POLICE ENCOUNTERS WITH PEOPLE EXPERIENCING MENTAL ILLNESS

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Abstract

Situations involving people who, due to a mental illness, are unable to care for themselves or pose a threat to others are typically handled by the police. Dealing with people experiencing mental illness who are in crisis is inherently challenging work and police officers are often considered to be unprepared and unsupported. When resolving such encounters, police officers have a number of options, including formal dispositions, such as arrest or involuntary hospitalisation, and informal dispositions, such as calming the person down or ignoring the situation. Given that there is no single framework which can be applied to all encounters between law enforcement personnel and people experiencing mental illness, police officers are necessarily afforded some discretion when resolving these situations. Much research has been conducted regarding the factors which influence outcomes following police encounters with people experiencing mental illness. Among these are the policies and procedures which operate in different police organisations, the availability of community mental health resources, whether the encounter was invoked by the police or the public, and the characteristics of the offender and the police officers involved.

The broad aims of this thesis were to (i) describe police officers' perceptions regarding their experiences dealing with people experiencing mental illness in Victoria, Australia, (ii) describe police officers' attitudes toward working with people experiencing mental illness, and (iii) investigate the predictive capacity of police officers' attitudes regarding mental illness related to their preferred means for handling cases involving people experiencing mental illness.

Three main studies are reported. The first is an investigation of the current interface between police officers in Victoria and people experiencing mental illness. Based on survey data, findings related to the frequency of police contacts, the types of encounters, the signs and symptoms associated with mental illness and the challenges faced by police officers when performing these duties are reported.

The second study is an examination of police officers' attitudes toward people experiencing mental illness. Participants completed a survey measuring their attitudes and the results were then analysed using Principal Components Analysis (PCA). Analyses revealed four distinct themes underlying the attitudes of surveyed police officers. Broadly speaking, the officers held positive attitudes toward people experiencing mental illness, but negative attitudes about the system that cared for them. Multivariate analyses revealed that the measured attitudes were not associated with demographic characteristics.

The third study explored factors which are related to police officers' preferred means for resolving encounters with people experiencing mental illness. Participants watched one of three vignettes depicting an encounter with a man who might be mentally ill, and were asked to speculate on how they would "likely" and "ideally" resolve the encounter. Each of the vignettes differed according to the apparent severity of the man's psychiatric symptoms. Discriminant function analysis revealed that the outcomes chosen by officers were related to both the severity of the man's psychiatric symptoms and the officers' attitudes toward people experiencing mental illness.

These findings highlight the important role played by police officers in managing people in the community who experience mental illness. Some police officers surveyed felt unprepared for this role and many perceived that there was inadequate cooperation from mental health services. Given these challenges, it was important to

begin to understand police officers' attitudes to their work involving people experiencing mental illness. Following quasi-experimental analysis, these attitudes, among with other situational variables, were found to relate to outcomes chosen by police officers following their encounters with people experiencing mental illness.

Papers Published or Submitted During Candidature

Godfredson, J. W., Thomas, S. D., Ogloff, J. R. P., & Luebbers, S. (2010). Police

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Zealand Journal of Criminology.

Godfredson, J. W., Thomas, S.D., Ogloff, J. R. P., & Luebbers, S. (2010). Policing

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submitted to Law and Human Behavior.

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discretion and encounters with people experiencing mental illness: The

significant factors. *Criminal Justice and Behaviour.*

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Declaration for thesis based or partially based on conjointly published or unpublished work

General declaration

In accordance with Monash University Doctorate Regulation 17 / Doctor of Philosophy and Master of Philosophy (MPhil) regulations the following declarations are made:

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes three original papers published in peer reviewed journals. The core theme of this thesis is the relationship between police officers and people experiencing mental illness. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the candidate, working within the School of Psychology and Psychiatry under the supervision of Professor James Ogloff and Dr Stuart Thomas. The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into team-based research.

In the case of Chapters 3, 4 and 5 my contribution to the work involved the following:

Project design (in consultation with my supervisors); review of appropriate literature; securing ethics approval; recruitment of participants and all experimental testing; conducting data analyses (in consultation with data analysis advisor), and writing of papers. Supervisors provided input into completed manuscript drafts.

Thesis chapter	Publication title	Publication status	Nature and extent of candidate's contribution
3	Police perceptions of their encounters with individuals experiencing mental illness: A Victorian Survey.	Revised and re-submitted	As above
4	Policing people experiencing mental illness: Factoring in officers' attitudes.	Submitted	As above
5	Police Discretion and Encounters with People Experiencing Mental Illness: The Significant Factors	Accepted	As above

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INTRODUCTION

0.1 Thesis Outline

In this thesis we report an investigation of the relationship between police officers in Victoria, Australia, and people experiencing mental illness. The thesis comprises six chapters and includes one manuscript accepted for publication, one revised and resubmitted manuscript and one submitted manuscript.

Chapter 1 is an introduction to the interface between the police and people experiencing mental illness. This includes a review of the literature regarding the historical context of this relationship, current legal principles, challenges faced by police officers, police officers' attitudes regarding mental illness and factors associated with outcomes following police encounters with people experiencing mental illness.

Chapter 2 describes the overarching methodology of the three studies which comprise this thesis. The studies are drawn from two data collection phases, including a pilot study, and a state-wide survey of police officers in Victoria, Australia.

Chapter 3 reports police officers' perceptions of their experiences dealing with people experiencing mental illness in Victoria, Australia. We report an investigation regarding the estimated frequency of contacts between police officers and people experiencing mental illness, describe the types of encounters, report signs and symptoms police believe are associated with mental illness and the challenges police officers report being faced with when dealing with people experiencing mental illness.

Chapter 4 describes the attitudes of police officers toward people experiencing mental illness as measured via a newly established attitudinal survey, the Mental Health Attitude Survey for Police (MHASP; Clayfield, Fletcher & Grudzinskas, 2009). Police

officers' attitudes are described along four dimensions as determined by factor analyses and were found to not relate to their demographic characteristics.

Chapter 5 reports results of a study in which attitudinal dimensions as measured using the MHASP are used to discriminate among outcomes chosen by officers after viewing a hypothetical encounter between two police officers and a person who might be experiencing mental illness.

Chapter 6 is a general discussion in which the broader implications of these studies are considered. These include implications for the police force and mental health system.

0.2 Research Aims

Prior to beginning this thesis, it is helpful to understand the broad aims of this research.

0.2.1 Research Aim One

Much overseas research has examined the relationship between police officers and people experiencing mental illness; however, to date no large scale study has explored this in the Australian context. *Therefore, the first research aim is to describe police officers' perceptions regarding their experiences dealing with people experiencing mental illness in Victoria, Australia.* Details are primarily reported in Chapter 2.

0.2.2 Research Aim Two

Given the challenges faced by police officers when dealing with people experiencing mental illness and the importance of their role, it is pertinent to understand police officers' attitudes regarding this type of work. *Therefore, the second research*

aim is to describe police officers' attitudes toward working with people experiencing

mental illness. Details are primarily reported in Chapter 3.

0.2.3 Research Aim Three

Although limited research has been conducted regarding police officers'

attitudes related to mental illness, to date no researchers have attempted to explore the

relationship between attitudes and dispositional outcomes following police officers'

encounters with people experiencing mental illness. *Therefore, the third aim is to*

investigate the predictive capacity of police officers' attitudes regarding mental illness

related to their preferred means for handling cases involving people experiencing

mental illness. Details are reported in Chapter 4.

CHAPTER 1: LITERATURE REVIEW

1.1 Introduction

It has long been recognised that the police stand at the forefront of the interaction between the criminal justice and mental health systems (Bittner, 1967). By fulfilling their legally sanctioned role in the management of people experiencing mental illness, police officers have earned themselves such titles as 'agents of social control for the mentally ill' (Bonovitz & Bonovtiz, 1981), 'psychiatrists in blue', 'psychiatric medics', (Menzies, 1987), 'street corner psychiatrists' (Teplin & Pruett, 1992), 'front line mental health workers' (Green, 1997), and 'de facto mental health professionals' (Patch & Arrigo, 1999). Over the years, several factors such as deinstitutionalisation, increasingly restrictive involuntary commitment criteria, and a limited availability of community-based mental health services have been thought to increase the involvement of the police in dealing with people experiencing mental illness (Bonovitz & Bonovitz, 1981; Menzies, 1987; Pogrebin & Poole, 1987; Teplin & Pruett, 1992). Parallel with this trend, has been a high prevalence of people found to be experiencing mental illness in police cells (Ogloff, Warren, Tye, Blaher & Thomas, 2010) and prisons (Butler & Allnut, 2003; Fazel & Danesh, 2002; Ogloff, 2003). There is little doubt that mental health issues exist across all phases of criminal justice process. But it is the police who act as the first point of contact for many people with mental illness who are experiencing a crisis in the community.

In most countries, the involvement of the police in dealing with people experiencing mental illness is implicit in two legal principles, including 1) to protect the safety and welfare of the public, and 2) 'parens patriae', which describes protection for the disabled or otherwise incapacitated citizen (Teplin, 2000). In

Australia, these principles are implicit in the relevant states' mental health acts (e.g., *Mental Health Act 1986* (Vic)). Although these legal concepts outline the relatively limited responsibility of the police regarding the protection of people who present as a threat to themselves or others, it has long been recognised that they do not represent a framework which the police can apply to specific instances (Bittner, 1967). Often times, the police deal with people for whom it is not obvious whether dispositions which lead to the involvement of the criminal justice or mental health systems should be invoked. Even if the involvement of mental health support services is deemed essential, police officers often face insurmountable obstacles when attempting to access these services.

When faced with the ambiguity inherent in their encounters with people experiencing mental illness, members of the police force must exercise careful judgement. In this thesis, this power afforded to police officers is referred to as 'police discretion'. Much research has examined factors which are associated with police discretion as it applies to people experiencing mental illness. The types of variables which have been examined include the resources available to the police (Borum et al., 1998), offenders' mental state and gender (Finn & Stalans, 1997) and the knowledge, experience (Green, 1997; Teplin, 2000) and level of education (LaGrange, 2003) of police officers.

Given the ongoing challenges faced by police officers when dealing with people experiencing mental illness, it is perhaps surprising that only one prior study has incorporated police officers' attitudes as determinants of outcomes for these people (Green, 1997). An understanding of the relationship between police officers' attitudes and police discretion is important because it follows that variability in

police decision making is likely to be associated with variable outcomes for people experiencing mental illness.

The purpose of this chapter is to review the literature regarding the involvement of the police in the management of people experiencing mental illness. There are four sections in this chapter, followed by a description of three proposed studies which aim to apply and extend this body of knowledge in an Australian context. First, the historical context and an examination of criminalisation theory will be provided. Second, the current legal context governing the involvement of police with people experiencing mental illness will be discussed, together with the challenges inherent in this interface. Third, the issue of police discretion will be discussed, including a review of the literature concerning the factors which have been found to relate to police officers' decision making. These factors include the resources available to police officers, the characteristics of offenders, and the characteristics of police officers, such as their education, training and experience. Fourth, research regarding police officers' attitudes regarding people experiencing mental illness will be reviewed. In this section it will be highlighted that the relationship between police officers' attitudes and their decision making following encounters with people experiencing mental illness has not yet been thoroughly explored. Finally, a series of studies which will address this gap in understanding will be proposed.

1.2 Historical and Theoretical Context

In this section, historical factors that have contributed to police involvement with people experiencing mental illness will be examined. To provide a framework for this discussion, a number of tenets associated with criminalisation theory will be

explored. This will include a discussion of deinstitutionalisation and a review of research which has attempted to explain police contacts with, and arrest rates of, people experiencing mental illness.

Few researchers have examined whether police contacts with people experiencing mental illness have increased over time. Bonovitz and Bonovitz (1981) reported that between 1975 and 1979 in the US, there was a 227.6% increase in mental illness related incidents which came to police attention. In Australia, the police have also reported an increase in contacts with people experiencing mental illness; however, these reports are solely anecdotal (Wylie & Wilson, 1990). Around the time these trends were first observed, Abramson (1972) proposed the 'criminalisation' hypothesis. Patch and Arrigo (1999) define this as *'the police invoking criminal justice rather than mental health options for dealing with mentally ill people'*. Junginger, Claypoole, Laygo and Crisanti (2006) cite the literal interpretation of the criminalisation hypothesis offered by the National Alliance on Mental Illness, which is based on two tenets, including, *'1) that people who exhibit signs of mental illness are more likely to be arrested than people not showing such signs,* and *2) that the symptoms of mental illness play a causal role in offending behaviour'*. These tenets are not mutually exclusive and they rely on different types of evidence to determine their usefulness in explaining the nature of the contact between police officers' and those experiencing mental illness. Therefore, these tenets of criminalisation theory provide a useful framework with which to explore the interface between police officers and people experiencing mental illness. Before examining the evidence for these tenets, however, it is important to briefly review deinstitutionalisation which, arguably, laid the foundations for greater interface between the mental health and criminal justice systems.

1.2.1 Deinstitutionalisation

Beginning in the early 1960s in the United States, mental health systems saw fundamental change in the methods used to treat and accommodate people experiencing mental illness. Those patients who had been living in psychiatric institutions were accommodated back with their families, in residential units or elsewhere in the community (Wachholz & Mullaly, 1993). The rationale for re-locating these people was to provide for them more humane surroundings and a better chance for rehabilitation. Legally, it was successfully argued that detaining people experiencing mental illness in hospitals involuntarily when they were not at risk of serious harm to themselves or others was a violation of their civil rights (see Melton, Petrila, Poythress, & Slobogin, 2007). In part, this opportunity was facilitated by the discovery of pharmacological therapies which could control some of the symptoms associated with mental illness. The process of deinstitutionalisation was also motivated by economic factors. As is the case today, the cost of caring for people experiencing mental illness in inpatient settings was considered to be far greater than caring for them in the community. Taken together, these factors provided considerable support for limiting the availability of involuntary psychiatric hospitalisation for caring for people experiencing mental illness. Accordingly, laws were enacted which enhanced the rights of people experiencing mental illness, and civil commitment criteria were tightened (Patch & Arrigo, 1999). Many countries around the world, including Australia, adopted these principles. According to New South Wales Department of Health statistics, in 1963 there were 12,717 psychiatric inpatients who had an average inpatient stay of 11 months. In contrast, in 1989 there were 2,031 psychiatric inpatients with an average length of stay estimated to be between one and three weeks (Wylie & Wilson, 1990).

As first noted by Abramson (1972), deinstitutionalisation had a number of negative side-effects. Due to inadequate government funding for suitable facilities and staff to care for people experiencing mental illness in the community, many people who had been treated in psychiatric institutions were apparently being dealt with by the criminal justice system (Wachholz & Mullaly, 1993). At the present time there is a large proportion of people experiencing mental illness housed in gaols and prisons both in Australia (Butler & Allnutt, 2003; Ogloff, 2003) and abroad (Fazel & Danesh, 2002). While on the one hand this might reflect a steady rise in the actual numbers of people with mental illness living in prisons (Davis, 1992), it might also reflect improved forensic mental health practices and an increased awareness of mental illness. According to McLearen and Ryba (2003) such trends may also be attributed to police misidentification of psychosis as intoxication, although there are no data to confirm this.

1.2.2 Evidence for Criminalisation Theory

Literature concerning the interface between the police and people experiencing mental illness is replete with citations regarding deinstitutionalisation and its purported relationship to the criminalisation process. Nearly thirty years ago evidence ostensibly in support of criminalisation theory (Patch & Arrigo, 1999) was reported by Bonovitz and Bonovitz (1981) following their finding of an increase in police contact with people experiencing mental illness (Bonovitz & Bonovitz, 1981). Furthermore, Rabkin (1979) compared the arrest rates of former psychiatric patients prior to and after 1965 and found that those who had been discharged from psychiatric hospitals after 1965 were more likely to be arrested. The rarely articulated assumption is that had deinstitionalisaiton not occurred and psychiatric

patients remained housed involuntarily in hospitals, then the police would not need to deal with them. However, as will be explored in the following section, investigations regarding arrest rates of people experiencing mental illness relative to those without mental illness have led to inconsistent conclusions.

As previously stated, the first tenet of the criminalisation hypothesis offered by the National Alliance on Mental Illness is *that people who exhibit signs of mental illness are more likely to be arrested than people not showing such signs.* In an observational study of 1,396 police-citizen encounters in the US, Teplin and Pruett (1992) found that the arrest rate for mentally disordered offenders was twice that of non-mentally disordered offenders (46.7% versus 27.9%). A similar pattern of results has been also been found by research conducted much earlier (e.g., Sosowsky, 1978; Zirtin, Hardesty, Burdock, et al., 1976). To explain their findings, Teplin and Pruett speculated that the police might actually resort to arrest as a way of handling or resolving encounters with people experiencing mental illness. The researchers reported that police officers used arrest in three types of situations: 1) when officers believed that the person would not be accepted by hospital admission staff; 2) in situations which were highly visible and considered to be offensive by the public; and 3) in situations when the police felt that there was a high likelihood that the person would continue to cause a problem and result in the police having to return to the scene.

A number of researchers have highlighted the difficulties faced by police officers when attempting to facilitate a hospital admission for a person experiencing mental illness (Bonovitz & Bonovitz, 1981; Green, 1997; Lamb, 1982); these will be reviewed in greater detail in the 'legal context' section of this chapter. According to Holley and Arboleda-Florez (1988), compared to other dispositions, arrest offers a

degree of control and familiarity for the police. Furthermore, the outcome of this response is relatively predictable; suspects cannot be rejected from police holding cells on the basis of ineligibility. The process of handling people experiencing mental illness via arrest, which has been termed 'mercy booking' (Lamb & Weinberger, 1998), has also been discussed by other researchers (e.g., Lamb, 1982; Monahan, Caldeiera, & Friedlander, 1979).

Not all researchers have replicated Teplin and Pruett's findings, however. Although Bonovitz and Bonovitz (1981) reported an increase in police encounters with people experiencing mental illness, they also reported that officers were reluctant to use arrest as a means for dealing with these people in non-dangerous incidents. In fact, some officers reported the belief that people experiencing mental illness should not be considered responsible for minor criminal offences. Similarly, Hiday (1992) examined follow-up data from 1226 candidates for initial civil commitment hearings and found that there were few arrests (5.9%) in the six months following the court hearings and that most of the arrests (50.9%) were accounted for by a small proportion (1.6%) of the entire sample. Combined with the finding that nuisance crimes represented only a small proportion of arrests, Hiday, like Bonovitz and Bonovitz, took her results to infer that the police *do not* resort to arrest to 'handle' people experiencing mental illness. Engel and Silver (2001) also examined the relationship between suspects' mental health and the use of arrest by police. After taking into account the influence of legal and extra-legal factors, they found that the police were in fact not more likely to arrest suspects experiencing mental illness; thus interpreting their findings as evidence against the criminalisation hypothesis.

It is possible that the use of different approaches to data analysis might have contributed to variability in the aforementioned research findings. Whereas Engel

and Silver took into account differences attributable to demographic variables, including suspects' gender, age, race, homelessness, alcohol and drug use, disrespect and non-compliance, Teplin and Pruett did not. It is possible that variables such as drug and alcohol use, disrespect and non-compliance are actually behaviours which are more prominent among people experiencing mental illness, thus making them more likely to attract police attention. By removing the differences attributable to these variables, Engel and Silver might have also removed the variance attributable to mental illness. This hypothesis is supported by the high comorbidity between mental illness, substance abuse (e.g., Swartz & Luigio, 1999), and antisocial behaviour in prison populations. Further, Rabkin (1979) and Steadman (1982) both posited that crime among people experiencing mental illness can be predicted by the same factors that predict crime among the general population, including class, race, gender, age and prior criminality. Following a meta-analysis of 131 studies, Gendreeau, Little and Goggin (2006) reported that among the strongest predictors of adult offender recidivism were criminogenic needs, which are dynamic or changeable factors including peer group, attitudes and values, problem solving skills, substance use and employment status. Other strong predictors included criminal history/history of antisocial behaviour, social achievement, age/gender/race and family factors (see also Bonta, Law & Hanson, 1998). Factors with a lower predictive capacity included intellectual functioning, personal distress factors and socioeconomic status in family of origin. Importantly, these findings suggest that offending behaviour results from an interaction between a number of competing factors, and cannot be understood in the context of isolated variables, for example, mental illness.

It is also possible that methodological factors contributed to the discrepant findings of Engel and Silver and those of Teplin and Pruett. For example, there are differences in both research teams' approaches to data collection. Whereas Teplin and Pruett relied on mental health fieldworkers to determine the presence of psychiatric symptomatology, Engel and Silver relied on the ratings of police officers. It is possible that some participants identified in Engel and Silver's study by police officers as being mentally ill were, in fact, false negatives; in other words, the officers might have incorrectly believed some participants were not experiencing mental illness. From this it follows that one plausible explanation for the high rates of arrest among people experiencing mental illness is because their psychiatric symptoms are not active or otherwise apparent to police officers. This hypothesis is supported by Finn and Stalan's (1997) finding that if a police officer is certain a person is experiencing mental illness (i.e., they read a hypothetical scenario depicting a suspect who is described as experiencing mental illness), they report being less likely to resort to arrest them than if the person was not described as mentally ill. Additional support for this hypothesis comes from the finding that the police who took part in Teplin and Pruett's study identified just half of those identified as experiencing symptoms of mental illness by fieldworkers. It is possible that officers' attempts to determine a suspect's mental state might sometimes be thwarted by a suspect's socially inappropriate behaviour, non-compliance or intoxicated state. In fact, the symptoms of mental illness, which might include socially inappropriate behaviour and mannerisms, could have led some officers to adopt a more punitive response; however, there are no research findings which confirm or deny this.

Evidently, contradictory findings exist with regard to whether there are in fact increased rates of arrest among people experiencing mental illness relative to people

without mental illness. While some researchers suggest that police officers, in line with criminalisation theory, resort to arrest for dealing with people experiencing mental illness, others argue that police officers are reluctant to use this approach.

1.2.3 Relationship between Psychiatric Symptoms and Offending

More recently, researchers have examined the role of psychiatric symptoms in leading to high arrest rates of people experiencing mental illness. Junginger and colleagues (2006) examined the effect of serious mental illness on criminal offending by reading 113 police report descriptions of criminal offences. The researchers found that substance abuse led to a minority of offences and was more likely than mental illness to lead to an offence. The researchers concluded that their findings were evidence against the criminalisation hypothesis. Notably, the retrospective analysis used in this study was based on the researchers' subjective evaluations of the causes of individual instances of criminal behaviour. To explain criminal behaviour, Junginger and colleagues came to the same conclusion as previous researchers (e.g., Engel & Silver, 2001; Monahan & Steadman, 1982; Rabkin, 1979); that is, criminal acts most likely result from risk factors for crime which are more common in the social settings of people experiencing mental illness. Other researchers utilising more rigorous methodologies have come to different conclusions regarding the role of mental illness in offending behaviour. For example, following a comparison of criminal records of 2,861 patients whose first hospital admission was related to schizophrenia and community subjects matched on demographic variables, Wallace, Mullen and Burgess (2004) concluded that high rates of contact between police officers and individuals with mental illnesses can be explained by an increased risk of violence and substance use among people who have a mental illness. Other

researchers have also reported that the link between violence and mental illness is compounded by drug use (Ferguson, Ogloff & Thomson, 2009).

Studies which seek to inform the criminalisation theory have yielded variable and sometimes contradictory conclusions. The main problem is that no reliable epidemiological data exist regarding the prevalence of mental illness in the criminal justice system prior to deinstitutionalisation. Most researchers would agree that criminal behaviour arises as a result of a number of interacting variables, among which include sociodemographic variables and symptoms of mental illness. And there is little doubt that the landscape of the mental health and criminal justice systems plays an important role in determining the way in which the behaviour of people experiencing mental illness is managed. In the third section of this chapter, a number of variables which might further inform a discussion of criminalisation theory will be discussed. These include various factors which have been found to relate to police officers' decision making outcomes following encounters with people experiencing mental illness. Prior to examining these variables it is useful to first consider the legal context of police involvement in situations involving people experiencing mental illness.

1.3 Legal Context and Challenges Faced by Police Officers

This section describes the legal concepts which govern police involvement in situations involving people experiencing mental illness. Some of the ambiguities associated with these principles will be discussed, together with an examination of some challenges faced by police officers when trying to enact their discretionary powers.

In many countries, police officers are afforded special responsibilities regarding the involuntary apprehension and detention of people experiencing mental illness who are in crisis. Police officers' powers to apprehend people experiencing mental illness are provided in the *Mental Health Act 1986* (Vic). According to the *Act*, a person is mentally ill if he or she has a mental illness, "being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory" (s. 8). In the case of those people experiencing mental illness who are unable to care for themselves, or pose a risk of harm to themselves or others, the *Act* has provisions for their involuntary detention and treatment. The *Act* also has provisions for such people to be forcibly taken to a mental health facility for assessment by members of the police force. According to Section 10 of the *Act*:

(1) A member of the police force may apprehend a person who appears to be mentally ill if the member of the police force has reasonable grounds for believing that-

  (a) the person has recently attempted suicide or attempted to cause serious bodily harm to herself or himself or to some other person; or

  (b) the person is likely by act or neglect to attempt suicide or to cause serious bodily harm to herself or himself or to some other person.

(1A) A member of the police force is not required for the purposes of subsection (1) to exercise any clinical judgment as to whether a person is mentally ill but may exercise the powers conferred by this section if, having regard to the behaviour and appearance of the person, the person appears to the member of the police force to be mentally ill.

(2) For the purpose of apprehending a person under subsection (1) a member of the police force may with such assistance as is required-

  (a) enter any premises; and

  (b) use such force as may be reasonably necessary.

(3) A member of the police force exercising the powers conferred by this section may be accompanied by a registered medical practitioner or a mental health practitioner.

(4) A member of the police force must, as soon as practicable after apprehending a person under subsection (1), arrange for-
   (a) an examination of the person by a registered medical practitioner; or
   (b) an assessment of the person by a mental health practitioner.

(5) The mental health practitioner may assess the person, having regard to the criteria in section 8(1) and-
   (a) advise the member of the police force to-
   (i) arrange for an examination of the person by a registered medical practitioner; or
   (ii) release the person from apprehension under this section; or
   (b) complete an authority to transport the person to an approved mental health service in accordance with section 9A(1).

(6) If the mental health practitioner assesses the person and advises the member of the police force to arrange for an examination of the person by a registered medical practitioner the member of the police force must do so as soon as practicable.

(7) If the mental health practitioner assesses the person and advises the member of the police force to release the person from apprehension under this section the member must do so unless the member arranges for a personal examination of the person by a registered medical practitioner.

(8) If an arrangement is made under this section to have a person examined by a registered medical practitioner, a registered medical practitioner may examine the person for the purposes of section 9.

(9) Nothing in this section limits-

(a) any other powers of a registered medical practitioner or mental health practitioner in relation to that person under this *Act*; or

(b) any other powers of a member of the police force in relation to that person.

In those situations where a person experiencing mental illness has committed a serious crime, police officers' responses are typically straightforward: to arrest the individual and transport them to police holding cells. According Wylie and Wilson (1990), however, these situations are the exception rather than the rule. Less than 5% of 65 NSW police officers surveyed reported 'arrest' as the outcome of their last encounter with a person experiencing mental illness.

Police officers' responses are also straightforward in those situations involving people experiencing mental illnesses who meet strict involuntary admission criteria and are not in breach of the law: to apprehend the individual and take them to hospital for assessment by a medical practitioner. However, police officers are sometimes reluctant to take people to hospital. Teplin and Pruett reported that only 13.3% of suspects and 10.9% of the non-suspects who were assessed by fieldworkers as experiencing mental illness were taken to hospital. Police officers were reportedly cognisant of the stringent requirements for admission to hospital; that is, the person had to be actively delusional or suicidal. Similarly, it was believed by police that people with pending criminal charges were not likely to be accepted. In an earlier study, Lamb (1982) reported that officers were reluctant to take people experiencing mental illness to hospital because they believed the person would be refused admission as they did not meet the involuntary commitment criteria, or that there would be a shortage of beds. The initiation of involuntary hospitalisation procedures is perceived by police officers to be cumbersome, time-consuming

(Holley & Arboleda-Florez, 1988) and a waste of resources as it is often felt that the patient will be soon back on the street (Teplin & Pruett, 1992). Over thirty years ago, Monahan, Caldeira and Friedlander (1978) reported that 30% of individuals who were arrested could have been involuntarily committed. Apparently, commitment was not pursued as officers did not believe the severity of mental illness was sufficient to warrant admission. Green (1997) also found that officers avoided initiating hospital admissions due to a perception that beds were lacking. Police officers surveyed by Bonovitz and Bonovitz (1981) reported that it had become more difficult to have people admitted to hospital and that even if people were admitted to hospital, their stay was likely to be short. Green also discussed the effects of officers' beliefs regarding the accessibility of community mental health treatment. He reported that more experienced officers in Hawaii chose not to take people experiencing mental illness to hospital as they felt it resulted in unsatisfactory outcomes. The difference in Green's study, however, was that officers did not resort to arrest to handle the people. Rather, the officers felt that informal dispositions were the most effective way of dealing with people experiencing mental illness (Bonovitz & Bonovitz, 1981; Green, 1997; Lamb, 1982).

