. Though these two concepts within Freidson's theory are inextricably linked, they have for analytical purposes been separated out here. This is because police officers can, at different stages, be perceived both as an autonomous profession as well as a subordinate profession to psychiatrists.

Professional autonomy

i)Police autonomy

> "To attain the autonomy of a profession the para-medical occupation must control a fairly discrete area of work that can be separated from the main body of medicine that can be practised without routine contact or dependence on medicine' (p69, Freidson, 1970)".

The recognition of 'autonomy' as central to an understanding of police officer/psychiatric interaction was developed at the pre-planning stage. This was assumed to apply mainly to the psychiatric profession. Consideration was not given to the nature of autonomy that officers had prior to their contact or involvement with psychiatrists. An interest with police autonomy developed from the study itself. It was found that the processing of

referrals was, until matters were dealt with at the hospital subject to the norms and discretion of police work, with little reference to psychiatric authority. This has two related implications. First, in the early stages, police have considerable autonomy over the management of referrals. Second, the greater the distance from their dealings with the medical profession the greater the autonomy officers have in organising their work.

Whilst the notion of autonomous professional practice proved to be an appropriate and useful one, it should not be seen in the overinclusive way suggested by Freidson. At certain points in the referral process, such as responding to and managing incidents on the streets, where it might have been expected that police had a great deal of discretion, structural factors, and a variety of external contingencies were also important in determining events. This view is based on the findings of the unpredictable nature of incidents attended by the police, the high inititiation rate of referrals by the public, and the lack of certainty regarding the category of deviance that was being dealt with. It follows from this that Freidson's model is perhaps less appropriate to

aspects of professional practice than takes place in the context of an 'open system', compared to that which occurs within the confines of a hospital.

Freidson's analysis also tends to ignore factors relating to formal bureaucratic organisations. He gives primacy to the controlling aspects of professional practices. It was not possible to evaluate how far certain events were due to autonomous police action compared to action determined by the administrative constraints surrounding police work. The latter did appear to be relevant. This was suggested by the finding that officers were much more able to manage referrals effectively within the physical confines of the police station than they were on the streets.

ii) Psychiatrists' autonomy.

Like the police, psychiatrists' ability to control the content and the terms of their work in relation to psychiatric referrals varied. It was clear that the psychiatrists assumed a structural position of professional dominance. They had the ability to determine their own work and direct and organise aspects of police officers' work (e.g. deciding to accept referrals at the hospital). However, the

effectiveness of psychiatrists to exert control over their conditions of work varied. This was shown when psychiatrists tried to disuade the police from making future referrals. Psychiatrists had limited control over rejection or acceptance once referrals were actually on hospital premises. The issue of the extent of autonomy which each of the professions were able to exercise, was bound up with the nature of the relationship between the two professions.

Dominant and subordinate professional relationships.

The over-riding impression gained from this study was that psychiatrists assumed a dominant position in the division of labour in processing referrals from the police. The ideal type of the subordinate versus superordinate position was most in evidence in relation to findings concerning interaction at the hospital. However, Freidson's account of professional dominance appears too static and all-embracing. The roles of subordinate/ superordinate profession interchangeable at different points in the referral process. Sometimes psychiatrists were dominant and the police undertook a role according to the organisation of

work as demanded by the psychiatrists. At others, this role was more ambiguous or reversed. For example, the police were able to select and categorise detainees as suitable for psychiatric referral according to police rather than psychiatric criteria.

Yet, it is arguable that in one sense the police acted as the dominant profession over medical practitioners. The police's autonomy to employ police surgeons enabled them to use medical authority over which they had some control. They could use this to offset the strategies of psychiatrists reluctant to accept referrals. Even when it was clear who was in the subordinate role, Freidson does not appear to be able to account for the reverse dependencies that arose. This view is based on the finding that the psychiatrists required the police to wait until the outcome of their assessments, in order to maintain complete control over the assessment and disposal of referrals.

Boundary encroachment.

So far, theoretical concepts of autonomy and relationship between the professions in their direct dealings with referrals have been examined.

Yet one can take a more general view of the position of psychiatry as a dominant profession and it relationship to the police. The influence of psychiatrists certainly extended beyond the immediate referral situation and did not require their physical presence. This was shown in Chapter 8, when police officers appeared to take into account the type of management provided at particular hospitals. However, it was not possible to ascertain how far this influenced police action in general.

A further implicit assumption of the theory is the presupposition that subordinate professionals inherently attempt to encroach on others' professional boundaries. Although the study showed that police did affect the monopoly of control over a market for services, by taking control over who was referred and questioning the efficacy of psychiatry, this particular process was not strongly evident. In the main police accepted the limited role prescribed for them and viewed psychiatrists as holding a legitimately dominant position in mental health care.

As stated in the introduction to this section, this study has not led to a devaluation of Freidson's

theory of professional dominance. However from an assessment of its applicability to the police and psychiatrists two refinements can be suggested. The first is to re-conceptualise power relationships between subordinate and dominant professions as flexible, rather than static. In order for this to happen the "zero-sum" perception of power used by Freidson needs to be abandoned. Secondly, there is a need to take into account the structural elements and external factors impinging on the contemporary work context within which professionals operate.

