CONTACTS WITH, AND ATTITUDES TOWARD, THE MENTALLY ILL IN THE NEW ZEALAND POLICE

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Abstract

Deinstitutionalisation and changes to the Mental health Act (1992) relating to committal and treatment for those with a mental illness has resulted in increased numbers of people with a mental illness living in the community. Internationally these changes in the care of mentally ill people have resulted in increased contacts between the police and the mentally ill. The present study investigated the amount, and nature of, contacts between the New Zealand police and the mentally ill and the attitudes of the police toward mentally ill persons using Cohen and Struenings Opinions about Mental Health (OMI) scale. Self-administered questionnaires were distributed to all police stations within region three of the New Zealand police districts and a total of 261 sworn police participated. The results show that New Zealand police, like their international colleagues, experience regular contacts with the mentally ill that are time consuming, stressful and largely non-criminal in nature. While the police expressed a dislike to attending call outs involving the mentally ill, their attitudes as measured by the OMI were overall positive and accepting of mentally ill people. The participants expressed a desire for additional training and education to better prepare themselves to deal with the mentally ill.

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CHAPTER ONE

INTRODUCTION

At any given time, 25-30% of the population meet the criteria for a mental illness, and one-third of these people have an illness which is of a serious or chronic nature (Mason, 1996). The care of the mentally ill has shifted from long term hospitalisation to community care in a process referred to as deinstitutionalisation, which accelerated internationally from the 1950s. In the United Kingdom for example, Gilmartin (1986) reported that in 1955 75% of care for the mentally ill was provided on a inpatient basis, while by 1986 75% of mental health care was provided on a outpatient basis.

The process of deinstitutionalisation and the successful integration of the mentally ill into community based care is in part reliant on the public's acceptance of the mentally ill (Cohen & Struening, 1962; Taylor & Dear, 1981). Following the downsizing and closing of mental health facilities attention was focussed on the attitudes of the public toward mentally ill persons (Nunnally, 1961; Taylor & Dear, 1988; Triandis, 1971). While there have been improvements in the attitudes held by the public toward the mentally ill since the early 1960s, recent research has found that generally attitudes toward the mentally ill have largely remained negative (Antonak & Livneh, 1995; Colombo, 1997; Lopez, 1991).

Historically, researchers concentrated on the attitudes of the general public, hospital and health workers, however, attention has recently been drawn to the attitudes of police officers toward the mentally ill. Internationally it has been found that since the deinstitutionalisation of mental health care has occurred, police have experienced a significant increase in contacts with the mentally ill (Gilmartin, 1986; Murphy, 1986; Fogarty, 1991), and there is a greater probability of police contact with people who have psychiatric illnesses during their routine and daily duties (Berry, 1996; Bonovitz & Bonovitz, 1981; Gilmartin, 1986; Teplin & Pruett, 1992).

Attitudes can influence behaviour by acting as a predisposition to respond in a favourable or unfavourable manner to given objects (Oskamp, 1977; Triandis, 1971; Antnoak & Livehn, 1988). The remainder of chapter one will discuss the definition of attitude, factors which are important in the formation of attitudes and the relationship between attitudes and behaviour. Chapter two discusses the attitudes of the general public toward the mentally ill and identifies several factors which influence attitudes toward the mentally ill. This is followed by chapter three which introduces the police role with the mentally ill. Chapter three also discusses the findings from both international and New Zealand research exploring police contacts and attitudes toward the mentally ill. The training of police to work with the mentally ill is also discussed. Finally, chapter four introduces the present study and the background to this study.

ATTITUDES

Attitude definition

Throughout the history of social psychology attitudes have played a central role in the explanation of social behaviour (Oskamp, 1977), and attitudes and attitude change continue to be researched extensively. Despite this long history of attitude research there remains no universally agreed upon definition of the attitude concept. However, there is a general consensus that as a hypothetical construct, attitudes are not directly observable and must be inferred from measurable responses which generally reflect a positive or negative evaluation to an attitude referent of varying strengths. Once established, attitudes are enduring and remain relatively stable over time (Olson & Zanna, 1993; Oskamp, 1977; Triandis, 1971).

Allport's (1935) often cited definition of an attitude as a "mental or neural state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related" continues to be influential, and has many common elements shared with other definitions. Another influential definition of attitude is that of Fishbein and Ajzen (1975), who offer a comprehensive definition of an attitude as "a learned predisposition to respond in a consistently favourable or unfavourable manner with respect to a given object"

Another common view however is that attitudes have three components. This is illustrated by Trinadis' (1971) definition of attitude as "an idea charged with emotion which predisposes a class of actions to a particular class of social situations". This tripartite definition suggests attitudes are inferred from a cognitive component, which reflects the individuals knowledge, ideas, and thoughts about the attitude referent; an affective component that reflects the feelings and emotions toward the referent; and a behavioural component which refers to the individuals behavioural intentions, or the predisposition to act in a certain way when confronted with the attitude referent.

Debate continues as to whether such a breakdown is either useful or necessary (Oskamp, 1977), and more recent research has emphasised the notion that attitudes can be based on just one or two of the above components (Miller & Tesser, 1986; Tesser, 1995). There appears to be a growing consensus among theorists that the most prominent feature of an attitude is its evaluative character and Franzoi (1996) simply defines attitude as "a positive or negative evaluation of an object" (p.173).

Attitudes and related concepts

Attitudes are often compared with and used synonymously with other concepts, in particular beliefs, opinions, and values.

Beliefs are traditionally referred to as the cognitive component of attitudes and Fishbein and Azjen (1972) define beliefs as statements which indicate the probability that an attitude object possesses a particular characteristic, quality, or attribute. Beliefs are associated with the amount of information the individual has about a particular object, which leads to the formation of an attitude that can influence the person to behave in a certain manner toward the attitude referent (Antonak & Livneh, 1988).

Opinions are considered to be primarily non-evaluative in nature and are narrower in content than attitudes (Oskamp, 1977). McGuire (as cited in Oskamp, 1977) argues that opinions are beliefs associated with ones expectations or predictions regarding the likelihood of events or relationships, while attitudes involve a persons wishes and desires regarding these same events or relationships.

While attitudes refer to evaluations of specific objects, values are enduring beliefs about important life goals or standards of behaviour (Franzoi, 1996; Oskamp, 1977). Values are central elements in a person's system of attitudes and beliefs and constitute an important aspect of an individuals self-concept (Antonak & Livneh, 1988).

Attitude formation

Attitude formation refers to the initial change from having no attitude toward a given object to having some attitude toward it, either positive or negative, in varying strengths. Attitudes and opinions are learned (Oskamp, 1977; Triandis, 1971), and there are a variety of factors and processes which can operate in the acquisition of attitudes.

The most fundamental factor in attitude formation is direct personal experience (Fazio & Zanna, 1981; Oskamp, 1977; Olson & Zanna, 1993; Tesser, 1996). Salient incidents, especially those that are particularly traumatic or frightening are stressed by many theorists in the development of attitudes. Traumatic or frightening incidents can be influential in attitude formation as they can be a source of powerful negative conditioning (Oskamp, 1977; Olson & Zanna, 1993; Triandis, 1971), and clinical psychologists have described many phobias which originated from a single traumatic experience (Olson & Zanna, 1993). Another way in which attitudes can be formed through personal experience is by the mere exposure effect. Developed by Zajonc (1968), this is the tendency to develop more favourable attitudes toward objects or individuals the more we are exposed to them. Evidence indicates that attitudes formed by repeated exposures operate more strongly during the initial exposures, but continue to develop and intensify during later contact (Oskamp, 1977; Olson & Zanna, 1993).

Imitation or modelling of others, particularly role models, including caregivers and members of a desirable group, can also be a contributing factor to the formation of attitudes. Allport (1954, as cited in Triandis, 1971) suggests that many attitudes held by individuals are acquired from family and friends' expressed attitudes towards the same attitude referent. Parental influence is particularly influential to forming the child's early attitudes, and throughout the aging process, parental influence is replaced by group determinants such as schools, peer groups, and reference groups (Tesser, 1995).

The influence of the mass media, including television, movies, radio, newspapers, and magazines should also be considered. The media can be a contributing factor in attitude formation as it can serve as a major source of information. The media selects, emphasises, and interprets particular events (Oskamp, 1977; Thornton & Wahl, 1996). Wahl (1992) found the impact of this selective and often sensationalised reporting on forming or strengthening attitudes is at its greatest when the individual has no pre-existing evaluations toward the attitude referent.

Attitudes are also formed and maintained by forming stereotypes (Franzio, 1996; Triandis, 1971) which function to help reduce the complexity of our environment by grouping all members of a group together (Oskamp, 1977). A stereotype can be defined as an evaluation, image or set of beliefs that a person holds about most members of a particular group (Olson & Zanna, 1993). These beliefs are usually simplified and may be highly evaluative and resistant to change. More often than not stereotypes are negative (Oskamp, 1977). Olson and Zanna (1993) draw attention to the role of illusory correlations as a strong influence on developing stereotypes and biases about minority groups. Illusory correlations can occur when the co-occurrence of those from a minority group and unusual behaviours, or behaviours that make the person feel uncomfortable or at risk, are overestimated (Olson & Zanna, 1993).

Negative attitudes and stereotypes can also be developed and maintained by the interpretation of actions by the individual. If the person already has a negative attitude of a particular group, then behaviours and actions by members of that group that may otherwise be overlooked if performed by a member of a neutral group, will be interpreted in a negative manner and will serve to strengthen already held negative attitudes (Oskamp, 1977; Triandis, 1971).

Finally, once attitudes and stereotypes have been formed, they are supported and strengthened through selective memory and generalisation (Olson & Zanna, 1993; Oskamp, 1977). Generalisation is the tendency to associate similar objects together and to apply previously formed attitudes to these items, and selective

memory occurs when people find information supporting their attitudes easier to learn and remember than information that contradicts their attitudes.

Functions of Attitudes

As discussed above, attitudes are formed by a number of processes and are largely formed and developed unconsciously by the individual. Once formed, attitudes serve the function of keeping a complex world simple for the individual (Olson & Zanna, 1993; Triandis, 1971). Functional theorists (e.g. Katz, 1960; and Smith, Bruner, & White, 1956) argue that the purpose or function of attitudes is to satisfy different psychological needs of the individual. The functional approach emphasises that individuals develop and change their attitudes to satisfy current needs. Katz (1960) in his widely accepted analysis, has suggested attitudes serve four main functions.

The first function Katz (1960) proposed was that attitudes perform a utilitarian or adjustment function to help individuals to achieve rewards and gain approval from others while minimising potential penalties or negative consequences. Attitudes are formed in part by positive and negative experiences and help guide behaviour towards maximising various goals and rewards and away from potential adverse or unfavourable outcomes.

The second function of attitudes proposed by Katz (1960) is the knowledge function which he suggests helps individuals in understanding and making sense of the world by efficiently processing complex information about the social world. Attitudes allow people to interpret and remember social information by providing a frame of reference for the individual toward a group of objects so that their evaluation of these objects remain stable and organised each time the attitude referent is encountered.

Thirdly, attitudes are also suggested to perform an ego-defensive function which allows the individual to protect themselves by helping the individual cope with

emotional conflicts and protect their self-esteem by not accepting or acknowledging basic self-truths about themselves.

The final function proposed by Katz (1960) is the value-expression function of attitudes which helps to establish the persons self-identity. This function gives satisfaction to the individual by allowing a sense of self-realisation from the expressions of their basic central values.