Police officers often face considerable difficulties when attempting to facilitate hospital admissions for people experiencing mental illness; however, there are individuals from other professions who are also affected by these difficulties. In a recent review of literature, Fisher (2007) highlighted the problems faced by nursing staff in the dual role of controlling the behaviour of violent patients (a small number of whom account for the majority of violent incidents) and providing care to patients. In one study reviewed by Fisher, it was found that 88% of nurses surveyed had been assaulted by patients, and that 97% of patients who assaulted staff were involuntary

patients (Delany, Cleary, Jordan & Horsfall, 1999). The difficulties inherent in managing people experiencing mental illness who are considered dangerous are likely to lead to conflict between police and hospital and personnel regarding appropriate courses of action. However, the power and influence of the police in invoking community mental health resources should not be underestimated. Durham, Carr and Pierce (1984) compared involuntary referrals in which the police were and were not involved. In those situations where a person was referred for civil commitment without police involvement, 19% of people were accepted for commitment by hospital admissions staff. In contrast, 39.2% of people referred for civil commitment by police officers were accepted. These differences might be attributable not only to the power and influence of police officers, but the fact that police officers probably have a relatively high threshold for bringing people to hospital.

The results of the small-scale survey conducted by Wylie and Wilson (1990) suggest that, for various reasons, both arrest and hospitalisation might be relatively uncommon outcomes following Australian police officers' encounters with people experiencing mental illness. Further research is needed to describe the circumstances surrounding these outcomes, including the factors which differentiate these situations from those which are ignored or handled informally by police officers.

Some researchers have expressed concern regarding police officers' skills in recognising mental illnesses (Bittner, 1967; Green, 1997). Although this responsibility is not explicitly prescribed, it is implied in the duties that police officers must perform. The *Mental Health Act 1986* (Vic) states that "a member of the police force is not required… to exercise any clinical judgement as to whether a person is mentally ill" (p. 27). However, the *Act* goes on to say that the police may

apprehend a person who "appears to be mentally ill". Irrespective of the way in which identifying and inferring the importance of psychopathological symptoms differs from 'clinical judgement', police officers must therefore arrive at a decision to invoke criminal justice or mental health outcomes. Of course, this begs the question whether officers are accurate in their determinations. To reconcile the findings that people experiencing mental illness were (Teplin & Pruett, 1992) and were not (Engel & Silver, 2001) more likely to be arrested than people not experiencing mental illness, it was proposed that the officers in Engel and Silver's study might have actually failed to recognise psychiatric symptomatology. However, the hypothesis that police officers might not always identify the signs, symptoms and behaviours of mental illness is not supported by anecdotal evidence from police officers. Green (1997) reported that although they had not received any training on how to recognise and deal with people experiencing mental illness, all of the police officers interviewed believed that they could identify serious psychiatric symptoms, although they felt less confident identifying comorbid mental illness and substance use. In contrast, Cherrett (1995) found that 38% of patrol officers in the Gwent Constabulary in the United Kingdom reported that they were not adequately trained to deal with situations involving people experiencing mental illness. The author, whom herself is a police constable, suggested that those who were confident dealing with people experiencing mental illness gained their skills not through any training, but as a result of experience.

Most likely, the differences in cited research reflect methodological variation, as well as real world differences in the policies and procedures of police organisations in various jurisdictions. In any case, there is a need for future research to systematically examine the accuracy of the judgement of police officers when

determining a person's mental health needs. Such research should also examine the inferences made by the police regarding people experiencing mental illness when their symptoms are not recognised as indicative of mental illness. In particular, future research should test the hypothesis that the police sometimes arrest people experiencing mental illness not to 'handle' them, but because the symptoms of an unrecognised mental illness are taken to infer culpability and/or dangerousness, or as hypothesised by McLearen and Ryba (2003), that psychosis is sometimes misidentified as intoxication. Future research should also examine whether 'confidence' and 'competence', in terms of police officers' abilities to recognise the signs and symptoms of mental illness, necessarily go hand in hand.

1.4 Police Discretion

Although common law directs police officers to protect the public and people experiencing mental illness from harm, this law does not stipulate how police officers should respond in any given situation. In situations where a person experiencing mental illness is considered too dangerous to be admitted to hospital, yet too unwell to remain on the streets, the outcome is somewhat dependent on the discretion of the officer(s) involved (Teplin & Pruett, 1992). Such discretion is also required in situations involving people who are unlikely to meet the now strict criteria for involuntary hospitalisation. In these instances, police discretion can encompass the use of less formal tactics, such as calming a person down or taking them home as 'psychiatric first aid' (Bittner, 1967).

By exercising their discretion, it has been proposed that the police have the power to determine whether an individual should progress through the mental health or criminal justice systems (Bittner, 1967; Pogrebin & Poole, 1987; Teplin, 1984;

Teplin & Pruett, 1992; Wachholz & Mullaly, 1993). According to Teplin (1984), by fulfilling this role, the police function as a front line community health resource. Conversely, critical criminologists argue that although the police function for the welfare state, they actually inhibit the development of long-term policies for people experiencing mental illness (Wachholz & Mullaly, 1993). Lamb, Weinberger and DeCuir (2002) suggest that if the police do not do their job properly, the result is criminalisation. Indeed, once criminal proceedings, including arrest, have been invoked, they are extremely difficult to stop. Goldstein (1960) takes yet another perspective, suggesting that the 'low visibility' decisions not to invoke the law made by police prevent a judge or jury from determining guilt.

A review of challenges faced by police officers when attempting to enact various outcomes following their encounters with people experiencing mental illness revealed that the options available to police officers are constrained by inadequate community mental health resources. Nevertheless, police discretion affords police officers with the power to make important decisions relating to the handling of people experiencing mental illness. Therefore, it is important to review some of the factors which have been found to influence the outcome of these decisions.

In the next section, the factors which influence police officers' decision making following encounters with people experiencing mental illness will be discussed. This will include a discussion of the resources available to police officers, situational and contextual variables, and characteristics of both offenders and police officers.

1.4.1 Resources Available to Police

Some researchers have found that police officers' responses to situations involving people experiencing mental illness are constrained by the policies and procedures which govern individual police departments. Borum, Deane, Steadman and Morrissey (1998), surveyed police officers from three police agencies in the United States each of which had different systems for dealing with crisis calls involving people experiencing mental illness. The three departments included: 1) Knoxville, Tennessee, which relied on field assistance from a mobile mental health crisis team, 2) Birmingham, Alabama, which had a team of officers specially trained in crisis intervention and management of people experiencing mental illness in crisis, and 3) Memphis, Tennessee, which had a team of in-house social workers to assist in responding to calls. Police officers who were from the departments which relied on mobile support teams and had in-house social workers rated their programs as being moderately effective in meeting the needs of people experiencing mental illness in crisis, keeping these people out of jail and maintaining community safety. Police officers from Memphis, whose police department has a specially trained Crisis Intervention Team, rated their program as highly effective in these areas. It should be noted, however, that the officers in the Crisis Intervention Team volunteered for this program, and as such might already have considerable awareness and concern regarding mental health issues. Because of their personal characteristics, these individuals might place a particular emphasis on achieving positive mental health outcomes for consumers of police services.

In another study comparing the same three departments, Steadman, Deane, Borum and Morrissey (2000) examined the way in which the officers responded to people experiencing mental illness and whether they were able to resolve cases

without resorting to arrest. It was found that the Memphis Crisis Intervention Team had the best procedures for linking people experiencing mental illness to mental health resources, with 75% of calls regarding such people resulting in a treatment disposition. The proportion of individuals with a suspected mental illness who were transported to a treatment facility by the department in Birmingham which had six in-house community service officers and the department in Knoxville which relied on the mobile mental health crisis team was 20% and 42%, respectively. Similarly, the departments differed in terms of the arrest rate following situations which required a specialist response. The team in Memphis reported arrest rates of 2%, while the programs in Birmingham and Knoxville reported arrest rates of 5% and 13%, respectively. It should be noted that in Memphis there is an emergency protective custody unit that has a 'no-refusal' policy for people experiencing psychiatric crisis (Steadman et al., 2001) that surely would have contributed to this pattern of results.

Nevertheless, these two studies indicate that preparing officers with the skills required for dealing with crises involving people experiencing mental illness, there might be fewer people with mental illness who are taken into police custody for processing through the criminal justice system. Furthermore, these studies highlight the importance of encouraging awareness regarding mental illnesses among police officers. If officers are not informed as to the resources they can use for dealing with people experiencing mental illness, their response is naturally limited. For example, Wylie and Wilson (1990) reported that only 2% of NSW officers surveyed had some knowledge regarding the availability of a 24-hour crisis intervention service which could assist them with interventions involving people experiencing mental illness. The findings regarding the Memphis Crisis Intervention Team provide some support

for the notion that police officers who volunteer to learn about dealing with mental illness might be more prepared to enact mental health outcomes. It is unclear whether this is by virtue of their pre-existing attitudes or the particular training they receive. It is clear that, to some extent, police discretion is related to the policies and procedures of police departments, which in turn, relates on the preparedness of officers as well as the scope of resources available to them. The precise directionality of these relationships remains unclear.

1.4.2 Situational and Contextual Variables

Some researchers have described how the outcomes of police officers' encounters with people experiencing mental illness can be influenced by the nature of the call or the context of the encounter, for example, whether the encounter was invoked by the police or the public. According to Patch and Arrigo (1999), "police-invoked order maintenance situations" are scenarios which involve someone who was approached by the police because of a perceived need to diffuse a socially disruptive situation, such as public drunkenness or disorderly conduct. In these situations they argue that police officers have the greatest amount of discretion as they are not immediately concerned meeting the expectation of members of the public, thus a particular disposition is not expected.

Green (1997) examined the role of offence type in predicting dispositions recorded by officers on incident coding forms following encounters with people experiencing mental illness. Not surprisingly, it was found that arrest dispositions were associated with misdemeanour (i.e., summary conviction) offences, informal dispositions were related to violations or 'no offence' and 'no action' was related to instances involving 'no offence'. Contextual variables evidently play an important

role in determining the outcome of encounters between police officers and people experiencing mental illness.

1.4.3 Suspects' Socio-demographic Characteristics

Researchers have also examined the relationship between the characteristics of suspects and the outcomes of their encounters with police officers. Finn and Stalans (1997) used hypothetical scripts to examine how suspects' characteristics influenced police officers' methods for resolving domestic assault cases, hypothesising that police officers would be more likely to refer females for involuntary civil commitment. Such a pattern was observed, which was consistent with Cherrett's (1995) observation that women form 44% of police contacts regarding mental illness whereas they traditionally form only 25% of police contact regarding criminal matters. Conversely, situations involving male victims were more likely to lead to arrest. Finn and Stalans reported that this result was consistent with the 'medicalisation of women's deviance thesis' (Smart, 1977) and the 'evil woman hypothesis' (Nagel et al., 1982).

More than 25 years ago, Smith, Visher and Davidson (1984) examined the way in which race might influence arrest in real-world police-citizen encounters. Although the researchers reported that there was little evidence of racial bias is relation to suspects, the police were observed to be more responsive to white victims of crime, compared to black victims. To date no Australian researchers have examined whether there is any interaction between race and mental illness in predicting arrest.

There is a vast array of suspect characteristics which might be found to relate to the outcomes of encounters with police officers, among which include race and

gender. Another important variable might be apparent socioeconomic status, inferred through presenting features such as language and style of appearance.

1.4.4 Suspects' Mental State

Central to this thesis is consideration of police officers' assumptions regarding what it means to have a mental illness and how this impacts on the resolution of encounters with people experiencing mental illness. Watson, Corrigan, and Ottati (2004) found that surveyed police officers viewed people experiencing schizophrenia as being more dangerous than people without mental illness. These individuals were also viewed as less responsible for their situation and more worthy of assistance. Finn and Stalans (1997) also found that inferences by police officers were shaped by stereotypes of people experiencing mental illness; that is, they believed that suspects who were described as experiencing mental illness were more likely to be viewed as more dangerous and less in control of their actions. However, police officers were not more likely to choose 'arrest' in response to the scenarios they used that depicted perpetrators of domestic assault who had been labelled 'paranoid', 'delusional' and/or 'alcoholic'. Similarly, LaGrange (2003) found that people who officers rated as dangerous to themselves were about four times less likely to be arrested compared to those who were not described as dangerous. On the other hand, people who officers rated as a danger to others were eight times more likely to be arrested. These findings are contrary to observations that people experiencing mental illness are more likely to be arrested relative to people without a mental illness (e.g., Teplin & Pruett, 1992). This reinforces the notion that, despite their good intentions, officers who are found to be more likely to arrest people with mental illness might do so without an understanding of the person's mental state.

While they may not be recognised as indicators of mental illness, suspects' presenting symptoms might, in fact, be associated with the way in which police officers view the social responsibility, desirability and culpability of suspects.

If stereotypes regarding people experiencing mental illness affect the way in which police officers resolve encounters with such people, then educating officers regarding the effects of mental illness on a person's behaviour might improve the likelihood of treatment dispositions. However, it is not only negative attitudes which can cause challenges for policing people experiencing mental illness; attitudes which are too sympathetic toward the needs of this population could lead to problematic outcomes. For example, if police officers believe that people experiencing mental illness are not responsible for their behaviour, they might also believe that they should not face legal consequences. Such attitudes make it difficult to regulate the behaviour of psychiatric inpatients who break the law (Bayney & Ikkos, 2003). Similarly, absolving people experiencing mental illness of responsibility for their actions does not protect the safety of the public nor does it serve the interests of people experiencing mental illness themselves (Cotton, 2004).

Evidently, police officers' views or stereotypes regarding mental illness bear some relationship to the dispositions invoked by police officers. Among these stereotypes include beliefs that people experiencing mental illness are dangerous, and less responsible and/or less in control of their actions. Future research should aim to explore the impact of these beliefs on police officers' decision making.

1.4.5 Police Officers' Education, Experience and Knowledge

Researchers have also examined the way in which police officers' education, experience and knowledge is related to their chosen outcome following encounters

with people experiencing mental illness. For example, LaGrange (2003) examined how police officers with different levels of education reported handling encounters with people experiencing mental illness. It was found that those with a university education were three and half times more likely to have reported the use of psychiatric referral following an encounter with a person experiencing mental illness during the last year. LaGrange cited a number of reasons higher education might be beneficial for police officers, including a greater appreciation of ethical, legal and social issues, and a more professional approach to work. This study was enhanced by two factors. First, the researcher controlled variables such as officers' gender, age and experience, and whether the offender was substance affected. Second, officers were required to reflect on real situations. A limitation of this study, however, was that the officers were required to reflect on up to two situations which occurred in the past year. The potential complication with this is that not only would officers be likely to reflect on the most unusual and probably non-representative case (as it might be at the fore in their minds), but they were required to re-construct events, making them subject to bias and misinterpretation. It is possible that the university educated officers were more influenced by demand characteristics and selected a case from their memory associated with a socially desirable outcome. Nevertheless, this research indicates that police officers with higher levels of education might be more attuned to mental health issues.

Green (1997) analysed 148 incident coding forms which were completed by police officers in Hawaii following encounters involving people with a suspected mental illness. It was found that years of officers' experience had a positive effect on the likelihood that they would engage in 'no action'. That is, more experienced officers were the least likely to invoke criminal justice or mental health involvement.

The researchers speculated that these officers might have learned that these options are ineffective or have simply lost motivation to engage people experiencing mental illness. Indeed, interviews with the officers revealed that official sanctions can be punishing for both the police officer and the offender. For example, they report either incurring the wrath of their superior at the police cell block or spending hours waiting in hospital. As one officer stated, "(I'm) screwed either way" (p. 481). In contrast, officers' lack of experience contributed significantly to the model predicting arrest.

Presumably correlated with police officers' experience, is their knowledge of relevant policies and procedures. According to LaGrange (2003), officers with more knowledge of civil commitment procedures were more likely to have made psychiatric referrals. Conversely, officers who were less familiar with these procedures were more likely to have engaged in informal dispositions. Similarly, officers' knowledge of the local community is also likely to be associated with appropriate dispositions. Green (1997) reported that people experiencing mental illness who are known to police as "neighbourhood characters" and those who had no intent to break the law were the most likely to escape any kind of police action. In contrast, a known criminal history was a significant predictor of arrest.

The results of these studies suggest that the likelihood of treatment dispositions might be positively correlated with police officers' number of years of education, number of years in the force and/or their knowledge of policies and procedures and the local community. If these findings reflect real world trends, police organisations might benefit from drawing on the knowledge and experience of older, more experienced officers, and targeting interventions aimed at improving awareness and knowledge of new recruits. Furthermore, these results suggest that

university educated recruits might be more sensitive to the needs of people experiencing mental illness, and thus represent the best candidates to be trained as officers in specialised response teams. This finding is consistent with an on-the-job approach to police education regarding mental health issues.

The research reviewed suggests that there are a number of factors which are related to police officers' decision making processes following police encounters with people experiencing mental illness. These include differing resources available to the police, situational variables, suspects' characteristics, including mental state, and characteristics of police officers, such as their education, experience and knowledge. Of all these factors, the characteristics of police officers are especially important to understand because if variability in police officers' knowledge and understanding regarding mental illness is related to variability in their decision-making, then it follows that outcomes for people experiencing mental illness will also depend on these factors. Therefore, it is pertinent to understand police officers' attitudes toward people experiencing mental illness and whether these attitudes bear any relationship to outcomes chosen by police officers. In this next section, research regarding police officers' attitudes toward people experiencing mental illness will be examined.

1.5 Police Officers' Attitudes

Given the challenges faced by police officers when attempting to resolve encounters with people experiencing mental illness, it would not be surprising if they felt frustrated with this type of work. Teplin and Pruett (1992) suggested that because police officers' activity index and criminal arrest quota does not include psychiatric dispositions, involvement with people experiencing mental illness was unrecognised

and unrewarded by the police department. According to Wylie and Wilson (1990), police officers in Australia reported that in almost 70% of incidents with people experiencing mental illness there had not been an official record made of the encounter. This was in spite of each instance being estimated to take an average of 3.7 hours to resolve. Similarly, Green (1997) reported that 72% of instances where the police had contact with people experiencing mental illness were not recorded. The fact that police are not required to record or report encounters with people experiencing mental illness indicates that they are under pressure to resolve such situations informally. Furthermore, it might perpetuate the belief among some police officers that they are doing someone else's job. However, research exploring police officers' attitudes toward people experiencing mental illness does not necessarily support this view.

Researchers who examine police officers' attitudes toward people experiencing mental illness tend to employ the use of attitudinal surveys, the results of which are analysed using techniques which elucidate the underlying themes in the data. More than thirty years ago, Lester (1978) utilised this approach to examine the attitudes of a small sample of police officers and reported them to be slightly more 'authoritarian' and less 'benevolent' than health care workers.

Following a more recent survey of 138 police officers in Canada, Cotton (2004) reported that most officers agreed that dealing with people experiencing mental illness was part of the role of a police officer and that special training was required to fulfil this role. However, about half of respondents felt that people experiencing mental illness took up more than their fair share of police time. Cotton described four dimensions on which police officers' attitudes could be described. The first dimension, 'benevolence', described the sentiment that society should

accept and share the responsibility of caring for people experiencing mental illness in a human manner, and attracted the highest rate of positive endorsement. The next highest level of endorsement was reported on the 'community mental health ideology' dimension, which portrayed, consistent with the general principles of deinstitutionalisation, that that people experiencing mental illness should be integrated into the community. Lower levels of endorsement were found on the 'authoritarianism' dimension, which described institutionalisation, hospitalisation, and a need for firm discipline. Similarly, the 'social restrictiveness' dimension, which described a belief that people experiencing mental illness are dangerous, attracted low levels of endorsement. By adding the two scores which reflected positive attitudes and then subtracting the scores which indicated negative attitudes, Cotton created an overall measure of officers' attitudes toward people experiencing mental illness, in which a lower score was deemed "nicer" (p. 141). Interestingly, none of the variables including age, rank, years of experience, gender, how often the officers came into contact with offenders and whether they had taken any studies related to mental illness reached significance in predicting officers' attitudes. Cotton concluded that officers' views about their role in working with people experiencing mental illness were distinct from their attitudes about mental illness in general. This makes it difficult not only to describe the majority of officers who reported positive attitudes, but also the 11% who endorsed the belief that they should not be dealing with people experiencing mental illness at all and, similarly, the 17% who did not perceive people experiencing mental illness as a disadvantaged group who require special attention.

Cooper and colleagues (2004), who surveyed 92 American police officers, reported no association between six attitudinal items and gender, ethnic group or

years in the department. A sample of 156 Greek police officers surveyed by Psarra and colleagues (2008) tended to hold the beliefs that escorted patients were often violent, threatening or unpredictable, that people experiencing mental illness should be permanently hospitalised, but that medication could reduce violent behaviour. Generally speaking, these attitudes could be considered much more negative than those reported by Cotton. Nonetheless, these researchers also found no discernable relationship between police officers' attitudes and demographic variables. They did, however, report slightly more positive attitudes among participants with 12 or more years of education compared to those with less than 12 years education.

According to the results of these relatively small scale studies, police officers' attitudes might not be adequately explained by demographic characteristics alone. However, given that some of these studies had results approaching statistical significance, the inclusion of a greater number of research participants might have increased their statistical power and revealed patterns or relationships in the data with some real world significance.

It is also possible that the variability in attitudes reported in these studies is a function of the relevant legislation and or police culture in which the study was conducted. In the studies from Greece (Psarra et al., 2008), New Zealand (Dew & Badger, 1999) and Australia (Fry, O'Riordan & Geanellos, 2002), it was reported that police officers tended to hold the sentiment that dealing with people experiencing mental illness should not be the responsibility of police officers, and that police officers have little training in this area and are inadequately supported. In contrast to these studies, American police officers surveyed by Cooper, McLearen and Zapf (2004) reported, on average, strong endorsement of the statement 'it is my responsibility to deal with the mentally ill' (p. 302). Similarly, Watson and

colleagues (2004) reported that after reading a hypothetical scenario, American officers reported being more likely to help a person with a mental illness who is in need of assistance than a person who did not have a mental illness. The hypothesis that regional or cultural differences can account for some variability in police officers' attitudes is further supported by the finding that different models of policing are associated with differences between officers' sense of preparedness and perceived effectiveness in their dealings with people experiencing mental illness (Borum, Deane, Steadman & Morrissey, 1998).

To date researchers have not examined whether police officers' attitudes bear any relationship to the way in which they resolve encounters with people experiencing mental illness. Following a meta-analysis of 797 studies, Wallace and colleagues (2005) reported that attitudes were moderately effective at predicting behaviours. From this it follows that variability in police officers' attitudes might result in variable outcomes for people experiencing mental illness following encounters with police officers. Despite the absence of research incorporating systemically examined attitudes, there has been research regarding police officers' 'engagement of ideals' and how this relates to chosen outcomes. Mendias and Kehoe (2006) examined the cognitive schema which police officers used to justify their discretionary powers. After reading hypothetical scenarios, police officers were asked to indicate whether they would make an arrest and to rank the importance of four policing ideals in justifying their decision. The researchers concluded that officers used two schemas to justify their actions; a law-procedure and a peace-procedure. Specifically, the use of law to justify an officers' decision was associated with an 87% likelihood of an arrest. These results can be taken to infer that police officers who believe that their role is primarily to enforce the law, might be more

likely to resort to arrest. Furthermore, these results indicate that policing ideals include not only law enforcement, but due process and the maintenance of peace - an idea which has long been supported by other researchers (Rabkin, 1979; Teplin, 2000).

Police officers' attitudes regarding people experiencing mental illness are probably related to the mental health resources or support available to them, which most likely differs across differing policing jurisdictions. Despite research suggesting that, generally speaking, attitudes do relate to behaviour, to date no studies have examined the relationship between police officers' attitudes and the way in which they resolve encounters with people experiencing mental illness.

1.6 Rationale for Current Research

There is much to be explored in relation to police encounters with people experiencing mental illness, including in the Australian context. For example, the frequency and types of contacts between police officers and people they believe are experiencing mental illness needs to be examined. An investigation of this nature should also examine the perceived and real world the challenges faced by Australian police officers when performing these duties.

In light of the challenges faced by police officers when dealing with people experiencing mental illness and the importance of their role, there also needs to be a systematic examination of police officers attitudes toward people experiencing mental illness. Such research should seek to determine themes in officers' attitudes, and whether these themes are related to other individual characteristics.

A relatively wide body of research exists regarding the way in which contextual variables and suspect and police officers' characteristics influence the

outcomes of encounters between the police and people experiencing mental illness; however, no research to date has incorporated police officers' attitudes. Therefore, the third area of research proposed is an examination of the relationship between police officers' attitudes and their chosen outcomes following encounters with people experiencing mental illness. Research in this area is important because if there is a relationship between police officers' attitudes and their decision making, then it follows that variability in these attitudes is likely to lead to variability in outcomes for people experiencing mental illness.

There are a number of general methodological limitations to the existing research in this field. Most of the research studies cited in this thesis have incorporated sample sizes of around 100 participants or fewer. Therefore the extent to which the findings generalise to real world populations is limited. Further, researchers investigating police officers' attitudes regarding mental illness have generally not considered the issue of social desirability; that is, whether reported attitudes actually reflect the true sentiments of respondents. Research regarding the preferred outcomes of police officers following their encounters with people experiencing mental illness often relies on the use of written vignettes. This methodology is problematic, as text can only portray a limited amount of information, and because of this there is likely to be a great deal of homogeneity in regards to response patterns thus leading to spurious conclusions. Observations of police encounters in naturalistic settings are also limited as police officers and fieldworkers have limited data with which to make a diagnosis.

Factors such as the availability of community mental health resources will continue to have a profound impact on the outcome of police encounters with people experiencing mental illness. Nevertheless, by ensuring the validity and reliability of

future research in this area, much can be learned about the safe handling and appropriate referral of people experiencing mental illness following their encounters with the police.

There is no doubt that the police play a critical role in the management of some people experiencing mental illness who live in the community and are in crisis. Over the years, there has been an increase in these types of encounters, and the mental health and criminal justice systems are now inextricably intertwined. This criminalisation process is complex and arose out of a number of factors, including limited mental health resources, strict involuntary commitment criteria and symptoms of mental illness, which have been found to relate to an increased risk of violent and general offending, especially when comorbid with alcohol and other drug disorders. By fulfilling their role in the management of people experiencing mental illness, the police serve to protect both people experiencing mental illness themselves and others to whom they may pose a threat. Although there are legal principles which govern police involvement with people experiencing mental illness, there exists no framework that the police can apply when attempting to resolve such encounters. As noted previously, police officers are afforded a degree of discretion following such encounters; however, their decision making is constrained by many contextual and situational variables, not least of which are limited community mental health resources.

Of particular interest to researchers have been some factors which relate to the way in which police officers resolve encounters with people experiencing mental illness. These variables include characteristics of both police officers and suspects. There has also been limited research regarding the way in which police officers perceive mental illness and how this may relate to their decision making. For

example, inferences regarding culpability, responsibility and dangerousness might all contribute to outcomes following police encounters with people experiencing mental illness. Research in this area is limited because, to date, no studies have incorporated a systematic evaluation of police officers' attitudes. By continuing to develop our understanding of the interface between the police and people experiencing mental illness, awareness of the need for greater resources and support for police officers' who undertake this invaluable community service is likely to be improved. Such enhancements represent a move toward limiting the use of prisons for housing people experiencing mental illness and to ensuring their humane treatment in accordance with the initial promise of deinstitutionalisation.

1.7 The Present Investigation: Preamble to Methodology

As alluded to in the introduction and throughout this chapter, this thesis involves an investigation regarding the interface between police officers and people experiencing mental illness in Victoria, Australia. It is anticipated that this research will contribute to the literature regarding the nature of police encounters with people experiencing mental illness, police officers' attitudes regarding mental illness and some of the factors which are related to the way in which police officers resolve encounters with people experiencing mental illness. A greater understanding of these areas is important to understand ways in which outcomes for vulnerable people can be improved, and further, to understand how police officers can be better supported in their work with people experiencing mental illness. In Chapter 2 the methodology of the three studies that form the basis of this thesis is described.

CHAPTER 2: METHOD

This chapter includes details of the overarching method incorporated in this thesis. First, a brief explanation of the relationship between the two data collection phases and the three studies is provided. Second, the population and recruitment procedures, questionnaire materials and approaches to analysing data relevant to each of the three studies are described.

2.1 Overview of Method

The three studies incorporated in this thesis include results arising from two data collection phases. The first phase occurred between the 1st and 13th of October, 2007, and included a sample of 310 Victorian police officers. The first phase was used, in part, used to pilot a questionnaire which included the Mental Health Attitudes Survey for Police (MHASP; Clayfield, Fletcher & Grudzinskas, 2009). This phase also incorporated the use of video scenarios, which were used to examine the relationship between police officers' attitudes and their decision-making following hypothetical encounters with people experiencing mental illness. The results of this investigation are reported in the third study.

The second data collection phase, which occurred between January and June, 2008, included 3534 Victorian police officers. This much larger sample size was used to determine frequency data which are reported in the first study and to examine the underlying factor structure of the MHASP which is reported in the second study. Both data collection phases received full ethical scrutiny and approval from the Monash Standing Committee on Ethics in Research Involving Humans and the Victoria Police Human Research Ethics Committee.

Table 1. Relationship between two data collection phases and the three studies.

	Data collection phase one	Data collection phase two
Date	October 2007	January – June 2008
n	304	3534
Study one		Frequency data – setting the scene
Study two		Factor analysis – describing attitudes
Study three	Video scenarios (relationship between attitudes and outcomes to hypothetical scenarios)	

2.2.1 Study One and Two: Source Population and Recruitment

All operational police officers in the state of Victoria up to and including the rank of Inspector are required to attend Operational Safety and Tactics Training (OSTT) twice a year. All officers who attended OSTT sessions at the police academy during the data collection phase (between January and June, 2008) were eligible to participate. This phase included officers from 9 of the 13 training sites around Victoria. Of the 7914 police officers who participated in the OSTT sessions during the data collection phase, 3811 were invited to participate in the study. There were 277 surveys returned blank, resulting in a sample size of 3534. Therefore, the response rate of those who were invited to participate was 92.7%. The sample represented 44.7% of the available population at the time of sampling. The research was introduced by the OSTT training facilitator and questionnaire packs were given to all potential participants. To ensure voluntariness, participants were invited to post their surveys, completed or left blank if they chose not to participate, in an opaque box at the front of the room. This procedure ensured that those who chose not to complete the survey could not be identified.