Theory and future research

Having evaluated the usefulness of Freidson's theory for the research, it is evident that certain important changes would be necessary to consider in any extension of this study. These have been considered below together with the implications for the theory.

Referrals' social networks and use of services

Throughout this study, the characteristics and behaviour of referrals have been used as a background to the main focus of police action and interaction with psychiatrists. It has been implicitly accepted that in Section 136, officers'

actions can only be understood in relation to the referrals. However, little attention has been given to the careers and lifestyles of those referrals prior to being referred to the police. During the research, plans for mental hospital closure and rundown accelerated. These have implications for police contact with mentally disordered people. Not only will the long term residents of mental hospitals be released into the community but hospitals will become a less viable option for those who have traditionally been termed 'revolving door patients'. In the USA, the emergence of an underclass of ex-patients who have little contact with services and who live in conditions of extreme poverty and deprivation has been well documented (Scull 1981, 1984). Speculation that a similar trend is occuring here has only been recently acknowledged. For this reason, future research should focus on the characteristics of potential police referral's social networks and linkages (Mueller 1980), in order to understand more fully their utilisation of mental and welfare services and the lifestyles of psychiatric patients. A macro-perspective would help to understand the context within which psychiatric referrals from the police arise. This would involve an examination of the impact which housing and welfare and mental

health policy have on psychiatric patients. These refinements require a modified view of professional dominance, in which external social factors would be given greater importance.

Changes in legislation

The legal rules relating to Section 136 and the duties of the police officer and psychiatrist in relation to these, was the starting point of this research. Throughout the study such rules have also been used as a logistical framework for examining both the police handling of psychiatric referrals and interaction with psychiatrists. It has been accepted that decisions by officers need to be understood in relation to these legal rules. But little attention has been given to the emergence of such rules, or what changes to them may be made in the future. With regard to the former, the ahistorical nature of this research needs to be acknowledged. An historical analysis may reveal something of changing relationships between police and psychiatrists over time, as policy shifts in relation to the management of psychiatric patients.

No new legislation is due to be enacted. However, minor changes may have already occurred as the result of changes in the guidelines issued by the

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Mental Health Act Commission (MHAC) to hospitals and police departments during their visits to hospitals. In this respect, some of the findings in this study may have already been overtaken by events. Despite my personal doubts about the efficacy of the Mental Health Act Commission, as a quasi-legal body, whose job it is to oversee the implementation of the Mental Health Act, further changes in the near future cannot be excluded. The impact of proposed changes in related areas of mental health legislation may require future consideration. For example the introduction of a community compulsory treatment order, recently advocated by the Royal College of Psychiatrists, would have an impact on the use of police and psychiatrists powers in a non-hospital based context.

Changes in psychiatric police and social services.

Two aspects concerned with organisational change seem important to address. The first relates to the interaction between social services departments, police and mental health services; and the second between the criminal justice system, police and psychiatric services. Regarding the first, it has been noted that at the time of the study there was little involvement by social workers in the

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implementation of Section 136. What is important to consider is the ability of social services' departments to provide social work input in this area given other changes in the organisation of their work. For example, the pressure to make child abuse a priority within social services departments, the fiscal crisis over local government spending and recruitment problems have led some Directors of social services to advocate the withdrawl of hospital social workers and emergency teams. The latter could be expected to have the greatest involvement with psychiatric emergencies. Whether or not the recent Griffiths report (1988) is implemented may be another factor which will need consideration in any future social services response to mental health care in general[1].

With regard to connections between changes in mental health policy, one pessimistic prediction is that a the number of people in prison with psychiatric problems will rise concurrently with the closure of large mental hospitals. Certainly, there is support for this contention from research conducted in the USA (Teplin 1984). The effect of

[1] The Griffiths report advocates a shift towards providing services arranged by local authorityies and the introduction of a person with responsibility for providing overall care.

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organisational changes in relation to mentally disordered offenders within the context of the community mental health movement, such as the progress in the introduction of local secure facilities, is therefore likely to be important with regards to police involvement with psychiatric referrals.

Police officers' and psychiatrists ideology

Linked to the need to examine organisational variations are changes in police and psychiatrists relations. Certain characteristics of the police officers and psychiatrists roles in the study were highlighted. In addition to the pertinence of officers' individual discretion, the overall ideology associated with the two core professions was also important. The ethos of police officers (though at times glossed over in the rhetoric of seeking help and treatment), placed an emphasis on the need to prevent the referral from causing social and public disruption. Psychiatrists on the other hand tended to emphasise the treatment rather than the controlling/containment aspects in dealing with referrals. As with the social networks of referrals and organisational aspects of services, little attention was given in this study to

possible changes in the ideology of the police and psychiatrists.