Attitudes and Behaviour

One of the most researched and debated qualities of attitudes relates to the assumption that attitudes can influence and determine behaviours (Tesser, 1995). The relationship between attitudes and behaviour was questioned after a period in the 1970s when a number of studies failed to reliably predict behaviour from expressed attitudes (Wicker, 1969; Oskamp, 1977). However, after a revision of methodological issues and a return of interest and research, it is now generally accepted that while attitudes themselves are not sufficient to cause a behaviour, they are a contributing factor and can influence behaviour. Assuming certain conditions are met, attitudes may strongly influence behaviours and can be used to help predict future behaviours (Ajzen, 1989; Ajzen & Fishbein, 1977; Antonak & Livneh, 1988; Baron, 1992).

While attitudes can be a factor in influencing behaviour, it is also important to take into account the other factors found to have an influence on behaviour, including the individuals ability, effort and motivation, societal norms and expectations, past behaviours, prior experience with the attitude referent, personality factors, and reinforcement and punishment expectations (Antonak & Livneh, 1988; Olson & Zanna, 1993; Triandis, 1977). Fishbein and Ajzen's theory of reasoned action (1975), for example, proposes that attitudes and subjective norms combine to determine behavioural intentions. This theory proposes that before an individual acts out on their attitudes, they take into account their own and others' attitude toward the behaviour in question by considering subjective norms and their perceived control over the behaviour

concerned (Oskamp, 1977; Antonak & Livneh, 1988; Olson & Zanna, 1993). It is also important to consider the individuals behaviour from the past, as if the behaviour has been performed previously, this increases the likelihood that the individual will repeat the behaviour in question (Oskamp, 1977; Triandis, 1971).

A number of studies have found that the relationship between attitudes and behaviour is greater when the attitude itself is strong (Fazio & Zanna, 1981; Olson & Zanna, 1993). Tesser (1995) reports a source of attitude strength is the amount of personal involvement the person has with the attitude referent. Attitudes that are formed through direct personal experience are stronger and are better predictors of later behaviour than attitudes that are formed without such experiences (Fazio & Zanna, 1981).

One reason for attitudes that are formed by direct personal experience having a strong influence on behaviour is because they are highly accessible. Fazio and his colleagues (see Fazio 1990 for a review) have shown in a series of studies that attitudes which come to the mind quickly are better predictors of behaviour than those that come to mind more slowly. When an attitude comes to mind quickly, it can bias your evaluation of the attitude object, and the more you perceive the object as consistent with your attitude, the more likely you are to behave in an attitude-consistent manner (Olson & Zanna, 1993; Tesser, 1995).

CHAPTER 2

ATTITUDES TOWARD THE MENTALLY ILL

Public attitudes toward the mentally ill

Since the process of deinstitutionalisation was implemented, a substantial number of studies investigating the public's attitude toward the mentally ill have been conducted. By the 1960s, several influential studies had shown that the mentally ill were generally feared by the public (Rosenhan, 1973; Star, 1955), and those labelled as mentally ill were disliked and avoided (Rabkin, 1974; Cumming & Cumming, 1965). Nunnallys' (1961) findings that people believed the mentally ill were 'unpredictable' and 'dangerous' were typical and Nunnally concluded that the mentally ill "are regarded with fear, distrust, and dislike. A strong negative halo surrounds all mentally ill, they are considered, unselectively, as being all things bad" (p. 51).

The degree of acceptance of mentally ill people by the general public continues to be debated (Taylor & Dear, 1982). Internationally while there has been a gradual improvement in the public's attitude toward the mentally ill (Antonak & Livneh, 1995; Angermeyer & Matschinger, 1997), it is still evident that mentally ill persons remain largely rejected by the public (Angermeyer & Matschinger, 1997; Lopez, 1991; Taylor & Dear, 1982) and acceptance into the community continues to be limited by negative attitudes (Rabkin, 1974). A 1987 study in New Zealand (Green, Walkey, Taylor, & McCormick) revealed that attitudes were substantially the same as they had been 20 years previously, and people were only slightly less conservative, fearful, and rejecting of mentally ill people. Therefore, in New Zealand also, despite an improvement in attitudes over time, it can be concluded the public largely continues to hold negative attitudes toward the mentally ill (Rabkin, 1975; Anotank & Livenh, 1988).

Factors influencing attitudes toward the mentally ill

Attitudes toward the mentally ill can be influenced by several factors. As already mentioned, the mass media can be influential in attitude formation. Mass media portrayals of the mentally ill have been found to encourage and maintain negative attitudes (Domino 1983; Noe, 1997; Wahl, 1992; Wahl & Lefkowits 1989). The indiscriminate coverage by the popular media of violent crimes committed by people with a history of psychiatric disorders appears to have a particularly negative impact (Nunnally, 1961; Scheff, 1966; Wahl & Harman, 1989).

An example of this discriminate media coverage can be drawn from headlines of two newspapers regarding the recent murder of Malcolm Beggs in Auckland by Lachlan Jones, a young man who was receiving mental health services. Headlines of articles included "Killer sought psychiatric help" (The Dominion, 29.09.00), "Axe killer said murderous voice was just a trick of the mind" (Dom, 22.06.00), "Killer a confused man" (The Dominon, 22.07.00), "Psychiatric treatment of axe murderer questioned" (Waikato Times, 23.06.00) and "Many mental time bombs ticking, says psychiatrist" (The Dominion, 22.07.00). In comparison, two separate murder charges, one of which also involved extensive violence, received newspaper coverage around this time also. The headlines, of which there were only one per murder, simply read "Man charged with women's murder" (Waikato Times, 7.09.00) and "Man guilty of murder" (Waikato Times, 24.05.00). The two men charged with these murders had no history of psychiatric illnesses.

It is suggested that this sensationalism of 'news' communicates a connection between mental illness and violence, hence, while the mass media's portrayal and use of headlines of such incidents helps to maintain negative attitudes they also reinforce the widely held belief that those with a mental illness are unpredictable, dangerous, and violent (Nunnally, 1961; Oskamp, 1977).

While the media's portrayal of the mentally ill can contribute to negative attitudes, attitudes can, as indicated earlier, be formed and shaped by the mere exposure effect. Contact with the mentally ill can help reduce feelings of

resentment and promote more accepting and positive attitudes toward the mentally ill (Angermeyer & Matschinger, 1997; Taylor & Dear, 1980; Yuker, 1988). Several studies have found that those who have contact with mentally ill people perceive them more favourably (Kolodziej & Johnson, 1996; Ogedengbe, 1993), and with less fear (Brockington, Hall, Levings, & Murphy, 1993) than those who have no contact. These effects are intensified when the person experiences intimate contact with mental illness, by either experiencing a mental illness themselves, or having a close relative or acquaintance experience a mental disorder (Link & Cullen, 1986; Oskamp, 1977).

However, the positive effect of contact on attitudes toward the mentally ill is dependent on the nature of contacts, and contact per se is not automatically beneficial (Lyons & Hayes, 1993). As already discussed, phobias and stereotypes can be initiated by a single exposure that is frightening, stressful, or out of the ordinary and these salient events can cause negative attitudes or reinforce already held negative attitudes (Olson & Zanna, 1993; Oskamp, 1977). However, if the contact is voluntary rather then forced (Callaghan, Shan, Yu, Ching, & Kwan, 1997; Lyons & Hayes, 1993), of a continual nature, and if the contact is between persons of equal status (Colombo, 1993; Lyons & Hayes, 1993) then contact per se will promote more favourable attitudes toward the mentally ill.

Nunnally (1961) suggested that negative attitudes toward those with a mental illness are largely due to a lack of information, rather than misinformation. Reviews of recent research have revealed a significant increase in public knowledge about mental illness and the ability to correctly recognise mental illness (Lopez, 1991; Rabkin, 1974). Rabkin (1974) attributes this to the extensive educational campaign launched by health organisations to re-educate the public in terms of the medical model of mental illness which is based on the premise that mental illness is an illness like any other.

This increased knowledge about mental illness has in part been a contributing factor to the measured improvements in public attitudes toward the mentally ill (Rabkin, 1974). The more knowledgable the individual is about mental illness, the more favourable their attitudes will be (Colombo, 1997; Taylor & Dear, 1981; Teplin & Pruett, 1992). This can be illustrated by the more favourable attitudes held by those working in the field of mental health who receive extensive education regarding mental illness as part of their training (Nunnally, 1961; Patrick, 1981; Taylor & Dear, 1981). Also supporting this hypothesis, Godschalx (1984) and Colombo (1997) report favourable attitude change toward the mentally ill following education about mental health and the mentally ill, and Brockington et al (1993) found that higher general education levels were negatively related to fear of the mentally ill.

Researchers have also investigated the effect of age and gender on attitudes toward the mentally ill. While there have been no conclusive findings regarding the impact of gender on attitudes toward the mentally ill (Taylor & Dear, 1981), the research clearly shows that attitudes are influenced by age. It has been continually found that acceptance of the mentally ill generally diminishes with age (Brockington et al., 1993) and advanced age is strongly correlated with negative attitudes (Trinadis, 1971; Olson & Zanna, 1997; Oskamp, 1971). One suggestion is that this may be due partially to young people having more education regarding mental illnesses and more contact with mentally ill as a result of deinstitutionalisation (Lopez, 1991).

CHAPTER 3

Police contact with mentally ill persons

The modern police officers job has often been referred to as the most difficult job in the world. Police are expected to be efficient crime fighters and, at the same time, skilled peace keepers. Society not only demands that the police officer enforces the law, but that they also perform the role of marriage counsellors, scientists, social workers, lawyers, doctors and psychologists (Fogarty, 1991; Kirkham, 1994; Murphy, 1986).

Interacting with mentally ill persons has historically been identified as having always been a necessary part of police work (Berry, 1996; Teplin & Pruett, 1992), and it appears the majority of police officers agree and accept that dealing with the mentally ill is a required service of the police. A 1973 study by Jackobson, Draven and Kushmer (cited in Kimhi et al., 1998) found three out of four officers believed dealing with the mentally ill was an appropriate task and similarly in 1995 Cherret found that only 21 percent of officers felt that dealing with the mentally ill should not form part of their role as a police officer. Numerous studies have found that while the police acknowledge that working with the mentally ill is an integral part of police work, they do so reluctantly and police feel that dealing with such persons is not a 'proper task' for police and report that it is an undesirable aspect of their work (Bittner, 1967; Murphy, 1986).

International research has shown a marked increase of police contacts with mentally ill people since deinstitutionalisation (Arcaya, 1988; Berry, 1996; Bonovitz & Bonovitz, 1981; Murphy, 1985; Teplin & Pruett, 1992), and it has been suggested that the police have more contact with the mentally ill than all other health and social services combined (Blankenship & Cramer, 1976; Fogarty 1991). Between 1955 and 1979 during which time deinstitutionalisation occurred in the United States, Bonovitz and Bonovitz (1981) reported a 225% increase in incidents involving the police and the mentally ill, and in the United Kingdom,

Berry (1996) reported 238 official police contacts in 28 days, an average of 8.5 incidents involving mentally ill people per day. A one month study which drew respondents from two States in America found that 92% of the officers had responded to an incident involving a mentally ill person in the past month, and of those, 84% attended more than one such incident (Borum, Deane, Steadman & Morrissey, 1998). Similarly, Gillig, Dumaine, Stammer, Hillard, and Grubb (1990) found that nearly 60% of officers in their study had responded to at least one incident, and 42% had more than one involvement in dealing with a mentally ill person. It has also been found that police working in urban centres are likely to have more frequent contact with mentally ill people than their colleagues working in rural areas, and Berry (1996) concluded this is due to the higher number of mentally ill living in urban areas.