2.2.2 Study One and Two: Questionnaire Material

A multi-component questionnaire (see Appendix 3) was developed by the authors in collaboration with senior police personnel and policy makers from Victoria Police. Specific sections sought to document the sources of information used to understand and identify whether someone had a mental illness, bases of knowledge regarding mental illness and the frequency of various outcomes following encounters with people experiencing mental illness. These items were scored according to a six-point Likert scale, (where 1 = "strongly based/very often" to 6 = "not based at all/never"). Other questions were included to measure the frequency with which participants reported coming into contact with people experiencing mental illness and whether they were interested in further training. Participants were also invited to list the signs, symptoms and behaviours they believed were associated with mental illness, and the challenges faced in their duties. The questionnaire was published in a format which could be later scanned allowing the data to be automatically entered into Microsoft Excel, and then later converted for use in SPSS (version 16, 2007).

A second section incorporated the Mental Health Attitude Survey for Police (MHASP; Clayfield, Fletcher & Grudzinskas, 2009), which included 37 items rated on a 6-point Likert scale (where 1 = "strongly disagree" to 6 = "strongly agree"). Minor amendments were made to the original MHASP scale to ensure cultural sensitivity and appropriateness; these were checked for face validity by the multidisciplinary research team. Social desirability was considered using the 13-item version of the Marlowe Crowne Social Desirability Scale (Reynolds, 1982).

2.2.3 Study One and Two: Approach to Data Analysis

Descriptive statistics were used to explore the frequency of participants'
responses on the questions which utilised a Likert-type scale. A factor analysis was
conducted on the responses to 'sources of information used to determine if someone
is mentally ill' and 'bases of knowledge regarding mental illnesses'. The
relationship between the frequency of outcomes following officers' encounters with
people who have a mental illness and the sources of information and bases of
knowledge were then analysed using canonical correlations. Information gathered
through open-ended questions was considered, grouped and interpreted using
established qualitative techniques, exploring common themes arising in participants'
responses. To examine the signs, symptoms and behaviours believed to be associated
with mental illness, a random subset of 15% of participants' responses were selected.
These were then analysed utilising a qualitative approach to explore recurring
themes. The results of the descriptive statistics, canonical correlation and qualitative
techniques were incorporated into the first paper titled 'Police perceptions of their
encounters with individuals experiencing mental illnesses: A Victorian survey.'
(Godfredson, Thomas, Ogloff & Luebbers, 2010a) (see Chapter 3).

The 37 items comprising the MHASP were analysed using Principal
Components Analysis (PCA) to explore underlying themes and patterns in the
officers' attitudes. The eight factors derived from this analysis were again analysed
using PCA, resulting in a two-tiered model of police officers' attitudes. These factors
were then related to officers' demographic characteristics using a multiple analysis of
variance (MANOVA). Missing data were excluded from analyses on a case-wise
basis. The results of this factor analysis were incorporated in the second paper, titled

'Policing people experiencing mental illness: Factoring in officers' attitudes'
(Godfredson, Thomas, Ogloff & Luebbers, 2010b) (see Chapter 4).

2.3.1 Study Three: Source Population and Recruitment

The results of the third study are based on data collected during the first of the
two data collection phases. All police officers who attended OSTT sessions at the
police academy during the data collection phase (1-13th of October, 2007) were
eligible to participate. A member of the research team (the author of this thesis)
introduced the study and questionnaire packs were handed out to all potential
participants. After participants had completed the first section of the survey, they
were invited to watch one of three short video scenarios which was projected onto a
screen. The three videos were alternated each day so that at the end of the data
collection phase, approximately the same number of participants had viewed one of
three scenarios. After viewing the scenario, participants were invited to complete the
last section of the survey. The issues of consent and voluntariness were handled in
the same manner as the first and second studies with participants invited to post their
surveys, whether complete or left blank, in an opaque box at the end of the session.
Of the 310 surveys returned, 304 were completed.

2.3.2 Study Three: Questionnaire Material

The first data collection phase provided an opportunity to pilot the original
questionnaire (see Appendix 2). Therefore, the third study included the original
version of the questionnaire which was later incorporated into the first and second
studies. The original version of the questionnaire pack incorporated three
hypothetical vignettes (see Appendix 4), which depicted an interaction between a

man who might be mentally ill drinking in a park and two police officers. The scenarios were developed after consultation with senior Victoria Police personnel in the Victoria Police Behavioural Analysis Unit. Several features were incorporated to ensure that the scenarios depicted a scene which afforded the officers maximum discretionary power (see Patch & Arrigo, 1999), including a minor offence (drinking in a park), an anonymous complainant and an absence of bystanders. The three versions of the scenario included depictions of the man as 1) not mentally ill, 2) possibly mentally ill, and 3) clearly mentally ill. Each scenario ended prior to the encounter being resolved. The questionnaire included a final section which participants completed after viewing one of the three scenarios. This included two multiple choice questions regarding how participants would 'likely' and 'ideally' resolve the encounter, with the options being (a) walk away from the situation, (b) handle the matter informally, (c) call a CAT (Crisis Assessment and Treatment) team, (d) apprehend the man under Section 10 of the *Mental Health Act 1986* (Vic), and (e) arrest.

2.3.3 Study Three: Approach to Data Analysis

Responses from completed surveys ($n = 304$) were manually entered into SPSS (version 16, 2007). The two-tiered factor structure derived from the factor analysis of the larger sample ($n = 3534$) was applied to this smaller sample. These factors were then incorporated as predictive variables in a discriminate function analysis, which was used to examine variables which differentiated participants' 'likely' and 'ideal' outcomes chosen after viewing one of the three hypothetical scenarios. The results of this analysis were reported in a paper titled 'Police discretion and encounters with

people experiencing mental illness: The significant factors' (Godfredson, Thomas,

Ogloff & Luebbers, 2010c) (see Chapter 5).

CHAPTER 3: THE INTERFACE BETWEEN THE POLICE AND PEOPLE EXPERIENCING MENTAL ILLNESS IN VICTORIA, AUSTRALIA: SETTING THE SCENE

3.1 Preamble to Empirical Paper

This chapter presents the first study of this thesis. The aim of this study was to describe police officers' perceptions regarding their experiences dealing with people experiencing mental illness in Victoria, Australia. By collecting data regarding the estimated frequency of police contacts with people experiencing mental illness, the way in which differing sources of information and knowledge relate to various outcomes, and exploring the challenges faced by police officers when undertaking this type of work, this first study provides a foundation on which more specific aspects of police encounters with people experiencing mental illness can be explored.

This article has been submitted to the Australian and New Zealand Journal of Criminology.

Monash University

3.2 Declaration for Thesis Chapter 3

Declaration by candidate:

In the case of Chapter 3, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Literature review, project design, data collection and analysis and writing of paper.	80

The following co-authors contributed to the work:

Name	Nature of contribution	Extent of contribution (%)
Prof James Ogloff	Review of paper drafts and general supervisory input	7.5
Dr Stuart Thomas	Review of paper drafts and general supervisory input	7.5
Dr Stefan Luebbers	Assisted with statistical analyses	5

Candidate's Signature		Date

Declaration by co-authors

The undersigned hereby certify that:
(1)   the above declaration correctly reflects the nature and extent of the candidate's contribution to this work, and the nature of the contribution of each of the co-authors.
(2)   they meet the criteria for authorship in that they have participated in the conception, execution, or interpretation, of at least that part of the publication in their field of expertise;
(3)   they take public responsibility for their part of the publication, except for the responsible author who accepts overall responsibility for the publication;
(4)   there are no other authors of the publication according to these criteria;
(5)   potential conflicts of interest have been disclosed to (a) granting bodies, (b) the editor or publisher of journals or other publications, and (c) the head of the responsible academic unit; and
(6)   the original data are stored at the following location(s) and will be held for at least five years from the date indicated below:

Location(s)	Centre for Forensic Behavioural Science, Monash University, 505 Hoddle Street, Clifton Hill, VIC 3068

Signature 1		Date
Signature 2		
Signature 3		

3.3 Police Perceptions of their Encounters with Individuals Experiencing Mental Illnesses: A Victorian Survey

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Abstract

Objectives: Police have long played a central role in the management of people experiencing mental illness. This study explored 1) the frequency of contact between the police and people experiencing mental illness; 2) the way in which police officers' knowledge and the sources of information used relates to various dispositions; 3) the signs, symptoms and behaviours that police officers consider are associated with mental illness; and 4) the challenges police face in this respect when performing their duties.

Method: A survey was completed by 3534 police officers in Victoria, Australia. Canonical correlations were used to explore the 'approach styles' of police when responding to people with a mental illness. Thematic analyses, based on grounded theory, were utilised to examine and code open-ended responses.

Results/conclusions: Police reported that a considerable amount of their time each week was spent dealing with people they believed to be mentally ill. These encounters were reportedly associated with considerable practical difficulties for police, both in terms of knowing how to deal with people experiencing mental illness and how to best find appropriate supports for them. The most common results of their encounters were instigating a mental health apprehension, followed by arrest, but decision-making was influenced by the differential weight police placed on different sources of information received at the scene. Recommendations for police training, while based on practical wisdom, need to be multi-modal and should engage mental health experts in design and delivery.

More than 40 years ago, Bittner highlighted the challenges faced by police officers in their encounters with people experiencing mental illness (Bittner, 1967). Since that time, changes in policy, practice and legislation have all contributed to a common perception that there is a scarcity of mental health resources. This argument has been used to explain, in part, why the frequency of contacts between the police and people experiencing mental illness has continued to increase (Bonovitz & Bonovitz, 1981; Menzies, 1987; Patch & Arrigo, 1999; Pogrebin & Poole, 1987; Teplin & Pruett, 1992). Anecdotal reports of police officers (Wylie, 1990), the high prevalence of psychiatric symptoms among detainees in police cells (Ogloff, Warren, Tye, Blaher & Thomas, 2010) and, concomitantly, an increased rate of major mental illnesses found in prison populations as compared to estimated rates in the community (Butler & Allnutt, 2003; Fazel & Danesh, 2002; Ogloff, 2002) have all added to this persuasive stance.

The over-representation of mental illness in prisons has been attributed, in part, to the process by which police officers may arrest people experiencing mental illness due to an absence of appropriate mental health options (Holley & Arboleda-Florez, 1988; Lamb, Weinberger, & DeCuir, 2002; Teplin & Pruett, 1992), although there are contradictory viewpoints on this (Bonovitz & Bonovtiz, 1981; Engel & Silver, 2001; Green, 1997). On one hand, it might be that symptoms of mental illness have been 'criminalised', with mentally ill people being arrested for behaviours that are actually a direct consequence of their illness (e.g., bizarre behaviour and public order offences). However, what is clear from large scale epidemiological data linkage studies is that individuals with severe mental illnesses have a disproportionately high offence, and particularly violent offence, rate compared to people without such diagnoses (e.g., Wallace, Mullen & Burgess, 2004). Regardless

of whether the police play a role in any 'criminalisation of the mentally ill' (Lamb, Weinberger & DeCuir, 2002), when dealing with people experiencing mental illness in their work, police officers can and do have to make difficult decisions, often without the assistance of experts in mental health.

Encounters with people experiencing mental illness are now considered part and parcel of contemporary police practice; with recent police reforms emphasizing the need to go beyond what was traditionally the polices' core functions of catching and locking up the criminals to a more global remit covering broader concepts of security, harm reduction and prevention (Stenning & Shearing, 2005). Against this social welfare doctrine to community policing, the police have three options open to them when faced with resolving an encounter: 1) arrest if the person has committed a crime pursuant to the relevant criminal code in that jurisdiction; 2) detain and convey the person to a place of safety for a proper assessment of safety and risk, as set out in relevant mental health legislation; or 3) to use their discretionary powers. These 'street-level decision-making' processes, universal to police in all jurisdictions under the guidance of locally determined mental health legislation and criminal codes, are influenced by a number of practical and logistical factors. Of all of these options, it is their decision-making around the enactment of their discretionary powers that has been of most interest. Within this, the potential influence of the encounter being police or citizen-initiated (Sanders & Young, 2005, pg 229) has received attention as these characteristically different encounters carry with them a whole range of, sometimes different, political and social expectations. These forces can be particularly problematic when the individual or group of 'interest' are socially marginalised and stigmatised (Karminia, Law, Butler, Levy, Corben, Kaldor &

Grant, 2007) and, to an extent, demonised by the local community (Dinos, Stevens, Serfaty, Weich & King, 2004; Hudson, 2007).

Quite apart from societal pressures, police are faced with the fundamental complication of their own ability to recognise signs, symptoms and behaviours associated with mental illness (Bayney & Ikkos, 2003; Finn & Stalans, 1997; Green, 1997; LaGrange, 2003). In Victoria, although police are not compelled or required to exercise clinical judgment in these situations under their powers in the *Mental Health Act 1986* (Vic), their 'duty of care' in these encounters has recently been debated in *Stuart v Kirkland-Veenstra [2009] HCA 15*. Scott (2010) argues on the grounds of what would be reasonably expected when encountering anyone in a vulnerable state, that police should in fact err on the side of caution and facilitate access to a proper assessment of safety and risk.

Different jurisdictions have taken individualised approaches to providing training on mental health awareness to police officers. One recent American study suggested the median time devoted to this training was 6.5 hours, but this varied widely and was commonly grouped with information about other vulnerable populations. Some developed and delivered the training totally in-house, while others either liaised with local mental health providers on content or developed and delivered part or all of the content (Hails & Borum, 2003). Whatever the case, Borum (2000) argues that the training is unlikely to be sufficient to fundamentally change the nature or outcome of the encounters. The lack of training in this regard has been attributed to the excessive (and fatal) use of force by police on people experiencing mental illness internationally (Fyfe, 2000). Indeed, issues around police training, policy and practice in Victoria have come under particular scrutiny over the last twenty or so years, following a number of reviews into the number of police

shootings in the State and the over-representation of mental illness among the victims of these shootings (Dalton, 1998; Kesic, Thomas & Ogloff, 2010). While training initiatives embarked upon have, at least temporarily reinvigorated the focus on mental health awareness, and more recently moved away from classroom-based didactic teaching methods to a more realistic reflective and hands-on scenario-based training developed in collaboration with mental health specialists, these encounters account for a relatively unknown burden on police time.

The evidence regarding the frequency and nature of contacts between police and people experiencing mental illness is very limited, often amounting to little more than anecdote and conjecture. A recent small-scale study conducted in New South Wales suggested that approximately 10% of police time was spent dealing with people experiencing mental illness (Fry, O'Riordan & Geanellos, 2002), while a similar study conducted in New Zealand reported a comparable figure of 8.6% (Dew & Badger, 1999). Apart from these two studies, very little empirical evidence is available. There is clearly a pressing need to gain a detailed understanding of the commonality and circumstances around these encounters. Such empirically derived evidence would provide a much needed starting point to help identify service gaps, inform the potential need for a clearer and more substantial focus in training on these issues, and act as a catalyst for commencing an informed dialogue about the need for broader health and justice reforms by recognising the potentially significant role played by police at this interface. Against this background, the aims of this study were to explore: 1) the frequency of contact between the police and people experiencing mental illness; 2) the relationship between police officers' knowledge and the sources of information they use when exercising their discretion; 3) the signs, symptoms and behaviours police officers believe are related to mental illness; and 4)

the biggest challenges faced by police officers when dealing with people experiencing mental illness.

Method

Source Population and Recruitment

All operational police officers in the State of Victoria are required to attend Operational Safety and Tactics Training (OSTT) twice a year. All officers, up to and including the rank of Inspector attending OSTT during the data collection phase (January - June 2008) were eligible to participate. Officers were recruited from 9 of the 13 training sites around the state, thereby allowing for a total potential sample of 7914 officers. The research was introduced by the OSTT training facilitator and questionnaire packs were handed out to all potential participants. Once participants had completed the questionnaires they were invited to post them in a sealed opaque box. Participation was voluntary; with potential participants instructed to post surveys, whether completed or left blank if they chose not to participate, in the box at the end of the session. The study received full ethical scrutiny and approval from the Monash Standing Committee on Ethics in Research Involving Humans and the Victoria Police Human Research Ethics Committee.

Questionnaire Composition

A multi-component questionnaire was developed by the authors in consultation with senior police personnel and policy makers from Victoria Police. Specific sections sought to document the following: 1) the sources of information used to understand and identify whether someone had a mental illness, scored according to a six-point Likert scale, (1 = "not based at all/never" to 6 = "strongly

based/very often"; 2) the relative frequency of different outcomes resulting from their interactions with people experiencing mental illness (e.g., arrest, mental health apprehension, no further action or referral to another agency) according to a 6-point Likert scale (1 = "never" to 6 = "very often"); 3) up to five, signs, symptoms or behaviours that they believed were useful in determining whether someone had a mental illness; 4) the biggest challenges they faced when attempting to resolve situations involving people experiencing mental illness; and 5) their attitudes toward mental illness using the Mental Health Attitude Survey for Police (MHASP; Clayfield, Fletcher & Grudzinskas, 2009) again according to a 6-point Likert scale ranging from 1 = "strongly disagree" to 6 = "strongly agree". Minor amendments were made to the original MHASP scale to ensure cultural sensitivity and appropriateness; these were checked for face validity by the multidisciplinary research team. Finally, social desirability was considered using the short 13-item version of the Marlowe Crowne Social Desirability Scale (Crowne & Marlowe, 1960; Reynolds, 1982).

Data Manipulation and Approach to Analysis

Returned surveys were scanned and participants' free text responses were recorded verbatim in a database which was later converted for use with SPSS (version 16, 2007). Descriptive statistics were used to explore the frequency of participants' responses on the questions which utilised a Likert-type scale. A factor analysis was conducted on the responses to 'sources of information used to determine if someone is mentally ill' and 'bases of knowledge regarding mental illnesses'; each being considered a 'set of variables'. The relationship between these two sets were considered using canonical correlations (Tabachnick & Fidell, 2007,

pgs 567-606). Data gathered through free text responses to the open-ended questions were grouped, considered and interpreted using thematic analysis, based on the grounded theory framework described by Strauss and Corbin (Strauss & Corbin, 1998, pg 12). A random subset of 15% of completed questionnaires were selected for these purposes to gain an in-depth understanding of the how the thoughts and experiences of police officers can be explained by their narratives on common signs, symptoms and behaviours they ascribe to mental illness. The latter sampling method was adopted to allow for a manageable data set and for the emergence of thematic saturation across the diversity of police experiences.

Results

Of the 3811 surveys handed out to participants, 277 were returned blank resulting in a total of 3534 participants, corresponding to a response rate of 92.7%. The demographic characteristics of participants are presented in Table 1. These were broadly consistent with the demographic profile of all operational officers in Victoria Police (Personal Communication; Victoria Police: Policy, Research, Intelligence and Training Department, 14 August 2009).

Table 1. Demographic data

Demographics	Number (%)	Victoria Police
Gender		
Males	2749 (77.8)	76.8%
Females	757 (21.4)	23.2%
Unspecified	28 (0.08)	
Age		Average = 40.4 years
18-25	160 (4.5)	
26-30	438 (12.4)	
31-35	579 (16.4)	
36-40	871 (24.6)	
41-49	1044 (29.5)	
50+	417 (11.8)	
Unspecified	25 (0.07)	
Rank		
Inspector or above	19 (0.05)	359 (3.1)
Senior Sergeant	125 (3.5)	576 (5.0)
Sergeant	550 (15.6)	1879 (16.4)
Senior Constable	2113 (59.8)	6552 (57.3)
Constable	644 (18.2)	1904 (16.7)
Protective Services Officer	51 (1.4)	
Missing	32 (0.09)	
Years of service		Average = 15.4 years
1-3	496 (14.0)	
3-6	343 (9.7)	
6-10	638 (18.1)	
10-15	460 (13.0)	
15+	1552 (43.9)	
Unspecified	45(1.3)	
Work location*		
Metropolitan	1607 (45.5)	
Rural	865 (24.5)	
Regional	969 (27.4)	
Unspecified	93 (2.6)	
Duties*		
General	2284 (64.6)	
SOCA	79 (2.2)	
Criminal Investigation Unit	355 (10.0)	
Traffic Management Unit	270 (7.6)	
Other	432 (12.2)	
Missing	114 (3.2)	

*Data for Victoria Police not provided

1. Frequency of Contacts between the Police and Mentally Ill People

Participants estimated that approximately 20% of people with whom they have contact in any week are mentally ill. This figure did not differ depending on whether the people were offenders, suspects, victims, vulnerable/at risk people, or people in need of assistance. Just under half (48.2%; $n = 1705$) reported that they had contact with someone who appeared to be mentally ill 1-2 times per week, 26.1% ($n = 923$) reported 3-5 times, 10.1% ($n = 356$) reported "never", 9.2% ($n = 324$) reported 6-10 times, 3.5% ($n = 125$) reported "ten or more times" a week.

2. Police Identification of Mental Illness

Participants were asked to record the factors they considered in indentifying whether people had a mental illness. The most frequently cited factors reported related to 1) speech/speech content, 2) behaviour/actions, 3) appearance/hygiene, 4) aggression/violence and 5) body language/movements (see Table 2).

Table 2. Signs, symptoms and behaviours police officers associated with mental illness

Sign, symptom or behaviour	Frequency (%)
Speech; speech content	251 (19.3)
Behaviour; actions	128 (9.9)
Appearance	99 (7.7)
Aggression; violence	81 (6.3)
Body language; movements	69 (5.3)
Communication; comprehension	66 (5.1)
Emotions; mood	61 (4.7)
Self harm; suicide	59 (4.6)
Eye contact	52 (4.0)
Anxiety; nervousness	41 (3.2)
Paranoia	39 (3.0)
Hallucinations	36 (2.8)
Delusions	35 (2.7)

Third party report; prior knowledge	35 (2.7)
Irrational; erratic; unpredictable	33 (2.5)
Orientation; confusion	28 (2.2)
Concentration	22 (1.7)
Demeanour; attitude	20 (1.6)
Self report	16 (1.2)
Thoughts	14 (1.0)
Medication	12 (0.9)
Intoxicated; drug use	11 (0.9)
Circumstances; environment	6 (0.5)
Uncategorised	83 (6.4)
Total	**1297 (100)**

According to participants' responses on a Likert-type scale, the category of 'sources of information used to determine if someone is mentally ill' used most often was 'person-based information' ($M = 4.90$, $SD = 1.02$), followed by 'police sources' ($M = 4.65$, $SD = 1.23$) and 'medical practitioners' ($M = 3.79$, $SD = 1.53$). None of these variables were related to the measure of social desirability. It should be noted that some of these themes represent aggregate items, as their relationships were revealed following a factor analysis. For example, the items 1) previous knowledge of the individual, 2) behaviour observed at the scene, and 3) "other" were combined to form the aggregate item "person-based information". Similarly, the items 1) information provided on dispatch, and 2) information from police database were combined to form "police sources".

According to participants' responses on another Likert-type scale, participants' 'bases of knowledge regarding mental illness' were most likely drawn from 'on-the-job experience' ($M = 4.46$, $SD = 1.21$), followed by 'personal experience' ($M = 4.22$, $SD = 2.00$) and 'Victoria Police training and education' ($M = 3.57$, $SD = 1.30$). It should be noted that 'personal experience' was made a composite

factor based on items including 'interactions in private life' and 'personal experience', after a factor analysis revealed these items were related.

3. Outcomes Following Police Encounters with Mentally Ill People

In response to the item 'how frequently do you use the following outcomes following your encounters with mentally ill people' the item with the highest rating was 'mental health apprehension' ($M = 4.31$, $SD = 1.40$), followed by 'arrest' ($M = 3.71$, $SD = 1.31$), 'no further action' ($M = 3.23$, $SD = 1.20$) and 'referral to another agency' ($M = 3.17$, $SD = 1.31$).

A canonical correlation was conducted using the outcome variables 'mental health apprehension' (Section 10 of the *Mental Health Act 1986* (Vic)), 'arrest', 'no further action' and 'referral to another agency' as the dependent variables and the sources of knowledge, including i) on-the-job and ii) personal experience, and sources of information, including i) 'police sources', ii) 'person-based information', and iii) 'medical practitioner', as covariates. The first canonical correlation attained significance, Wilk's $\Lambda = .64$ $F(24,10826.28) = 62.44$, $p< .001$. Canonical loadings pertaining to the dependents and covariates are shown in Figure 1 and interpreted in the following Text Box.
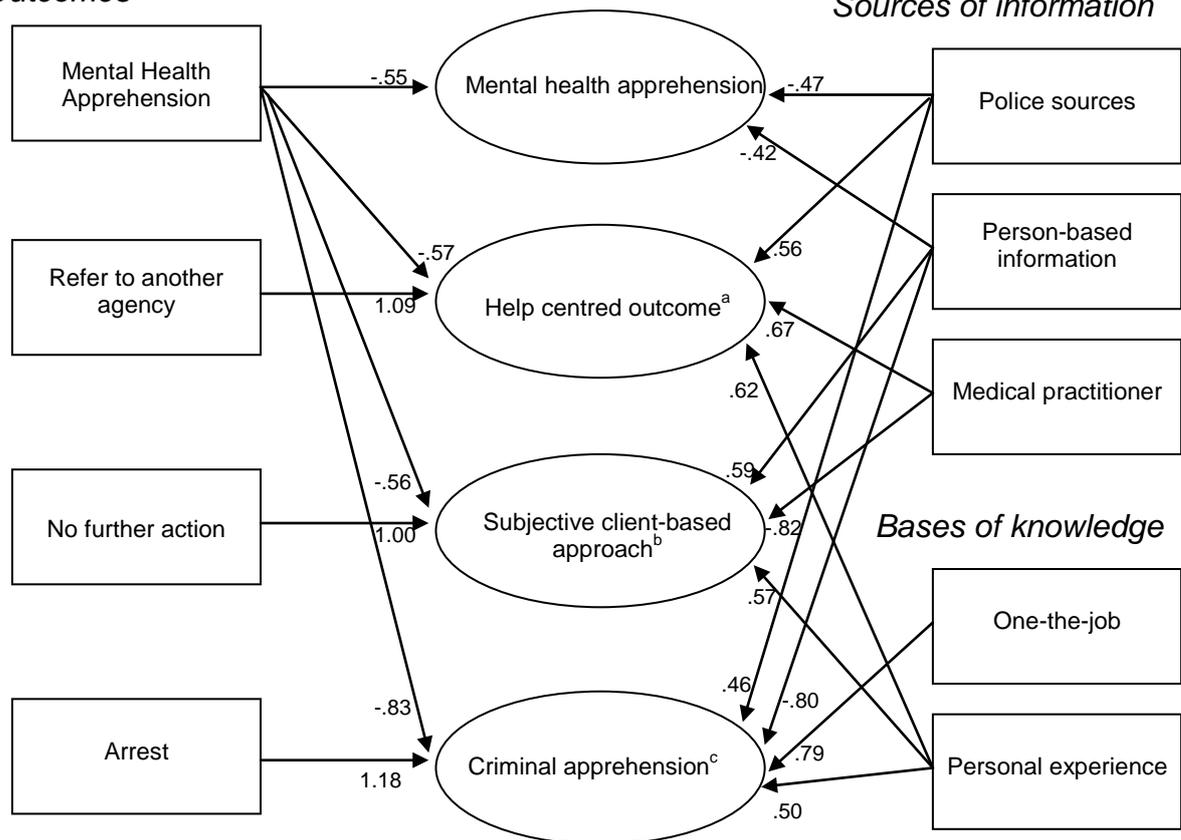
All loadings <.40 have been suppressed; [a] = Wilk's = .93, $F(15, 8569.18) = 15.56$, $p<.001$; [b] = Wilk's = ..99, $F(8, 6210) = 4.87$, $p<.001$; [c] = Wilk's = 1.00, $F(3, 3106) = 3.17$, $p<.05$.

Figure 1. Standardised canonical coefficients for the dependents (outcomes) and covariates (predictors).

Text box 1. Interpretation of approach style components

i. *Mental-health apprehension:* The likelihood of a mental health apprehension increases as information is garnered from police sources and the person;

ii. *Help-centred outcome:* The likelihood of referring to another agency increases as knowledge is derived from personal experience and information is gathered from medical practitioners, but decreases as information is garnered from the police;

iii. *Subjective-client centred approach:* The likelihood of taking no further action increases as a member's knowledge is derived from personal experience and information is garnered from the person rather than medical practitioners.

iv. *Criminal apprehension:* The likelihood of arrest increases as knowledge is derived from 'on-the-job' and personal experience and information is garnered from police sources rather than the person.

Notably, the 'help-centred outcome', 'subjective client-centred approach' and 'criminal apprehension' canonical variates were all negatively related to the decision to make an apprehension under the *Mental Health Act 1986* (Vic).

4. Biggest Challenges

Of a total of 809 challenges reported by respondents; 17 distinct themes emerged (see Table 3). There were four themes identified by more than five percent of participants. These included, in order of most frequently cited, (1) gaining support from mental health services; (2) communicating with the mentally ill; (3) avoiding violence / aggression; and (4) cooperation and compliance.