This research was limited in that the focus was directed at the interaction of officers with referrals and psychiatrists at a particualr time, in a specific area and circumstances. What would be required to extend the analysis would be to introduce a study of treatment ideology, management strategies and the status of these within the process of professionalisation in the context of social change. For example, will the current containment/custodial ideology of psychiatrists working in the large hospitals reduce with the move from hospital to community based facilities?. And if so how will this fit with the police ideology of the need for custodial care?. What are the implications for individual discretion of officers in making decisions to send detainees with mental health problems to court?.

Implicit in these questions, is the need for a theoretical perspective able to deal with changes in mental health policy, the position of professions and their relationships with patients' lifestyles, within the context of social change. This would require a theory of the state, which

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would be able to take account of these factors at a number of different levels. Claus Offe's theory of the state which examines changes of social provision in the light of the 'crises of crises management', seems appropriate in this respect[1]. Offe's theoretical stance necessitates analysing welfare provision as a dialectical process between three multi-functional structural sub-systems (one of which includes welfare provison) and elements within these sub-systems such as professional expertise.

Future research

No research can ever be complete, but this study did suggest certain areas which may be pursued further. One possible development would be a comprehensive analysis of the effect of police and psychiatrists action on the patients themselves. Although the actions of patients were addressed in a limited way, this was not from the point of view of the patients themselves. Further research could seek to establish the precipitating events, management and eventual outcome from a different vantage point. Such a perspective would add the other side to a study which has examined processes

The welfare state from this perspective is viewed as a multi -functional heterogeneous set of political and administrative institutions in which social policy is defined by the goal of crises management.

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mainly from the point of view of the professionals.

A second possibility is a study of the impact of deinstitionalisation on the police use of Section 136. For example, will the police use the provision more frequently as a result of the hospital closure programme? Will new community facilities seek to disuade more disturbed clients neccessitating increased police involvement? Will the police be called upon to deal with social disruption, and the consequences of a likely lack of social and material support? And and will the possibility of increased police involvement lead to different ways of responding to psychiatric emegencies which occur in the community?. There are many aspects of Section 136 which could be pursued from this exploratory study. The items and ideas mentioned above are simply the ones that appear most pertinent to the researcher at the present time.

APPENDIX 1.

INTERVIEW AND OBSERVATION SCHEDULES

5. NATURE OF MENTAL DISORDER

6. DISPOSAL AND OUTCOME

Time of release
Transport to hospital and management problems
Interaction with hospital staff

7. SUBSEQUENT OUTCOME IF KNOWN

8. ALTERNATIVE COURSES OF ACTION

Charge, nature and likely outcome
Voluntary removal to hospital

5. NATURE OF MENTAL DISORDER

6. DISPOSAL AND OUTCOME

Time of release
Transport to hospital and management problems
Interaction with hospital staff

7. SUBSEQUENT OUTCOME IF KNOWN

8. ALTERNATIVE COURSES OF ACTION

Charge, nature and likely outcome
Voluntary removal to hospital

INTERVIEW SCHEDULE B

POLICE INTERVIEW SCHEDULE

REFERENCE NO

PRELIMINARY INFORMATION		Code	Col No
Card No		2	(1)
1. Case Number:	---		(2,3,4)
2. Interviewer	AR	1	
	AF	2	
	ER	3	(5)
3. Place of safety	Claybury	1	
	Whittington	2	(6)
	Other (specify)	3	

I. DETAILS OF OFFICER AND STATION

1. Rank:

Inspector	1	
Sergeant	2	
Constable	3	(10)
Other (state)	4	
Uncertain	8	

2. Police station to which subject was taken (to be coded later)

(11,12)

3. Sex:

Male	1	
Female	2	(13)

4. Ethnicity

Caucasian	1	(14)
Afro-Carribean	2	
Asian	3	
Other (specify)	4	
Uncertain	8	

5. Length of time in the service:

0-5 years	1	(15)
6-10 "	2	
11-15 "	3	
16-20 "	4	
21+	5	
Uncertain	8	
DNA	9	

6. Number of s136 cases dealt with in the past:

None	1	(16)
1-5	2	
6-10	3	
11-15	4	
16-20	5	
21+	6	
Uncertain	8	
DNA	9	

II. INCIDENT INFORMATION

1. Agent of Referral:

Police initiated	1	(19,20)
Self-referral	2	
Relative(s)	3	
Neighbour(s)	4	
Hospital/Soc Servs/Stat Agency	5	
Passerby/Stranger	6	
More than one of the above (specify)	7	
Other(specify)	8	
Uncertain/dont know	88	
Question not asked	99	

2. How did agent make contact with police?

Police on patrol	1	(21)
Local call to station	2	
999 call	3	
Attendance at station	4	
More than one of the above (specify)	5	
Other(specify)	6	
Uncertain	8	
QNA	9	

3. Were you aware <u>prior to attending the incident</u> that the subject may b mentally disordered?

Yes(state source of information)	1	(22)
No	2	
Uncertain	8	
QNA	9	

4. Place of arrest:

Street	1	(23,24)
Own home	2	
Someone else's home	3	
Shop	4	
Police station	5	
Own garden	6	
Someone else's garden	7	
Communal property	8	
Other(specify)	9	
Uncertain	88	
QNA	99	

5. Was the arrest in a place to which the public have access?(rate assessment)

Yes	1	(25)
No	2	
Uncertain	6	

6. For 'public place' arrests(ie. those coded 1 in 5. above), was the person coerced or otherwise moved into the place for the purposes of the provision?

