

***POLICE INTERVENTION UNDER
THE MENTAL HEALTH ACT***

A comparison of rural and urban approaches

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1996

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of Ottawa, in partial fulfilment of the requirements
for the degree of Master of Arts***



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ABSTRACT

DESCRIPTION OF RESEARCH

This thesis explores how police intervene with clientele signalled as mentally ill, or acting in such a way that the presence of a mental health problem is perceived. Officers were interviewed in rural and urban detachments and forces in neighbouring jurisdictions in Eastern Ontario. All of the officers interviewed were bound by the same legislation and guidelines with respect to mental health and to policing, described in the theoretical framework of this thesis. Rural and urban perceptions are compared to determine differences in the areas explored: available information, general knowledge, descriptions of incidents, causes of disturbed behaviour, police actions, and interactions with community or health authorities to whom clients may be referred for further mental health interventions.

RESEARCH METHOD

The thesis compares non-directive interview material for differences in and within themes addressed. Seven interviews, all with male officers, are analyzed. Three interviews were conducted in urban stations; four in rural detachments. In both of the compared groups, one officer is

a senior officer and all others are constables. The choices of topic, research subject, and other features of the methodology are defended based on feminist and other critical analyses of traditional sociological research.

OVERVIEW OF FINDINGS

There were no apparent differences in the type of clientele managed, or the source or nature of referrals. Differences arose in assumptions regarding mental illness and various manifestations of mental illnesses. Differences in the nature of associations between officers and their clientele, and in their experiences and training in this area, were reflected in differences in descriptions of incidents and attributions of causes of disturbed behaviour. Attribution Theory (described in the theoretical framework) provides the basis of an analysis of attitude.

Differences in intervention styles appeared linked to physical proximity and access to resources. Urban officers were more likely to refer clients for further mental health interventions; rural officers sought solutions that did not require transportation to facilities. Differences arose among the authorities with whom officers interacted most; urban officers referred clients directly to psychiatric facilities; rural officers first consulted local doctors for authorization to transport clientele, if required.

There were variations among rural detachments with respect to community resources available; where these were few, officers indicated a wish for more community resources. Both types of officers described a shortage of formal mental health services, and indicated a wish for greater cooperation from mental health authorities.

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CHAPTER 1

INTRODUCTION

INTRODUCTION

The choice of topic for this thesis represents a combination of fortuitous situations: a call for submissions by the Canadian Mounted Police College, received at the Criminology Department, to write an article concerning community policing, and a student placement which led to work with former and current psychiatric patients. Early in the research, it became apparent that a specialized psychiatric community exists only in urban areas; persons with mental health problems are members of broader communities in rural areas.

Production concerning police activity under mental health legislation is rare in criminological journals, and more frequently addressed in health journals. As will be shown in the literature review, however, opinions concerning mental illness differ among learned authors, as they do concerning the role of police in other areas. Bittner's (1967) article remains the most important work concerning policing with mentally ill persons, and this thesis will refer to Bittner's work for similar themes to be explored with respect to current police activities, as reported by rural and urban officers in Eastern Ontario.

The Ontario Mental Health Act and Police Services Acts, and reports concerning training, provide the authority and criteria for police/mental health interventions. These

generally fall into the category of peacekeeping rather than crime prevention or response to crime. Peacekeeping is an activity that is generally undefined and unregulated; police training and other guidelines do not provide a framework to describe peacekeeping ideals. Police accounts, based on their experiences, provide a description of those activities.

A comparison will be made of rural and urban officers' perceptions concerning why persons ask police to intervene, who makes these referrals, how often such referrals are made, and which features of the referral signal a possible intervention under the Mental Health Act. Urban and rural police training, knowledge, and familiarity with clientele will be explored and compared. Police descriptions of the situations in which they intervene will be examined for attribution of causation, inferred from officers' descriptions and analyzed according to Attribution Theory and its sub-theories concerning bias and error in attribution.