While international research has repeatedly found that police contact with mentally ill people is now extremely common, contacts with the mentally ill have also been found to be time consuming and it has been widely reported that police are frustrated at the amount of time incidents involving mentally ill take (Berry, 1996; Fogarty, 1991; Teplin & Pruett, 1992).

In Los Angles prior to 1985 when a specialist mental evaluation unit was developed, DeCuir (1996) reported 28 000 police and administration hours in a 28 day deployment were involved in contacts with mentally ill people. Berry's (1996) study from the United Kingdom found the average amount of time police spent with incidents involving mentally ill people was just over three hours. In contrast to this, Meadows, Calder, & Van den Bos (1994) found officers spent an average of 1 hour per incident involving a mentally ill person, with a range of time of 10 minutes to 8 hours. Another example of both the time consuming nature involving incidents with mentally ill people and the frequency of contact between police and the mentally ill is provided by Walker (1992, cited in Berry, 1996) who found that police spent 9056 hours working with incidents involving the mentally ill during the time period of the study compared to 7589 hours involved in domestic burglary.

The frustration felt by police is exacerbated by the fact that the majority of incidents involving the mentally ill are not of a criminal nature, which also partially accounts for officers reporting that working with mentally ill is not 'real' police work and a waste of police resources (Murphy 1985). Meadows et al (1994) found that just over 72% of police contacts with the mentally ill were not related to a criminal offence. Similarly, Berry (1996) found that from 238 police involvements with mentally ill, only 21 incidents were of a criminal nature, meaning that 91% of contacts with the mentally ill did not involve any criminal offence.

While the majority of police contact with the mentally ill appears to be unrelated to criminal behaviour, the police have by default become providers of psychiatric 'first aid' and are routinely the first line of response for those displaying symptoms of a mental illness (Arcaya, 1988; Cherret, 1995; Murphy, 1985). This is attributed to the police being the only free, 24 hour help service with unique mobility and a legal obligation to respond (Berry, 1996; Finn & Sullivan, 1989; Murphy, 1985). Murphy (1986) also adds that police contact with mentally ill is regularly the first point of contact for the mentally ill because the police are perceived by the public as being more accessible and are often the first choice for the public when requesting assistance when a persons mental health has deteriorated (Fogarty, 1991; Murphy, 1986,) or when they witness bizarre or disturbing behaviour (Sheridan & Teplin, 1981). A 1990 study in England for example found that amongst care givers for people with schizophrenia, the police were rated as the best carers in the community, over and above health services (Smith, 1990).

One consequence of the police regularly being the first to encounter and aid the mentally ill, is that the police officer ends up dealing with the mentally ill in crisis situations (Borum & Williams 1998), when they have decompensated, lost control, are confused, or are difficult to engage with rationally (Acarcya 1988; Colombo, 1991; Fogarty, 1991; Murphy, 1986). To add further difficultly to the situation, a study by Liberman (1969) found that when police were involved with

mentally ill people, 94% denied their illness and only 17% acknowledged and accepted they needed help. In contrast only 29% of those that presented to the hospital at first contact denied their illness and 80% accepted help. Police therefore are dealing with the mentally ill who are unwilling to accept help and who, due to this reluctance, may require more coercive handling and care (Murphy, 1986).

Working with the mentally ill under such conditions, police officers find their contact with the mentally ill stressful and the mentally ill difficult to manage (Berry, 1996; Borum & Williams, 1998; Finn & Sullivan, 1989; Murphy, 1986). Police officers have expressed anxiety feelings of futility, lack of control and confusion as to the most appropriate course of action to take when working with mentally ill (Borum & Williams, 1998; Murphy, 1986).

In both the United Kingdom and United States, police have identified a lack of sufficient training to deal effectively and properly with this population (Borum & Williams, 1998; Cherret, 1995; Finn & Sullivan, 1989; Fogarty, 1991), and Murphy (1986) found an average of only 4.27 hours across the United States Police training academies were devoted to working with mentally ill people. While police officers have a dislike of attending call outs involving mentally ill, they have also expressed a desire and need to gain increased knowledge and better skills to work efficiently and effectively with the mentally ill (Gillg et al; 1990; Fogarty, 1991; Murphy, 1986).

While the police are not trained nor expected to perform the role of mental health professionals, the nature of their job and the public's reliance on the police when they require assistance with persons displaying symptoms of mental illness, often places them in the front line of mental health crisis care (Berry, 1996; Cherret 1995; Fogarty, 1991; Meadows, Calder, Van Den Bos, 1994). Teplin (1984) sums up the unique position of the police by stating "police have become the street psychiatrist; moreover, their office never closes" (p. 4).

International Police attitudes toward the mentally ill

The police have regular contact with mentally ill people under difficult circumstances (Berry, 1996; Fogarty, 1991; Murphy, 1986). It has been suggested that constantly dealing with the mentally ill when they are acutely unwell cannot help but affect police officer attitudes and may serve to reinforce and strengthen any negative attitudes held toward the mentally ill (Colombo, 1997; Fogarty, 1996).

Several international studies have examined police attitudes toward the mentally ill. A predominate attitude that continues to be held by police officers is that there is a relationship between the mentally ill and acts of violence or danger to others (Gillig et al., 1990; Kimhi et al., 1998; Matthews, 1970; Murphy, 1986). Gillig et al. (1990) found that police officers expect the mentally ill to become violent or to behave in abnormal ways and Fogarty (1991), a police superintendent, records that the mentally ill are irrational, unpredictable, and makes reference to the 'potential danger' of the mentally ill.

While the belief that the mentally ill are dangerous continues to be widespread among police, this can be understood in terms of and attributed to the nature of contact the police have with the mentally ill. As discussed previously, the police are more likely to be called to incidents involving the mentally ill when they are in crisis situations and therefore witness the symptoms of mental illness and associated behaviour at its worst when there is a heightened probability that violence may occur (Gillig et al. 1990; Murphy, 1986)

Several researchers have also looked at police attitudes toward the mentally ill using Cohen and Struenings' (1962) Opinions About Mental Illness (OMI) scale. These studies have found that police officers attitudes vary according to their age, education, rank, length of service in the police, and personal experience or contact with people who have a mental illness (Lester & Patrick, 1978; Patrick, 1978).

Attitudes toward the mentally ill vary according to police rank. The higher the rank, the more favourable their attitudes are (Patrick, 1978). Patrick (1978) believes this is related to those having a lower rank being more likely to have contact with the mentally ill as part of their routine duties. Also related to rank is the length of time the officer has been in the police. Those with longer years of service had more caring attitudes and there was a correlation between increased years of service and more favourable attitudes toward the mentally ill.

Attitudes of the police toward the mentally ill differed from the general population when age was considered. Police officers with increasing age held more positive attitudes toward the mentally ill, whereas in the general population increasing age is correlated to negative attitudes. This effect can be explained in relation to both rank and years of service also, as officers with increased age are likely to have longer service with the police, hence, are also likely to have higher ranks. Young police officers may be more negative toward the mentally ill because they are likely to be lower in rank and therefore are more likely to attend incidents involving mentally ill people (Lester & Pickett, 1978; Patrick, 1978).

Similar to the general population is the finding that police officers with higher education hold more favourable attitudes toward the mentally ill (Lester & Pickett, 1978; Patrick, 1978). Training designed to increase police officers' knowledge about mental illness also proved beneficial to police attitudes toward the mentally ill. Lester and Pickett (1978) compared attitudes before and after a training programme specifically related to understanding and increasing knowledge about mental health and mental illness, and found that prior to training, police officers were less positive in expressed attitude, but upon completion of the training the police were found to have more positive attitudes, similar to those of mental health professionals.

Police who had either had a personal experience with mental illness or who had known a close acquaintance with a mental illness also expressed more favourable attitudes toward those with a mental illness. Those that had either experienced

mental illness themselves or who had a close acquaintance with a mental illness were less authoritarian and restrictive and showed a greater tolerance and more humanistic attitudes toward the mentally ill (Patrick, 1978). No conclusions are able to be made regarding gender differences and attitudes in the police as neither the Patrick (1978) or Lester and Pickett (1978) studies included female police officers.

New Zealand Police and the mentally ill

In 1996 Greg O'Connor, the New Zealand Police Association President spoke at the launch of a book, 'Slain on Duty' which details the deaths of 24 New Zealand police and traffic officers killed while on duty. Reference was made by O'Connor that the mentally ill are especially dangerous to police officers and he stated that many of those responsible for the deaths of the officers detailed in the book were "obviously psychiatrically disturbed" (p.126). O'Connor (1996) was also quoted as stating that the police were watching with "extreme concern the run-down of the mental health system, which is increasing alarmingly the number of disturbed people walking our streets" (p. 126).

As previously mentioned, the 1994 Police Complaints Authority report following the death of Matthew Francis Innes stated that the New Zealand Police have had a long association of working with the mentally ill, and that working with the mentally ill is regarded as ordinary front line duties. There is however limited data available on the number or extent of contacts New Zealand police actually have with mentally ill people or how frontline staff actually feel about their work with mentally ill people. To date only one published study has been conducted to measure contacts between New Zealand police and mentally ill.

The New Zealand study which drew responses from police across New Zealand found that over a five week period, just over 76 percent of police had dealt with an incident that involved a person who they perceived to be mentally ill (Dew & Badger, 1999). Of those 87 incidents that involved the mentally ill, 12 percent or just 11 from the 87 incidents attended by the police were crime related. Police

estimated that they spend on an average 8.6% of their time working with incidents involving mentally ill people over the five-week period. Taken over a forty hour week, this equates to an average of just under three and a half hours per week dealing with mentally ill persons.

Dew and Badger (1999) also found that over 15 percent of police officers in their study claimed they had little or no training that was useful in dealing with mentally ill people. Respondents in their study reported that education and training came more from the first hand experience of attending call outs involving the mentally ill than the training given at the Royal New Zealand Police College.

Currently, the training provided at the Royal New Zealand Police College for police recruits regarding the mentally ill is included in the module of "Intellectual Disability and Mental Disorder". Staff from the Recruit Training Group of the Royal New Zealand Police College are currently revising all of the training materials used in the Police recruit course (B. Horne, personal communication, March 29, 2001). However, as the training currently stands, the training module provided to police recruits broadly defines mental illnesses, and distinguishes between neurosis and psychosis. The module concentrates on psychosis, namely manic depression and schizophrenia, and provides brief written examples of police contacts with individuals suffering from either of these two mental illnesses. The module provides a list of 'do's' and 'don'ts' for dealing with people who have schizophrenia and attempts to inform recruits of the experiences likely to occur when dealing with a mentally ill person. While relatively brief, the training manual encourages positive and respectful interactions from police when dealing with the mentally ill. The training manual also includes a module specific to the Mental Health (Compulsory and Treatment) Act 1992 and the role of police.

CHAPTER FOUR

The proposed Research

International research has shown a significant increase in the amount of contact between police officers and the mentally ill since deinstitutionalistaion has occurred, and it is largely recognised that these contacts are a undesirable, time consuming, and difficult aspect of policing. While New Zealands health care for the mentally ill has also gone through the process of deinstitutionalisation, to date only one study has been conducted to investigate New Zealand police contacts with mentally ill persons.