Table 3: Challenges faced by police when dealing with mentally ill people

Challenge	Number of citations (%)
Gaining support from mental health agencies	228 (28.2)
Communicating with mentally ill people	133 (16.4)
Avoiding violence / aggression	57 (7.1)
Cooperation & compliance	51 (6.3)
Identifying and understanding mental illness	40 (4.9)
Unpredictability	40 (4.9)
Insufficient police resources	37 (4.6)
Time	35 (4.3)
Gaining trust	28 (3.5)
Determining appropriate outcome	25 (3.09)
Inadequate police training	20 (2.5)
Interference from family & friends	18 (2.2)
Getting background information	13 (1.6)
Drug & alcohol abuse	11 (1.4)
Increased pain threshold	6 (0.8)
Transport	4 (0.5)
Own reactions	3 (0.4)
Uncategorised	60 (7.4)
Total	809 (100)

Discussion

The aim of this study was to examine the estimated frequency of contact between police officers and people experiencing a mental illness, the process by which officers evaluate whether someone is mentally ill, the bases of officers' knowledge and sources of information used when dealing with people who have a mental illness and the challenges faced by officers when performing these duties.

1. Frequency of Contacts

Surveyed police officers reported coming into contact with people experiencing mental illness on a regular basis; with almost half coming into contact with at least one to two people who have a mental illness per week, and over one third of respondents reported coming into contact with between three and ten mentally ill people each week. This suggests that a significant amount of police time is taken up dealing with people experiencing mental illness; a finding that is consistent with previous research (Fry, O'Riordan & Geanellos, 2002). For decades now, the factors which have been associated with increasing contacts between the police and people who have a mental illness have been debated. These include deinstitutionalisation and restrictive commitment criteria, which, have been said to culminate in the "criminalisation of the mentally ill" (Abramson, 1972). More recently, however, relatively high levels of violence (Wallace, Mullen & Burgess, 2004) and substance abuse (Junginger, Claypoole, Laygo & Cristanti, 2006) among people experiencing mental illness have been claimed to account for these encounters. Further research should establish whether these specific types of suspect/offender encounters are increasing and if and how these encounters are resolved.

Of particular note, though, these results further suggest that the social welfare role is now indeed commonplace in contemporary community policing (e.g., Stenning & Shearing, 2005), with police indicating that roughly equal proportions of their contacts with people experiencing mental illness were as suspects, victims, persons in need of assistance and vulnerable persons. It becomes increasingly important, therefore, to start to acknowledge the significant role police are playing supporting vulnerable members of the community; a role above and beyond traditionally defined and envisaged policing functions (e.g., Foster 2005). More objective and descriptive accounts of the frequency and nature of these broader policing functions has a real potential to meaningfully contribute to a dialogue concerning the need for closer working partnerships between police and health service providers. This is an area under current study by some of the authors.

2. Police Identification of Mental Illness

Police officers reported a wide range of signs, symptoms and behaviours that they believed to be associated with mental illness. Four out of the top five signs cited by officers, including 'speech/speech content', 'behaviour', 'appearance/hygiene', and 'body language', might be used by a mental health professional for the purposes of a mental status examination; all of these signs are readily observable and can provide valuable insight into a person's mental functioning. Of some importance was the identification of 'aggression/violence' as being indicative of mental illness. Several officers reported an "increased pain threshold" or "high pain tolerance" as being a sign of mental illness. On the one hand, extant evidence suggests that such beliefs are associated with more negative assumptions about dangerousness (i.e., increased dangerousness) and thus contribute to differential engagement,

containment and resolution strategies (Finn & Stalans, 1997; Watson, Corrigan & Ottati, 2004). Even if police can identify common signs and symptoms of mental illness, the more pressing concern when engaged in an encounter with a person in emotional distress does not relate to the identification of such indicators, but how to approach, engage and reassure the distressed person most effectively. The latter arguably represents a much more pressing training need for police members in relation to mental health awareness.

An examination of the sources of information used by officers to determine whether someone is mentally ill revealed that person-based sources and police information were used more frequently than reliance on medical practitioners. Possibly, this reflects the limited availability of medical practitioners to provide such advice. Consistent with previous research (Fry, O'Riordan & Geanellos, 2002) police officers felt unsupported by mental health agencies. However, previous Australian research reported that 98% of police officers had no knowledge regarding the availability of a 24 hour crisis intervention service available to assist them with interventions involving people experiencing mental illness (Wylie, 1990). This suggests a significant information gap and points to the need for improved and enhanced information sharing and collaborations between service providers.

This study also indicated that officers were more likely to base their understanding of mental illness on their on-the-job training and personal experience, rather than information gained from more formalised courses provided by Victoria Police or other external agencies. This model of learning is consistent with the apprenticeship-type model adopted in community policing whereby junior officers are paired with more senior, experienced officers. To maximise the impact of training, it is most important that training is delivered in a style consistent with

officers learning preferences. While police may not be so enthusiastic about certain elements of training, such as role plays (Vermette, Pinals & Appelbaum, 2005), a multi-modal learning program is in fact consistent with specialised training in other core elements of policing (Price, 2005). Given the frequency of contact with people experiencing mental illness and the challenges that arise, there is an ongoing need for formalised policies and training for police regarding mental illness with proper systematic evaluation. To overcome potential concerns about police providing all of the training due to the need to overcome underlying aspects of organisational culture, the more proactive involvement of mental health professionals in devising and/or delivering training content should be emphasized (Hails & Borum, 2003). This modality of expert-developed scenario-based training, where police have the opportunity to rehearse their skills, is now being rolled out by Victoria Police and will be the subject of ongoing evaluation and review.

3. Outcomes Following Police Encounters with Mentally Ill People

The 'figure' revealed the nature of the relationship between 1) the bases of officers' knowledge and sources of information used to determine whether someone is mentally ill, and 2) the four outcomes they might engage in following their encounters with people experiencing mental illness. According to the results, the likelihood of engaging in a mental health apprehension increased as information was gathered from the police and the person. Indeed, the *Mental Health Act 1986* (Vic) allows officers to apprehend someone if they "appear to be mentally ill". As indicated in the *Act*, officers are not required to exercise 'clinical judgement'. This research suggests that the addition of pre-recorded information from police sources regarding an individual may influence or otherwise reinforce an officer's 'layperson'

assessment that a mental health apprehension is the most appropriate course of action.

The results indicated that the likelihood of referring an individual to another agency increased as knowledge was derived from personal experience and information gathered from medical practitioners, but decreased as information was garnered from police sources. This suggests that a reliance on personal experience is more strongly associated with 'help-centred outcomes' than more restrictive options for dealing with people experiencing mental illness. The finding that referrals to other agencies are associated with advice from medical practitioners is not surprising, as advice from a medical practitioner represents a referral to another agency in itself. The finding that this outcome is associated with decreasing information from Victoria Police sources might be associated with the absence of police information regarding the person, and thus the need to seek third-party advice.

It was also revealed that the likelihood of taking no further action increased as a member's knowledge was derived from personal experience and information garnered from the person rather than medical practitioners. This is consistent with previous research that years of police officer' experience has a positive effect on the likelihood that police take no further action (Green, 1997). The 'figure' also described this 'no further action' outcome was associated with person-based information rather than medical practitioners. Perhaps individuals who adopt this 'subjective client-based approach' feel confident in their own decision making. On the other hand, it might be that officers viewed both 'arrest' and 'hospitalisation' as unfavourable outcomes due to concern the person would not get care and/or the time involved. Thus, taking no further action might have been considered the 'least bad' option.

The likelihood of arrest increased as knowledge was derived from 'on-the-job' and personal experience, and information was garnered from police sources rather than the person. The use of 'arrest' for dealing with mentally ill people has been cited as a 'last resort' option for handling mentally ill people (Teplin & Pruett, 1992). If this were the case, however, officers who chose this option would be likely to rely on information garnered from the person and, in particular, their observations of the individual. However, these results suggest that police based information was associated with the decision to arrest; that is, existing information regarding a person's previous misdemeanours might increase the likelihood of a 'criminal apprehension', irrespective of an individual's apparent mental health needs and presentation.

Notably, previous research has established that the outcomes of police officer encounters with people who have a mental illness are strongly dependent on situational variables; for example, the presence or absence of a complainant (Patch & Arrigo, 1999), the systems available to the police for dealing with people in crisis (Borum, Deane, Steadman & Morrissey, 2000) and the offence type (Green, 1997), among others. Nevertheless, these data suggest that the relative frequency of each outcome was also related to the bases of police officers' knowledge and the relative weight placed on sources of information regarding the people with whom they have contact.

4. Challenges

The dominant theme arising from the challenges listed by participants was 'gaining support'. This included support from different mental health agencies including hospitals and emergency psychiatric teams. One participant noted

"*hospitals haven't got the resources to assess mentally ill patients… therefore takes up valuable police time to find alternative answers*". Several officers also expressed frustration at having to "*baby-sit mentally ill people*" in hospital waiting rooms, while others found the mental health system to have a "*revolving door policy*", indicating that, often times, people are released from mental health services only to come back to the attention of police officers. Other themes included 'communicating with the mentally ill' and 'identifying and understanding mental illness'. For example, one officer reported difficulty "*being able to communicate with someone who is not rational*". Another participant reported problems with "*knowing different types of mental illness (and) what approach to take*". Other frequent themes included 'avoiding violence/aggression' and 'cooperation and compliance'. Within these themes were concerns regarding keeping individuals calm, avoiding harm to both people experiencing mental illness and police officers and people to comply with instructions. For example, one participant listed the challenge "*gaining trust from mentally ill person to enable you to ultimately get them to medical facility without physical confrontation*".

These challenges highlight broad areas which can be considered for improvement in the interface between the police and people experiencing mental illness. First, and perhaps most importantly, police organisations might benefit from more formal partnerships with mental health services; police officers need to be able to refer mentally ill people to mental health agencies without consuming an unreasonable level of police resources (Borum, 2000). Although officers are not required to diagnose individuals with mental illness, officers would benefit from knowing how specific mental illnesses, such as psychotic disorders, might affect a person's thinking and behaviour. Such training could be coupled with strategies for

improving communication and compliance when dealing with mentally ill people, especially those who present in an irrational state. Added to this, a common issue that arose from participants' responses was the lexicon used for describing mentally ill people. In the instance that officers were equipped with an appropriate discourse for dealing with mentally ill people, one benefit might be improved communication between police officers and mental health professionals.

Several limitations should be noted when interpreting these research findings. Although the response rate among the 3811 police officers who were invited to participate was 92.7%, the actual number of police officers who attended OSTT during the data collection phase was 7914; however, surveys were only given to 44.6% of the available population by the OSTT facilitators at the time of sampling. Nevertheless, our response rate was substantially higher than recent research of a similar nature (e.g., Cooper, McLearen & Zapf, 2004). Due to the size and scope of the research undertaken, a cross sectional methodology was adopted; however, this brings with it some limitations, particularly concerning interpretations of causality and directionality of relationships between variables. The research also relied on self-report by consenting police thus increasing the anonymity of respondents, but leaving an opportunity for increased risk of socially desirable responses; the latter was essentially controlled for by considering and measuring social desirability alongside other police responses. Complementary methodologies, combining the scaled responses with more focussed follow-up discursive questions delivered via face-to-face method may have helped uncover some of the stark differences and more subtle nuances between individual decision-making processes. Research of this nature is currently underway, the details of which are available from the authors.

To most recruits, joining the police force is about dealing with those people who break the law and their victims. While this remains the essence of what is popularly considered 'real police work', it is increasingly only filling a small portion of their role (Foster, 2005, pg 200). One of the key challenges therefore is for police to consider the significant social welfare dimension of community policing an integral and important core component of their role. Despite the reported enthusiasm by large numbers of police to undertake training about mental illness, there potentially remains a real challenge of translating this new found knowledge into practice when there is an underlying culture that measures and rewards 'real police work', but does little to formally recognise the broader supportive roles they perform on a daily basis. This kind of cultural shift is an endeavour that cannot occur in isolation in any one agency; instead such an initiative will require a whole of system response. Only with a concerted, focussed and sustained program of interagency collaboration will the police become better equipped for resolving encounters at this interface and recognised for their pivotal role in this vital community service.

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CHAPTER 4: POLICE OFFICERS' ATTITUDES REGARDING MENTAL ILLNESS

4.1 Preamble to Empirical Paper

This chapter is the presentation of the second study incorporated in this thesis. The aim of this study was to describe police officers' attitudes regarding mental illness as measured using the Mental Health Attitude Survey for Police (MHASP; Clayfield, Fletcher & Grudzinskas Jr., 2009). This paper adds to the literature by describing police attitudes along four dimensions as determined using Principal Components Analysis (PCA), and further, discusses the significance of these attitudes in the context of police officers' extensive involvement with people experiencing mental illness.

This article has been submitted to Law and Human Behavior – the journal of the American Psychology-Law Society.

Monash University

4.2 Declaration for Thesis Chapter 4

Declaration by candidate:

In the case of Chapter 4, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Literature review, project design, data collection and analysis and writing of paper.	80

The following co-authors contributed to the work:

Name	Nature of contribution	Extent of contribution (%)
Prof James Ogloff	Review of paper drafts and general supervisory input	7.5
Dr Stuart Thomas	Review of paper drafts and general supervisory input	7.5
Dr Stefan Luebbers	Assisted with statistical analyses	5

Candidate's Signature		Date

Declaration by co-authors

The undersigned hereby certify that:
(1)   the above declaration correctly reflects the nature and extent of the candidate's contribution to this work, and the nature of the contribution of each of the co-authors.
(2)   they meet the criteria for authorship in that they have participated in the conception, execution, or interpretation, of at least that part of the publication in their field of expertise;
(3)   they take public responsibility for their part of the publication, except for the responsible author who accepts overall responsibility for the publication;
(4)   there are no other authors of the publication according to these criteria;
(5)   potential conflicts of interest have been disclosed to (a) granting bodies, (b) the editor or publisher of journals or other publications, and (c) the head of the responsible academic unit; and
(6)   the original data are stored at the following location(s) and will be held for at least five years from the date indicated below:

Location(s)	Centre for Forensic Behavioural Science, Monash University, 505 Hoddle Street, Clifton Hill, VIC 3068

Signature 1		Date
Signature 2		
Signature 3		

4.3 Policing People Experiencing Mental illness: Factoring in Officers' Attitudes

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ABSTRACT: Police officers play a significant role in the management of people experiencing mental illness who live in the community. The aim of this study was to explore police officers' attitudes toward mental illness and their work-based activities involving people who experience mental illness. A survey of 3811 police officers in Victoria, Australia, revealed that officers' attitudes can be ascribed to four distinct dimensions. On the whole, attitudes about people experiencing mental illness were positive, but negative about the mental health system that cares for them. Multivariate analyses revealed that officers' attitudes were not associated with demographic characteristics. The importance of further research investigating the relationship between attitudes, police discretion, and decision-making is highlighted.

By fulfilling their legally sanctioned role in the management of people who experience mental illness, police officers have become known as 'gatekeepers' to the criminal justice and mental health systems (Bittner, 1967). Over the years, factors such as deinstitutionalisation, increasingly restrictive involuntary commitment criteria, and a limited availability of community-based mental health services have increased the involvement of the police in dealing with individuals who have a mental illness (Bonovitz & Bonovitz, 1981; Borum, Deane, Steadman & Morrissey, 1998; Menzies, 1987; Patch & Arrigo, 1999; Pogrebin & Poole, 1987).

Although most people who are mentally ill are not violent and do not commit serious offences, they are more likely to do so than people who do not have a mental illness (Wallace, Mullen & Burgess, 2004). The police therefore find themselves in the dual role of curtailing antisocial behaviour as well as helping those who are vulnerable and in need of assistance. Despite having to act in this 'pseudo case management role' it has been reported that the police generally feel unsupported by the mental health system (Godfredson, Ogloff, Thomas & Luebbers, 2010). The question then arises as to whether the police do in fact display any evidence of punitive or malevolent attitudes regarding people who experience mental illness.

More than thirty years ago, Lester (1978) investigated the attitudes of a small sample of police officers and reported them to be slightly more '*authoritarian*' and less '*benevolent*' than health care workers. More recently, Cotton (2004) investigated the attitudes of 138 police officers in Eastern Ontario and British Columbia using the Community Attitudes toward Mental Illness scale (CAMI; Taylor & Dear, 1981). She found attitudes could be explained along four dimensions. Among these was a high degree of '*benevolence*', which described a paternalistic and sympathetic view of people with a mental illness, a moderate degree of '*community mental health*

ideology', and lower levels of *'authoritarianism'* and *'social restrictiveness'*. Of note, none of age, gender, years of service, education, amount of previous contact, rank or region were associated with the attitudes, which given their high intercorrelations had been combined to a single measure. Cotton concluded that officers' attitudes are *"highly idiosyncratic and not particularly related to organisational or demographic factors"* (p.144). A similar conclusion was drawn by Cooper and colleagues (2004) who, following a survey of 92 American police officers, reported no association between six attitudinal items and gender, ethnic group or years in the department.

Following a study of 156 police officers in Greece, Psarra and colleagues (2008) reported that the surveyed police officers tended to believe that escorted patients were often violent, threatening or unpredictable, that mentally ill people should be permanently hospitalised, but that medication could reduce violent behaviour. Although the attitudes reported by Psarra and colleagues were much more negative than those described by Cotton, they too, found no overall relationship between attitudes and demographic variables. Nevertheless, they reported more positive attitudes among participants with 12 or more years of education compared to those with less than 12 years education.

Taken altogether, these studies suggest that police officers' attitudes might not be explained by demographic characteristics. However, some of the small scale studies had results 'approaching significance', suggesting that further investigation incorporating larger samples might reveal relationships between attitudes and demographic characteristics. A range of studies from a variety of cultural settings suggest that disparities in police officers' attitudes toward people with a mental illness reported in the aforementioned studies might be attributable to the culture or

region in which the police officer operates. For example, the majority of police officers in Psarra and colleagues' study reported that it was not their responsibility to deal with people experiencing mental illness. Following a survey of 200 police officers in New Zealand, Dew and Badger (1999) reported the sentiment that dealing with mentally ill people was "*something that is not a police problem and for which they have little training*" (p.36). Similarly, officers in New South Wales, Australia, reported that while officers remained inadequately trained and supported, work with mentally ill people was not considered valid police work (Fry, O'Riordan & Geanellos, 2002).

By contrast, American police officers surveyed by Cooper, McLearen and Zapf (2004) reported, on average, strong endorsement of the statement '*it is my responsibility to deal with the mentally ill*'. Similarly, following a study of 382 police officers in Chicago, Watson and colleagues (2004) reported that after reading a hypothetical scenario, officers reported being more likely to help a person with a mental illness who is in need of assistance than a person who did not have a mental illness. These findings therefore suggest that perhaps the culture in which police officers work might influence their attitudes. This position is further supported by the finding that different models of policing are associated with differences between officers' sense of preparedness and perceived effectiveness in their dealings with the mentally ill (Borum, Deane, Steadman & Morrissey, 1998).

In the wake of deinstitutionalisation and changing mental health laws, the legal responsibilities of the police appear juxtaposed by the lack of support they receive from mental health services. In light of this conflict there is likely to be confusion and disagreement regarding what policing is really about. An understanding of police officers' attitudes regarding people who have a mental

illness is important, because these factors might impact on officers' willingness and preparedness for responding to the needs of people with a mental illness. Following a meta-analysis of 797 studies, Wallace and colleagues (2005) reported that attitudes were moderately effective at predicting behaviours. From this it follows that variability in police officers' attitudes might result in variable outcomes for people experiencing mental illness following encounters with police officers.

This study represents the first time police officers' attitudes toward people with a mental illness have been explored on such a large scale. It is also the first study of its kind in Victoria, Australia. This study was exploratory in nature; however, a particular emphasis was placed on describing the dimensions of police officers attitudes, and the relationships between these and demographic characteristics.

Method

Source Population and Recruitment

Victoria is a State of approximately 5 million people (Australian Bureau of Statistics, 2005). Mental health services are regionalised to 22 catchment areas across the state, excluding the state-wide forensic mental health service. Victoria Police employs approximately 13,600 people and incorporates five regions (consisting of four to five divisions each), totalling 339 police stations across the state. Police regions/divisions and mental health catchments rarely overlap, meaning that 2-3 distinct mental health services may have responsibility within a specific police division, or vice versa.

Police officers up to and including the rank of inspector were invited to participate in this study during Operational Safety Tactics Training (OSTT) which

officers must attend biannually. This study recruited officers from nine of these

training sites around the state of Victoria from January to June, 2008, thereby

allowing for a total possible sample of 7914 officers. An OSTT training facilitator

introduced the study then explanatory sheets and the questionnaires were distributed

to all potential participants. At the end of the session, participants were invited to

post their questionnaire in a sealed opaque box, regardless of whether or not they had

chosen to complete them. This ensured that participation was voluntary and that

those who chose to not participate could not be identified. The study was approved

by the Monash Standing Committee on Ethics in Research Involving Humans and

the Victoria Police Human Research Ethics Committee.

Questionnaire Composition

A multicomponent questionnaire was developed by the authors in

consultation with senior police personnel and policy makers from Victoria Police.

The questionnaire included a section on demographic variables, such as age, gender,

rank and years of experience. The questionnaire also included the Mental Health

Attitude Survey for Police (MHASP; Clayfield, Fletcher & Grudzinskas, 2009)

which was intended to measure their attitudes toward mental illness and their work

with people experiencing mental illness. Participants rated their responses to the

MHASP on a 6-point Likert scale ranging from 1 = "strongly agree" to 6 = "strongly

disagree". Minor amendments were made to the original questionnaire to ensure

cultural sensitivity and appropriateness and these were checked for face validity by

the multidisciplinary research team. Finally, social desirability was considered using

the short 13 item version of the Marlowe-Crowne Social Desirability Scale (Crowne

& Marlowe, 1960). The questionnaire also included other sections not described

here, but which have been reported in a previous paper (Godfredson, Thomas, Ogloff & Luebbers, 2010).

Data manipulation and approach to analysis

Returned surveys were scanned into a database which was later converted for use with SPSS (version 16, 2007). The 37 items in the MHASP were analysed using Principal Components Analysis (PCA) to explore underlying themes and patterns in officers' attitudes. The eight factors derived from this analysis were again analysed using PCA, resulting in a two-tiered model of police officers' attitudes. These factors were then related to officers' demographic characteristics using multivariate analysis of variance (MANOVA). Missing data were excluded from analyses on a case-wise basis.

Results

Of the 3811 surveys given to potential participants, 277 were returned blank resulting in a total of 3534 participants and a response rate of 92.7%. None of the items were associated with social desirability.

Approximately three quarters of the respondents were male ($n = 2749$, 77.8%) and one quarter were female ($n = 757$, 23.2%). The most represented age bracket was 31-40 years ($n = 1450$, 41%), followed by 41-50 years ($n = 1044$, 29.5%). The majority of respondents were senior constables (n = 2113, 59.8%), followed by constables ($n = 644$, 18.2%) and sergeants ($n = 550$, 15.6%). The most frequently reported length of years in the force was 15 or more years of service ($n = 1552$, 43.9%), while 638 (18.1%) had served 6-10 years and 496 (14%) between 1 and 3 years. Nearly half of respondents worked in the metropolitan area (n = 1607, 45.5%), while approximately one quarter worked in each of regional ($n = 969$,

27.4%) and rural ($n = 865$, 24.5%) areas. Comparison with data provided by police officials indicated that the demographic characteristics of the respondents were broadly representative of Victoria Police.

Officer Attitudes

The initial PCA and subsequent examination of a scree plot supported an eight factor model, and this made theoretical sense. An oblique rotation was used as the factors were expected to be interrelated. The factor structure explained 55.17% of the variance (see Appendix A).

The factors in the model were assigned descriptive names reflecting the themes arising from the data, which are presented in Text box 1 together with the mean rating of each factor.

Text Box 1. Lower order attitude factor names and mean ratings*

> 1. *Segregated mental health services:* Mental health services should be isolated from the rest of the community ($M = 3.38$; $SD = 0.91$);
> 2. *Comfort regarding response:* Comfort level responding to people experiencing mental illness and confidence in the system adequately cares for them ($M = 2.63$; $SD = 0.74$);
> 3. *Increased resources:* Increased spending for mental health and specialised training for police are needed ($M = 4.48$; $SD = 0.68$);
> 4. *Lack of confidence:* Unpreparedness for resolving situations involving people experiencing mental illness ($M = 2.52$; $SD = 0.85$);
> 5. *Role rejection:* Dealing with people experiencing mental illness is not real police work ($M = 3.52$; $SD = 0.74$);
> 6. *Informal interventions:* Due to limited hospital beds and pressure in my organisation, many people with mental illnesses are dealt with informally ($M = 3.68$; $SD = 0.86$);
> 7. *Acceptance and involvement:* Rejection of ideas that people experiencing mental illness should be avoided and that they lack discipline and willpower ($M = 4.46$; $SD = 0.86$);
> 8. *Heteronomy and negativity:* Paternalistic care and restrictions to the autonomy of people with a mental illness should apply; they are different and childlike ($M = 3.53$; $SD = 0.67$).

*Range = 1 (strongly disagree) to 6 (strongly agree)

Facet scores were calculated for participants on each of the eight factors using the regression method. The regression method was used to take into account the initial correlations between items and factors. The eight facet scores derived from this analysis were then factor analysed to identify higher order factors. A PCA was used with an oblique rotation. The model explained 65.82% of the variance, representing 36.31% of the variance in the initial 37 items. Details of the corresponding four factor structure are presented in Appendix B. The intercorrelations between the four factors and internal consistency reliability (coefficient α) are presented in Appendix C. The higher order factors were assigned names reflecting the combined themes of the lower order factors and are presented in Text box 2 together with the mean ratings.

Text box 2. Higher order attitude factor names and mean ratings*

> 1. *Segregation, role rejection and avoidance* ($M = 3.78$; $SD = 0.38$)
> 2. *Comfort regarding own response and advocating paternalistic management* ($M = 3.00$; $SD = 0.52$)
> 3. *Increased resources in the context of informal outcomes* ($M = 4.08$; $SD = 0.54$)
> 4. *Lack of confidence* ($M = 2.52$; $SD = 0.85$)

*Range = 1 (strongly disagree) to 6 (strongly agree)

A series of MANOVAs were then conducted to explore the relationships between this two tiered model of officers' attitudes regarding mental illness and demographic variables. The resulting multivariate statistics revealed that although there were statistically significant relationships between the attitudes and all the demographic variables, the effect sizes were very small. The variables included age, Wilk's $\Lambda = 0.96$, $F(4, 20) = 5.61$, p < .001, $\eta^2 = .01$; gender, Wilk's $\Lambda = 0.98$, $F(4, 4) = 15.15$, $p < .001$, $\eta^2 = .02$; rank, Wilk's $\Lambda = 0.93$, $F(4, 24) = 8.44$, $p < .001$, $\eta^2 = .02$;

years of service, Wilk's $\Lambda = 0.97$, $F(4, 16) = 5.87$, $p<.001$, $\eta^2 = .01$; and region, Wilk's $\Lambda = 0.99$, $F(4, 8) = 4.44$, $p < .001$, $\eta^2 = .01$.

As *p*-values are a function of the sample size and the difference between reality and the null hypothesis, a sufficient sample will always lead to a 'statistically' significant result (Cohen, 1994; Thompson, 1998). Our large sample size combined with such small effect sizes suggested that any 'real-world' significance was likely to be negligible. Therefore, further univariate analyses were not deemed necessary or appropriate.

Discussion

For people with a mental illness to live successfully in the community depends, in part, on the willingness and preparedness of police officers to 'handle' and 'deal with' a small proportion of people experiencing mental illness who attract their attention. The aim of this study was to explore Victorian Police officers' attitudes regarding mental illnesses and their work with people who are mentally ill. The following section describes the various dimensions of police officers' attitudes, explores the significance of the multivariate analyses of officers' attitudes and demographic characteristics, and highlights the importance of variability in these attitudes.

Attitude Dimensions

Data reduction techniques revealed that the attitudes of police officers, as assessed using the Mental Health Attitude Survey for Police (MHASP), can be categorised across four broad themes, including *'segregation, role-rejection and avoidance'*, *'comfort regarding response and paternalistic management'*, *'increased*

resources in the context of informal outcomes' and *'lack of confidence'*. Unlike the four attitude factors of police attitudes reported by Cotton (2004), these factors did not have high intercorrelations and thus represent distinct attitudinal dimensions.

The first higher order attitude factor, *'segregation, role-rejection and avoidance'*, was positively related to two lower order attitude factors, including *'segregated mental health services'* and *'role rejection'* and negatively related to *'acceptance and involvement'*. This suggests that those officers who believe that mental health services should be isolated from communities tend also to believe that dealing with people who have a mental illness people is not real police work. Those who endorse these items tend to agree with ideas that people with mental illnesses should be avoided and that such people lack discipline and willpower. This finding is inconsistent with Cotton's (2004) finding that police officers did not display high levels of *'authoritarianism'* and *'socially restrictive attitudes'*, but consistent with Psarra and colleagues (2008) study in which Greek police officers advocated for restrictive treatment options for people with mental illnesses. The average level of endorsement of this factor in our sample was slightly above the midpoint (with a relatively small spread) indicating that our sample of police officers held a moderate overall endorsement of this cluster of unhelpful beliefs concerning people who experience mental illness, the treatment of such individuals and the police role.