NA	0	
Yes	1	
No	2	(26)
Uncertain	8	
ONA	9	

Describe incidents where coercion was used to move person into a publi place prior to arrest.

7. What were your reasons for arresting the person? (to be coded later):
(27)

8. What do you think would have happened if the police had not removed th person (open question to be coded later)?
(28)

III. INDICATIONS OF VIOLENCE

1. Was there any evidence of the following.?(rate most serious behavio only, include behaviours prior to arrest as well as subsequent to it)

a. Deliberate self injury

No	1	(35)
Verbal threat only	2	
Attempt at self injury but no harm done	3	
Minor injury inflicted	4	
Serious injury inflicted	5	
Uncertain	8	
Question not asked	9	

b. Where threat and/or injury is rated above, did it amount to a suici attempt (code NA for those coded 1. above)?

NA	0	(36)
Yes	1	
No	2	
Uncertain	8	
Question not asked	9	

c. Violence towards other persons (not including police)

No	1	(37)
Verbal threat only	2	
Attempt but no injury done	3	
Violence of a minor nature	4	
Violence of a serious nature	5	
Uncertain	6	
Question not asked	9	

Specify:

d. Violence towards the police

No	1	(38)
Verbal threat only	2	
Attempt but no injury done	3	
Violence of a minor nature	4	
Violence of a serious nature	5	
Uncertain	8	
Question not asked	9	

Specify:

e. Damage to property

No	1	(39)
Verbal threat only	2	
Attempt but no damage done	3	
Violence of a minor nature	4	
Violence of a serious nature	5	
Uncertain	8	
Question not asked	9	

Specify:

IV. POLICE MANAGEMENT OF MENTALLY DISORDERED PEOPLE

1. Transport to police station:

NA	1	(43)
Panda car	2	
Area car	3	
Van	4	
Foot	5	
Other	6	
Uncertain	8	
QNA	9	

2. How did you deal with the person prior to arrival at the station (to coded later)?

(44)

TEXT BOUND INTO

THE SPINE

e any of the following used as methods of management(at any time)?

Handcuffs

Yes	1	(45)
No	2	
Uncertain	8	
Question not asked	9	

Physical restraint

Yes	1	(46)
No	2	
Uncertain	8	
Question not asked	9	

Placed in cell

Yes	1	(47)
No	2	
Uncertain	8	
Question not asked	9	

hilst in custody, did the police do anything for the person at they would not normally have done for a person held in stody? State:

Yes	1	(48)
No	2	
Uncertain	8	
QNA	9	

ibe:

e. Self-injury

Yes	1	(57)
No	2	

f. Withdrawn behaviour/muteness

Yes	1	(58)
No	2	

g. Other (specify)

Yes	1	(59)
No	2	

4. a. Was mental disorder mentioned/suggested by any of the following?

	Yes	No	Unc	QNA	
Subject	1	2	8	9	(64)
Relative	1	2	8	9	(65)
Neighbour/friend	1	2	8	9	(66)
Divisional Surgeon	1	2	8	9	(67)
Social Worker	1	2	8	9	(68)
Previous police record	1	2	8	9	(69)
Information from local or assessing hospital	1	2	8	9	(70)
Other police officers who knew subject	1	2	8	9	(71)
Other (specify)	1	2	8	9	(72)

State nature of information (eg. diagnosis from assessment, known previous in-patient, etc. To be coded later)

(73)

b. Where information re mental disorder was provided above, how did influence the police officer's judgement/decision (code NA where information re mental disorder was given in a. above)?

N/A	0	(74)
No influence	1	
Acted to confirm police decision	2	
Was the main basis for police decision	3	
Uncertain	8	
QNA	9	

ard No 3 (1)

ubject No ___ (2,3,4)

I. DANGEROUSNESS RATINGS

. To what extent did person present a danger to him/herself?

Serious	1	(6)
Moderate	2	
A little	3	
Not at all	4	
Uncertain/dont know	8	
Question not asked	9	

hat is rating based?(open question; note distinction between actual and otential danger)

. To what extent did the person present a danger to other persons?

Serious	1	(7)
Moderate	2	
A little	3	
Not at all	4	
Uncertain/dont know	8	
Question not asked	9	

n what is rating based?(open question; note distinction between actual and otential danger)

II. FUNCTIONING

. To what extent was the person unable to care for him/herself?

Seriously incapable	1	(10)
Moderately incapable	2	
Slightly incapable	3	
Capable	4	
Uncertain/dont know	8	
Question not asked	9	

ate in what way:

III. CAUSATION OF MENTAL DISORDER

Which of the following does the officer consider to be the most likely use of the person's mental disorder?(present all the alternatives)

Family background and upbringing	1	(15)
City living, housing, poverty unemployment etc	2	
Disease of the mind, similar to a disease of the body	3	
More than one of the above(specify)	4	
Other(specify)	5	
Uncertain	8	
Question not asked	9	

Does the police officer consider the person a typical s136 case?