The 1996 Mason report which examined mental health services in New Zealand found that since deinstitutionalisation has occurred in New Zealand, insufficient care services have been implemented in the community to provide services for the mentally ill, and as a consequence community treatment has been less successful than intended. A possible consequence of this is that New Zealand police will experience greater contact with mentally ill persons, similar to the experience of international police. Adding to increased likelihood of contacts is the 1992 Mental Health (Compulsory Assessment and Treatment) Act which has resulted in more stringent commitment laws for enforcing care and treatment upon the mentally ill.

While the 1994 New Zealand Police Complaints Authority investigation into the death of Matthew Francis Innes, a young man with a psychiatric illness who died from positional asphyxiation as a result of being transported by Police, reports that New Zealand Police have long been involved in the handling of people with psychiatric illnesses and that this is accepted as ordinary frontline duties, it has become apparent that the current legalisation and services available to the mentally ill are of some concern to the New Zealand Police.

In 1998 a New Zealand Police Attrition report (Miller, 1998) identified the 1992 Mental Health (Compulsory Assessment and Treatment) Act as legislation that

indirectly affects Police Officers attrition. The report suggested that as a result of deinstitutionalisation and the less stringent enforcement of care under the 1992 Act, New Zealand police may experience greater contact with the mentally ill and suggested that the 1992 Act provides "a subtle and significant psychological environment that potentates job satisfaction or dissatisfaction, elevates or depresses morale, and affects values and attitudes of those who are less resilient because of occupational and other stressors" (page 58).

While Dew and Badger (1999) explored New Zealand police contacts with mentally ill persons and the nature of those contacts, they did not investigate how the officers actually felt about their work with the mentally ill or their attitudes toward mentally ill persons. It is therefore timely that a study be conducted in New Zealand to look at the effects of deinstitutionalisation which has increased the number of mentally ill persons in the community and the associated changes in mental health legislation has on New Zealand police.

The present study is designed to further quantify the amount of contact and the nature of contacts that the New Zealand police have with mentally ill persons. It also aims to investigate the attitudes of New Zealand police officers toward the mentally ill and what factors may influence these, taking into account the findings from international research on attitude formation and factors which influence attitudes toward the mentally ill.

The questions asked will be drawn from the two main aims of the present study and the expected outcomes for the current study are outlined below in the specific questions to be asked:

1. How common are contacts with the mentally ill and what constitutes these contacts for New Zealand Police:

- as a flow-on effect of deinstitutionalisation and the changes to current mental health legislation, New Zealand police will experience regular contact with mentally ill persons as part of their routine duties and these contacts will be

time consuming. The majority of police contacts with the mentally ill will be non-criminal in nature, as has been found internationally

- police working in urban stations will experience a higher number of contacts with the mentally ill than rurally based police as has been found internationally. While no studies could be located which directly investigated differences of time spent with the mentally ill for police working at rural and urban stations, it is expected that rural police will report spending longer with the mentally ill due to the distance and immediate availability of mental health services, in particular crisis care
- Police will express frustration at the length of time call outs involving the mentally ill take, and will express a dislike to attending call outs involving the mentally ill
- police will express a desire for more training in dealing with incidents that involve mentally ill persons, as has been found internationally
- police will hold a belief that the mentally ill are dangerous and unpredictable, as has been found internationally

2. What are the attitudes of New Zealand police officers towards the mentally ill and what factors influence these:

- New Zealand police will express similar attitudes as those found internationally among police administered the OMI, specifically:
  - positive attitudes will be expressed by those with a higher rank, increased age, and who have a higher level of completed education across all five OMI factors
  - increased years of services with the police will produce favourable attitudes toward the mentally ill in factor B, D and E.
- respondents with personal experience of mental illness (having a family member, friend or close acquaintance who has sought professional help for a mental health or emotional problem), those who have previously worked in mental health field, and who have received specialised training or education in the field of mental health will score overall more favourably on the OMI

- salient events that occurred while on duty involving a mentally ill person and which were unpleasant or disturbing will have a negative influence on expressed attitudes

Overall, while the findings are expected to be similar to those found internationally, slightly more positive attitudes are expected on the OMI to account for the public education and anti-discrimination campaigns which are screened on national television, and the mere exposure effect of having an increased number of mentally ill in the community as a result of deinstitutionalisation that has occurred during the past twenty years since the international research was conducted.

CHAPTER FIVE

METHOD

Respondents

The respondents were 261 police officers from one geographical section (Region 3) of the New Zealand Police districts who volunteered to complete and return the questionnaire. The respondents were required to be a sworn member of the New Zealand Police with a current rank of either Recruit, Constable, Senior Constable, Sergeant, Senior Sergeant, or Commissioned Officer. A total of 41 females and 219 males completed the questionnaire, one respondent did not identify their gender. The ages of the respondents ranged from 21 to 58 years with a mean age of 35.5 years, as shown in Table 1.

Table 1
Age Distribution of Respondents

Age	Number of Respondents
21-30	68
31-40	127
41-50	48
51-58	10
Missing	8
Total	**261**

Procedure

Support and approval from the New Zealand Police was sought in consultation with Dr Ian Miller, Co-ordinator Psychological Services for the New Zealand police, who also provided feedback and clarification on several items of the questionnaire, that were ever edited or removed at his suggestion. The final edited version of the questionnaire was approved by the Massey University Human Ethics Board.

The Palmerston North Police Welfare staff coordinated and distributed 500 self-explanatory questionnaires, information sheets and freepost envelopes addressed to the researcher via internal mail to all stations throughout Region 3 in August 1999. The information sheet (see Appendix) recorded that the research had the approval and support from the New Zealand Police and explained the purpose of the research, who the researchers were and their contact details, eligibility and criteria to complete the questionnaire, what their rights were should they choose to complete the questionnaire, and what their participation would include, including the estimated time to complete the questionnaire. Confidentiality and anonymity were assured, and consent to participate was met by the following which appeared in bold italic writing at the conclusion of the information sheet *"It is assumed that filling in the questionnaire implies consent."* Those that chose to participate in the present study were asked to remove the covering information sheet for future reference should they wish to contact the researchers and at the beginning of the questionnaire it was requested that no names be recorded.

Within four weeks 52% (261) completed questionnaires had been returned in the pre-paid envelope provided. No follow up or reminder notices to encourage further responses were sent to the individual stations as police officers were drawn from the regional area to help police the 1999 Asia-Pacific Economic Cooperation (APEC) conference which took place in Auckland from 7-13 September, 1999. Those that were not drafted to Auckland were working increased hours. The response rate of 52% is similar with other recent mail-out

questionnaires involving the New Zealand Police. For example, in 1996 Stephens also received a 52% response rate and Dew and Badger in 1999 reported a 57% response rate.

The measures

Participants completed a self-administered questionnaire (see Appendix) which took approximately 20 minutes. The questionnaire had four subsections, three of which were designed specifically for the present study. The first set of questions were general demographical items that were used to record the age, gender, ethnicity, education, length of service in the police, rank, and type (size) of station the respondents were based in. It also asked whether the respondents had received any education or held a job which specialised in mental health, and whether they knew anyone whom they were close to who had experienced a mental illness, and their perceived effect which the illness had on them.

The second section of the questionnaire attempted to quantify police contacts with the mentally ill while on duty. The questions were focussed on the number of contacts with mentally ill persons respondents experienced during the past month and whether this was an average number of contacts, the amount of time incidents with the mentally ill took and how this compared to incidents involving non-mentally persons, and whether the respondent themselves had been involved in an incident involving a mentally ill person, or a person they suspected to have a mental illness, which had been unpleasant or disturbing for them. Those that had experienced an incident involving a mentally ill person which they found unpleasant or disturbing were asked to complete a further eight questions which measured their emotional responses to the incident and respondents were asked to rate their reactions to the incident on a 5 point Likert scale ranging from "I did not feel this way at all" to "I strongly felt this way".

In the third section, respondents were asked how they felt about their work with the mentally ill and how their contacts with the mentally ill impacted on their work. This section was designed to explore whether New Zealand police officers

held similar opinions regarding the mentally ill as has been reported internationally. The answers to the eleven questions were in a 5 point Likert format, ranging from "Strongly agree" to "Strongly disagree".

The fourth and final section of the questionnaire was the Opinions about Mental Illness (O.M.I.) scale designed by Cohen and Struening (1962). The OMI is a 51 Likert-type self administered questionnaire which was originally developed through a factor analysis from a pool of over 100 items in a study of hospital personnel. The developers drew upon existing scales, including the Custodial Mental Illness Ideology Scale (Gilbert & Levinson, 1956), the California F Scale (Adorno et al., 1950), and Nunnally's (1957) multiple item scale.

The OMI continues to be one of the most widely used instruments to measure attitudes toward the mentally ill (Kolodzij & Johnson, 1996; Lopez, 1991). The OMI Scale requires participants to respond to 51 statements which reflect the extent to which the respondent agrees or disagrees with statements regarding the nature, cause and treatment of mental illness on a 6-point Likert scale ranging from "strongly agree" to "strongly disagree". The OMI yields five factor (attitude) scores which are computed through summation of a series item weights (for scoring formula refer to Strueng & Cohen, 1963, p294). The five factors are as follows:

Factor A: Authoritarianism (A): This factor consists of 11 items that refers to difference and inferiority of the mentally ill when compared to non-mentally ill people, and includes the suggestion that those with a mental illness require coercive handling. High scores on this factor indicate a belief that the mentally ill are inferior to normal individuals, and a low score from the subscore range of 1-56 would reflect positive attitudes toward the mentally ill.

Factor B: Benevolence (B): This factor is composed of 14 items and reflects a tendency to enact a kindly paternalistic orientation toward the mentally ill which is derived from a moralistic and humanistic view. It views the mentally ill as

individuals in need of care and a higher score is reflective of positive attitudes towards the mentally ill and reflects an orientation toward general care for the mentally ill, not treatment based on a scientific or professional model. Due to the direction of some of the questions in this subscale, some questions are scored in reverse, and the subscore for factor B ranges from 1 to 66.

Factor C: Mental Hygiene Ideology (M.H.I): This 9-item subscale has a range of 1 to 46 and a high score reflects a positive view towards treatment ideology for mentally ill and would suggest positive and optimistic views that effective treatment and outcomes are possible. Some items in those subscale also require reverse scoring.

Factor D: Social Restrictiveness (S.R.): This subscale of 10-items suggests that the mentally ill are a danger to society and should be restricted in their functioning both during and after hospitalisation. This subscale has a scoring range of 1 to 51 and a lower score would indicate support for less restrictive environments, hence is reflective of positive attitudes toward the mentally ill.

Factor E: Interpersonal Etiology (E.I): This factor consists of 7-items and measures the belief that mental illness is primarily caused by faulty interpersonal experiences, particularly deprivation of parental love and attention during childhood. A high score from the possible range of 1 to 36 for factor E would indicate the opinion that mental illness is related to personal choices in life and as such minimises the biomedical causes of serious mental illness.

The OMI was selected as the measure for attitudes toward the mentally ill for several reasons. Very few psychometric measures for attitude measurement toward the mentally ill are available (Antonak & Livneh, 1988) and the OMI has over time adequately reflected a mental health ideology by consistently illustrating the validity and stability of the five factors (Drolen, 1993) and the OMI is reliable in attitude measure toward the mentally ill across sample types (Wahl, Zastowny, & Briggs, 1973). The researcher was also able to locate three other studies that

used this instrument to measure police attitudes toward the mentally ill from the international literature, one of which gave the mean scores for the sample across the five subscales. The current sample scores for the five OMI factors would also be able to be compared to the scores of a general New Zealand sample of adults.