The second higher order attitude factor, *'comfort regarding response and paternalistic management'*, encompassed the lower order attitude factors *'comfort regarding response'* and *'heteronomy and negativity'*. The lower order factor *'comfort regarding response'* revealed a correlation between individuals who reported feeling more comfortable responding to males *and* females who have a mental illness and are in crisis. It is possible that participants' cursory reading of the

item led them to overlook the inferred comparison between males and females and simply report their degree of comfort responding to individuals in crisis. These items were positively correlated with having confidence in the mental health system. Further, this higher order factor reflected an endorsement of paternalistic care and restrictions to the autonomy of people with a mental illnesses and the attitude that people with mental illnesses are childlike and easily differentiated from normal people. The overall endorsement of this higher order attitudinal factor was tending toward disagreement with a relatively small standard deviation; the majority of participants did not endorse this cluster of attitudes.

The third attitude factor *'increased resources in the face of informal outcomes'* describes an attitudinal dimension on which officers endorsed *'increased spending'* and *'informal interventions'*. This suggests that officers who support increased spending for mental health and specialised training for police tended also to endorse items reflecting pressure to solve situations informally due to pressure within the police organisation combined with limited hospital beds. Previous research has indicated that 70% of encounters with mentally ill people were handled informally (Teplin & Pruett, 1992) and, similarly, that around 70% of instances of contact with mentally ill people were not recorded (Green, 1997; Wylie, 1990). This attitudinal dimension had the highest mean rating out of all the higher order factors. It appears that in the face of having to resolve encounters informally, many officers tend to advocate for more mental health and police resources.

The fourth attitude factor, *'lack of confidence'* represented the same dimension as the lower order factor structure. This factor incorporated items related to officers' confidence handling decisions and situations involving people who experience mental illness and knowing when to apply the *Mental Health Act 1986*

(Vic). This attitude factor had the lowest rating of all the attitudes, indicating that most officers did not endorse items reflecting low confidence. Relative to the other attitudinal dimensions this item had a high standard deviation reflecting considerable variation with regard to participants' levels of confidence.

Relationships with Demographic Variables

Although the multivariate analyses of police officers' attitudes with demographic variables reached statistical significance, the effect sizes indicated that these differences most likely had little 'real-world' significance. While previous researchers have reported variability in police officers' attitudes, no research to date has reported any significant relationships with demographic variables (Cooper, McLearen & Zapf, 2004; Cotton, 2004; Psarra et al., 2008), thus suggesting that variability in attitudes might not be related to demographic characteristics. Further investigations might reveal, in fact, that such differences in attitude relate to more local factors such as different regions and models of policing. For example, Borum and colleagues (1998) compared three models of policing, including specially trained police officers, in-house mental health professionals and mobile crisis teams. The officers who took part in the specialised training reported being significantly better prepared and having more positive perceptions of the mental health system than officers from the other models. It is possible that organisational differences might have influenced the officers' attitudes regarding their preparedness and the mental health system, but equally plausible is that officers who volunteered for specialised training may have a particular pattern of more positive attitudes. Furthermore, the increasing existence of local-based collaborative initiatives between police and

mental health providers may also impact on dispositional attitudes, thus providing the potential for identifying and championing best practice models and practices.

Future Directions

Of particular importance is determining whether the attitudes of police officers regarding mental illness relate to different behaviours and outcomes following their encounters with people who experience mental illness. According to previous research, the predictive capacity of attitudes is strongest in behaviours which are easy to enact, but also low in social desirability (Wallace, Paulson, Lord & Bond, 2005). It might be that negative police attitudes regarding mental illness are most strongly associated with outcomes following encounters that require minimal effort, such as ignoring the situation.

Furthermore, it should be examined whether assumptions regarding people experiencing mental illness relates to officers' preferred outcomes. Although the common assumption among police officers that people experiencing mental illness are more dangerous than people who do not have a mental illness (Watson, Corrigan & Ottati, 2004) is, in fact, commensurate with research findings (Wallace, Mullen & Burgess, 2004), this might translate into a heavy-handed approach for dealing with *all* individuals who have a mental illness. Indeed, Green (1997) reported that lesser experienced police officers were the most likely to arrest following real-world encounters with people experiencing mental illness. This supports a hypothesis that inexperience might be associated with particular assumptions regarding the likelihood that people who have a mental illness pose a threat to others.

Of equal importance is establishing any relationship between positive attitudes of police officers and their methods for dealing with people experiencing

mental illness. If these attitudes do correlate with helpful outcomes for people who have mental illness then it might be worth consolidating and promoting such attitudes with the aim of reducing variability in outcomes.

Limitations

A number of limitations should be considered when interpreting the results of this study. The response rate among the 3811 police officers who were invited to participate was 92.7%; however, the actual number of police officers who attended OSTT during the data collection phase was 7914. Surveys were only given to 44.6% of the available population by the OSTT training facilitators. Nevertheless, our response rate was substantially higher than recent research of a similar nature (e.g., Cooper, McLearen & Zapf, 2004; Cotton, 2004; Fry, O'Riordan, & Geanellos, 2002). This study also relied on self-report measures that carry with them a risk of socially desirable responses; however this was controlled for using a social desirability scale. This research utilised a cross-sectional survey design, which also carries with it some limitations. While we have described dimensions of officers' attitudes on which certain beliefs or assumptions tend to 'cluster' together, we cannot determine directionality or causality between these variables. Such an examination would require a longitudinal study design, which might be especially useful in the study of interventions designed to modify or influence police officers attitudes and understanding regarding mental illnesses and their work with people experiencing mental illness.

Conclusion

The results of this study suggest that there is considerable variability in the attitudes of police officers in Victoria regarding their work with people experiencing mental illness. The most strongly endorsed attitudinal dimension reflected a desire for increased mental health and police resources in the context of having to rely on informal outcomes. Most officers reported being adequately trained and confident in their decisions following encounters with people who have a mental illness. However, some officers who hold pejorative attitudes regarding people with mental illnesses tend to believe that dealing with such people is not real police work.

This study was enhanced by the use of a large sample size. Within this sample of police officers, the relationship between attitudes and demographic variables did not hold any 'real world' significance. The current lack of understanding regarding the factors which are associated with police officers' attitudes and whether these attitudes relate to police officers' chosen outcomes for resolving encounters with mentally ill people represents a significant gap in this growing and important body of knowledge. Further understanding of this latter point is particularly important, because variability in police officers' decision-making, combined with insufficient mental health resources, is likely to lead to variable, and at times negative, outcomes for individuals whose access to treatment should be timely, effective and determined by their mental health needs.

Appendix A. Factor structure of the Mental Health Attitudes Survey for Police (MHASP)

Item number	Segregated mental health services	Comfort regarding response	Increased resources	Lack of confidence	Role rejection	Informal interventions	Acceptance and involvement	Heteronomy and negativity
28	0.81							
Local residents have good reason to resist the location of mental health services in their neighbourhood								
15	0.78							
Mental health facilities should be kept out of residential neighbourhoods								
31	0.77							
Having mentally ill people living within residential neighbourhoods might be good therapy but the risks are too great								
25	-0.76							
Locating mental health services in residential neighbourhoods does not endanger local residents								
17	0.74							
Locating mental health facilities in a residential area downgrades the neighbourhood								
5	-0.67							.35
Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community								
14	-0.57							
Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services								
6	0.50							
It is frightening to think of mentally ill people living in residential neighbourhoods								
16	0.50							
Mentally ill persons should be isolated from the rest of the community								
26		0.76						
I feel more comfortable responding to calls involving mentally ill females in crisis								
34		0.73						
I feel more comfortable responding to calls involving mentally ill males in crisis								
27		0.43						
I have confidence in the mental health system to adequately care for mentally ill people								
7		0.82						

#	Statement	1	2	3	4	5
	More money should be spent on the care and treatment of mentally ill people					
8	We have a responsibility to provide the best possible care for mentally ill people		0.74			
29	Increased spending on mental health services is a waste of money		-0.62			
9	Nowadays, police officers need to have specialised training in dealing with mentally ill people		0.48			
24	Mentally ill people are a disadvantaged group who deserve special consideration from the police	0.37	0.38		-0.37	
33	I feel confident in my ability to handle decisions involving mentally ill people			-0.85		
19	I feel that I am adequately trained to handle situations/calls involving mentally ill people			-0.73		
30	I know when to apply Section 10 of the *Mental Health Act*			-0.72		
18	Dealing with mentally ill people should be an integral part of community policing		-0.68			
36	If mental health services were adequate, the police would not have to deal with mentally ill people				0.62	
22	Responding to calls involving mentally ill people is not really part of a police officer's role				0.58	
23	We need to adopt a far more tolerant attitude toward mentally ill people in our society		0.30	-0.31		
35	A large percentage of calls involving mentally ill people who violate the law are dealt with informally					0.76
32	There is pressure within my organisation to solve the problems associated with mentally ill people on an informal basis					0.72
37	Hospital personnel are reluctant to accept mentally ill people referred by the police				0.40	0.46

Item	F1	F2	F3	F4	F5	F6	F7	F8
12 It would be foolish to marry a person who has suffered from a mental illness, even though she/he seems fully recovered							-0.80	
13 I would not want to live next door to someone who has been mentally ill	0.36						-0.60	
10 It is best to avoid anyone who is mentally ill							-0.57	
3 Wellness and recovery are possible and achievable for mentally ill people							0.52	
11 One of the main causes of mental illness is a lack of self-discipline and willpower							-0.51	
4 Mentally ill people need the same kind of control and discipline as a young child								0.66
2 As soon as a person shows signs of mental illness, he/she should be hospitalised								0.57
21 There is something about mentally ill people that makes it easy to tell them from normal people								0.38
1 Mentally ill people take up more than their fair share of police time								0.37
20 Mentally ill people should not be given any responsibility								0.33
Eigenvalue	8.08	2.90	2.30	1.99	1.69	1.39	1.06	1.00
% variance explained	21.85	7.84	6.21	5.38	4.57	3.75	2.87	2.71
α	0.89	0.52	0.67	0.67	0.64	0.44	0.72	0.55

Appendix B. Higher order factor structure for the Mental Health Attitude Survey for Police (MHASP)

Factor (Facet)	1	2	3	4	Eigenvalue	% variance explained
1. Segregation, role rejection and avoidance						
Segregated mental health services (1)	0.76				1.88	23.49
Role rejection (5)	0.71					
Acceptance and involvement (7)	-0.69					
2. Comfort regarding response and paternalistic management						
Comfort regarding response (2)		0.85			1.24	15.47
Heretonomy and negativity (8)		0.54				
3. Increased resources in context of informal outcomes						
Increased resources (3)			0.78		1.15	14.43
Informal interventions (6)			0.67			
4. Lack of confidence						
Lack of confidence (4)				1.00	1.00	12.44

Appendix C. Inter-correlations between factors.

	1	2	3	4
1. Segregation, role rejection and avoidance	α = 0.89			
2. Comfort regarding response and paternalistic management	.12**	α = 0.55		
3. Increased resources in the context of informal outcomes	0.07**	.01	α = 0.53	
4. Lack of confidence	0.07**	.10**	-0.01	α = 0.67

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CHAPTER 5: POLICE DECISION MAKING FOLLOWING ENCOUNTERS WITH PEOPLE EXPERIENCING MENTAL ILLNESS

5.1 Preamble to Empirical Paper

This chapter is the presentation of the third study incorporated in this thesis. The aim of this study was to describe some of the factors which relate to the way in which police officers chose to resolve hypothetical encounters with people experiencing mental illness. This paper builds on findings in Chapter 3, including the way in which differing sources of information and bases of knowledge regarding mental illness are related to the frequency with which police officers report engaging in various outcomes, and the challenges police officers face when undertaking this type of work. This paper also investigated if, among other factors, the four attitudinal dimensions describing police officers' attitudes regarding mental illness which were identified in Chapter 4 can be used to discriminate among the outcomes chosen by police officers after viewing hypothetical scenarios depicting police encounters with a person experiencing mental illness. This paper significantly adds to the literature by describing the importance of police officers' attitudes, and further, the discrepancy between the way in which police officers would 'ideally' versus 'most likely' resolve their encounters with people experiencing mental illness.

This article has been submitted to Criminal Justice and Behavior, the journal of the International Association for Correctional and Forensic Psychology (IACFP).

5.2 Declaration for Thesis Chapter 5

Declaration by candidate:

In the case of Chapter 5, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Literature review, project design, data collection and analysis and writing of paper.	80

The following co-authors contributed to the work:

Name	Nature of contribution	Extent of contribution (%)
Prof James Ogloff	Review of paper drafts and general supervisory input	7.5
Dr Stuart Thomas	Review of paper drafts and general supervisory input	7.5
Dr Stefan Luebbers	Assisted with statistical analyses	5

Candidate's Signature		Date

Declaration by co-authors

The undersigned hereby certify that:
(1)   the above declaration correctly reflects the nature and extent of the candidate's contribution to this work, and the nature of the contribution of each of the co-authors.
(2)   they meet the criteria for authorship in that they have participated in the conception, execution, or interpretation, of at least that part of the publication in their field of expertise;
(3)   they take public responsibility for their part of the publication, except for the responsible author who accepts overall responsibility for the publication;
(4)   there are no other authors of the publication according to these criteria;
(5)   potential conflicts of interest have been disclosed to (a) granting bodies, (b) the editor or publisher of journals or other publications, and (c) the head of the responsible academic unit; and
(6)   the original data are stored at the following location(s) and will be held for at least five years from the date indicated below:

Location(s)	Centre for Forensic Behavioural Science, Monash University, 505 Hoddle Street, Clifton Hill, VIC 3068

Signature 1		Date
Signature 2		
Signature 3		

5.3 Police Discretion and Encounters with People Experiencing Mental Illness: The

Significant Factors

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Abstract:

Police discretion, as it applies to encounters with people experiencing mental illness, has far reaching implications. In this study some of the factors which are related to police officers' decisions following encounters with people experiencing mental illness were explored. Officers were presented with one of three videos depicting a police encounter with an individual who was either mentally ill, not mentally ill or had an ambiguous mental state. Participants were asked how they would "likely" and "ideally" resolve the encounter. Discriminant function analysis revealed that officers' responses were related to 1) the severity of symptoms presented, and 2) the officers' attitudes toward people experiencing mental illness, as measured by an attitudes questionnaire. There was a discrepancy between participants' 'likely' and 'ideal' outcomes to the scenarios, which supported the well-known fact that police officers face considerable obstacles when attempting to resolve encounters with people experiencing mental illness.

For many years, the frequency of encounters between police officers and people experiencing mental illnesses has been steadily increasing (Bonovitz & Bonovitz, 1981; Pogrebin & Poole, 1987). To this end, the alarmingly high proportion of people diagnosed with mental illnesses housed in Australia's police cells (Ogloff, Tye, Blaher, Warren & Thomas, 2010) and prisons (Butler & Allnutt, 2003; Mullen, Holmquist & Ogloff, 2003) serves as compelling evidence. These data do not, however, account for the myriad of police encounters which result in mental health dispositions or other less formal outcomes which nonetheless consume police resources.

Literature concerning the interface between the police and people experiencing mental illness is replete with citations regarding the 'criminalization theory' (Abramson, 1972), which typically refers to defining behaviours related to symptoms of mental illness as criminal, thus resulting in arrest. However, evidence ostensibly in support of criminalisation theory, in particular, higher arrest rates among people with a mental illness relative to people without a mental illness (Teplin & Pruett, 1992), have been discounted or reinterpreted following further enquiry (Bonovitz & Bonovitz, 1981; Engel & Silver, 2001; Hiday, 1992). One explanation for the increased contact between people experiencing mental illness and the criminal justice system is that deinstitutionalisation provided more opportunities for people who otherwise would have been institutionalised to come into contact with the police. Some researchers have attributed high rates of contact between police officers and individuals with mental illnesses to an increased risk of violence among people who have a mental illness (Wallace, Mullen & Burgess, 2004), which is often compounded by drug use (Ferguson, Ogloff & Thomson, 2009). Other researchers have highlighted that sociodemographic factors which predict offending among people experiencing mental illness are the same as factors which predict offending among the general population (Fisher et al., 2006).

Mental health legislation in most jurisdictions outlines the responsibility of the police regarding the protection of people who present as a threat to themselves or others. It has long been recognised, however, that these laws represent a framework which can be difficult to apply in specific situations (Bittner, 1967). Given that most encounters between the police and people experiencing mental illness do not involve people who meet civil commitment or criminal arrest criteria (Green, 1997; Wylie, 1990), police officers must often exercise considerable discretion. This discretion is particularly evident in what Goldstein (1960) termed "low-visibility" encounters, for example, when there is no victim, or the victim does not wish to pursue charges.

In addition to restrictive outcomes including mental health apprehension (which in Victoria is described by Section 10 of the *Mental Health Act 1986* (Vic) and criminal arrest, police officers can chose to ignore the situation, handle the matter themselves, or refer the matter to a community mental health service, such as Crisis Assessment and Treatment (CAT) teams, which provide 24 hour psychiatric assessment and treatment to people who are experiencing psychiatric crisis. In this paper, the responsibility of police officers to select and engage in one of the aforementioned options following an encounter with someone experiencing mental illness is referred to as 'police discretion'.

Much research has highlighted factors associated with police discretion as it applies to people experiencing mental illness, including, for example, situational barriers to care (Dupont & Cochran, 2000), the type of encounter (Patch & Arrigo, 1999), and the training and resources available to the police (Borum et al., 1998; Cherrett, 1995). Also of interest to researchers have been offenders' mental state, gender and race (Finn & Stalans, 1997; Smith, Visher & Davidson, 1984) and the knowledge, experience and education of police officers regarding working with people who are mentally ill (Green, 1997; LaGrange, 2003; Patch & Arrigo, 1999; Teplin,

2000; Watson, Corrigan & Ottati, 2004). More recently, researchers have become

interested in the influence of police officers' attitudes regarding mental illness. Some

argue that police officers' attitudes strongly affect their decision making (Anasseril,

2004; Medias & Kehoe, 2006), while others argue that, as a general rule attitudes can

account for little more than slight variation in police behavior (Worden, 1989). Cotton

(2004) conducted a factor analysis of police officers' attitudes as measured using the

Community Attitudes toward Mental Illness (CAMI) Scale (Taylor & Dear, 1981). She

reported attitudes which were, broadly speaking, benevolent, tolerant and non-

restrictive. In contrast, other researchers have reported that police officers tend to reject

the idea that dealing with people experiencing mental illness should be part of the police

role (Dew & Badger, 1999; Fry, O'Riordan & Geanellos, 2002; Psarra et al., 2008).

Only one published study exists which has explored the relationship between

police officers' decision making and their attitudes regarding mental illness. Following

a survey of 554 American police officers, Watson, Corrigan and Ottati (2004) reported

that the label of mental illness was not significantly related to police officers' responses

to hypothetical scenarios. To the best of our knowledge, the relationship between police

discretion and attitudes as measured via a standardised questionnaire has never been

examined in an Australian context. An increased understanding of police officers'

attitudes is important because research suggests that attitudes can impact on our

behavior; in particular, behaviors which are easy to enact and are low in social

desirability (Wallace, Paulson, Lord & Bond, 2005).

Some theorists argue that the authority given to the police affords them the role

of "gatekeeper" for the criminal justice system (Bittner, 1967). Others have argued that

police discretion is a causal factor in the criminalisation process (Lamb, Weinberger &

DeCuir, 2002) and, further, that police involvement with people experiencing mental

illness actually inhibits the development of a long-term mental health care policy (Wachholz & Mullay, 1993). Continued research in this area is necessary to increase our understanding and stimulate debate regarding society's responses to individuals experiencing mental illness.

The aim of this study was to examine factors which are related to police discretion following a hypothetical encounter with a person experiencing mental illness. Among the variables which will be explored include 1) the apparent severity of an individual's symptoms of mental illness, and 2) officer characteristics including attitudes toward people experiencing mental illness and the sources of information officers use to identify and understand mental illness.

Method

Source Population and Recruitment

Victoria is a State of approximately 5,000,000 people (Australian Bureau of Statistics, 2005). Mental health services are regionalised to 22 catchment areas across the state, excluding the state-wide forensic mental health service. Victoria Police employs approximately 13,600 people and incorporates five regions (consisting of four to five divisions each), totalling 339 police stations across the state. Police regions/divisions and mental health catchments rarely overlap, meaning that 2-3 distinct mental health services may have responsibility within a specific police division, or vice versa.

All operational police officers in the State of Victoria up to and including the rank of Inspector are required to attend Operational Safety Tactics Training (OSTT) twice a year. All officers who attended this training during the data collection phase (1-13th of October, 2007) were eligible to participate. Given rostering demands around the

state, a broad representation of officers from different locations and at different ranks is found in each training group. The research was introduced by a member of the research team and questionnaire packs were handed out to all potential participants. After participants had completed the first section of the survey, they watched one of three short video vignettes which were projected onto a screen. After viewing the scenario they completed the last section of the survey. To ensure voluntariness, participants were invited to place their surveys, completed or left blank if they chose not to participate, in the box at the end of the session. This procedure ensured that those who chose not to complete the survey could not be identified. The study received full ethical scrutiny and approval from the Monash Standing Committee on Ethics in Research Involving Humans and the Victoria Police Human Research Ethics Committee.

Questionnaire and Vignette Composition

A multicomponent questionnaire was developed by the authors in consultation with senior police personnel and policy makers from Victoria Police. Specific sections sought to document 1) the sources of information used to understand and identify whether someone had a mental illness, scored according to a six-point likert scale (where 1 = "strongly based/very often" to 6 = not based at all/never); and 2) the attitudes of police officers toward people experiencing mental illness. This second section incorporated the Mental Health Attitude Survey for Police (MHASP; Clayfield, Fletcher & Grudzinskas, 2009) which included 37 items rated on a 6-point Likert scale (where 1 = "strongly disagree" to 6 = "strongly agree"). Minor amendments were made to the original MHASP scale to ensure cultural sensitivity and appropriateness; these were checked for face validity by the multidisciplinary research team. Social desirability was measured separately using the 13-item version of the Marlowe Crowne Social

Desirability Scale (Reynolds, 1982). A further question was included to examine whether officers were interested in further training.

Three hypothetical vignettes were filmed depicting an interaction between a man who might be mentally ill drinking alcohol in a park and two police officers. The scenarios were developed after consultation with a multidisciplinary team including psychologists, a psychiatrist and a psychiatric nurse. Advice was also sought from senior Victoria Police personnel from the Victoria Police Behavioural Analysis Unit. Several features were incorporated to ensure that the scenarios depicted a scene which afforded the officers maximum discretionary power (see Patch & Arrigo, 1999), including a minor offence (drinking in a park), an anonymous complainant and an absence of bystanders. The three versions of the scenario included depictions of the man as 1) 'not mentally ill', 2) 'possibly mentally ill', and 3) 'clearly mentally ill'. In the third scenario the man exhibited symptoms sometimes associated with a psychotic episode. For example, he was highly agitated, suspicious and his speech was loud and pressured. Further, the man's speech content indicated the presence of a formal thought disorder. Each scenario ended prior to the encounter being resolved.

The questionnaire included a final section which participants completed after viewing one of the three scenarios. This included two multiple choice questions regarding how participants would 'most likely' resolve the encounter with the options being (a) walk away from the situation, (b) handle the matter informally, (c) call for assistance from a CAT (Crisis Assessment and Treatment) team, who provide 24 hour assessment and treatment for people in psychiatric crisis, (d) apprehend the man using police powers under the *Mental Health Act 1986* (Vic), and (e) arrest. Participants were also asked to indicate how they would 'ideally' resolve the encounter with the options

the same as listed above. Participants were also asked to indicate, if relevant, why their 'ideal' response differed from their 'most likely' response to the hypothetical scenarios.

Data Manipulation and Approach to Analysis

Data from returned surveys were manually entered into SPSS (version 16, 2007). In a previous study incorporating 3534 respondents the MHASP scale was factor analysed, resulting in a two-tiered factor structure (see Godfredson, Thomas, Ogloff & Luebbers, 2010). The first tier of the factor structure included eight factors. These were summarised by three higher order factors, including a) 'segregation, role rejection and avoidance', which described attitudes that mental health services should be kept out of residential neighbourhoods; dealing with people who are mentally ill is not real police work; and that people with mental illnesses lack discipline and willpower and should be avoided, b) 'comfort with response and paternalistic management', which described comfort responding to males and females experiencing mental illness who are in crisis; support for paternalistic care and restrictions to the autonomy of people experiencing mental illness; and those who have a mental illness are different and childlike, c) 'increased resources in the context of formal involvement', which described attitudes that increased spending in mental health and specialised training for police officers is needed; and there is pressure in the police organisation and from hospitals to resolve encounters on an informal basis. This factor structure was applied to the current sample and the higher order attitude factors were incorporated as predictive variables.

Discriminant function analysis was used to predict group membership according to a series of predictor variables. In this sense, it was used to examine variables which differentiated participants' 'likely' and 'ideal' outcomes chosen after viewing one of the three hypothetical scenarios. Likely outcomes were those officers would ordinarily use

given their normal resources and options. The ideal outcomes were those officers would use if there were no constraints on the resources or options available to them. The independent variables included 1) symptoms of mental illness, 2) the four higher order attitude factors from the MHASP, and d) 'lack of confidence', which described feeling inadequate in relation to own knowledge, training and decision making in encounters with people experiencing mental illness, 3) bases of knowledge, including a) education provided by Victoria Police, b) personal experience, and c) on the job training, and 4) the sources of information, including a) police sources, b) person-based information, and c) medical practitioner information.

Results

Demographic Characteristics

Of the 310 surveys handed out to potential participants, 304 were returned resulting in a response rate of 98.1%. The average age of respondents was 37.9 years ($SD = 8.6$) and the average years of service on the force was 13.0 years ($SD = 9.3$). There were 228 (75%) males, 59 (20.6%) females and 17 (5.6%) people did not report their gender. There were 166 (54.6%) constables, 55 (18.1%) senior constables, 49 (16.1%) sergeants, 8 (2.6%) senior sergeants and 26 (8.6%) participants did not report their rank. Most participants ($n = 254$; 84.4%) worked in metro areas, four (1.3%) worked in country areas and 46 (15.1%) did not specify region. The extent to which the findings of this study apply to police officers from country areas is uncertain. Aside from region, these data are broadly consistent with state-wide demographic data provided by Victoria Police. There were no significant differences in the size or demographic variables of the groups assigned to each of the three vignettes.

There were a number of discrepancies in the proportion of participants' 'likely' and 'ideal' responses to the scenarios. For example, in response to the scenario depicting ambiguous symptoms of mental illness, a higher proportion of officers chose 'call a CAT team' as their 'ideal' response (40%) than participants who chose it as their 'likely' response (7.2%). A similar pattern of response regarding 'call a CAT team' was reported in the scenario depicting obvious signs of mental illness (ideal = 55.1%; likely = 22.5%). The most commonly chosen 'likely' outcome for these two vignettes differed, however. In the scenario depicting ambiguous symptoms, the most frequently reported 'likely' outcome was 'handle the matter informally', chosen by 56.8% of participants. In contrast, in the scenario depicting obvious signs of mental illness, the most frequently reported 'likely' outcome was 'mental health apprehension', chosen by 55.1% of respondents (see Figure 1). Participants' responses to the scenarios were not related to their demographic characteristics.
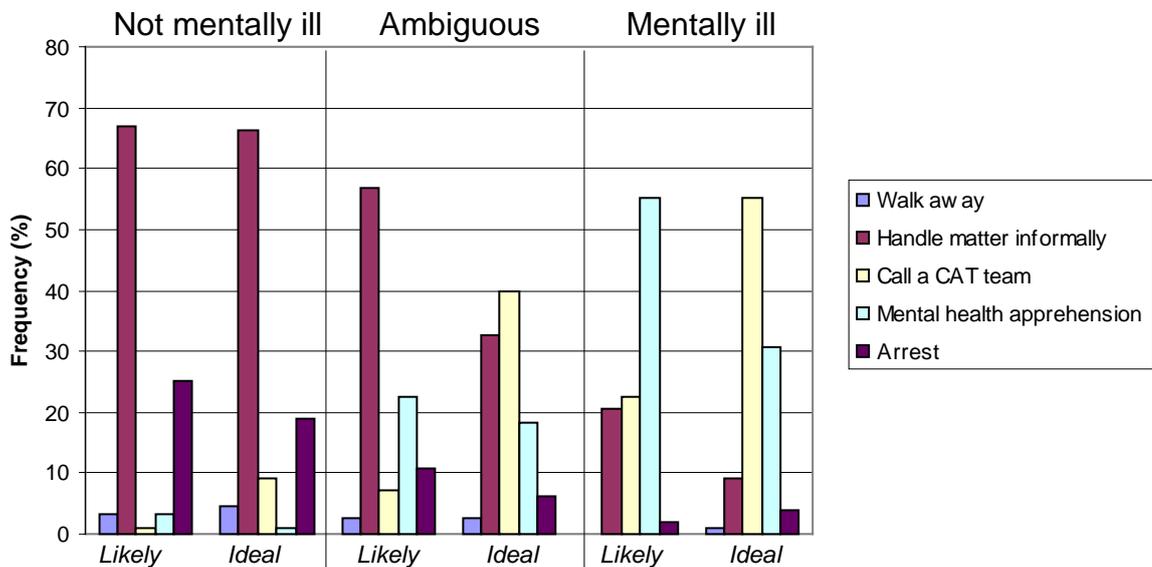
Figure 1. Proportion of 'likely' and 'ideal' responses by mental state of accused

Following discriminant function analysis of participants' 'likely' responses to the hypothetical scenario, it was revealed that the first and second functions significantly differentiated the groups, Wilk's $\Lambda = 0.458$, $\chi^2 (44) = 193.68$, $p < .001$, and Wilk's $\Lambda = 0.810$, $\chi^2 (30) = 51.22$, $p < .05$. Similarly, for participants 'ideal' responses to the scenario, the first and second functions significantly differentiated the groups, Wilk's $\Lambda = 0.463$, $\chi^2 (44) = 189.24$, $p < .001$, and Wilk's $\Lambda = 0.801$, $\chi^2 (30) = 54.62$, $p < .05$.