Officers' responses to particular situations will be examined to determine whether these follow guidelines and meet the criteria provided by the Ontario Mental Health Act. Officers' attempts to meet situational demands or to resolve problems involving mental illness will be compared to determine contemporary "psychiatric first aid", to which Bittner (1967) alludes. The use of restraints, always an

important question in areas involving mental illness, will be examined. Lastly, the thesis explores the relationships and interactions between police and other authorities who may become involved in the intervention.

Mental health interventions require officers to act with empathy and creativity, qualities not generally associated with policing. They must respond to immediate situations whose regulation is not predetermined by police training or guidelines. The thesis explores this area of policing perceived as unpredictable, often dangerous, in which access to an appropriate solution may be difficult or impossible. Interventions will be examined in which officers must rely on their acquired repertoire of skills and their personal qualities. This thesis will examine whether such repertoires and qualities differ among rural and urban officers. The early chapters of analysis will provide a basis for understanding the differences in interventions.

The thesis was long in writing, as activities in a career in the field of mental health seemed to require more urgent attention. During its writing, the Mental Health Act was supplemented with legislation concerning advocacy, consent, and substitute decision making which were repealed within a year. In 1996 the 1987 Mental Health Act (on which officers based criteria for intervention) was replaced with a new Mental Health Act and a Health Care Consent Act, which

redefined the nature of treatment for which consent is necessary, providing a greater range of decisions for substitute decision makers (for example, to authorize aversive conditioning using electroconvulsive therapy, or ECT) as well as physicians (for example, to authorize treatment when it is difficult or impossible to communicate for the purposes of obtaining consent), and protection for both from liability in the case of harm.

While mental health legislation in Ontario has been frequently revised, no legislation has provided officers with clear instructions on what is disturbed behaviour, and how to proceed in their interventions. Decisions to intervene may be examined in a context of legislated criteria; actions and agreement by mental health authorities concerning those actions cannot be determined from a study of legislation. The constraints officers face far exceed those described in any of the documents to which they may refer for guidance.

CHAPTER 2

THEORETICAL FRAMEWORK

THEORETICAL FRAMEWORK

The boundaries of knowledge appropriate to Criminology have evolved considerably since classical and positivistic studies of crime and its causes. Limits placed on research subjects such as "the actions which and actors who transgress laws" are no longer relevant or useful. More recent studies have taken Criminology far beyond its original search for a cause of crime, and actors of current interest include all actors in the Criminal Justice System: service providers as well as clientele. Research examines objects of control, means of control, experiences of victims, activities of control agents: judges, lawyers, police officers, corrections workers, social workers, doctors and psychiatrists. Research that explores how police perceive and intervene with a particular form of deviance is within the boundaries of what is appropriate to Criminology.

As Criminology has evolved, so the field of mental health has evolved. The advent of neuroleptic medications since the 1960s and a "wave" of deinstitutionalization have changed perceptions as well as treatment of mental illness. The situation of persons who once occupied the leprosariums turned asylums, and more recently rest homes, mental hospitals, and locked wards of general hospitals, has changed considerably. Many formerly institutionalized

persons now live in the community; social awareness of their number and situation has increased. Their increased representation in the community has also increased the potential of their becoming the object of police intervention.

LEGAL CONTEXT

The Ontario Police Services Act

Ontario's 1989 Police Services Act describes how police services should be delivered, citing "the need for co-operation between the providers of police services and the communities they serve"(P.3). It confers on police officers the responsibility to respond to the demands of the community; it does not describe or limit the range of services offered. It provides a general police mandate: "to ensure the safety and security of all persons and property in Ontario"(P.3). It provides no guidelines by which to assess the need for intervention. It does not define risk to the safety or security of persons or property. Potential victims may report a threat to safety and security, but officers must decide whether the threat is real, whether to intervene, and how to intervene.