The statistical package, SPCC/PC (Norusis, 1988) was used to analysis the data and evaluate the relationships among the variables. Prior to analysis, it was obvious from the raw data (questionnaires) that several respondents had not completed all of the OMI. Those that had not answered 5 or less of the questions had the mean of the entire sample for the missed question substituted. This was done to retain the remainder of their responses and the cut off of 5 missed items or less was chosen as this is 10% of the total OMI questionnaire. Questions from the other sections of the questionnaire were also missed by several respondents, however it was not necessary to replace these items with the mean, hence, there are some slight variations across the number of responses (*N*).

CHAPTER SIX

RESULTS

Sample Description

Summaries of the demographic and police service information for the present sample are presented in Table 2 and Table 3 respectively. The current police statistics were provided by Dr Ian Miller, Coordinator of Psychological services for the New Zealand Police and are current as of January 1st, 2001.

Age distribution of respondents is shown in Table 1. The mean age of all respondents was 35.5 years with a range of 21 to 51, which reflects the mean age of 36.8 years for all sworn staff of the New Zealand police ($N = 7024$). The age range for all sworn police is 20.59 to 60.46 years. Female respondents accounted for only 15.7% (41) of the sample.

The majority of respondents (85.1%, $N = 222$) identified themselves as New Zealand European and 6.6% or 17 of the respondents identified themselves as Maori. Five respondents circled both New Zealand European and Maori and these were coded as 'Other'. Seven (2.7%) respondents identified themselves as Other European and two (0.8%) identified as themselves as Pacific Islander. No respondents identified themselves as being Asian or Indian. Due to the low number of Maori respondents, no significant evidence could be drawn from the present study regarding ethnicity therefore ethnic group was not included as a variable in further analyses.

Respondents were asked to identify their highest education level. Just over 5% of the respondents (5.4%, $N = 14$) respondents had no school qualifications. 13% (34) had completed School Certificate, 41.3% (108) had schooling up to 6th form certificate and Bursary, and 22.6% (59) had a trade or professional certificate. 16.9% (44) had completed a university degree or diploma.

Table 2
Summary of Police Demographics

Variable	Number	Percentage
Gender	**260**	
Male	219	83.9
Female	41	15.7
Ethnic Group	**259**	
Maori	17	6.5
N.Z. European	222	85.1
Other European	7	2.7
Pacific Island	2	.8
Other	11	4.2
Education	**215**	
No School Qualifications	14	5.4
School Certificate	34	13.0
Sixth form Certificate	39	14.9
University Entrance	69	26.4
Trade or Professional Certificate	59	22.6

Police service

A summary of police service information is provided in Table 3. Length of service to the New Zealand Police ranged from under one year to 37 years, with a mean of 9.91 years. The mean years of service for all sworn staff in the New Zealand police is 10.22 years. Years of service were regrouped into four groups, 0-10 years, 11-20 years, 21-30 years and 31-40 years of experience. Over half of the sample (60.9%, $N = 159$) had between 0-10 years experience, 26.4% (69) had 11-20 years, 11.1% (29) reported 21-30 years, and 1.1% (3) respondents had between 31-40 years of service to the New Zealand Police.

The majority of respondents were constables. 76.2% (199) were Constables or Senior Constables, and 20.7% (54) respondents had a rank of Sergeant or Senior Sergeant. Only one recruit and six commissioned police officers completed the questionnaire, and these two rank types were therefore excluded from further analysis due to the small sample size. For analysis purposes all Constables were grouped together and all Sergeants were regrouped into one group.

The majority of respondents came from urban stations. 36.9% (96) indicated they were based at a large urban station, and 29.2% (76) respondents came from a small urban station. Ten (3.8%) police officers were based at sole charge stations and a further 77 (29.6%) of the questionnaires returned were from police based at a rural station. Due to the low number of respondents based at sole charge stations no further analysis was conducted for this station type as no reliable or meaningful results could be concluded from such a small sample size.

The majority of respondents (88.5%, $N = 231$) had received no other training or education in the area of mental health aside from that which is provided in the Royal New Zealand Police College training. 11.1% (29) had received training or education in the field of mental health, including several respondents who had completed university extramural psychology papers. 94.6% (247) of the respondents had no previous work that specialised in the area of mental health, of the 5% (13) who had, several were registered nurses specialising in the area of mental health.

Table 3
Summary of Police Service Information

Variable	Number	Percentage
Length of Service	**258**	
0 - 10 years	159	60.9
11 - 20 years	69	26.4
21 - 30 years	29	11.1
31 - 37 years	3	1.1
Rank	**258**	
Recruit	1	1.1
Constable / Senior Constable	199	76.2
Sergeant / Senior Sergeant	54	20.7
Commissioned Officer	4	1.5
Type of Station	**259**	
Large Urban	96	36.8
Small Urban	76	29.1
Rural	77	29.5
Sole Charge	10	3.8

Police contacts with the mentally ill

The respondents were asked to provide details of their contacts with the mentally ill, including personal contacts and contacts specifically while on duty, and the amount of time they spend with the mentally ill involved in call outs. Table 4 summarises police contacts with the mentally ill while on duty. When asked whether they knew either a family member, friend or close acquaintance who had sought professional help for a mental health issue 53.3% (139) respondents reported yes. 46.4% (121) of the respondents reported having no personal contact with mental illness.

Over three quarters of the respondents (79%, N = 207) recorded they had experienced some contact with a mentally ill person in the past month while on duty. Only 20.3% (53) respondents had not been involved in a call out or had any contact with the mentally ill during this time. 39.8% (104) reported experiencing 1 to 2 contacts in the past month, 25.7% (67) had 3 to 4 contacts, and 9.6% (25) respondents had 5 to 6 contacts. 4.21% (11) respondents reported 7 or more contacts with mentally ill persons while on duty during the past month.

Police generally felt (62.8%, N = 164) the number of contacts they had with the mentally ill during the past month was average, with 24.9% (65) of respondents experiencing less then average and 11.5% (30) reported experiencing more contacts with mentally ill persons while on duty in the past month then could be normally expected.

Just under half of the respondents (47.5%, N = 124) reported spending an average of 1 to 2 hours per incident involving a mentally ill person, with 27.6% (72) reporting an average of under one hour, and 22.2% (58) respondents spending between 3 to 4 hours dealing with the mentally ill. Five (1.9%) respondents reported an average of 5 hours or longer in dealing with incidents involving the mentally ill.

Respondents were asked to compare the amount of time they spent dealing with mentally ill persons to the average time they spent with people not considered to be mentally ill, and over 60% of the respondents indicated they spend more time with the mentally ill. Of these, 31% (81) indicated they spend 'a great deal longer' dealing with the mentally ill than they do with non-mentally ill people involved in a call out. 12.6% (33) of the respondents reported spending similar amounts of time with the mentally ill and non-mentally ill, and 25.3% (66) of the

Table 4
Police contacts with the mentally ill while on duty

	Number	Percentage
Contact with mentally ill persons during past month	**260**	
Yes	207	79
No	53	20.3
Number of contacts in past month	**207**	
1 - 2	104	39.8
3 - 4	67	25.7
5 - 6	25	9.6
7 +	11	4.21
Time spent the with mentally ill	**259**	
Less than 1 hour	72	27.6
1 - 2 hours	124	47.5
3 - 4 hours	58	22.2
5 + hours	5	1.9
Time spent with mentally ill compared to non-mentally ill persons	**259**	
A lot less	66	25.3
Similar	33	12.6
More	79	30.3
A great deal longer	81	31.0
Contact with mentally ill related to criminal behaviour	**207**	
Yes	60	28.9
No	147	71.1

respondents reported spending less time with the mentally ill than they do with people who they considered not to have a mental illness.

Respondents were also asked about the nature of their contacts with the mentally ill. Of those that provided an answer to this question, 71.1% (N = 147) reported that the majority of their contacts with the mentally ill while on duty are not related to criminal offending, and 28.9% (60) indicated that the majority of their contacts with the mentally ill are criminally related. Fifty-four respondents did not answer this question.

Urban police contacts vs Rural police contacts with the mentally ill

Nonparametric statistical procedures were used to test the hypothesis that urban police would experience more contacts with the mentally ill than rural police, but rural police would report spending longer per incident involving a mentally ill person. Nonparametric procedures are suitable for comparing the means between two groups when the level of measurement is ordinal.

A Kruskal-Wallis test was conducted which indicated that there were differences between station type and the number of contacts with the mentally ill, 22.407 (3) = $p<.05$, and duration of contacts police experienced with the mentally ill, 19.797 (3) = $p<.05$. Individual Mann-Whitney U-tests were further conducted to test for any significant differences between the mean number and duration of contacts with the mentally ill for police stationed at large urban and small urban stations, large urban and rural stations, and small urban and rural stations. The mean rank and sum of ranks can be seen in Table 5.

A Mann-Whitney U-test was conducted to test for any differences between the number and length of contacts with the mentally ill experienced by police stationed at large urban and small urban stations. No significant differences were found for the number of contacts with mentally ill persons meaning police stationed at either a large urban or a small urban station experience similar amounts of contact with the mentally ill while on duty. A significant difference

was found for the average amount of time police reported spending with the mentally ill, indicating that police stationed at a small urban station spend longer with mentally ill persons than those based at a large urban station ($U = 2872.00$, $p < 0.05$).

Table 5
Mean ranks and sum of ranks for number and duration of contacts involving the mentally ill and police based at large urban, small urban, and rural stations.

	N	Mean Rank	Sum of Ranks
Number of contacts with the mentally ill			
Large Urban	96	91.83	8816.00
Small Urban	76	79.76	6062.00
	172		
Large Urban	96	100.98	9694.50
Rural	76	68.20	5183.50
	172		
Small Urban	76	85.43	6493.00
Rural	76	67.57	5135.00
	152		
Average time spent with the mentally ill			
Large Urban	95	78.23	7432.00
Small Urban	75	94.71	7103.00
	170		
Large Urban	95	72.70	6906.50
Rural	77	103.53	7971.50
	172		
Small Urban	75	69.61	5221.00
Rural	77	83.21	6407.00
	152		

A Mann-Whitney *U*-test was conducted to test for differences between the number and duration of contacts with the mentally ill experienced by police stationed at small urban and rural stations. Significant differences for number of contacts ($U = 2209.00$, $p<0.01$), and the amount of time spent with the mentally ill person ($U = 2371.00$, $p<0.05$) were found, indicating police based at small urban stations experience more contacts with the mentally ill than police based at a rural stations, but police based at rural stations on average spend longer with the mentally ill than those based at small urban stations.

As expected, significant differences were also found for number of contacts with mentally ill and duration of these contacts for police based at a large urban station and those at a rural station. Results indicated police at large urban stations experience more contacts with the mentally ill than those based at a rural station ($U = 2257.50$, $p<0.01$), but police at rural stations spend longer with the mentally ill once contact is made than those based at a large urban station ($U = 2346.50$, $p<0.01$).

Police perception of their work with the mentally ill

Respondents were questioned how they felt about working with the mentally ill as part of their role as a police officer. The midpoint (3) of the Likert scale gave the respondents a neutral or undecided choice. Percentages in this section are therefore calculated by removing the answers of respondents who did not answer the question or who were undecided or neutral (3).

Over half of the respondents (57.5%, $N = 129$) believed that dealing with the mentally ill is not an appropriate service of the police, and 68.8% (128) did not believe they were the appropriate person to be dealing with the situation when called to incidents involving the mentally ill. The majority of police indicated they disliked attending call outs that involved the mentally ill (78.5%, $N = 132$) and when asked how their colleagues felt about attending call outs the majority of respondents indicated that their colleagues also largely disliked such call outs (87%, $N = 188$). The majority of respondents (79.3%, $N = 169$) reported

frustration at the outset of a call out involving a mentally ill person due to the expected amount of time the call out was likely to take.