The structure matrix for the first and second functions is presented in Table 1. The first function for participants' 'likely' response primarily represents 'symptoms of mental illness'. The second function for participants' 'likely' response is positively related to 'lack of confidence' and 'education provided by Victoria Police' but negatively related to 'segregation, role rejection and avoidance' and 'police sources (of information)'. The first function for participants' 'ideal' response also primarily

represents 'symptoms of mental illness'. The second function is, again, positively

related to 'lack of confidence' and negatively related to 'segregation, role rejection and

avoidance' and 'police sources (of information)', but also negatively related to 'comfort

regarding response and paternalistic management'.

Table 1. Structure matrix for the first and second functions from the discriminant function analysis.

	Likely response		Ideal response	
	Function			
	1	2	1	2
Symptoms of mental illness	**.92**	.06	**.93**	-.15
Segregation, role rejection and avoidance (A)	0	**-.58**	-.04	**-.61**
Comfort regarding response and paternalistic management (A)	-.02	-.14	-.04	**-.26**
Increased resources in the context of informal outcomes (A)	.14	.01	.22	.15
Lack of confidence (A)	.06	**.61**	.04	**.52**
Education provided by Victoria Police (K)	-.11	**.29**	.01	.16
Personal experience (K)	-.14	.19	-.10	.09
On the job experience (K)	-.03	.08	-.04	-.01
Police sources (I)	.07	**-.27**	.03	**-.33**
Person-based information (I)	-.04	-.02	-.02	-.06
Medical practitioner (I)	.15	0	.12	.02

Note. A = higher order attitude factor; I = source of information used to determine if someone is mentally ill; K = bases of knowledge regarding mental illness. Values in **bold** represent those above a function loading cut-off of .25.

Relationship between Predictive Variables and Outcomes

According to the plot of group centroids (Figure 2), an increased severity of

symptoms of mental illness is associated with the outcomes 'call a CAT team' and

'mental health apprehension'. A lower severity of symptoms of mental illness is

associated with the outcomes 'walk away from the situation', 'arrest' and 'handle the

matter informally'.
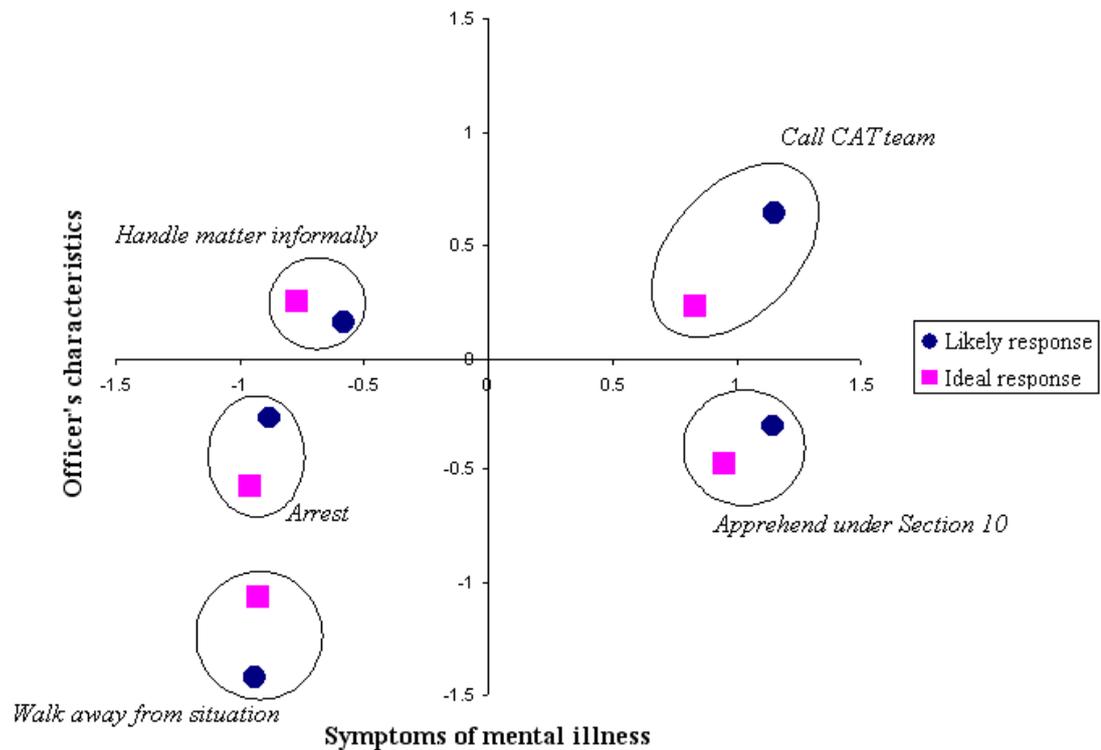
Figure 2. Plot of group centroids.

Note that high scores on officers' characteristics represent a positive association with *low* confidence, and a negative association with pejorative views; high scores on symptoms of mental illness represent a high severity of mental illness symptoms depicted in the scenario.
Note that x axis = symptoms of mental illness and y axis = officer characteristics

The plot of group centroids also indicates that higher levels of both 'segregation, role rejection and avoidance' and 'confidence' are associated with 'walk away from situation' and, to a lesser extent, 'arrest' and 'mental health apprehension'. Conversely, a decrease in both 'segregation, role rejection and avoidance' and 'confidence' is associated with 'handle matter informally' and 'call a CAT team'.

In response to the open ended question, "what additional training would you like to receive?" 21.6% (*n* = 67) of participants provided a response indicating they would like some form of additional training. A further 57% (*n* = 177) wrote "nil" and 19% (*n* = 60) did not provide a response.

Discussion

Within the bounds of situational and contextual variables, police officers are necessarily afforded considerable discretion when resolving encounters with members of the public, including those who experience mental illness. The aim of this study was to explore some of the factors that are related to the outcomes chosen by Victoria Police officers after viewing one of three hypothetical scenarios, each of which differed in the degree of apparent psychiatric symptomatology presented by the accused.

The outcomes chosen by a representative sample of Victorian police officers after viewing hypothetical encounters with people experiencing mental illness were found to relate to two factors. The factor with the highest predictive capacity was the severity of symptoms of mental illness portrayed in the vignettes. This suggested that, broadly speaking, officers were adept at selecting outcomes which were appropriate given the mental health needs depicted in the vignette. The second factor which predicted participants' chosen outcomes was 'officers' characteristics'. This dimension encapsulated 'pejorativeness' and 'confidence' and was interpreted as describing a degree of awareness regarding the issues faced by people experiencing mental illness. This factor was related to the outcomes whereby increasing awareness was linked to help-centred outcomes and decreasing awareness was related to inaction, and to a lesser extent, restrictive outcomes.

The discrepancies between officers' 'likely' and 'ideal' outcomes suggested that officers face considerable obstacles when attempting to resolve encounters with people experiencing mental illness. These situational and contextual obstacles might also moderate the extent to which officers' attitudes influence their behavior . The following section describes the factors which discriminated between the outcomes chosen by the officers, and discusses the discrepancies between their 'likely' and 'ideal' responses.

Discriminating Outcomes to Scenarios

The two functions which discriminated the outcomes chosen by the participating officers after viewing the hypothetical scenarios shed some light on the factors which might influence police officers' decision-making in cases involving mental illness. Higher scores on the first function for both outcomes primarily represented an increasing severity of mental illness symptoms. This outcome confirmed the trend which was apparent simply by comparing the frequency of outcomes across the three scenarios. The scenario which portrayed a man who was clearly not experiencing mental illness was predominantly associated with the outcome 'handle the matter informally'. The scenario depicting ambiguous symptoms of mental illness was associated with a mix of the formal and informal outcomes, indicating that this scenario was interpreted by officers as affording the greatest discretion. Lastly, the depiction of a man who was clearly experiencing severe mental illness was associated with the highest endorsement of mental health outcomes, which included 'call a CAT team' and 'mental health apprehension'. This pattern of responding indicated that officers chose outcomes which reflected appropriately the increasing severity of depicted symptoms of mental illness.

To date, there exist no Australian studies with which these findings can be compared. Nevertheless, police powers in Australia are similar to Canada and the United States; that is, police officers can apprehend a person for the purpose of having them assessed by a medical professional if the person appears to be experiencing mental illness and they pose a risk of harm to themselves or someone else. The findings of this study are inconsistent with findings of Watson, Corrigan and Ottati (2004) that the label 'mental illness' was not related to outcomes chosen in response to hypothetical scenarios involving a suspect who was experiencing mental illness. However, the

researchers found that the label 'mental illness' was related to other call types. It should be noted that the methodology used in Watson, Corrigan and Ottati's study was quite different to the methodology described in this paper. In accordance with their particular research questions, these researchers did not include mental health outcomes as a response to the "suspect" scenario and they chose to use descriptive vignettes as opposed to video-based scenarios.

The results of this study are, however, consistent with the results of a study by Engel and Silver (2001) who examined the relationship between suspects' mental health and the use of arrest by police. After controlling for legal and extra-legal factors, the researchers found that the police were not more likely to arrest suspects experiencing mental illness.

These findings are commensurate with the powers of Victorian police officers described in the *Mental Health Act 1986* (Vic); although police officers are not required to 'diagnose' an individual with a mental illness, they may invoke their powers if, in addition to meeting other criteria, an individual *appears* to be mentally ill.

Importantly, the proportion of participants who chose 'arrest' in response to the scenarios tended to decrease as symptom severity increased. This is inconsistent with previous suggestions that police officers engage in 'mercy booking' (Lamb & Weinberger, 1998) or that they 'handle mentally ill people via arrest' (Teplin & Pruett, 1992). In fact, these data indicate that officers might demonstrate leniency when dealing with people experiencing mental illness who are involved in minor law infractions. These findings might not apply to situations involving more serious offending.

The second function which discriminated between the outcomes chosen by participants was associated with a decrease in the cluster of negative attitudes 'segregation, role rejection and avoidance' and an increase in 'lack of confidence'.

Higher levels of this factor could be described as 'decreasing pejorativeness' combined with 'increasing awareness', or in other words, officers who 'know what they don't know'. Higher levels of these characteristics were associated with the outcomes 'call a CAT team' and 'handle the matter informally'. This is consistent with findings of La Grange (2003) that officers with enhanced knowledge were more likely to have reported the use of psychiatric referral following an encounter with a person experiencing mental illness. It should be noted, however, that 'handle the matter informally' might have been interpreted by some officers as requesting the man to move on, rather than attempting to assist him in some way.

These results are also consistent with findings of Green (1997) that more experienced officers were the least likely to invoke restrictive criminal justice or mental health involvement due to the perceived ineffectiveness of these outcomes. It should be noted, however, that Green's 'no action' outcome could be considered synonymous with both our 'handle the matter informally' and 'ignore the situation' outcomes. Nevertheless, it makes sense that greater experience might be linked to enhanced awareness of the issues faced by people experiencing mental illness, and concomitantly, engagement in outcomes which are perceived to be helpful.

A decrease in the second function was associated with increasing 'pejorativeness' and increasing confidence, which following our line of reasoning could be interpreted as officers who 'don't know what they don't know'. These officer characteristics were most strongly associated with the outcome 'walk away from the situation'. This is consistent with findings that attitudes have their strongest relationship with behaviors which are easy to enact and low in social desirability (Wallace, Paulson, Lord & Bond, 2005). To a lesser extent, this factor was also associated with the restrictive 'arrest' and 'mental health apprehension' outcomes. This suggests that,

depending on the symptoms exhibited by a person experiencing mental illness, these negative characteristics might also be associated with restrictive outcomes. These findings are consistent with previous research which found that police officer decision making was related to inferences regarding a suspect's dangerousness and, further, officers' endorsement of restrictive treatment options (LaGrange, 2003; Watson, Corrigan & Ottati, 2004). Similarly, Medias and Kehoe (2006) reported that officers who believe their role is primarily to enforce the law will be more likely to resort to arrest. These findings are important because they indicate that particular attitudes among police officers' might be associated with restrictive outcomes following encounters with people experiencing mental illness.

One of the most striking features of these data is the discrepancy between officers' 'likely' and 'ideal' responses to the hypothetical scenarios. Across scenarios depicting ambiguous and severe symptoms of mental illness, a much greater proportion of participants chose 'call a CAT team' as their 'ideal' response relative to their 'likely' response. The obstacles which might prevent officers from initiating a psychiatric referral could include a delayed response time or strict attendance criteria of these teams, among others. In the face of these potential obstacles it is interesting to note participants' 'likely' responses to the vignettes. In the scenario depicting ambiguous symptoms, the most frequently reported 'likely' outcome was 'handle the matter informally', describing a situation where officers are left to deal with the matter themselves. This is consistent with research indicating that many police officers feel unsupported and perceive mental health systems as inadequate (Cherrett, 1995; Fry, Riordan & Geanellos, 2002). In the scenario depicting obvious signs of mental illness the most frequently reported 'likely' outcome was 'mental health apprehension', while 'call a CAT team' was the common 'ideal' response. That 'mental health apprehension'

was not the preferred response is consistent with an abundance of evidence that police officers feel frustrated with hospital eligibility criteria and lengthy waiting times (Fry, Riordan & Geanellos, 2002; Green, 1997; Lamb, 1982; Teplin & Pruett, 1992; Wylie, 1990). It is clear just by looking at the discrepancies between participants' 'likely' and 'ideal' responses that police officers face considerable obstacles when resolving encounters with people experiencing mental illness.

The subtle differences in the relationships between the discriminating functions and participants' nominated 'likely' and 'ideal' outcomes potentially reveal further important contextual information. In the absence of environmental constraints, as was intended to be captured by officers' 'ideal' response, the strength of the relationship between officer characteristics (including pejorative attitudes and increased confidence) and the outcome 'walk away from the situation' is increased. The reverse pattern was evident in the outcomes 'arrest', 'call a CAT team' and 'mental health apprehension'. This pattern of responses suggests that officers' preferred outcomes might be constrained by situational and contextual variables and is consistent with the hypothesis that police officers experience a number of 'barriers to care' (Dupont & Cochran, 2000). These findings are also consistent with what Patch and Arrigo (1999) described as 'police-invoked order maintenance encounters' which are said to afford police officers the greatest discretion and thus have the greatest potential to be influenced by officers attitudes and beliefs. Due to the subjectivity of the analytic process used in determining what are ultimately subtle differences, this remains speculative.

Only one fifth of police officers who participated in this study nominated particular topics related to mental illness in which they would like further training. This is in stark contrast to a study by Carey (2001) in which 77% of 210 surveyed officers in Scotland indicated they would like further training. The police officers we surveyed

who did nominate topics for further training tended to be of a higher rank than those who did not nominate topics. Victoria Police currently provides for its members six hours training in mental health at the recruit level and 1.5 hours training at the probationary level. Victoria police also offers two days mental health first aid training to officers by expression of interest; however, it was anticipated that by the end of 2009 only ten percent of the Victorian police force would have completed this training. Further, the Victoria Police Operational Safety and Tactics Training (OSTT), which officers must attend biannually, recently incorporated a small component of mental health awareness training. The limited training offered to police officers in Australia has been associated with the excessive use of force by police on people experiencing mental illness internationally (Fyfe, 2000) and police training, policy and practice in Victoria have come under particular scrutiny over the last twenty or so years, following a number of reviews into the number of police shootings involving people experiencing mental illness (Dalton, 1998; Kesic, Thomas & Ogloff, 2010). The relatively small proportion of surveyed police officers who would like further training lends weight to the suitability of a model whereby police officers volunteer for specialised training and as a result become 'in-house' specialists (e.g., Borum, Deane, Steadman & Morrissey, 1998).

These findings should be interpreted in light of two main limitations. First, this experimental study employed the use of hypothetical scenarios. Even if our results can be extrapolated to real world settings, these findings might not apply in all situations, such as encounters which were sparked by more serious offending, or encounters involving female offenders experiencing mental illness. While these limitations could be overcome through the use of a naturalistic study, the observational method carries with it the problem of accurately controlling for the mental state of individuals

concerned, and as such is liable to contradictory findings (e,g., Engel & Silver, 2001; Teplin & Pruett, 1992). Second, this study utilised a cross-sectional survey. Although these results indicated that police officers' attitudes were related to their chosen outcomes to hypothetical scenarios, to actually determine directionality or causality between these variables a longitudinal study would need to be conducted.

In the wake of a broad shift toward community-based care, the management of people experiencing mental illness has defaulted to police officers. According to the results of this study, police officers' preferred outcomes following encounters with people experiencing mental illness are related to, among other variables, their attitudes toward mental illness. While attitudinal change might be achievable through educational and promotional activities, there could be no more powerful an intervention than to equip police officers with the training, resources and interagency support required to undertake this invaluable community service.

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CHAPTER 6: GENERAL DISCUSSION

This chapter includes critical examination of the major findings which emerged from the three studies which have been incorporated in this thesis. First, the findings related to the three aims presented in the introduction will be summarised. Second, the implications of these findings are discussed, including an examination of the complexity of the interface between police officers and people experiencing mental illness and police officers' attitudes. This section will also examine the factors which have been found to relate to police officers' decision-making following encounters with people experiencing mental illness, including the sources of information police officers use to determine if someone is mentally ill, the bases of police officers' knowledge regarding mental illness, police officers' attitudes regarding mental illness and the symptoms of mental illness among those who attract police attention. Third, the research findings will be used to inform recommendations regarding changes to service delivery including service enhancements and training for new recruits. Finally, limitations and directions for future research are provided.

6.1 Overview of Main Findings

In this thesis, we examined the interface between police officers in Victoria, Australia, and people experiencing mental illness. In relation to the three broad aims identified in the introductory section, the following major findings emerged.

6.1.1 Research Aim One: Police Officers' Perceptions Regarding their Experiences Dealing with People Experiencing Mental Illness

The study reported in Chapter 3 described an investigation of the estimated frequency of contacts between police officers and people experiencing mental illness, the signs, symptoms and behaviours that police officers consider are associated with

mental illness, the bases of police officers' information and knowledge regarding mental illness, the way in which police officers' knowledge and the sources of information used relates to the frequency with which they report engaging in various outcomes following their encounters with people experiencing mental illness and the challenges police officers face when performing these duties. It was found that surveyed police officers reported frequent contacts with people experiencing mental illness. Over half of respondents reported coming into contact with at least one to two people experiencing mental illness per week, and one third reported between three and ten contacts per week. These findings are consistent with previous research which has found that a significant amount of police time is taking up dealing with people who are mentally ill (Fry, O'Riordan & Geanellos, 2002).

Police officers reported a number of signs, symptoms and behaviours that they believed might be associated with mental illness, which were similar to those which might be used by a mental professional for the purposes of a mental status examination.

It was found that police officers tended to use information available to them from the person experiencing mental illness themselves, which might be related to the limited availability of mental health or medical practitioners to provide such advice. This finding indicates the need for improved and enhanced information sharing and collaborations between service providers. It was also found that police officers tended to base their understanding of mental illness on their work and personal experience, as opposed to formal courses provided by Victoria Police. Most likely this experiential model of learning, which is consistent with an 'on-the-job' learning style of policing, could be enhanced with formal, evidence-based knowledge provided by experts.

The frequency with which officers reported engaging in mental health outcomes was associated with information which is gathered from the police and the person,

which is consistent with the *Mental Health Act 1986* (Vic), which states that police officers can apprehend a person if they "appear to be mentally ill". Referral to other agencies was associated with knowledge derived from personal experience and information gathered from medical practitioners, but decreased as information was garnered from police sources. The outcome 'no further action' was associated with knowledge derived from personal experience and information garnered from the person, rather than medical practitioners. Finally, arrest was associated with knowledge derived from 'on-the-job' and personal experience, and information garnered from police sources rather than the person. Taken together, these findings suggest that differences in police officers' bases of knowledge and the sources of information they chose to rely on to determine if someone is mentally ill is related to officers' estimates regarding the frequency with which they invoke various outcomes following their encounters with people experiencing mental illness.

Finally, police officers identified a number of challenges they face when working with people experiencing mental illness. The challenges raised covered a number of core themes, including 'gaining support from mental health agencies', 'communicating with the mentally ill', 'identifying and understanding mental illness', 'avoiding violence and aggression' and 'cooperation and compliance'. The identified areas suggest that police officers are faced with a range of significant difficulties in their work with people experiencing mental illness, and point to a need to improve partnerships between the police and mental health agencies, and the provision of practical training for police in various issues related to mental illness.

6.1.2 Research Aim Two: Police Officers' Attitudes Toward Working with People Experiencing Mental Illness

The aim of the second study was to explore police officers' attitudes toward working with people experiencing mental illness. Participants completed the Mental Health Attitude Survey for Police (MHASP; Clayfield, Fletcher & Grudzinskas, 2009). The 37 MHASP items were analysed using Principal Components Analysis (PCA), which yielded eight factors. These factors were again analysed using PCA, resulting in four higher order factors. The first factor, 'segregation, role-rejection and avoidance', described the belief that mental health services should be isolated from communities and that dealing with people experiencing mental illness is not real police work. This factor attracted average endorsement slightly above the midpoint. The second factor, 'comfort regarding response and paternalistic management' described feeling comfortable responding to men and women in crisis, having confidence in the mental health system and endorsement of paternalistic care. Participants tended toward disagreement on this factor. The third factor, 'increased resources in the face of informal outcomes', described endorsement of increased spending and specialised training and a sense of pressure to resolve encounters informally due to pressure in the police force and limited mental health resources. This factor attracted the highest average endorsement. The last factor, 'lack of confidence', incorporated items related to officers' confidence handling decisions and situations involving people experiencing mental illness and attracted the lowest average endorsement of all the factors.

We concluded that there was no 'real-world' significance in the relationship between officers' attitudes and their demographic variables. This is consistent with other contemporary research (Cooper, McLearen & Zapf, 2004; Cotton, 2004; Psarra et al., 2008).

6.1.3 Research Aim Three: Police Officer Decision Making

The aim of the third study was to explore whether police officers' attitudes and other factors related to their decisions of how to resolve encounters with people experiencing mental illness. It was found that there were two factors which discriminated among the outcomes chosen by police officers after watching a hypothetical encounter of a person who might be mentally ill interacting with two police officers.

The factor with the best predictive capacity was the severity of symptoms portrayed in the three hypothetical encounters, with more severe symptoms attracting mental health outcomes such as calling a CAT team or initiating involuntary apprehension according to the *Mental Health Act 1986* (Vic). Our finding that the proportion of participants who chose 'arrest' in response to the scenarios decreased as symptom severity increased was inconsistent with the notion of 'mercy booking' (Lamb & Weinberger, 1998) or the assertion that the police 'handle mentally ill people via arrest' (Teplin & Pruett, 1992). The second function which discriminated among the outcomes was associated with increasing pejorative attitudes and increasing confidence. Officers with high scores on these attitudinal dimensions were significantly more likely to choose the outcome 'walk away from the situation' than officers with low levels of pejorative attitudes and low confidence.

The finding that police officers' attitudes are, in fact, related to the way in which they chose to resolve hypothetical encounters with people experiencing mental illness is important, because it suggests that variability in police attitudes might result in variable outcomes for people experiencing mental illness. In particular, attitudes which are punitive and high levels of confidence might be associated with more restrictive or unhelpful outcomes, such as ignoring the situation. Conversely, positive attitudes which

are not associated with high levels of confidence might be related to mental health outcomes, such as referral to health services, or attempts by police officers to handle the matter themselves.

Another important outcome of this study was the finding of a discrepancy between the ways in which officers would 'likely' and 'ideally' resolve encounters with people experiencing mental illness. This suggests that there are considerable environmental constraints that impede police officers' attempts to engage in their ideal outcome. This finding that officers' face numerous challenges when attempting to resolve encounters with people experiencing mental illness was also supported by participants' responses to open-ended questions.

6.1.4 Preamble to General Discussion

In this next section, the implications of this research will be discussed, including a general discussion of the complex interface between police and people experiencing mental illness, determinants of outcomes following police officers' encounters with people experiencing mental illness and much needed enhancements to partnerships with mental health agencies and the training of police officers regarding mental health issues. Limitations of this research and suggested directions for future investigations are noted at the end of this chapter.

6.2 Implications: A Complex Interface

Broadly speaking, across Canada, the United States, the United Kingdom, New Zealand and Australia, there are similarities with regard to the apprehension and involuntary detention of people experiencing mental illness who pose a risk of harm to themselves or other people. It has long been recognised, however, that because of the

presence of many competing factors involved in police officers' encounters with people experiencing mental illness, the legal principles that govern police involvement do not represent a framework that can be applied to specific instances (Bittner, 1967). Therefore, police officers are necessarily afforded considerable discretion when resolving such encounters, particularly in situations which involve people who do not meet strict involuntary commitment criteria and are unlikely to be accepted by mental health services. It was reported in Chapter 3 that officers estimated spending, on average, ten percent of their time dealing with people experiencing mental illness, which is broadly consistent with previous estimates from police officers in New South Wales (Fry, O'Riordan & Geanellos, 2002) and New Zealand (Dew & Badger, 1999). Police officers routinely face significant challenges when attempting to resolve encounters with people experiencing mental illness. It is difficult to quantify these difficulties; however, a number of common themes were clearly evident in the open-ended responses provided by surveyed officers. Many of the responses which were categorised under the most often cited theme 'gaining support', was that a perceived absence of support from mental health agencies such as Crisis Assessment and Treatment (CAT) teams and hospitals meant that police officers had been burdened with a responsibility that nobody else wanted.

The issue of *why* the police have found themselves spending so much time dealing with people experiencing mental illness is poorly understood and the subject of much debate among social researchers. The often cited 'criminalisation' theory (Abramson, 1972), which refers to defining symptoms of mental illness as criminal thus resulting in arrest, has lost credence in recent years and researchers now believe that the high degree of overlap between the criminal justice and mental health systems exists due to a number of interacting factors, such as a move toward community based care

which facilitates greater opportunities for contact between the police and people experiencing mental illness. This is supported by the fact that just being in the community as opposed to an institution means that people experiencing mental illness are more likely to come into contact with police due to their behaviour and presentation. Importantly, this trend is also related to the breadth of contemporary policing, which is now understood to incorporate concepts of security, harm reduction and prevention (Stenning & Shearing, 2005). In terms of serious or violent offending, researchers have highlighted the increased risk of violence among those who experience mental illness (Wallace, Mullen & Burgess, 2004), while others have emphasised that the sociodemographic features which predict offending among people experiencing mental illness are the same as those which predict offending among the general population (Fisher at al., 2006; Gendreeau, Little & Goggin, 2006). Irrespective of the precise factors which have led to the extensive involvement of police officers in dealing with people experiencing mental illness, it is clear that there exists no simple solution for dealing with the minority of people experiencing mental illness who break the law or find themselves in crisis situations. Although dealing with people experiencing mental illness is often unrewarding and unrecognised work, it is clear that the police have historically, and perhaps by default, offered a proxy solution to this inherently challenging and complex problem.

6.3 Implications: Police Officers' Attitudes

Given the difficulties faced by police officers when attempting to resolve encounters with people experiencing mental illness, it would not be surprising if some police officers were found to hold negative attitudes toward people experiencing mental illness. It was reported in Chapter 4 that police officers' attitudes, as measured using the

Mental Health Attitudes Survey for Police (MHASP), can be described along four dimensions. There was much variability across the sample with regards to their endorsement of the attitude variables, which might be because police officers' attitudes resemble those of the general public (Cotton, 2004). However, some useful comparisons with the results of officers surveyed in other jurisdictions can be made. Generally speaking, there was a moderate endorsement of authoritarian and socially restrictive values, which is in contrast to both Canada (Cotton, 2004), where there is a low endorsement of these values among police officers, and Greece, where these values were more strongly endorsed (Psarra et al., 2008). Consistent with previous research, the attitudes of surveyed officers were not related to their demographic variables (Cooper, McLearen & Zapf, 2004; Cotton, 2004; Psarra et al., 2008). Intuitively, one would expect that newly recruited police officers might have a broader understanding of what contemporary policing involves as a result of their more recent training, and thus have different attitudes compared to more experienced police officers. Prior to the current study this surprising finding could have been attributed to the use of small sample sizes; however, following the use of a large sample of Victorian police officers it holds true that police officers' attitudes are not related to their demographic characteristics. This suggests that officers' attitudes are probably influenced by external factors, such as cultural factors, or differing models of policing, collaborations with service providers and the resources available to police for dealing with people experiencing mental illness. This finding is important, because it suggests that changes to police officers' attitudes could be effected by changes in policies, training and resourcing related to mental health. This hypothesis is supported by the general assumption that changes to behaviour can effect attitudinal change (Kelly, 1955). This hypothesis is also supported by the results of a study by Borum and colleagues (1998)

who found that different models of policing and different resources available to officers significantly impacted their perceptions of their own preparedness for dealing with people experiencing mental illness and the perceived adequacy of the mental health system.

The attitudinal dimension which attracted the highest average level of endorsement among the police officers surveyed reflected a need for increased resources in the face of having to deal with many people experiencing mental illness in an informal manner. Other researchers have also reported that police officers are under considerable pressure to resolve situations informally, and that often times, these encounters are not recorded (Green, 1997; Teplin & Pruett, 1992; Wylie, 1990). It is likely that the perceived lack of support from mental health agencies combined with pressure to resolve situations informally, often times without recognition, perpetuates the belief that the police are picking up the slack due to inadequacies in the mental health system.