Yes	1	(16)
No	2	
Uncertain	8	
QNA	9	

State reasons:

X. POLICE DECISION MAKING

a. Had the person committed an offence for which he could be charged (question to be put to officer)?

Yes	1	(20)
No	2	
Uncertain	8	
QNA	9	

b. If yes above, what were the most likely grounds for a charge(open question to be coded later)?

(21,22)

c. If yes in a. above how serious does the officer consider the offence t
be?

NA	0	
Very serious	1	(23)
Moderately serious	2	
Not serious	3	
Uncertain	8	
DNA	9	

d. If yes in a. above, what was the primary reason why the officer di
not press charges(open question to be coded later)?

(24,25)

2. Did you give serious consideration to any other action apart from takin
the person to hospital under s136(open question; to be coded later)

(26)

3. a. Did the officer contact or attempt to contact a social worker in orde
to arrange an assessment?

Yes	1	(27)
No	2	
Uncertain	8	
DNA	9	

Give reasons:

b. If yes above, did the social worker assess the person?

NA	0	
Yes	1	(28)
No	2	
Uncertain	8	
DNA	9	

Describe interaction with social worker and result of assessment/ reason
for not assessing.

14. Did the officer contact or attempt to contact a divisional surgeon in order to arrange an assessment?

Yes	1	(29)
No	2	
Uncertain	8	
DNA	9	

Give reasons:

b. If yes above, what was the major purpose?

NA	0	
To decide whether the person was mentally ill	1	(30)
To assess a physical injury	2	
To persuade the hospital to accept the person	3	
To comply with force instructions	4	
Other (specify)	5	
Uncertain	8	
DNA	9	

Describe assessment and outcome:

X. LIAISON WITH HOSPITAL

1. When arranging the assessment, who did the police officer have contact with at the hospital (phone contact):

	Yes	No	Uncer	DNA	
Receptionist	1	2	8	9	(34)
Duty psychiatrist	1	2	8	9	(35)
Consultant psychiatrist	1	2	8	9	(36)
Nurses on the ward	1	2	8	9	(37)
Other (specify)	1	2	8	9	(38)

2. a. Were any problems or obstacles encountered by the police in obtaining an assessment?

Yes	1	(39)
No	2	
Uncert	8	
DNA	9	

b. Did any of the following problems arise? (no need to prompt, rater to assess from entire interview)

	Yes	No	Unc	DNA	
Wrong catchment area	1	2	8	9	(40)
No secure facilities	1	2	8	9	(41)
Shortage of beds	1	2	8	9	(42)
Black-listed patient	1	2	8	9	(43)
Patient considered unsuitable due to previous contact	1	2	8	9	(44)
Staffing problems	1	2	8	9	(45)

Describe nature of problems in full:

4. How long was the person at the station?

0-1 hour	1	(46)
1+-2 hours	2	
2+-3 hours	3	
3+-4 hours	4	
4+ hours	5	
Uncertain	8	
DNA	9	

5a. Did the police speak to any of the following persons at the hospital?

	Yes	No	Unc	QNA	
Receptionist	1	2	8	9	(49)
Duty psychiatrist	1	2	8	9	(50)
Nurses on ward	1	2	8	9	(51)
Other(specify)	1	2	8	9	(52)

b. What was sequence of contacts(open question)?

(53)

c. What information was requested and what was given(open question)?

(54)

d. Does the officer have any criticism of the way the hospital dealt with the case or with the police(open question to be coded later)?

(55)

e. How long did the officers wait at the hospital?

0-10minutes	1	(56,57)
11-30minutes	2	
31-60minutes	3	
1+ -2 hours	4	
2+ -4hours	5	
4+ -8hours	6	
8+hours	7	
Uncertain	88	
QNA	99	

f. Why did officers wait (note any requests by hospital staff;open question to be coded later)?

(58)

6. a .Does the officer know the outcome of the assessment?

No	1	(61)
Yes, waited at hospital	2	
Yes, informed by hospital	3	
Yes, informed by others	4	
Yes, subject come to police attention again	5	
Yes, by other means(specify	6	
Uncertain/dont know	6	
Question not asked	9	

b. If yes above, how satisfied was the officer with the outcome?