Police perceptions of training

Respondents were asked whether they felt the training they received prepared them to work with incidents involving the mentally ill, and whether they felt they would benefit by receiving more education or training in this area. The majority of respondents felt the training they received did not prepare them sufficiently to deal with mentally ill people (72.7%, $N = 147$) and felt they would benefit from more training or education on dealing with the mentally ill (84.6%, $N = 182$).

Sixteen (68.1%) of the respondents who had either held a job specialising in the area of mental health or who had received additional training or education over and above that received as part of their police training also felt they would benefit from additional training, and 21 (80.7%) of these respondents felt the initial training was not sufficient to prepare them for this aspect of their role as a police officer.

Police perception of the mentally ill

An overwhelming 92.8% ($N = 232$) of respondents believe the mentally ill are unpredictable, and 68.2% ($N = 150$) respondents believe the mentally ill are a greater risk of becoming violent than those that are not mentally ill. Related to these findings, the majority of respondents (77.2%, $N = 153$) believe they are at an increased risk when they attend call outs involving a mentally ill person, and 71.3% (186) of the present sample reported having experienced an incident involving a mentally ill person that had been particularly disturbing or unpleasant for them while on duty. The majority of respondents believe their work with the mentally ill adds to the stress of their job (84.6%, $N = 182$).

Police Attitudes (OMI findings)

Table 6 presents the mean scores and standard deviations for the five factors of the OMI for the present sample, a police sample drawn from Louisiana, United States, in 1979 (Levinson & Distefano, 1979), and a recent New Zealand adult community sample from Wanganui (Deane, Kazantzis, & Ronan, 2001). The results for the five factors are indicative that overall the police from the current sample have accepting and positive attitudes toward the mentally ill. No negative attitudes were revealed on any of the five individual OMI factors.

Table 6
Mean Scores and Standard Deviations for the five factors of the OMI of New Zealand police, New Zealand community and a United States police sample

	NZ POLICE		NZ COMMUNITY		US POLICE	
OMI FACTOR	Mean	SD	Mean	SD	Mean	SD
A	18.09	5.55	21.54	9.48	24.08	5.51
B	45.66	6.35	46.69	7.13	48.67	5.02
C	25.12	4.50	29.72	5.63	29.25	4.20
D	21.23	6.46	19.11	8.13	21.54	5.85
E	10.35	4.60	11.27	5.22	15.86	5.14

A = Authoritarianism (1-56)
B = Benevolence (1-66)
C = Mental Health Ideology (1-46)
D = Social Restrictiveness (1-51)
E = Interpersonal Aetiology (1-36)

Further analysis were conducted to test variables expected to influence attitudes, including demographics, police service and experience with the mentally ill on the scores of the five OMI factors.

OMI scores and demographics

Table 7 presents the mean scores and standard deviations for the five OMI factors and gender. Based on a review of international studies, it was hypothesised that gender would have no effect on the scores from the five OMI scales. However, independent t-tests revealed differences for gender on factor A ($t = -2.178$, 247, $p<.05$) and factor C ($t = 2.017$, 246, $p<.05$). These results can be interpreted to mean that females are less likely to view those with a mental illness as an inferior group of people who require coercive handling, and believe that mental illness is an illness like any other which can be treated successfully. No significant differences were found for the remaining three factors of the OMI and gender ($p>.05$).

It was hypothesised that increased age would be positively correlated to accepting and positive attitudes towards the mentally ill on the five factors of the OMI. A significant difference was found for age and scores on factor B ($r = .195$, $p<.05$) and factor C ($r = .151$, $p<.05$) of the OMI. These results can be interpreted to mean that there is a correlation between police with increased age and the believe that the mentally ill require care and that successful treatment is possible for mentally ill. No differences were found for age on Factors A, D or E of the OMI ($p>.05$).

It was also hypothesised that those with a higher level of completed education would hold more positive and accepting attitudes towards the mentally ill. To test for the effect of education on OMI scores, an ANOVA was computed to test across the six levels of education completed. No significant differences were found, and the means and standard deviations for the five factors of the OMI for the education levels can be seen in Table 7. This results suggests that for the present sample, completed education has no influence on expressed attitudes toward the mentally ill.

Table 7
Mean and Standard Deviations of factors A, B, C, D, and E of the OMI for personal contact, gender, and education.

	Factor A	Factor B	Factor C	Factor D	Factor E
Total Sample					
M (N = 261)	18.09	45.66	25.12	21.23	10.35
SD	5.55	6.35	4.50	6.46	4.60
Gender					
Male					
M (N = 212)	18.39	45.34	24.84	21.36	10.45
SD	5.64	6.45	4.37	6.31	4.72
Female (N = 36)					
M	16.25	47.28	26.54	20.68	9.71
SD	4.68	5.37	4.92	7.33	3.89
Education Level					
No Qualification					
M	19.92	44.95	25.07	23.46	11.42
SD	5.80	5.55	4.97	5.91	6.17
School Certificate					
M	17.15	47.07	26.32	21.50	10.73
SD	5.35	7.02	4.04	5.20	4.35
6th Form Certificate					
M	18.11	45.30	24.83	21.06	10.09
SD	5.53	6.28	4.82	7.43	4.06
University Entrance					
M	18.81	44.90	25.11	22.26	10.64
SD	5.92	6.07	4.50	6.59	4.93
Trade \ Professional Certificate					
M	18.35	45.57	24.39	21.05	10.36
SD	5.45	5.79	3.98	6.34	4.32
Degree \ Diploma					
M	16.66	46.30	25.60	18.92	9.45
SD	5.16	7.38	5.08	6.36	4.58
Personally known a close person with a mental illness					
No (N = 113)					
M	18.15	44.92	24.91	21.79	10.24
SD	4.95	5.76	4.31	6.13	3.89
Yes (N = 136)					
M	18.04	46.28	25.30	20.77	10.43
SD	6.02	6.76	4.66	6.70	5.13

OMI scores and police service

No correlations were found for OMI and number of years with the police. Therefore, the results of the present study do not support the hypothesis that increased service with the police is related to more accepting or positive attitudes towards the mentally ill.

It was also hypothesised that police with higher ranks would express more positive and accepting attitudes towards the mentally ill. The mean scores for the five OMI factors for the sample of the current study according to their rank can be seen in Table 8. Independent t-tests revealed no significant differences across the five OMI factors for constables or sergeants ($p>.05$), which implies the rank of constable or sergeant has no effect on police attitudes towards the mentally ill.

To investigate for any differences between attitudes and being based at a rural, small urban, or large urban station, a one-way analysis of variance (ANOVA) was computed of station type and OMI scores. No significant differences were found for any of the five factors of the OMI, indicating station type has no effect on attitudes ($p>.05$). Mean scores and the standard deviations for the OMI and station type can be seen in Table 8.

OMI scores and experience with the mentally ill

The third hypothesis anticipated that police who had personal experience of mental illness, defined by knowing a family member, friend or close acquaintance who had sought professional help for a mental health or emotional problem, would have overall more positive and accepting attitudes toward the mentally ill. Table 7 presents the mean and standard deviations. Also, those who had received other specialised training or education in the field of mental health other than their police training, and those who had previously worked in mental health would also hold more favourable and positive attitudes compared to their colleagues who had not. Independent t-test were conducted, and a significant effect was found for other mental health work and attitudes for factor A ($t = 2.371, 247, p<.05$) and factor D ($t = 2.435, 246, p<.05$).

No significant effects for other mental health training or knowing a close person with a mental illness and attitudes were found ($p>.05$), suggesting that personal experience with people who have a mental illness or mental health training has no influence on attitudes towards the mentally ill as measured by the five factors of the OMI.

Independent T-tests were conducted to test for differences between the OMI scores and those that had reported experiencing a bad or disturbing event involving a mentally ill person while on duty ($N = 179$). The means and standard deviations for the five OMI factors can be seen in Table 8. No significant differences were found, $p > .05$, suggesting the experience of a frightening or traumatic incident with a mentally ill person while on duty has no influence on attitudes toward the mentally ill.

Table 8
Mean and Standard Deviations of factors A, B, C, D, and E of the OMI for Police Service and experiences while on duty

	Factor A	Factor B	Factor C	Factor D	Factor E
Total Sample					
M (N = 261)	18.09	45.66	25.12	21.23	10.35
SD	5.55	6.35	4.50	6.46	4.60
Rank					
Constable (N = 167)					
M	17.65	45.57	24.80	21.04	9.98
SD	5.34	6.32	4.58	6.28	4.54
Sergeant (N= 75)					
M	18.64	46.12	25.75	21.60	10.90
SD	5.78	6.32	4.25	7.02	4.61
Station Type					
Large Urban (N = 93)					
M	17.47	45.03	24.61	20.78	10.58
SD	4.97	6.78	3.94	6.13	4.24
Small Urban (N = 70)					
M	18.50	45.96	25.83	21.37	10.04
SD	5.89	6.18	4.73	6.58	4.07
Rural (N = 75)					
M	18.72	45.94	25.05	21.47	10.38
SD	5.84	5.78	4.78	6.61	5.12
Bad Experience with mentally ill while on duty					
No (N = 71)					
M	18.30	45.26	25.31	20.46	9.95
SD	6.11	6.55	4.29	6.23	3.74
Yes (N = 178)					
M	18.01	45.82	25.05	21.54	10.57
SD	5.33	6.28	4.59	6.54	4.90

CHAPTER SEVEN

DISCUSSION

Review of main aims and findings

The present study had two main aims. Firstly, it aimed to quantify the amount of contact and the nature of contacts between the New Zealand police and the mentally ill. Secondly, it aimed to investigate the attitudes of the police toward the mentally ill and factors which may influence or impact on police attitudes toward the mentally ill, using the OMI, a standardised measure of attitudes toward the mentally ill.

The findings supported the expectation that police would experience frequent contact with the mentally ill while on duty, and that police would spend longer with the mentally ill than they do with those not considered to be mentally ill. The hypothesis that police would find the amount of time involved in dealing with the mentally ill frustrating was also supported. The present study found that 79.3% of police officers experienced contact with the mentally ill during their routine duties during a four week period which is similar to the findings of Dew and Badger (1999), who found 76% of the police in their study had attended a call out involving a mentally ill person, although Dew and Badger used a five week period for their study. Overall police generally felt they spend longer with mentally ill persons than they do with non-mentally ill persons, which is similar to the international findings (Berry, 1996; Meadows et al, 1994).

It was also found that the number and duration of contacts between police and the mentally ill is in part related to the type of station that the police officer is based at. It was found that the larger the station the more contacts there were between police and the mentally ill, and the smaller the station, the longer police spent with the mentally ill. This finding may be related to the fact that mentally ill people are more likely to live in larger urban areas, and that when mental health

services are required, rural people have a delay in receiving these services due to specialist services being based in larger, more populated areas.

It is not possible to say if the frequent contact with the mentally ill experienced by the New Zealand police is greater now due to deinstitutionalisation as there is no data available on the amount of contact between police and the mentally ill prior to deinstitutionalisation being implemented in New Zealand. However, when considered against the international findings in countries which had quantifying data prior and post deinstitutionalisation was implemented, it can be assumed with some confidence that the combination of deinstitutionalisation and the changes in the Mental Health Act (1992) has contributed to the frequent contact between police and the mentally ill. As previously discussed, the combined effects of deinstitutionalisation and the changes in the Mental Health Act (1992) is that there are more people with mental illnesses living in the community and it is increasingly difficult to enforce care and treatment upon individuals if they require hospitalisation.