Most likely, the attitudes of police officers are a function of individual experiences, police force culture and the resources available to assist officers in dealing with people experiencing mental illness, which are likely to vary across differing jurisdictions. There is little doubt that cultural attitudes are hard to change. However, if preparation for dealing with people experiencing mental illness commenced very early in new recruits' training, it should come as no surprise that this type of work is a significant and time consuming part of their role. Further, equipping them with appropriate resources and providing support from mental health agencies would send a clear message that their involvement is valued and important.

6.4 Implications: Determinants of Police Decision-Making Outcomes

Given that no single framework can be devised for guiding police officers in every encounter with people experiencing mental illness, police officers are necessarily afforded considerable discretion when resolving such situations. It follows, however, that variability with regard to police officer decision-making is likely to result in variable outcomes for people experiencing mental illness. It is this assumption which has led a number of researchers to investigate some of the factors which influence police officer decision-making. Among these factors, which were discussed in Chapter 4, include the type of encounter (Patch & Arrigo, 1999), the offender's mental state, gender and race (Finn & Stalans, 1997; Smith, Visher & Davidson, 1984) and the knowledge, experience and education of police officers regarding their work with people experiencing mental illness (Green, 1997; LaGrange, 2003; Patch & Arrigo, 1999; Teplin, 2000; Watson, Corrigan & Ottati, 2004). This thesis has expanded on this body of knowledge, by exploring the way in which police officer factors and symptoms of mental illness relate to police decision-making. In this next section some of factors which have been found to relate to various dispositions will be discussed, including the sources of information police officers use to determine if someone is mentally ill, the bases of police officers' knowledge regarding mental illness, police officers' attitudes regarding mental illness and the severity of psychiatric symptomatology of people experiencing mental illness who attract police attention.

6.5.1 Determinants of Outcomes: Sources of Information

In Chapter 3, it was reported that the frequency of outcomes chosen by police officers following their encounters with people experiencing mental illness was related to the extent to which they rely on different sources of information to determine if

someone is mentally ill. For example, information gathered from police sources was associated with an increasing likelihood of engaging in mental health apprehension, but was negatively related to referral to another agency and arrest. Information garnered from the person was associated with a mental health apprehension and arrest, but was negatively related to taking no further action. Information garnered from medical practitioners was positively related to making referral to another agency, but negatively related to taking no further action.

Evidently, differences exist among police officers with regards to the sources of information they rely on when making judgements about whether someone is likely to be experiencing a mental illness. The findings reported in Chapter 3 suggest that these differences are likely to impact of police officers' decision making, perhaps because they yield different types of information. For example, information garnered from police sources is likely to include descriptions of previous crises or misdemeanours, leading to an awareness of repetitious problematic behaviour. Indeed, Victorian police officers do now have available in their contacts database provisions for individual or carer self reported incidents of mental illness and intellectual disability. In contrast, information garnered from the person might result in a sympathetic response to the person's current situation or crisis, whereas information garnered from medical practitioners is likely to shed light on any particular known psychiatric or psychological difficulties faced by the person.

Given the variable impressions formed by the use of these different types of information sources, police officers should have available to them a range of information sources which can assist them in making a decision free from bias. For example, the police should routinely have access to well-recorded descriptions of previous police encounters with the individual. Furthermore, police officers should have

available to them specialist advice from mental health practitioners. This could occur through the use of an initiative such as the recently trialled Police Ambulance and Crisis Assessment and Treatment Team Early Response (PACER) initiative, whereby a dual police and mental health response was trialled as an effective model for responding to people experiencing mental illness. Similarly, this advice from a mental health clinician could be facilitated through the use of a telephone consultancy service, which will be described in greater detail later in this chapter.

6.5.2 Determinants of Outcomes: Bases of Knowledge

It was reported in Chapter 3 that the frequency of outcomes chosen by police officers following their encounters with people experiencing mental illness was related to the extent to which they based their knowledge regarding mental illness on personal versus on-the-job experience. It was found that knowledge gained on-the-job was positively related to the frequency with which officers reported arresting someone experiencing mental illness. Conversely, knowledge that was gained from personal experience was positively related to taking no further action, referral to another agency, and to a lesser extent, arrest.

While it is difficult to quantify the extent to which police officers' knowledge is derived from various sources, it is likely that there are differences among police officers with regards to the bases of knowledge that are considered relevant and meaningful. These findings highlight the importance of understanding precisely from where the police gain their knowledge, because the sources of their knowledge are likely to influence the way in which they resolve encounters with people experiencing mental illness.

6.5.3 Determinants of Outcomes: Police Attitudes

One of the most significant findings reported in this thesis was that police officers' attitudes regarding mental illness were related to the way in which they chose to resolve hypothetical encounters involving a person experiencing mental illness. It was reported in Chapter 5 that one of the factors which discriminated among the outcomes chosen by police officers after viewing the hypothetical vignettes encompassed two of the higher order attitude factors arising from the Mental Health Attitude Survey for Police (MHASP). High levels of this factor described decreasing pejorativeness and a lack of confidence and we interpreted this as describing 'officers who know what they don't know'. High score on this factor was associated with 'call a CAT team' and 'handle the matter informally', suggesting that this attitude might be associated with helpful outcomes for people experiencing mental illness, although the interpretation of our 'handle the matter informally' outcome is somewhat ambiguous. Conversely, lower levels of the factor which discriminated among the outcomes described increasing pejorativeness and increasing confidence, which we interpreted as describing 'officers who don't know what they don't know'. Low scores on this factor were associated with the unhelpful outcome 'walk away from the situation'.

The considerable degree of discretion afforded to police officers for resolving encounters with people experiencing mental illness is in recognition of the fact that these situations are rarely straightforward and there are many factors which need to be considered when determining an appropriate outcome. Our finding that police officers' attitudes are related to the way in which officers resolve hypothetical encounters with people experiencing mental illness is important, because it suggests the presence of another variable which is unrelated to the mental health needs of the person in need of assistance and situational factors. It is difficult to compare these findings to other

research, because our methodology represents a new approach to examining this phenomenon. However, Watson, Corrigan and Ottati (2004) reported that the label 'schizophrenia' was not related to outcomes chosen by officers. It was reported, however, that outcomes were related to officers' knowledge that the suspect was dangerous and their endorsement of restrictive treatment outcomes. Important differences between this study and ours include the use of the label 'schizophrenia' as opposed to our depiction of symptoms, and an absence of mental health outcomes. These methodological differences reflect differences in research questions. Further research should be conducted to establish whether our findings hold true in real world situations. It will also be important to determine what factors predict officers' attitudes to inform an understanding of what can be done to promote helpful attitudes, and concomitantly, to lessen the unhelpful impact of variables unrelated to the mental health needs of individuals with whom the police have contact. Future research should also investigate the extent to which attitudinal change impacts on decision-making behaviour among police officers, and similarly, whether behavioural change among police officers impacts on their attitudes (see Kelly, 1955).

6.5.4 Determinants of Outcomes: Symptoms of Mental Illness

In Chapter 5 it was reported that the function which best discriminated among the outcomes chosen by the representative sample of Victorian police officers after viewing hypothetical encounters with a person experiencing mental illness related to the severity of symptoms portrayed in each of the three vignettes. Generally speaking, officers selected outcomes which were appropriate given the symptoms portrayed. For example, the scenario depicting a man who was not experiencing mental illness was predominantly associated with the outcome 'handle the matter informally'. The scenario

depicting moderate symptoms of mental illness was associated with a mix of formal and informal outcomes, indicating that this scenario afforded participants the greatest opportunity to utilise their discretion. Finally, the depiction of severe symptoms of mental illness was associated with predominantly mental health outcomes, including 'call a CAT team' and 'mental health apprehension'. This finding suggests that police officers can recognise an increasing severity of psychiatric symptomatology. This is also consistent with our finding reported in Chapter 3 that many of the signs, symptoms and behaviours that police officers believe are associated with mental illness are similar to those which might be noted by a mental health professional for the purposes of a mental status examination.

While it might seem obvious which outcomes were 'supposed' to correspond with the mental health needs of the vignette character, previous research investigating this phenomenon have yielded variable results. Teplin and Pruett (1992), for example, reported that following an observational study of police-citizen encounters, officers were more likely to arrest someone experiencing mental illness relative to someone not experiencing mental illness. Our findings are, however, consistent with Engel and Silver (2001) who reported that after controlling for legal and extra-legal factors, police officers were not more likely to arrest suspects experiencing mental illness. It is important to note that our findings relate only to a male suspect involved in a minor law infraction. Although our approach limits the extent to which our findings can be generalised, it provided us with the opportunity to hold constant other variables, which is not possible in observational research. In light of the high prevalence of mental illness among police cell detainees (Ogloff, Warren, Tye, Blaher & Thomas, 2010) and prisoners (Butler & Allnutt, 2003; Fazel & Danesh, 2002; Ogloff, 2002) it is important to conduct further research regarding the factors that differentiate situations which result

in arrest from other outcomes following encounters with people experiencing mental
illness.

6.6 Implications: Changes in Service Delivery

Although police officers have at their disposal a range of options for resolving
encounters with people experiencing mental illness, police officers might not always be
able to engage in their preferred outcome, as indicated by the discrepancy between
participants' 'actual' and 'ideal' responses to the hypothetical scenarios. In many cases,
officers indicated that they would ideally resolve the encounters using the assistance of
mental health teams or hospital staff, but that the limited availability of mental health
resources or perceived difficulties associated with these options meant that other options
were selected, such as handling the matter themselves or ignoring the situation. This
pattern of responses highlights the need for enhancements regarding the cooperation
between services, better resourcing for mental health services, enhanced training for
recruits and a clearer definition regarding expectations of the role of police officers.
These service enhancements will be described in greater detail in the following section.

6.6.1 Service Enhancements

The dominant theme arising from participants' qualitative responses regarding
the challenges they face with regards to their work involving people experiencing
mental illness, as reported in Chapter 3, was gaining support from mental health
services. This was consistent with previous research involving Australian police officers
(Fry, O'Riordan & Geanellos, 2002). It is clear that police officers would benefit from
more formal partnerships with mental health services. Ideally, police officers should be
able to refer people to mental health services without consuming an unreasonable

degree of police resources (Borum, 2000). Evidently, for these partnerships to be enhanced, community mental health services would require better funding.

For police encounters with people who do not meet strict involuntary apprehension criteria but are too unwell to remain on the streets, police officers would benefit from the assistance of well-resourced mental health crisis teams. In Victoria, although CAT teams are available 24-hours a day, they are not an emergency response service for mental health crises. Rather, these services focus on providing assessment and treatment of people in their own homes thus avoiding unnecessary hospitalisation. In the face of limited funding for these services evidently there exists a significant service gap for people experiencing mental illness who attract police attention following psychiatric crises. Further funding should be directed toward the development of crisis teams who are specifically trained and resourced to assist the police, for example, the previously described PACER initiative. Such teams should have quick response times and broad criteria so that the police do not find themselves in the position of dealing with individuals deemed unacceptable for the involvement of other services. Successful initiatives overseas have incorporated the use of sworn police officers trained as special mental health responders (the Memphis Model) (Dupont & Cochran, 2000) or the use of mental health providers who are not police officers (Deane et al., 1999)

Under Section 10 of the *Mental Health Act 1986* (Vic), police officers must stay with a person they have apprehended until they have been assessed by a mental health practitioner. However, the routine delays involved in accessing assessments in emergency departments mean that police officers are faced with having to supervise an already distressed individual for sometimes lengthy periods. To improve outcomes for people who are likely to meet involuntary apprehension criteria, formal relationships should be established between police officers and hospital personnel. Further, hospitals

should be equipped with staff and the necessary resources to ensure that police officers do not experience prolonged waiting periods supervising a person before they are assessed. Expanding on the services available in emergency wards could also be achieved through the establishment of an emergency protective custody unit, such as that adopted as part of the 'Memphis Model' (Steadman et al., 2001) which would limit the use of police cells for detaining people experiencing mental illness under Section 10 of the *Mental Health Act 1986* (Vic) – a practice which contravenes the requirements in the *Act* that people experiencing mental illness be cared for in the least restrictive environment. It should also be considered whether the definition of 'mental illness' included in the *Act* should be expanded to include drug and alcohol intoxication and personality disorders as this group appear to be falling through the cracks but are taking up substantial police time.

In Chapter 3 it was reported that the type of information used by police officers to determine if someone had a mental illness was related to the frequency with which they reported engaging in various outcomes following encounters with people experiencing mental illness. As previously indicated, Victoria Police officers have available to them pre-recorded information pertaining to high-risk individuals including information which has been provided by the individual themselves or their carer. Similar databases are utilised by police departments in the United States, and include information pertaining to suicide attempts, instances of violence and how encounters were resolved are (Gilig, Dumaine & Hillard, 1990; Lamb et al., 1995). Some electronic databases even include photographs of individuals with whom the police have had contact (Way, Evans & Banks, 1993). In addition to making such information available to Victoria Police members, given the importance of information sources on outcomes

for people experiencing mental illness it would be necessary to ensure that policies and procedures encompassed the regular use of such information.

Further to these initiatives, police officers should have access to advice from mental health professionals, for example, through the use of a 24-hour telephone consultancy service. Such data would add to existing police sources of information, and increase the likelihood that an individual's behaviour is understood in the context of relevant mental health issues. This consultancy service could be manned by specialist mental health clinicians who could offer advice and recommendations, much like the Nurse on Call initiative adopted in Australia, which is designed to reduce unnecessary visits to general practitioners. The telephone consultancy staff might also be able to function as a liaison between the police family members or health professionals known to the individual who is in crisis for the purpose of gathering relevant information.

According to the results of previous Australian research, 98% of police officers had no knowledge regarding the availability of a 24-hour crisis intervention service available to assist them with interventions involving people experiencing mental illness (Wylie, 1990). Therefore, an essential part of mental health service enhancement is to ensure that police officers are aware of the services that are available to people experiencing mental illness and the scope of support available from these services. Victoria Police officers are now able to access an online resource known as the Mental Health Bank, which includes links to referral agencies and mental health service information. Victoria police has also commenced a program whereby 100 staff have become Mental Health Liaison Officers across each geographical division. These staff are responsible for communicating with local mental health service providers and disseminating information to other police officers with regards to mental health; however, the effectiveness of this initiative is unknown at this time. Mental health

service staff should be cognisant of the role and responsibilities of police officers such that they do not place unrealistic demands on police officers or leave them feeling unsupported, resulting in ineffective partnerships and, in some cases, reluctance among police officers to take on the burdensome work of dealing with people in crisis.

It is clear that there is much need for an expansion of mental health services and increased levels of partnership and cooperation between these services and police agencies. Such enhancements would go some way to reducing the common perception among police officers, doctors, nurses, ambulance personnel and crisis mental health teams that their own dealings with people experiencing mental illness are the result of someone else's reluctance to fulfil their service obligations, and would also improve outcomes for people experiencing mental illness in accordance with the initial promise of deinstitutionalisation.

6.6.2 Training for Recruits

Another dominant theme identified in participants' qualitative responses to the question regarding the challenges they face with regard to their work involving people experiencing mental illness included 'identifying and understanding mental illness'. Although police officers are not expected, from a legal perspective, to possess specialised skills in mental health, they are faced with the fundamental complication of their own ability to recognise signs, symptoms and behaviours associated with mental illness (Bayney & Ikkos, 2003; Finn & Stalans, 1997; Green, 1997; LaGrange, 2003). In Chapter 3, it was reported that the bases of police officers' knowledge regarding mental illness was related to the frequency with which officers reported engaging in various outcomes following their encounters with people experiencing mental illness. Therefore, it is important that police officers are equipped with training and education in

mental illness which prepares them for dealing with people experiencing mental illness. Currently, police officers can volunteer to participate in mental health first aid training. Further, Victoria Police Operational Safety and Tactics Training (OSTT), which police officers must attend biannually, has a small component of mental health awareness training; however, an inevitable trade-off of competing priorities during these training sessions, such as firearms training, can lead to a reduction in the perceived centrality of mental illness training. Victoria Police currently provides for its members six hours of training in mental health at the recruit level, 1.5 hours training at the probationary level, and two days mental health first aid training to officers by expression of interest. However, it was anticipated that by the end of 2009 only ten percent of the Victorian police force would have completed this training. There is also some mental health training available to specialised officers, such as force response unit members and police negotiators. The limited training offered to police officers in Australia has been associated with the excessive use of force by police on people experiencing mental illness internationally (Fyfe, 2000) and police training, policy and practice in Victoria have come under particular scrutiny over the last twenty or so years, following a number of reviews into the number of police shootings involving people experiencing mental illness (Dalton, 1998; Kesic, Thomas & Ogloff, 2010).

Given the extent of police officers' involvement with people experiencing mental illness, police officers should be provided with core competencies relevant to this type of work. For example, police officers should be familiar with the presenting symptoms associated with severe mental illness which might warrant use of their powers under the *Mental Health Act 1986* (Vic). Such training should take officers beyond their intuitive sense that someone is 'crazy', and build on the fact that, as reported in Chapter 3, officers do have the ability to recognise symptoms of mental

illness, but rarely can use descriptive labels such as 'delusional thinking', 'ideas of reference', 'perceptual disturbances' or 'thought disorder'. The advancement beyond a colloquial lexicon for describing the experiences of people experiencing mental illness would go someway to reducing pejorative expressions which stereotype and disempower people experiencing mental illness, and would enhance the effectiveness of communications with mental health professionals.

Other themes identified in participants' qualitative responses regarding the challenges they face in their work included 'communicating with the mentally ill', 'avoiding violence/aggression' and 'cooperation and compliance'. For example, one officer reported difficulty "*being able to communicate with someone who is not rational*". Other participants reported problems with "*knowing different types of mental illness (and) what approach to take*" and "*gaining trust from mentally ill person to enable you to ultimately get them to medical facility without physical confrontation*". The latter of these concerns is especially important, as it involves implications for potential harm and distress not only for the person experiencing mental illness, but the police officers faced with the inherent difficulty of containing them. Therefore, in addition to gaining knowledge regarding mental illness, police officers should be equipped with practical skills for dealing with people experiencing mental illness, in particular, when those people are vulnerable, irrational or noncompliant. Given the finding that police officers spend equal proportions of their contacts with people experiencing mental illness who are suspects, victims, persons in need of assistance and vulnerable persons, police officers should be equipped with these skills which take them beyond 'catching crooks', to incorporate the social welfare role, albeit beyond the traditional role of community policing (e.g., Foster, 2005; Stenning & Shearing, 2005). The aim of practical training should be to equip police officers with the skills required

to diffuse situations which might otherwise lead to a necessary use of force and potential harm to those involved.

As noted earlier, police officers were more likely to base their understanding of mental illness on their on-the-job training and personal experience, than information gained from more formalised courses provided by Victoria Police or other external agencies. While some content would be most effectively delivered in a classroom setting, this could be enhanced by an experiential mode of learning whereby junior officers are paired with more senior, experienced officers. This is consistent with the philosophy adopted in the OSTT training, which is only delivered by officers with ten or more years of experience. Further, police officers ranging from junior constable through to inspector are required to attend the training, therefore, scenario based training reflects and draws upon a vast array of experience. A multi-modal learning program is consistent with specialised training in other core elements of policing (Borum, 2000; Price, 2005).

As reported in Chapter 5, only one fifth of surveyed police officers nominated particular topics related to mental illness in which they would like further training. Those officers who nominated topics for further training tended to be of a higher rank than those who did not nominate topics. These findings suggest that the need for increased knowledge regarding mental illness is something which develops as police officers gain more experience and lends weight to scenario-based training involving the participation of police officers of differing ranks, so that senior police officers can share their experience and understanding with more junior police officers. Given that most police officers probably do not want to receive advanced training in mental health, Victoria Police could also adopt a model whereby police officers can volunteer for

specialised training and as a result become 'in-house' specialists (e.g., Borum, Deane, Steadman & Morrissey, 1998).

The inherent challenges faced by police officers in their frequent dealings with people experiencing mental illness suggest that there is a pressing need for formalised policies and training regarding mental illness. Providing comprehensive and effective training which is systematically evaluated to all police officers is no small task, and would likely benefit from the involvement of mental health professionals in devising and/or delivering training content (Hails & Borum, 2003). Such preparatory work would foster the realistic expectation among police recruits that dealing with people experiencing mental illness is an integral part of community policing. Further, police officers' willingness to engage in this work should be formally recognised and rewarded by the police force and the systems with which they interact.

6.7 Limitations and Future Directions

Although there were 7914 police officers who participated in OSTT sessions during the data collection phase, questionnaires were only given to 3811 officers by the training facilitators. Nevertheless, the response rate among those who were invited to participate was 92.7% and the sample was considered to be generally representative. This investigation has revealed important information regarding police officers' attitudes, which are likely to reflect the attitudes of the general population. From a broader perspective, this suggests that attitude change among police officers regarding people experiencing mental illness might be best addressed via a campaign directed toward the general public. Due to the size and scope of the research undertaken, a cross sectional methodology was adopted. Because of this, it was not possible to determine

directionality or causality between variables, which could only be inferred from the results of a study incorporating a longitudinal design.

To ensure the anonymity of respondents, this research relied on the use of self-report, leaving an opportunity for increased risk of socially desirable responses. However, this was controlled for by ensuring participants that their responses were anonymous, and further, consideration of social desirability alongside other police responses. The use of self-report also meant that officers were required to incorporate estimates into many of their responses, for example, the number of mentally ill people with whom they had contact per week, and the frequency with which they engaged in various outcomes. Although participants' responses to these types of questions provided some indication regarding officers' perceptions of their work involving people experiencing mental illness, it would be beneficial to gather further more objective data to support and add weight to these findings.

This research relied on the use of hypothetical vignettes depicting police interactions with a person experiencing mental illness, thus allowing us to vary the severity of presentation of psychiatric symptomatology of the individual concerned. It is not possible, however, to know whether our findings relate to different situations, such as females experiencing mental illness or situations involving more serious offending. It was also not explored whether police responses depended upon whether encounters with police or citizen initiated. To extrapolate our findings to real world settings, it would be necessary to conduct a naturalistic study, however, the observational method does not allow variables to be held constant and is thus liable to contradictory findings (e,g., Engel & Silver, 2001; Teplin & Pruett, 1992).

Following on from our finding that police officers' attitudes related to the way in which they responded to hypothetical scenarios, it would be useful to determine the

effectiveness of interventions aimed at promoting attitudes among police officers which are associated with outcomes which meet the needs of people experiencing mental illness. Such interventions would go some way to minimising the influence on outcomes of variables irrelevant to the needs of people experiencing mental illness. Importantly, the attitudes of police officers in any jurisdiction are likely to be a function of many interacting variables, in particular, the effectiveness of mental health systems to assist police and officers' preparedness for this type of work.

Contrary to some previous studies, our results indicated that the use of arrest decreased as the symptoms of mental illness increased. Given that there are a high proportion of mentally ill people in throughout the justice system, it is important to describe in further detail the factors differentiate the use of arrest for people experiencing mental illness as opposed to other outcomes. Complementary methodologies, combining the scaled responses with more focussed follow-up discursive questions delivered via face-to-face method may have helped uncover some of the stark differences and more subtle nuances between individual decision-making processes. Research of this nature is currently underway, the details of which are available from the authors.

Police involvement with people experiencing mental illness is now part and parcel of contemporary police practice. The discretion necessarily afforded to police in their dealings with people experiencing mental illness is in recognition that these situations are rarely straightforward, and that a competing factors influence what is the most appropriate course of action. This research has highlighted patterns in police responding which relate to the severity of an individual's symptoms, however, it has also been highlighted that outcomes for people experiencing mental illness following their dealings with police are influenced by some variables which have nothing to do

with the needs of the mentally ill person themselves. To assist police in facilitating ideal outcomes for people experiencing mental illness, it is clear that much needs to be done to improve police partnerships with mental health services and to prepare police officers for this challenging and invaluable part of their role.

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Appendix 1: Explanatory Statement

MONASH University

Explanatory Statement:
Police experience, attitudes and knowledge of mental illness

My name is Joel Godfredson and I am a student studying for the award of 'Doctor of Psychology (Clinical) at Monash University (Clayton campus). I would like to invite Victoria Police members to participate in a study I am conducting as part of my course. This research is being supervised by Professor James Ogloff and Dr Stuart Thomas.

The aim of this research is to examine the experience, knowledge and attitudes that police officers have regarding dealing with individuals who have a mental illness. The reason for doing this research is to better understand the interactions that occur between Victoria Police officers and mentally ill people. This research will also serve as a pilot study for an ARC funded project which will examine police officer attitudes regarding mental illness.

If you would like to take part in this research you will be asked to answer some general questions about yourself (for example, age, number of years in force) and to respond to 2 questionnaires. Examples of the questions and statements include:

"Do you know someone who has a mental illness?"
"Dealing with mentally ill people should be an integral part of community policing."
"Mentally ill people should not be given any responsibility."

You will then be invited to watch a short video clip depicting an interaction between a police officer and member of the public. This will be followed by some written questions which ask you to reflect on the movie clip. There are no right or wrong answers. It is important that you are as honest as possible and that you try to answer every question. This will take about 30 minutes of your time.

The responses you give will be strictly confidential. Your identity is not required, as findings of the study will only be presented as group results. Do not write your name on any of the forms. Please be advised that, based on legal requirements, there are a couple of limitations to confidentiality. Therefore you are warned not to disclose any non-adjudicated matters, including illegal behaviours that you have not been charged with or that have not been dealt with by the courts. Any personal information provided or disclosed will be kept private and any publication or other output will not identify any individual in any way. All information collected will be kept in accordance with Data Protection regulations, set by Monash University and the Department of Justice, in a locked filing cabinet for a minimum of seven years. Thereafter it will be destroyed. Participation is voluntary and you are free to withdraw your consent at any point of the study with no negative consequences. The research may not have any direct benefit to you, but a summary of the key findings will be made available to you upon request and/or in the Police Gazette.

If you would like to receive more detailed results or have any further inquiries please email me at joel.godfredson@med.monash.edu.au. If participating in this research raises any personal issues or if you would like to complain about how this study was conducted, please contact the Secretary to the Victoria Police Research Coordinating Committee (RCC), Joseph Ponanski on 9247 6732 or joseph.poznanski@police.vic.gov.au. You can contact the Monash University Standing Committee on Ethics in Research Involving Humans at the following address:

Human Ethics Officer
Building 3D
Research Office
Monash University VIC 3800
Tel: 9905 2052   Fax: 9905 1420
Email: scerh@adm.monash.edu.au

Thank you for participating in this research.

Police experience, attitudes and knowledge of mental illness

Mental illness and the police

A mental illness is a condition which might affect a person's behaviour, thinking and/or intellectual functioning. Examples of specific types of disorders include, but are not limited to, schizophrenia, depression, anxiety, obsessive compulsive disorder and intellectual disability. Although members of Victoria Police are not required to diagnose specific mental illnesses, they often have contact with individuals who exhibit signs of these illnesses.

The following questionnaire asks a series of questions about your experiences, training, knowledge, and attitudes towards people who have a mental illness. There are no right or wrong answers, so please answer all questions as honestly and completely as possible.

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1. Experience

Please read the following questions carefully and circle the most appropriate response

1.1 Whilst on duty, how often do you come into contact with people who appear to have a mental illness?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Daily

1.2 In an average week how many times do you have contact with someone who appears to have a mental illness?

_____ times per week

1.3 Thinking about the last month, what proportion of the following groups you have had contact with appeared to have a mental illness? (e.g., 10% of offenders appeared to have a mental illness).

a) Offenders

0%	10	20	30	40	50	60	70	80	90	100%

b) Suspects

0%	10	20	30	40	50	60	70	80	90	100%

c) Victims

0%	10	20	30	40	50	60	70	80	90	100%

d) Witnesses

0%	10	20	30	40	50	60	70	80	90	100%

e) Vulnerable/at risk persons

0%	10	20	30	40	50	60	70	80	90	100%

f) Persons in need of assistance

0%	10	20	30	40	50	60	70	80	90	100%

g) Motorists

0%	10	20	30	40	50	60	70	80	90	100%

1.4 Please indicate the extent to which your understanding of mental illness is based on each of the following:

		Strongly based					Not based at all
a)	Interaction with mentally ill persons on the job	1	2	3	4	5	6
b)	Interaction with mentally ill persons in my private life	1	2	3	4	5	6
c)	Training and education provided by Victoria Police	1	2	3	4	5	6
d)	Training and education provided by others	1	2	3	4	5	6
e)	Personal research	1	2	3	4	5	6
f)	Media	1	2	3	4	5	6
g)	Other (*please specify below*)	1	2	3	4	5	6

_____

_____

_____

_____

Police experience, attitudes and knowledge of mental illness

2. Training

2.1 The following courses run by Victoria Police have been identified as containing information regarding mental illness. If you have taken part in any of the following courses, please rate them in terms of 1) relevance, 2) practicality and 3) comprehensiveness, where 1 = excellent, and 6 = poor.