N/A	0	(62)
Very satisfied	1	
Satisfied	2	
Not satisfied	3	
Very dissatisfied	4	
Uncertain/dont know	8	
Question not asked	9	

Reasons for above rating(to be coded later): (63)

7. What does the officer think the psychiatric services should have provided for the person?(open question;to be coded later): (64)

8. In this case, what was the attitude of the hospital and psychiatrist towards the police? (police rating)

Positive	1	(65)
Indifferent	2	
Negative	3	
Uncertain	8	
QNA	9	

Reasons for above rating:

9. In this case, what was the attitude of the hospital and psychiatrist to the person?

Positive	1	(66)
Indifferent	2	
Negative	3	
Uncertain	8	
QNA	9	

XI. POLICE AND PSYCHIATRISTS; GENERAL POINTS. (These questions are not case specific).

1. What does the police officer think the job of a psychiatrist is in dealing with s136 cases and what sort of help can they provide for these people(to be coded later)? (69)

2. How effective does the officer think psychiatrists are in dealing with people referred to them by the police?

Effective	1	(70)
Ineffective	2	
Uncertain	8	
QNA	9	

Reasons for above rating(to be coded later): (71)

3. Are the police able to recognise people who are mentally disordered and if so, how able are they?:

Very able	1	(72)
Able	2	
Only with some difficulty	3	
Only with extreme difficulty	4	
Uncertain/dont know	8	
Question not asked	9	

4. Do you think psychiatrists take all possible factors into account when assessing a mentally disordered person referred by the police?

Yes	1	(73)
No	2	
Uncertain/Don't know	6	
Question not asked	9	

If no, what factors do they not take into consideration:
(open question, to be coded later) (74)

5. How much notice do you think psychiatrists take of the police account of the incident and the opinion of the police, in reaching their decision regarding the referred person?

No notice	1	(75)
Minimum notice	2	
Some notice	3	
A lot of notice	4	
Uncertain/dont know	8	
Question not asked	9	

6. In general, how would you best describe the relationship between the police and psychiatrists as compared to the relationship with GPs and other doctors?

Better	1	(76)
Same	2	
Worse	3	
Uncertain	8	
ONA	9	

Reason for above rating:

INTERVIEW SCHEDULE C

PSYCHIATRIST INTERVIEW SCHEDULE

REFERENCE NO

PRELIMINARY INFORMATION			Code	Col No
Card No			4	(1)
Case No			-------	(2,3,4)
Interviewer	AR		1	(5)
	AF		2	
	ER		3	
Place of safety	Claybury		1	(6)
	Whittington		2	
	Other (specify)		3	

I. DETAILS OF ASSESSMENT

1. Day of assessment

Weekday	1	(10)
Weekend	2	
Uncertain	8	
QNA	9	

2. Time of assessment

9am+-5pm	1	(11)
5+pm-midnight	2	
Midnight+-9am	3	
Uncertain	8	
QNA	9	

3. Approximate length of assessment under s136

0-15 mins	1	(12,13)
16-30mins	2	
31mins - 1 hour	3	
1+-2 hours	4	
2+-4 hours	5	
4+-24hours	6	
24+-71hours	7	
72hours	8	
Uncertain	88	
QNA	99	

4. Note any pecularities of assessment (eg timing, admissions prior to assessments etc; open question to be coded later):

II. POLICE ACTION

1. Did you meet the police when they brought the person in?

Yes	1	(20)
No	2	
Uncertain	8	
QNA	9	

If not, explain(to be coded later): (21)

2. Did the police provide you with information ?

Yes	1	(22)
No	2	
Uncertain	8	
QNA	9	

If yes, what information was provided(open question to be coded later) (23)

3. Did the police remain until the completion of your assessment ?

Yes	1	(24)
No	2	
Uncertain	8	
QNA	9	

If yes, state purpose and whether police remained at psychiatrist's request(to be coded later): (25)

If no, state reasons (to be coded later) (26)

4. Do you have any criticism of the police action ?

Yes	1	(27)
No	2	
Uncertain	8	
QNA	9	

Give your opinion about the way the police dealt with the person(+ve and -ve; open question to be coded): (28)

On the whole, do you think that the police made an appropriate referral the psychiatric services?

Yes	1	(29)
No	2	
Uncertain	8	
QNA	9	

no, state why (open question to be coded later):

(30)

Were the police made aware of the results of your assessment?

Yes	1	(31)
No	2	
Uncertain	8	
QNA	9	

yes, explain how police were informed(open question to be coded later)

(32)

Do you think it would have been more appropriate for the police to have harged the person or taken some other course of action?

Yes	1	(33)
No	2	
Uncertain	8	
QNA	9	

yes, explain what course would have been more appropriate and why (open stion to be coded later):

(34)

II. ASSESSMENT

At the time of interview is the key assessment

Complete	1	(39)
Ongoing	2	
Status unclear?	3	

At the time of assessment were you aware that the person had a previous sychiatric history?

Yes	1	(40)
No	2	
Uncertain	8	
QNA	9	

ive details of psychiatric history known at time of assessment (open uestion to be coded later):

(41)

. For those with a known psychiatric history at assessment(code NA for hose with no known history at assessment)

. Describe source(s) of information about psychiatric history(include ndirect sources such as from police via relatives)!