Related to the increase of contacts between the police and the mentally ill is the nature of the contacts experienced. The results of the present study supported the expectation that the majority of police contacts with the mentally ill would not be related to criminal behaviour or offending. The present study therefore support the findings of Dew and Badger (1999) who found only 12% of contacts between police and the mentally ill were related to criminal offending, and it can be concluded that the experience of New Zealand police in the present study is similar to that of police from the United Kingdom and United States, whose contacts with the mentally ill are also largely related to non-criminal behaviour. These findings therefore not only support the international literature but also the suggestion that by default, police in their daily duties are performing the role of mental health professionals for the mentally ill when their health begins to deteriorate (Fogarty, 1991; Murphy, 1985; Sheridan & Teplin, 1989).

While the majority of police contacts with the mentally ill are not related to criminal offending, over 70% of the sample reported experiencing an unpleasant or disturbing experience involving a mentally ill person and the majority of the present sample believe the mentally ill are unpredictable and dangerous. Over 75% of the sample feel they are at risk when dealing with the mentally ill and over 80% of the respondents feel their contacts and work with the mentally ill adds stress to their job. The present study therefore supports the suggestion made in the 1998 Police Attrition report that New Zealand police would not only experience an increase in the amount of contacts with mentally ill persons due to deinstitutionalisation, but that these contacts have a negative impact on police.

One reason that such contacts have a negative impact on police is related to the fact that the majority of contacts between the police and the mentally ill are unrelated to criminal offending, and are therefore likely to be related to a deterioration in the mental health of the individual, which places police in a mental health crisis management role, a specialist mental health role that they are not trained for. A wider implication of the frequent amount of contacts between police and the mentally ill that are not related to criminal behaviour is that police resources are being inadvertently used for non-policing matters.

The expectation that police would express a desire to receive more training in dealing with the mentally ill was well supported. Over 70% felt they did not receive training to sufficiently prepare them to work with the mentally ill, which is substantially more then the 15% that Dew and Badgers (1999) study found. Over 80% of the sample felt they would benefit from additional training to work effectively and efficiently with the mentally ill. The expression of interest and need in further education and training in the present sample is similar to the international findings (Gillg et al, 1990; Fogarty, 1991; Murphy, 1986).

The expression of interest in additional training may also be related to the nature of the contacts between police and the mentally ill. The current training provided for recruits is angled at dealing with the mentally ill in situations relating to

criminal offending or assisting a mental health professional in transporting or detaining an individual. Police are being called to work with the mentally ill outside this envisioned role and as a consequence the training provided is not adequate for many of the situations that the police are placed in when dealing with the mentally ill, as these are likely to be better handled by mental health crises teams and professionals.

While the police in the present study did not favour attending call outs involving the mentally ill, they did overall have positive attitudes towards the mentally ill as measured by the OMI, and the attitudes of the police in the present study are similar to those of the adult Wanganui sample. However, few of the other hypotheses regarding attitudes measured by the OMI were supported.

The first set of expected outcomes involving attitudes toward the mentally ill were related to rank, age, and level of completed education as had been found internationally. Increased age was found to impact on Factor B and C of the OMI. Respondents with increased age had more paternalistic and caring attitudes toward the mentally ill (factor B) and were optimistic that mental illness could be successfully treated (factor C). However, no differences were found between attitudes measured by the OMI and education completed or current rank, which suggests education and current rank have no impact on attitudes toward the mentally ill for the present sample. While these findings differ to the international research, attention is drawn to the fact that the present study only compared differences for two groupings of rank, constable and sergeant, due to restricted numbers of participants from other ranks. Therefore, the finding that rank has no impact on attitudes should be accepted with caution and limited to the ranks of constable and sergeant.

The second hypothesis, that the more years of service with the New Zealand police a respondent had, the more favourable their attitudes would be, particularly for Factors B (benevolence), D (social restrictiveness), and E (interpersonal aetiology) was not supported in the current study, as no differences for those with

more years of service with the New Zealand police across any of the five OMI scales were found. This finding suggests that attitudes toward the mentally ill are not influenced or impacted on by the number of years a person has been a police officer, hence, the amount of contact a police officer has with the mentally ill does not influence attitudes as it is expected that those with lower ranks, such as constables, experience more contacts with mentally ill as a result of their duties, which include such duties as the 'beat'. This is further evidenced by the findings that the attitudes of police based at the three different station types (large urban, small urban, rural) were the same, despite police experiencing different quantities and duration's of contacts with mentally ill persons depending on their station type.

The third set of hypothesis concerning attitudes was related to prior work and training or education in the field of mental health and having a close acquaintance with a person who has a mental illness. No differences were found in the scores of the OMI for those who had completed mental health training or education other than the police training, or knowing a close acquaintance with a mental illness. However, there were only 29 participants who had received other mental health education or training, so the results should be read with caution. The results did find differences for other mental health work experience with factors A (authoritarianism) and D (social restrictiveness) which indicates that those with previous specialised mental health work believe the mentally ill should be treated with less authoritarianism and be less socially restricted. However, the reader is again cautioned to the significance of these findings due to the small sample size of 13 respondents who had pervious work in the mental health field.

The final hypothesis regarding attitudes toward the mentally ill was that those who had experienced a salient event involving a mentally ill person which had been particularly unpleasant or disturbing would have negative attitudes compared to those who had not had such an experience. However, this was not supported by the results and it can be concluded that such experiences do not

influence attitudes. This may be explained in part by the fact that once formed, attitudes are relatively stable, hence, reducing the impact of such an experience.

Finally, the overall positive findings of the present study could also be an indicator that the national de-stigmatisation campaigns that are being screened regarding mental health are effective in improving understanding and attitudes toward the mentally ill. Also coupled with this increased knowledge and understanding of mental illness, is that attitudes could be improving due to the mere exposure effect of people experiencing more interactions with mentally ill people due to deinstitutionalisation.

Limits of study and methodological issues

A review of the literature regarding attitudes toward the mentally ill has found that those who have had a personal experience of a mental illness will have positive attitudes towards mental illness and the mentally ill. The respondents in the present study were not asked to identify whether they themselves had previously experienced or continued to experience a mental illness, although recruitment for the New Zealand police involves screening applicants for mental illness. If possible respondents had or were currently experiencing a mental illness it was thought they may have chosen not to participate, or if they chose to participate, may have held concerns of identification and any possible implications for non-disclosure regarding their mental health and therefore would not identify their past or present personal experience of mental illness. If this did occur, this may have produced false findings of positive or negative attitudes toward the mentally ill in regard to experiences with mental illness.

A further methodological issue of the current study was that the researcher set eligibility for participation in the current study of being a sworn member of the New Zealand police with a rank of Recruit, Constable, Senior Constable, Sergeant, Senior Sergeant, or Commissioned Officer. The initial reasoning was related to those with lower or unspecialised roles (ie, no Detectives which is a higher ranking) would have more likelihood of having some contact with the

mentally ill during their routine duties and would therefore be better able to answer the section regarding contacts with the mentally ill. However, in hindsight, this may have unintentionally excluded older respondents from the study as it is likely that higher ranks are related to increased age. It also resulted in restrictions in the statistical procedures and study findings when ranks were considered as a contributing factor toward attitudes as measured by the five factors of the OMI. Furthermore, it is also likely that those with higher ranks would not experience as much contact with the mentally ill as part of their routine duties, therefore, caution should be taken not to generalise the findings of the current study to the entire New Zealand police, but to those who met the criteria for participation.

Care should also be taken not to generalise the findings of the current study to the entire New Zealand police as while the findings of the present study can be taken into account beside the findings of Dew and Badger (1999), due to restraints on budgets and time of the present study, the participants were drawn only from Region 3 of the New Zealand police. It therefore does not include attitudes or contacts for police in the South Island, or those based at large cities, such as Wellington or Auckland.

Finally, a further methodological concern relates to the selected measure of attitudes toward the mentally ill. The OMI was selected to measure police attitudes toward the mentally ill as it has reputedly good reliability and validity, and it continues to be one of the most widely used instruments to measure attitudes toward the mentally ill, including several international studies that have used the OMI to measure police attitudes toward the mentally ill. However, several respondents did not complete the OMI and participants made comments relating to the content of the questions and the questions being too general. The comments made are considered by the researcher to be fair and relevant, and it can be suggested that this represents the increase in general education and knowledge of the public regarding mental illness since the development of this scale in the 1960s. The ability of the OMI to measure contemporary attitudes is

therefore questionable. Several of the items (ie "If parents loved their children more there would be less mental illness", "People who are successful in their work seldom become mentally ill", and "Sometimes mental illness is a punishment for bad deeds") require re-evaluation due to increased awareness of mental illness, and the change in philosophy of mental health care since its development. This would allow the OMI to incorporate current themes and attitudes regarding mental illness and the mentally ill.

Further research

As discussed earlier, the majority of contacts between the police in this sample and the mentally ill are not related to criminal offending. These findings could imply that, as found internationally, the public often rely on the police as their first point of contact when requesting intervention and assistance in regard to the deterioration of an individuals mental health. Further study is warranted in this regard to investigate the exact nature of calls for assistance the police receive regarding the mentally ill, as it could indicate that the general public require education regarding the services available from mental health professionals and mental health crisis services.

While there are memorandums of understandings between the police and the health services, it was apparent from the number of comments the researcher received that police feel frustrated at the time delay in requesting and receiving the services of mental health professionals, in particular the DAO (duly authorised officer). Dew and Badger (1999) also made reference to this apparent working difficulty, and a follow-up study to investigate the application of the memorandum to working situations with the police and mental health services may be necessary. It could also be warranted to investigate the validity of exploring international solutions to this issue as several police departments have either employed non-sworn police employers who specialise in attending call-outs involving mentally ill persons, or they have developed specialised police units who deal with such incidents.

are treated by the appropriate services for the appropriate reasons. In closing, the present study is further evidence that the police are recognised by the public as performers of many different roles in our society, and as Kirkham (1994) summed up the police position, "too much is asked of the police, yet we must, for there is simply no-one else" (p.30).

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ATTITUDES OF POLICE OFFICERS TO DEALING WITH MENTALLY ILL PERSONS

Information Sheet

This information sheet is for you to keep. Please read it, and if you choose to participate, please detach it before you return the completed questionnaire.

You are being invited to participate in a piece of research which is being conducted by Tracey Hansen, MA student, and being supervised by Mr Malcolm Johnson, Senior Lecturer in Psychology at Massey University. If at any time you have any questions or concerns regarding this research you may contact either Tracey at 06 - 354 7017 or Malcolm at 06 - 350 5799 extn 2060. This research has the approval and support of the New Zealand Police.

What is the purpose of the present study:

The purpose of this study is to investigate the impact of deinstitutionalization of the mentally ill (the shift of care for mentally ill people from hospitals to the community) on New Zealand police officers. I am particularly interested in the range of factors which influence how police officers feel about the mentally ill and their interactions with them. It is hoped that this research will help identify any difficulties or concerns Police may have in their work with mentally ill people, and the reasons why. The results will be used to complete a thesis, which will be provided to the New Zealand Police.

Eligibility:
You are eligible to participate in this research if you are a recruit or a sworn member of the New Zealand police with a current rank of either Recruit, Constable, Senior Constable, Sergeant, Senior Sergeant, or Commissioned Officer.