	Relevance	Practicality	Comprehensiveness
	Excellent Poor	Excellent Poor	Excellent Poor
a. School of Local Policing – Recruit Phase and Phase 9	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
b. Leadership and Management Development	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
c. Operational Safety & Tactics Training	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
d. Force Response Group – Tactical Communicators Course	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
e. Force Response Group – Negotiators Course	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
f. Sexual Offences & Child Abuse Co-Ordination Unit – Investigating Sexual Offences and Child Abuse	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
g. Psychological First Aid	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
h. Mental Health First Aid Department	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
Mental Illness Fellowship - Understanding the mentally ill	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
i. Other (please specify):	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
j. Other (please specify):	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6

2.3 What additional training would you like to receive? (If none, please state 'nil').

_____

_____

_____

_____

3. Knowledge

3.1 How confident are you in your knowledge of policy and procedures for dealing with people who have a mental illness who are:

	Very confident					Not at all confident
a) Person in need of assistance (e.g., missing person)	1	2	3	4	5	6
b) Victims	1	2	3	4	5	6
c) Witnesses	1	2	3	4	5	6
d) Suspects	1	2	3	4	5	6
e) Offenders	1	2	3	4	5	6

Police experience, attitudes and knowledge of mental illness

3.2 How often do you use the following sources of information to determine if someone has a mental illness?

		Very often					Never
a)	Information provided during call dispatch	1	2	3	4	5	6
b)	Database check (e.g., LEAP)	1	2	3	4	5	6
c)	My knowledge from previous interactions with the person	1	2	3	4	5	6
d)	Behaviour you observe at the scene	1	2	3	4	5	6
e)	It is not something you routinely consider	1	2	3	4	5	6
f)	Medical Practitioners (FMO, CAT team, custodial nurses)	1	2	3	4	5	6
g)	Other (please specify):	1	2	3	4	5	6

3.3 How often do the following outcomes occur as a result of your interactions with mentally ill people?

		Very often					Never
a)	Arrest	1	2	3	4	5	6
b)	Referral to a hospital under Section 10 of the *Mental Health Act*	1	2	3	4	5	6
c)	Referral to another government agency	1	2	3	4	5	6
d)	Referral to a health or welfare agency	1	2	3	4	5	6
e)	No further action taken (e.g., allegation not substantiated)	1	2	3	4	5	6
f)	No further action required (e.g., missing person found)	1	2	3	4	5	6

3.4 Please list up to five signs, symptoms or behaviours that you believe are useful in determining whether someone has a mental illness

1. _____

2. _____

3. _____

4. _____

5. _____

3.5 In your opinion, what are the biggest challenges you face when attempting to resolve situations involving people who are mentally ill?

1. _____

2. _____

3. _____

4. _____

Police experience, attitudes and knowledge of mental illness

Mental Health Attitude Survey for Police (adapted from Clayfield, Grudzinskas Jr., Fletcher, & Fisher, 2006)
The statements below represent beliefs or ideas about mental illness and about dealing with mentally ill people.
Please circle the number 1-6 as it applies to you. Please complete all questions.

For each of the following statements, indicate whether you:	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
1. Mentally ill people take up more than their fair share of police time.	1	2	3	4	5	6
2. As soon as a person shows signs of mental illness, he/she should be hospitalised.	1	2	3	4	5	6
3. Wellness and recovery are possible and achievable for mentally ill people.	1	2	3	4	5	6
4. Mentally ill people need the same kind of control and discipline as a young child.	1	2	3	4	5	6
5. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.	1	2	3	4	5	6
6. It is frightening to think of mentally ill people living in residential neighbourhoods.	1	2	3	4	5	6
7. More money should be spent on the care and treatment of mentally ill people.	1	2	3	4	5	6
8. We have a responsibility to provide the best possible care for mentally ill people.	1	2	3	4	5	6
9. Nowadays, police officers need to have specialised training in dealing with mentally ill people.	1	2	3	4	5	6
10. It is best to avoid anyone who is mentally ill.	1	2	3	4	5	6
11. One of the main causes of mental illness is a lack of self-discipline and willpower.	1	2	3	4	5	6
12. It would be foolish to marry a person who has suffered from a mental illness, even though s/he seems fully recovered.	1	2	3	4	5	6
13. I would not want to live next door to someone who has been mentally ill.	1	2	3	4	5	6
14. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.	1	2	3	4	5	6
15. Mental health facilities should be kept out of residential neighbourhoods.	1	2	3	4	5	6
16. Mentally ill people should be isolated from the rest of the community.	1	2	3	4	5	6
17. Locating mental health facilities in a residential area downgrades the neighbourhood.	1	2	3	4	5	6
18. Dealing with mentally ill people should be an integral part of community policing.	1	2	3	4	5	6
19. I feel that I am adequately trained to handle situations/calls involving mentally ill people.	1	2	3	4	5	6
20. Mentally ill people should not be given any responsibility.	1	2	3	4	5	6
21. There is something about mentally ill people that makes it easy to tell them from normal people.	1	2	3	4	5	6
22. Responding to calls involving mentally ill people is not really part of a police officer's role.	1	2	3	4	5	6
23. We need to adopt a far more tolerant attitude toward mentally ill people in our society.	1	2	3	4	5	6
24. Mentally ill people are a disadvantaged group who deserve special consideration from the police.	1	2	3	4	5	6
25. Locating mental health services in residential neighbourhoods does not endanger local residents.	1	2	3	4	5	6

Police experience, attitudes and knowledge of mental illness

	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
26. I feel more comfortable responding to calls involving mentally ill females in crisis.	1	2	3	4	5	6
27. I have confidence in the mental health system to adequately care for mentally ill people .	1	2	3	4	5	6
28. Local residents have good reason to resist the location of mental health services in their neighbourhood.	1	2	3	4	5	6
29. Increased spending on mental health services is a waste of money.	1	2	3	4	5	6
30. I know when to apply Section 10 of the Mental Health Act.	1	2	3	4	5	6
31. Having mentally ill people living within residential neighbourhoods might be good therapy but the risks to residents are too great.	1	2	3	4	5	6
32. There is pressure within my organisation to solve the problems associated with mentally ill people on an informal basis.	1	2	3	4	5	6
33. I feel confident in my ability to handle decisions involving mentally ill people.	1	2	3	4	5	6
34. I feel more comfortable responding to calls involving mentally ill males in crisis.	1	2	3	4	5	6
35. A large percentage of calls involving mentally ill people who violate the law are dealt with informally.	1	2	3	4	5	6
36. If mental health services were adequate, the police would not have to deal with mentally ill people.	1	2	3	4	5	6
37. Hospital personnel are reluctant to accept mentally ill people referred by the police.	1	2	3	4	5	6
38. In my opinion, dealing with people who have a mental illness is **not** real police work.	1	2	3	4	5	6
39. My colleagues believe that dealing with people with a mental illness is **not** real police work.	1	2	3	4	5	6
40. My colleagues are adequately trained to handle calls involving persons with a mental illness.	1	2	3	4	5	6
41. Mentally ill people are usually more dangerous than non-mentally ill people.	1	2	3	4	5	6
42. Dealing with mentally ill people is unrecognised and unrewarded by my organisation.	1	2	3	4	5	6
43. Mentally ill people are just as responsible for their own behaviour as non-mentally ill people.	1	2	3	4	5	6

Marlowe-Crowne Personality Scale (1968)

The following items represent personality traits, which may or may not apply to you. Please select true or false, as it applies to you. Try to be as honest as possible.

Read each statement, and circle true or false as it applies to you	TRUE	FALSE
It is sometimes hard for me to go on with my work if I am not encouraged	T	F
I sometimes feel resentful when I don't get my own way	T	F
On a few occasions I have given up doing something because I thought too little of my ability	T	F
There have been times when I have felt rebelling against people in authority even though I knew they were right	T	F
No matter who I'm talking to I'm always a good listener	T	F
There have been occasions when I took advantage of someone	T	F
I am always willing to admit when I make a mistake	T	F
I sometimes try to get even rather than forgive and forget	T	F
I am always courteous, even to people who are disagreeable	T	F
I have never been irked when people express ideas very different from my own	T	F
There have been times when I have been quite jealous of the good fortune of others	T	F
I am sometimes irritated by people who ask favours of me	T	F
I have never deliberately said something to hurt someone's feelings	T	F

Police experience, attitudes and knowledge of mental illness

Scenario

Please stop filling out the survey. In a moment you will be invited to view a short video clip. The video depicts an interaction between two police officers and a man who <u>might</u> be mentally ill.

When the video stops, please complete the questions below.

Outcome questions

1. Taking into account the resources available to you, how likely are you to engage in the following outcomes? (Circle response, where 1 = very unlikely to 4 = very likely)

Outcome	Very unlikely	Unlikely	Likely	Very likely
Walk away from the situation	1	2	3	4
Handle the matter informally	1	2	3	4
Call a CAT team and wait with the man until they arrive	1	2	3	4
Apprehend the man under Section 10 of the Mental Health Act	1	2	3	4
Arrest the man and take him to the station	1	2	3	4

2. Taking into account the resources available to you, and the obstacles you encounter in your duties, what is your most likely course of action? (Circle one response only)

   a) Walk away from the situation
   b) Handle the matter informally
   c) Call a CAT team and wait with the man until they arrive
   d) Apprehend the man under Section 10 of the Mental Health Act
   e) Arrest the man and take him to the station

3. What are the likely positive outcomes of dealing with this person in this way?

_____

_____

_____

4. What are the likely negative outcomes of dealing with this person in this way?

_____

_____

_____

4. In your view, what would be the <u>ideal</u> way to deal with this person?

   a) Walk away from the situation
   b) Handle the matter informally
   c) Call a CAT team and wait with the man until they arrive
   d) Apprehend the man under Section 10 of the Mental Health Act
   e) Arrest the man and take him to the station

5. What obstacles might prevent you from engaging in your <u>ideal</u> method for resolving the situation?

_____

_____

_____

_____

Police experience, attitudes and knowledge of mental illness

Other information

Age: _____ Gender: M / F   Rank: _____   Number of years of service: _____   Region / Dept:_____

Duties: General duties / CIU / TMU   Location: Metro / Country

_____

Please comment on any aspects of the survey that you particularly liked and disliked. You can also use this space to make additional comments regarding your experience of interacting with people who are mentally ill.

_____

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MONASH University

Centre for Forensic Behavioural Science

Police experience, attitudes and knowledge of mental illness

A mental illness or mental disorder is a condition which might affect a person's behaviour, thinking and/or intellectual functioning. Examples of specific types of disorders include, but are not limited to, schizophrenia, depression, anxiety, obsessive compulsive disorder and intellectual disability. Although members of Victoria Police are not required to diagnose specific mental illnesses, they often have contact with individuals who exhibit signs of these illnesses or disorders.

The following questionnaire asks a series of questions about your experiences, training, knowledge, and attitudes towards people who have a mental illness or disorder. There are no right or wrong answers, so please answer all questions as honestly and completely as possible.

HOW TO COMPLETE THIS QUESTIONNAIRE

Participants who feel concerned or distressed about issues raised in this Survey should contact the Victoria Police Employee Support Services on (03) 9301 6900. The Police Association and the CPSU also offer support services for members.

Please indicate your answers by COMPLETELY FILLING a response for each of your chosen answers.

Do this	O O O O O	Do NOT do this	✓ ☒ ⊘ ⊙ O O
Use a pencil or blue/black pen only. Make heavy marks that fill the circle.		Do NOT use red, green or yellow. Do NOT use highlighters.	

What to do if you make a mistake   O   ✗   ● O   O

Cross out the incorrect response and then COMPLETELY FILL in the correct response.

If you have problems reading this questionnaire, please contact the Project Manager to make alternative arrangements at telephone (03) 9495 9159 or email: primed@spppm.monash.edu.au

Questionnaire Privacy Collection Statement

The questionnaire is confidential. Your details and name are not recorded and are not in any way linked or associated with the responses you provide. If you wish to seek access to your personal information or inquire about the handling of your personal information, please contact the Monash University Privacy Officer on 9905 6011.

1. General Information

What is your gender?   O Female   O Male

To which age group do you belong?   O 18-25   O 26-30   O 31-35   O 36-40   O 41-49   O 50 and over

Years of service?   O 1-3 yrs   O 3-6 yrs   O 6-10 yrs   O 10-15 yrs   O 15+ yrs

Division?   O 1   O 2   O 3   O 4   O 5

Department?   O Crime   O SOSS   O SOES   O Education   O Specialist Support   O Other (please specify)

Duties?   O General   O S.O.C.A   O C.I.U   O T.M.U   O Other (please specify)

Location?   O Metropolitan   O Regional   O Rural

Rank?   O Inspector or above   O Senior Sergeant   O Sergeant   O L/S/C   O Senior Constable   O Constable   O PSO

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10. Please comment on any aspects of the survey that you particularly liked

11. Please comment on any aspects of the survey that you particularly disliked

Thank you for your time in participating and completing this survey

2. Experience

Please read the following questions carefully and mark the most appropriate

2.1 Whilst on duty, how often do you come into contact with people who appear to have a mental illness?

○ Never ○ Rarely ○ Sometimes ○ Often ○ Daily

2.2 In an average week how many times do you have contact with someone who appears to have a mental illness?

○ Never ○ 1-2 times ○ 3-5 times ○ 6-10 times ○ 10+ times

2.3 Thinking about the last month, what proportion of the following groups you have had contact with appeared to have a mental illness? (e.g., 10% of offenders appeared to have a mental illness).

	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
a) Offenders	○	○	○	○	○	○	○	○	○	○	○
b) Suspects	○	○	○	○	○	○	○	○	○	○	○
c) Victims	○	○	○	○	○	○	○	○	○	○	○
d) Witnesses	○	○	○	○	○	○	○	○	○	○	○
e) Vulnerable/at risk persons	○	○	○	○	○	○	○	○	○	○	○
f) Persons in need of assistance	○	○	○	○	○	○	○	○	○	○	○
g) Motorists	○	○	○	○	○	○	○	○	○	○	○

2.4 Please indicate the extent to which your understanding of mental illness is based on each of the following:

	Strongly based				Not based at all	
	1	2	3	4	5	6
a) Interaction with mentally ill persons on the job	○	○	○	○	○	○
b) Interaction with mentally ill persons in my private life	○	○	○	○	○	○
c) Training and education provided by Victoria Police	○	○	○	○	○	○
d) Training and education provided by others	○	○	○	○	○	○
e) Personal research	○	○	○	○	○	○
f) Media	○	○	○	○	○	○
g) Other (please specify)	○	○	○	○	○	○

3. Training

3.1 The following courses run by Victoria Police have been identified as containing information regarding mental illness. If you have taken part in any of the following courses, please rate them in terms of 1) relevance, 2) practicality and 3) comprehensiveness, where 1 = excellent, and 6 = poor

	Relevance (Excellent → Poor)						Practicality (Excellent → Poor)						Comprehensiveness (Excellent → Poor)					
	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6
a) School of Local Policing - Recruit Phase and Phase 9	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
b) Leadership and Management Development	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
c) Operational Safety & Tactics Training	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
d) Force Response Group - Tactical Communicators Course	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
e) Force Response Group - Negotiators Course	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
f) Sexual Offences & Child Abuse Co-Ordination Unit - Investigating Sexual Offences and Child Abuse	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
g) Psychological First Aid	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
h) Mental Health First Aid Department	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
i) Mental Illness Fellowship - Understanding the mentally ill	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
j) Other voluntary group	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

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3.2 Do you feel you have had sufficient training to assist you in your daily interactions with mentally ill people?　　O No　O Yes

4. Knowledge

4.1 How confident are you in your knowledge of policy and procedures for dealing with people who have a mental illness who are:

	Very confident 1	2	3	4	5	Not at all confident 6
a) Persons in need of assistance (e.g., missing person)	O	O	O	O	O	O
b) Victims	O	O	O	O	O	O
c) Witnesses	O	O	O	O	O	O
d) Suspects	O	O	O	O	O	O
e) Offenders	O	O	O	O	O	O

4.2 How often do you use the following sources of information to determine if someone has a mental illness?

	Very often 1	2	3	4	5	Never 6
a) Information provided during call dispatch	O	O	O	O	O	O
b) Database check (e.g., LEAP)	O	O	O	O	O	O
c) My knowledge from previous interactions with the person	O	O	O	O	O	O
d) Behaviour you observe at the scene	O	O	O	O	O	O
e) Medical Practitioners (FMO, CAT team, custodial nurses)	O	O	O	O	O	O
f) The person themselves	O	O	O	O	O	O

4.3 How often do the following outcomes occur as a result of your interactions with mentally ill people?

	Very often 1	2	3	4	5	Never 6
a) Arrest	O	O	O	O	O	O
b) Referral to a hospital under Section 10 of the Mental Health Act	O	O	O	O	O	O
c) Referral to another government agency	O	O	O	O	O	O
d) Referral to a health or welfare agency	O	O	O	O	O	O
e) No further action taken (e.g., allegation not substantiated)	O	O	O	O	O	O
f) No further action required (e.g., missing person found)	O	O	O	O	O	O

5. The statements below represent beliefs or ideas about mental illness and about dealing with mentally ill persons. Please complete all questions.

	Strongly agree 1	Agree 2	Slightly agree 3	Slightly disagree 4	Disagree 5	Strongly disagree 6
1. Mentally ill people take up more than their fair share of police time.	O	O	O	O	O	O
2. As soon as a person shows signs of mental illness, he/she should be hospitalised.	O	O	O	O	O	O
3. Wellness and recovery are possible and achievable for mentally ill people.	O	O	O	O	O	O
4. Mentally ill people need the same kind of control and discipline as a young child.	O	O	O	O	O	O
5. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.	O	O	O	O	O	O
6. It is frightening to think of mentally ill people living in residential neighbourhoods.	O	O	O	O	O	O
7. More money should be spent on the care and treatment of mentally ill people.	O	O	O	O	O	O
8. We have a responsibility to provide the best possible care for mentally ill people.	O	O	O	O	O	O
9. Nowadays, police officers need to have specialised training in dealing with mentally ill people.	O	O	O	O	O	O
10. It is best to avoid anyone who is mentally ill.	O	O	O	O	O	O
11. One of the main causes of mental illness is a lack of self-discipline and willpower.	O	O	O	O	O	O
12. It would be foolish to marry a person who has suffered from a mental illness, even though she/he seems fully recovered.	O	O	O	O	O	O
13. I would not want to live next door to someone who has been mentally ill.	O	O	O	O	O	O
14. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.	O	O	O	O	O	O

8. In your opinion, what are the biggest challenges you face when attempting to resolve situations involving people who are mentally ill? (List up to four)

1.

2.

3.

4.

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6. The following items represent personality traits, which may or may not apply to you. Please complete all questions.

	True	False
1. It is sometimes hard for me to go on with my work if I am not encouraged	○	○
2. I sometimes feel resentful when I don't get my own way	○	○
3. On a few occasions I have given up doing something because I thought too little of my ability	○	○
4. There have been times when I have felt like rebelling against people in authority even though I knew they were right	○	○
5. No matter who I'm talking to I'm always a good listener	○	○
6. There have been occasions when I took advantage of someone	○	○
7. I am always willing to admit when I make a mistake	○	○
8. I sometimes try to get even rather than forgive and forget	○	○
9. I am always courteous, even to people who are disagreeable	○	○
10. I have never been irked when people express ideas very different from my own	○	○
11. There have been times when I have been quite jealous of the good fortune of others	○	○
12. I am sometimes irritated by people who ask favours of me	○	○
13. I have never deliberately said something to hurt someone's feelings	○	○

7. Please list up to five signs, symptoms or behaviours that you believe are useful in determining whether someone has a mental illness

1.

2.

3.

4.

5.

5. The statements below represent beliefs or ideas about mental illness and about dealing with mentally ill persons. Please complete all questions.

Scale: 1 Strongly agree, 2 Agree, 3 Slightly agree, 4 Slightly disagree, 5 Disagree, 6 Strongly disagree

	1	2	3	4	5	6
15. Mental health facilities should be kept out of residential neighbourhoods.	○	○	○	○	○	○
16. Mentally ill persons should be isolated from the rest of the community.	○	○	○	○	○	○
17. Locating mental health facilities in a residential area downgrades the neighbourhood.	○	○	○	○	○	○
18. Dealing with mentally ill people should be an integral part of community policing.	○	○	○	○	○	○
19. I feel that I am adequately trained to handle situations/calls involving mentally ill people.	○	○	○	○	○	○
20. Mentally ill people should not be given any responsibility.	○	○	○	○	○	○
21. There is something about mentally ill people that makes it easy to tell them from normal people.	○	○	○	○	○	○
22. Responding to calls involving mentally ill people is not really part of a police officer's role.	○	○	○	○	○	○
23. We need to adopt a far more tolerant attitude toward mentally ill people in our society.	○	○	○	○	○	○
24. Mentally ill people are a disadvantaged group who deserve special consideration from the police.	○	○	○	○	○	○
25. Locating mental health services in residential neighbourhoods does not endanger local residents.	○	○	○	○	○	○
26. I feel more comfortable responding to calls involving mentally ill females in crisis.	○	○	○	○	○	○
27. I have confidence in the mental health system to adequately care for mentally ill people	○	○	○	○	○	○
28. Local residents have good reason to resist the location of mental health services in their neighbourhood.	○	○	○	○	○	○
29. Increased spending on mental health services is a waste of money	○	○	○	○	○	○
30. I know when to apply Section 10 of the Mental Health Act	○	○	○	○	○	○
31. Having mentally ill people living within residential neighbourhoods might be good therapy but the risks to residents are too great	○	○	○	○	○	○
32. There is pressure within my organisation to solve the problems associated with mentally ill people on an informal basis	○	○	○	○	○	○
33. I feel confident in my ability to handle decisions involving mentally ill people	○	○	○	○	○	○
34. I feel more comfortable responding to calls involving mentally ill males in crisis	○	○	○	○	○	○
35. A large percentage of calls involving mentally ill people who violate the law are dealt with informally	○	○	○	○	○	○
36. If mental health services were adequate, the police would not have to deal with mentally ill people	○	○	○	○	○	○
37. Hospital personnel are reluctant to accept mentally ill people referred by the police	○	○	○	○	○	○
38. In my opinion, dealing with people who have a mental illness is not real police work	○	○	○	○	○	○
39. My colleagues believe that dealing with people with a mental illness is not real police work	○	○	○	○	○	○
40. My colleagues are adequately trained to handle calls involving persons with a mental illness	○	○	○	○	○	○
41. Mentally ill individuals are usually more dangerous than non-mentally ill people	○	○	○	○	○	○
42. Dealing with mentally ill people is unrecognised and unrewarded by my organisation	○	○	○	○	○	○
43. Mentally ill people are just as responsible for their own behaviour as non-mentally ill people	○	○	○	○	○	○

Draft

Appendix 4: Script for vignettes

These three 1.5 minute vignettes depict an interaction between two police officers and a man who might be mentally ill. Each vignette is exactly the same, except for the man's apparent psychiatric symptoms. The reason for this is to examine whether differences in the man's psychiatric symptoms are associated with different responses from the police.

In the first clip the man is intoxicated and annoyed with being interrupted by the police officers. He displays no obvious signs of mental illness. In the second clip the man is intoxicated and displays symptoms which might be indicative of mental illness. His speech is slurred and uninhibited. He is annoyed with being interrupted by the police officers; however, he is also suspicious about what their presence might mean. In the third clip the man is clearly mentally ill. He is angry, paranoid and irrational.

Underline: Denotes variations between the man's symptoms across clips one, two and three.

Vignette 1: Not mentally ill

Still image of telephone with voice over

Telephone rings

Operator: What is the nature of your emergency?

Caller: Um… I'm just having a picnic with my family at Hillside reserve, and there is a man here…… he's yelling abuse at us. I don't know what his story is….I'm not sure….we don't really feel safe. I think someone should come and check this out.

Police car pulls up at park with two police officers inside.

Officer 1: (Speaks into radio): Just arriving at Hillside reserve now… complainants appear to have left the scene…..confirm that unidentified man is still in park…going to investigate now…..over.

Police officers exit vehicle and approach man sitting on a park bench with a bottle in a brown paper bag. The man is mumbling something inaudible to himself.

Officer 1: Excuse me sir, are you aware that drinking is prohibited in this reserve?

Man: (mumbles something inaudible)

Officer 1: Sir, can I ask you to place your drink in the trash and move along, please?

Man: <u>Oh, come on! Can't a man just enjoy a nice drink in the outdoors?</u>

Officer 2: Sir, can I see some identification please?

Man: <u>Well, can I see yours?</u>

Officer 2 removes badge from pocket and shows it to man.

Man: <u>Surely you've got some real crims to catch mate?</u>

Officer: Sir, please show me some identification.

Man: <u>Look, I lost my wallet alright. I ain't got nothing on me except this bottle. I'm not hurting no-one and I ain't broken any real laws. Can't you just leave me in peace?</u>

Officer 2 (*turns to officer 1*): What do you think his story is?

Officer 1: I'm not sure, what do you think we should do?

Vignette 2: Moderate severity of psychiatric symptomatology

Still image of telephone with voice over

Telephone rings

Operator: What is the nature of your emergency?

Caller: Um… I'm just having a picnic with my family at Hillside reserve, and there is a man here…… he's yelling abuse at us. I don't know what his story ….I'm not sure….we don't really feel safe. I think someone should come and check this out.

Police car pulls up at park with two police officers inside.

Officer 1: (Speaks into radio): Just arriving at Hillside reserve now… complainants appear to have left the scene…..confirm that unidentified man is still in park…going to investigate now…..over.

Police officers exit vehicle and approach man sitting on a park bench with a bottle in a brown paper bag. The man is mumbling something inaudible to himself.

Officer 1: Excuse me sir, are you aware that drinking is prohibited in this reserve?

Man: (mumbles something inaudible)

Officer 1: Sir, can I ask you to place your drink in the trash and move along, please?

Man: <u>Oh, come on! Can't a man just have a drink? I'm just…. I'm….I don't know why this is happening</u> (concerned/ confused)

Officer 2: Sir, can I see some identification please?

Man: <u>No! I mean, I don't have any…. I ….I lost it…it's gone…I don't have any…. What's your name </u> (suspicious)

Officer 2 removes badge from pocket and shows it to man.

Man: <u>I think you should leave me alone. I can't… I can't….</u>

Officer: Sir, please show me some identification.

Man: <u>I told you…. I…..it's gone.</u>

Officer 2 (*turns to officer 1*): What do you think his story is?

Officer 1: I'm not sure, what do you think we should do?

Vignette 3: Severe Psychiatric Symptomatology

Still image of telephone with voice over

Telephone rings

Operator: What is the nature of your emergency?

Caller: Um… I'm just having a picnic with my family at Hillside reserve, and there is a man here…… he's yelling abuse at us. I don't know what his story is ….I'm not sure….we don't really feel safe. I think someone should come and check this out.

Police car pulls up at park with two police officers inside.

Officer 1: (Speaks into radio): Just arriving at Hillside reserve now… complainants appear to have left the scene…..confirm that unidentified man is still in park…going to investigate now…..over.

Police officers exit vehicle and approach man sitting on a park bench with a bottle in a brown paper bag. The man is mumbling something inaudible to himself.

Officer 1: Excuse me sir, are you aware that drinking is prohibited in this reserve?

Man: (mumbles something inaudible)

Officer 1: Sir, can I ask you to place your drink in the trash and move along, please?

Man: When the clock strikes ½ past the hour then the time will be right for obeying your laws, until now I have worn only colours

Officer 2: Sir, can I see some identification please?

Man: A name! A name! Do you have a name? My brother had purple shoes.

Officer 2 removes badge from pocket and shows it to man.

Man: It's too late to forget the trouble. Piracy and pirates!

Officer: Sir, please show me some identification.

Man: You shall you see ….. my brother….my mother….. had red hair and never wore a hat. And that's that.

Officer 2 (*turns to officer 1*): What do you think his story is?

Officer 1: I'm not sure, what do you think we should do?

Appendix 5: Ethics Approval

MONASH University

Standing Committee on Ethics in Research Involving Humans (SCERH)

Prof James Ogloff
School of Psychology, Psychiatry and Psychological Medicine
Faculty of Medicine, Nursing and Health Sciences
Clayton Campus

02 May 2007

CF07/0394 - 2007/0117: Police experience attitudes and knowledge of mental illness

Dear Researchers,

Thank you for the information provided in relation to the above project. The items requiring attention have been resolved to the satisfaction of the Standing Committee on Ethics in Research Involving Humans (SCERH). Accordingly, this research project is approved to proceed.

Terms of approval
1. This project is approved for five years from the date of this letter and this approval is only valid whilst you hold a position at Monash University.
2. It is the responsibility of the Chief Investigator to ensure that all information that is pending (such as permission letters from organisations) is forwarded to SCERH, if not done already. Research cannot begin at any organisation until SCERH receives a letter of permission from that organisation. You will then receive a letter from SCERH confirming that we have received a letter from each organisation.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by SCERH.
4. You should notify SCERH immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. **Amendments to the approved project:** Changes to any aspect of the project require the submission of a Request for Amendment form to SCERH and must not begin without written approval from SCERH. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. Please provide the Committee with an Annual Report determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. SCERH should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by SCERH at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

All forms can be accessed at our website www.monash.edu.au/research/ethics/human/index.html

We wish you well with your research.
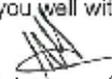
Mrs Lyn Johannessen
Acting Human Ethics Officer (on behalf of SCERH)

Cc: Mr Joel Godfredson, Dr Stuart Thomas

To whom it may concern.

Victoria Police and the Centre for Forensic Behavioural Science at Monash University are collaborating on an ARC funded Linkage Grant investigating the police-mental health interface from a number of different perspectives.

Senior members of Victoria Police were involved in conceptualising and developing all of the different aspects of this large-scale research project.

One of the initial studies in this five year project is a *knowledge, attitudes and experiences survey* of Victoria Police officers that Joel Godfredson is carrying out in part fulfilment of his Doctorate in Clinical Forensic Psychology. It is anticipated that his pilot studies will lead on to a large scale survey of all operational police officers in Victoria, which will give us important information about our current strengths and our training gaps in relation to mental health issues.

We support Mr Godfredson's application to the Monash University Human Research Ethics Committee.

Joseph Poznanski, PhD
Senior Researcher
Corporate Strategy & Performance Department
Victoria Police.

12 April 2007