	NA	Yes	No	Uncert	QNA	
ersonal contact n the past	0	1	2	8	9	(42)
ospital case records	0	1	2	8	9	(43)
rom the subject	0	1	2	8	9	(44)
rom relatives	0	1	2	8	9	(45)
rom nursing staff	0	1	2	8	9	(46)
P	0	1	2	8	9	(47)
ther psychiatrists	0	1	2	8	9	(48)
he police	0	1	2	8	9	(49)
ther(specify)	0	1	2	8	9	(50)

. To what extent did the information on the person s previous psychiatric istory help you and in what way? (open question) (53)

. At the time of your assessment what information did you have about the erson's social situation including accommodation, support from relatives nd professionals etc (open question to be coded later)? (54,55) 56,57)

a.At the time of assessment, what was your diagnosis(to be coded later on CD classification)? (59,60)

. For those given a diagnosis above, how certain was the psychiatrist of hat diagnosis (include 'not mentally ill' diagnoses) (62)

NA	0
Very certain	1
Fairly certain	2
Uncertain	8
QNA	9

6. On what did you base your diagnosis? (open question to be coded later)
(63,64)

5. How would you rate the severity of the subject's condition compared to other patients you see(code NA for those not mentally ill)?

NA	0	
Less severely ill	1	(65)
About average	2	
More ill than most	3	
Uncertain	8	
QNA	9	

7. To what extent do you think that the subject's mental illness can be alleviated (code NA for those not mentally ill)?

NA	0	(66)
Considerably	1	
To some extent only	2	
Minimally	3	
Not at all	4	
Uncertain	8	
QNA	9	

In what way can the illness be alleviated (open question to be coded later)?
(67,68)

8. Would you rate the person's problems as primarily clinical or social?

Primarily clinical	1	(70)
Primarily social	2	
Both clinical and social	3	
Non existant	4	
Uncertain	8	
QNA	9	

9. To what extent did you think the person's functioning (ability to care for self) was impaired?

Seriously	1	(72)
Moderately	2	
A little	3	
Not at all	4	
Uncertain	8	
QNA	9	

In what way (open question to be coded later): (73)

IV. DANGEROUSNESS

1. To what extent did the person present a danger to him/herself? (74)

Serious	1
Moderate	2
A little	3
Not at all	4
Uncertain	8
ONA	9

On what is this rating based?(open question to be coded later; note distinctions between potential and actual danger) (75)

2. To what extent did the person present a danger to other persons? (76)

Serious	1
Moderate	2
A little	3
Not at all	4
Uncertain	8
ONA	9

On what is this rating based?(open question to be coded later; note distinctions between potential and actual danger) (77)

Card No 5 (1)

Case No _____ (2,3,4)

V. DISPOSAL

1.a. What was the decision you took after assessment? (9)

Decision pending	0
Discharge	1
Admission	2
Other(specify)	3
Uncertain	8
ONA	9

c. Where decision is pending what is the subject's current status?

NA	0	(10)
Detained under s136	1	
Informal	2	
Other	3	
Uncertain	8	
DNA	9	

For persons discharged (code NA where decision pending or subject discharged)

e. What was the primary reason for discharging the person?

NA	0	(11,12)
Not ill	1	
Not ill enough	2	
Could be supported in the community	3	
Refused to enter hospital and could not be forced	4	
More than one of the above (specify)	5	
Other(specify)	6	
Uncertain/dont know	88	
Question not asked	99	

f. What after care arrangements did you make?

NA	0	(13,14)
Referral to GP	1	
Outpatient appointment	2	
Referral to social worker	3	
Referral to community psychiatric nurse	4	
Referral to other(specify)	5	
A combination of the above(specify)	6	
None(explain why)	7	
Uncertain /dont know	88	
Question not asked	99	

g. Do you think that the after care arrangments made are satisfactory ?

NA	0	(20)
No after care arrangements made	1	
Yes	2	
No	3	
Uncertain/dont know	8	
Question not asked	9	

If no, explain why (open question to be coded later) (21)

d. Was the person given any treatment prior to leaving?

NA	0	(22)
Yes	1	
No	2	
Uncertain	8	
DNA	9	

If yes, describe(open question to be coded later) (23)

3. For persons admitted to hospital (code NA where subject discharged or decision pending)

a. What was the person's legal status upon admission? (29,30)

NA	0
Informal	1
Detained under s136	2
Detained under s4	3
Detained under s5	4
Detained under s2	5
Detained under s3	6
Other(specify)	7
Uncertain	8
QNA	9

b. What do you expect to be the benefits of admission (open question to be coded later)? (33,34)

c. How long do you think the person will need to remain in hospital? (35)

NA	0
1 day - 1 week	1
1+-2 weeks	2
2+-4 weeks	3
4+wks-3 months	4
3 months+	5
Uncertain	8
QNA	9

4. Are you generally satisfied with the decision you took on disposal? (36)

NA	0
Yes	1
No	2
Uncertain	8
QNA	9

If no, explain (to be coded later) (37)

. Were there any other courses of action that you could have taken apart rom hospital admission (open question to be coded later; DO NOT PROMPT)
(38,39)

I. SOCIAL WORKER ASSESSMENT

. Did a social worker assess the person prior to disposal (where decision pending, will a social worker be called?) ?

Yes	1	(45)
No	2	
Uncertain	8	
QNA	9	

. If no social worker was called, give reasons (open question to be coded ater)?
(46)

. If social worker called: (code NA if social worker assessment not omplete)

Was the assessment joint or independent (with assessing psychiatrist)?