What you will be asked to do:
If you choose to participate, you will be asked to complete a questionnaire which will take about 20 minutes of your time. The questionnaire asks for general information about yourself, your service to New Zealand Police, your contact with mentally ill people, and how you feel about people with mental illnesses. All responses are anonymous and it will not be possible for the researchers to identify individual responses. Please return completed questionnaires in the self addressed envelopes attached, no postage is required.

Your rights as a participant:
All participants:

* have the right to contact the researchers at any time during the research to discuss any aspect of the study
* have the right to choose not to answer any particular question, and the right to withdraw from the research at any time
* provide information on the understanding that all information is completely confidential and anonymous, and that only the researchers will have access to the completed questionnaires. It will not be possible to identify individual responses in any reports of the results, and at the conclusion of the study, all questionnaires will be destroyed
* to have access to a summary sheet of the findings of this research

It is assumed that by filling in the questionnaire implies consent. You have the right to decline to answer any particular questions.

Please do not record any names. Your answers are anonymous and confidential.
First, we would like some general background information about you and your police service. Please circle the number that is best for you, or give details in the spaces provided.

1. What is your age? _____

2. What is your gender?

Female 1
Male 2

3. Which ethnic group do you identify most with?

NZ European 1
Maori 2
Other European 3
Pacific Islander 4
Asian 5
Indian 6
Other (specify) _____ 7

4. What is your highest educational qualification?

No school qualifications 1
School certificate 2
6th form certificate 3
University entrance 4
Trade certificate or Professional certificate 5
University degree or diploma 6

5. Length of service in the New Zealand Police? _____ years

6. What is your current Rank?

Recruit 1
Constable 2
Senior Constable 3
Sergeant 4
Senior Sergeant 5
Commissioned Officer 6

7. Is the station that you are based in a . . .

Large Urban Station 1
Small Urban Station 2
Rural Station 3
Sole Charge Station 4

8. Have you ever held a job that specialised in working in the area of mental health or with mentally ill people aside from your police work?

No 1
Yes 2
If yes, please state job _____
_____

9. Have you received any sort of training or education in the area of mental illness or mentally ill people aside from your police training/education?

No 1
Yes 2
If yes, please give brief details of training/education _____
_____
_____
_____
_____

10. Have you known a family member, friend, or close acquaintance who has seeked professional help for a mental health or emotional problem?

No (please continue over the page) 1

Yes (please continue) 2

In your opinion, how did the mental illness /emotional problem affect this person?

Very little affect 1

Moderately, but for a short period only 2

Moderately, life long affect 3

Significantly, but for a short period only 4

Significantly, life long affect 5

Was a factor in their death (i.e. suicide) 6

The following questions relate to your interactions with mentally ill persons, or people suspected of having a mental illness while you are <u>on duty</u>. Please answer how <u>you</u> personally feel for each question. Your responses are anonymous and confidential. Please circle the number that is best for you.

1. In the <u>past month</u> while on duty, how many contacts have you had with mentally ill people, or suspected mentally ill people?

0 contacts 1
1 - 2 contacts 2
3 - 4 contacts 3
5 - 6 contacts 4
7 - 8 contacts 5
9 - 10 contacts 6
10 + contacts 7

2. In comparison to the past year, would you consider this amount of contact

less than average 1
about average 2
more than average 3

3. When dealing with mentally ill people, or suspected mentally ill people, the average time you spend with them is

one hour or less 1
between 1 - 2 hours 2
between 3 - 4 hours 3
5 hours or more 4

4. Compared to people who you consider <u>not</u> to have a mental illness, the time you spend with mentally ill people is

a lot less 1
similar 2
more 3
a great deal longer 4

5. While on duty have you ever had an experience with a mentally ill person, or suspected mentally ill person, that was particularly unpleasant / disturbing for you?

No (please continue over the page) 1

Yes (please continue) 2

To answer the following questions please circle the number that best describes how you felt about the unpleasant / disturbing experience

1 = I did not feel this way at all

2 = I felt this way a little

3 = I felt this way

4 = I strongly felt this way

5 = undecided / neutral

5a. I felt frightened 1 2 3 4 5

5b. I felt anxious 1 2 3 4 5

5c. I felt angry / aggressive 1 2 3 4 5

5d. I felt confused / uncertain 1 2 3 4 5

5e. I felt ashamed / embarrassed..... 1 2 3 4 5

5f. I felt a desire to help 1 2 3 4 5

5g. I felt sad / sympathetic 1 2 3 4 5

5h. I felt a desire to keep out of things 1 2 3 4 5

Please answer the following questions by circling the number that best describes how <u>you</u> feel using this scale. There are no wrong or right answers. Your responses are anonymous and confidential.

1 = strongly agree
2 = agree
3 = undecided / neutral
4 = disagree
5 = strongly disagree

1. Dealing with mentally ill people is an appropriate service of the police 1 2 3 4 5

2. Most of my collegues dislike attending call-outs that involve mentally ill persons ... 1 2 3 4 5

3. The majority of incidents / call-outs involving mentally ill people are not crime related 1 2 3 4 5

4. My training for this job prepared me suffciently to work with mentally ill people 1 2 3 4 5

5. When I receive a call-out that involves dealing with a person who is mentally ill, I feel (please respond to all of the following questions):

5a. a little apprehensive, ill equiped to deal with the situation 1 2 3 4 5

5b. frustrated at the amount of time the call-out is going to take 1 2 3 4 5

5c. no more anxious than normal 1 2 3 4 5

5d. that I am at an increased risk of danger 1 2 3 4 5

5e. that I am not the appropriate person to be dealing with the situation 1 2 3 4 5

6. Mentally ill people are no more likely to become violent / dangerous than non-mentally ill 1 2 3 4 5

7. Working with mentally ill people adds to the stress of my job 1 2 3 4 5

8. I would feel more comfortable in my interactions with mentally ill people if I received more education / training in this area 1 2 3 4 5

9. Mentally ill people are predictable 1 2 3 4 5

10. I dislike attending call-outs that involve mentally ill persons 1 2 3 4 5

11. I have a good overall knowledge and understanding of the Mental Health (Compulsory Assessment & Treatment) Act 1992 ..... 1 2 3 4 5

The statements that follow are opinions or ideas about mental illness and mentally ill persons. By mental illness, we mean the kinds of illness which bring patients to mental hospitals, and by mental patients we mean mental hospital patients. There are many differences of opinion about this subject. In other words, many people agree with each of the following statements while many others disagree with each of the statements. We would like to know what you think about these statements. There are no wrong or right answers. Please circle the number that best describes how you feel. Your responses are anonymous and confidential.

1 = strongly agree
2 = agree
3 = not sure, but probably agree
4 = not sure, but probably disagree
5 = disagree
6 = strongly disagree

1. Nervous breakdowns usually result when people work too hard 1 2 3 4 5 6

2. Mental illness is an illness like any other 1 2 3 4 5 6

3. Most patients in mental hospitals are not dangerous 1 2 3 4 5 6

4. Although patients discharged from mental hospitals may seem alright, they should not be allowed to marry 1 2 3 4 5 6

5. If parents loved their children more, there would be less mental illness 1 2 3 4 5 6

6. It is easy to recognise someone who once had a serious mental illness 1 2 3 4 5 6

7. People who are mentally ill let their emotions control them: normal people think things out 1 2 3 4 5 6

8. People who were once patients in mental hospitals are no more dangerous than the average citizen 1 2 3 4 5 6

9. When a person has a problem or a worry, it is best not to think about it, but keep busy with more pleasant things 1 2 3 4 5 6

10. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of every day life 1 2 3 4 5 6

1 = strongly agree
2 = agree
3 = not sure, but probably agree
4 = not sure, but probably disagree
5 = disagree
6 = strongly disagree

11. There is something about mental patients that makes it easy to tell them from normal people 1 2 3 4 5 6

12. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh at them 1 2 3 4 5 6

13. Most mental patients are willing to work 1 2 3 4 5 6

14. The small children of patients in mental hospitals should not be allowed to visit them 1 2 3 4 5 6

15. People who are successful in their work seldom become mentally ill 1 2 3 4 5 6

16. People would not become mentally ill if they avoided bad thoughts 1 2 3 4 5 6

17. Patients in mental hospitals are in many ways like children 1 2 3 4 5 6

18. More tax money should be spent in the care and treatment of people with severe mental illness 1 2 3 4 5 6

19. A heart patient has just one thing wrong with them, while a mentally ill person is completely different from other patients 1 2 3 4 5 6

20. Mental patients come from homes where the parents took little interest in their children 1 2 3 4 5 6

21. People with mental illness should never be treated in the same hospital with people with physical illness 1 2 3 4 5 6

22. Anyone who tries to better themselves deserves the respect of others 1 2 3 4 5 6

23. If our hospitals had enough well trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital 1 2 3 4 5 6

24. A women would be foolish to marry a man who had a severe mental illness, even though he seems fully recovered 1 2 3 4 5 6

25. If the children of mentally ill parents were raised by normal parents, they would not become mentally ill 1 2 3 4 5 6

1 = strongly agree
2 = agree
3 = not sure, but probably agree
4 = not sure, but probably disagree
5 = disagree
6 = strongly disagree

26. People who have been patients in a mental hospital will never be their old selves again 1 2 3 4 5 6

27. Many mental patients are capable of skilled labour, even though in some ways they are very disturbed mentally 1 2 3 4 5 6

28. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for 1 2 3 4 5 6

29. Anyone who is in a hospital for a mental illness should not be allowed to vote 1 2 3 4 5 6

30. The mental illness of many people is caused by the separation or divorce of their parents during childhood 1 2 3 4 5 6

31. The best way to handle patients in mental hospitals is to keep them behind locked doors 1 2 3 4 5 6

32. To become a patient in a mental hospital is to become a failure in life 1 2 3 4 5 6

33. The patients in mental hospitals should be allowed more privacy 1 2 3 4 5 6

34. If a patient in a mental hospital attacks someone, they should be punished so they don't do it again 1 2 3 4 5 6

35. If the children of normal parents where raised by mentally ill parents, they would probably become mentally ill 1 2 3 4 5 6

36. Every mental hospital should be surrounded with a high fence and guards 1 2 3 4 5 6

37. The law should allow a women to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness 1 2 3 4 5 6

38. People who are unable to work because of mental illness should receive money for living expenses 1 2 3 4 5 6

39. Mental illness is usually caused by some disease of the nervous system 1 2 3 4 5 6

40. Regardless of how you look at it, patients with severe mental illness are no longer really human 1 2 3 4 5 6

1 = strongly agree
2 = agree
3 = not sure, but probably agree
4 = not sure, but probably disagree
5 = disagree
6 = strongly disagree

41. Most women who where once patients in a mental hospital can be trusted as baby sitters 1 2 3 4 5 6

42. Most patients in mental hospitals don't care how they look 1 2 3 4 5 6

43. College professors are more likely to become mentally ill than are business men 1 2 3 4 5 6

44. Many people who have never been patients in a mental hospital are more mentally ill than hospitalised mental patients 1 2 3 4 5 6

45. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill 1 2 3 4 5 6

46. Sometimes mental illness is a punishment for bad deeds 1 2 3 4 5 6

47. Our mental hospitals should be organised in a way that makes the patient feel as much as possible that they are living at home 1 2 3 4 5 6

48. One of the main causes of mental illness is a lack of moral strength or will power 1 2 3 4 5 6

49. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed 1 2 3 4 5 6

50. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked 1 2 3 4 5 6

51. All patients in mental hospitals should be prevented from having children by a painless operation 1 2 3 4 5 6

Please check that you have not missed any pages

Thank you

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