NA	0	(48)
Joint	1	
Independent	2	
Uncertain	8	
QNA	9	

. Did the social worker arrive promptly after being called?

NA	0	(49)
Yes	1	
No	2	
Uncertain	8	
QNA	9	

f not, give reasons for delay:

. Was there any disagreement with the social worker on the final disposal?

NA	0	(50)
Yes(specify)	1	
No	2	
Uncertain	8	
QNA	9	

Describe: (51)

d. What was the purpose of calling a social worker (open question to be coded later)? (52)

e. What difference did the social worker make to the outcome of the assessment? What action would you have taken if the social worker had not attended (open question to be coded later)? (53)

f. What, if any, further role will the social worker have in this case?

NA	0
None	1
Ongoing (specify)	2
Other (specify)	3
Uncertain	8
QNA	9

(55)

Describe: (56)

VII. OTHER ASSESSMENTS

1. Was any other person called to assess the subject (where decision pending will any other person be called to assess)?

Yes (specify)	1
No	2
Uncertain	8
QNA	9

(59)

State: (to be coded later) (60)

VIII. ASSESSMENT DIFFICULTIES

1. Were there any difficulties in assessing the person?

Yes (describe)	1	(61)
No	2	
Uncertain	8	
QNA	9	

Describe difficulties (to be coded later) (62)

2. Were there any problems in managing the person at assessment?

Yes (describe)	1	(63)
No	2	
Uncertain	8	
QNA	9	

(scribe problems (to be coded later) (64)

IX. TREATMENT

1. Did the assessing psychiatrist prescribe any immediate treatment?

Yes	1	(68)
No	2	
Uncertain	8	
QNA	9	

Describe treatment: (to be coded later) (69)

Card No	6	(1)
Case No	___	(2,3,4)

X. PSYCHIATRISTS AND POLICE; GENERAL POINTS. (These questions are not case specific).

1. How capable do you think the police are of recognising people who are mentally disordered?

Very capable	1	(10)
capable	2	
Not capable	3	
Very uncapable	4	
Uncertain	8	
QNA	9	

2. What do you consider the role of the police to be, in dealing with mentally disordered people under s136? (open question to be coded later) (11)

3. How well do you think the police handle mentally disordered people in their custody?

Well	1	(12)
Not well	2	
Uncertain	8	
QNA	9	

If not well, give reasons: (open question to be coded later) (13)

4. Are there any particular areas in which you think the police handling of mentally disordered people is deficient (open question to be coded later) (14)

5. Do you think the police should generally remain until the assessment is complete?

Yes	1	(15)
No	2	
Uncertain	8	
QNA	9	

If yes give reasons(to be coded later) (16)

If no give reasons (to be coded later) (17)

6. In general, how would you describe the relationship between psychiatrists and the police?

Good	1	(19)
Indifferent	2	
Poor	3	
Uncertain	8	
QNA	9	

Comments:

7. In general do you think it is appropriate for police officers to deal with mentally disordered people?

Yes	1	(20)
No	2	
Uncertain	8	
DNA	9	

State reasons for above response (to be coded later) (21)

OBSERVATION SCHEDULE

ENCOUNTER NUMBER:

DATE:

TIME:

OFFICERS PRESENT/INVOLVED:

DETAILS OF THE SUBJECT

AGE:

SEX:

ETHNICITY:

OCCUPATION:

APPEARANCE:

CIRCUMSTANCES OF THE INCIDENT

BEHAVIOUR OF SUBJECT WHILST IN POLICE CUSTODY

POLICE/ACTION MANAGEMENT

NATURE OF POLICE INTERACTION

SHIFT INFORMATION

RESEARCHERS COMMENTS

INFORMATION SHEET: (STUDY B)

(Sociodemographic Features)

Card No ____ (1)

Case No. ____ (2,3,4)

Date of arrest (uncoded) _____

Name of subject (if available;uncoded): _____

Name of assessing psychiatrist (uncoded) _____

Date of psychiatrist interview (uncoded) _____

Police station (uncoded) _____

Name of police officer involved (uncoded) _____

Date of police interview (uncoded) _____

Name of treating psychiatrist (uncoded) _____

1. SOCIODEMOGRAPHIC INFORMATION

1. Sex	Male	1	(10)
	Female	2	
2. Age (specify in years)		___	(11,12)
3. Ethnicity	Afro-Carribean	1	(14)
	Asian	2	
	Greek/Cypriot/ Turkish	3	
	Irish	4	
	Other Caucasian	5	
	Arab	6	
	Chinese	7	
	Other (specify)	8	
	Uncertain	9	
4. Marital status	Married/cohabit	1	(15)
	Single	2	
	Separated, divorced (not cohabiting)	3	
	Widowed	4	
	Uncertain	8	

5. Employment status	Employed	1	(18)
	Unemployed	2	
	Houseworker	3	
	Retired	4	
	Other (specify)	5	
	Uncertain	8	
6. Accommodation (to be coded later)			(19)
7. Dependants	Yes	1	(20)
	No	2	
	Uncertain	8	

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