Officers are trained to arrest, apprehend, and incapacitate; they are not trained in criminal justice programs to provide care, treat, or counsel. Two provincial reports (1992a; 1992b) on police training or learning, and

one federal report (1991) on mental health interventions, do not connect police officers with mental health interventions. Training guidelines are as silent as the Act concerning situations of perceived problems related to mental illness. This thesis, through the voice of urban and rural police officers, will be eloquent on the topic.

The Ontario Mental Health Act

Officers exercise their discretion in laying charges, arresting, or maintaining a person in custody when the law so authorizes. In peacekeeping activities, officers exercise even greater discretion and may apprehend persons and maintain them in custody who may not have violated any law. When peacekeeping involves disturbed behaviour, the situation may be regulated by the Mental Health Act. When a person's actions appear likely to cause impairment or harm, to self or another, criteria authorizing intervention may be met.

The Act restricts intervention to situations in which officers have observed the disordered behaviour. A *Guide to the Act* specifically states that *reported* (emphasis in text) behaviour "is not sufficient as grounds for action"(P.8-9). The Act authorizes police in Ontario to take a person into custody and requires the person in custody to be taken "for an immediate initial examination by a physician"(P.8-9). It requires the officer to remain

until custody is accepted by the facility, but not until the person is admitted. Variations arise in the Act's application based on the requirement for immediate assessment, which requires an additional procedure by rural officers.

A sequence of police interventions under the Mental Health Act may be constructed:

Table 1: Police intervention under the Mental Health Act

Event	Action
Crisis	Appearance of need for assistance
Police assessment	Police perceive that person in need of assistance is suffering from a mental illness, based on observation of behaviour; person taken into custody
Immediate assessment	Police transfer custody to physician, or obtain from physician an application for psychiatric assessment (Form-1), based on his/her examination and inquiry
Psychiatric examination	Police retain custody until facility accepts custody, following determination by physician that person is in need of psychiatric treatment
Involuntary or voluntary admission	Police transfer custody; person remains in the custody of the psychiatric facility

The crisis described in the first line is a threat or attempt to cause bodily harm to self or another, or incompetence to care for oneself because of a psychological disorder that may result in serious bodily harm or a physical impairment. The officer is required to assess that reported or observed behaviour constitutes such a crisis, to judge that intervention is appropriate. Neither the Mental Health Act nor police guidelines describe the behaviour that

may be so judged, as criminal codes describe criminal behaviour. The sequence assumes consistent assessment among the authorities concerned.

The 1980 Ontario Mental Health Act was amended in 1986 and 1987. The final amendment gave competent (currently "capable") psychiatric patients an absolute right to consent to or refuse treatment. It was again amended in April, 1995, by the enactment of consent to treatment, substitute decision, and advocacy legislation -- all of which have been suspended or altered since enactment due to difficulties of implementation. All were replaced by the 1996 Mental Health and Health Care Consent Acts, which do not redefine police authority to intervene.

Deinstitutionalization

Various reasons have been given for deinstitutionalization. Szasz' (1961) *The Myth of Mental Illness* is credited by some with increasing public awareness of the plight of the mentally ill, and public concern for the rights of persons so labelled. Lobbying to restrict involuntary hospitalization, by organizations of former mental hospital patients in the United States and Canada (including Ontario), is important; such activities brought recognition that persons perceived as mentally ill continue to enjoy some civil rights. At the time of this research, safeguards were legislated in Ontario to provide persons

with the means to defend or protect themselves from arbitrary involuntary hospitalization and treatment.

Palermo et al (1992) describe the "process of deinstitutionalization" of the mentally ill as "one of the major forces in changing mental health care and policy", which resulted in a massive transfer of patients from formal psychiatric care to "a wide range of nursing homes, boarding home facilities, and other community living arrangements"(P.53). Wachholz & Mullaly (1993) report a 75% drop in daily mental hospital populations in the United States from 1955 (560,000) to 1981 (125,000) (P.284); Cohen (1985) reports an even greater drop: "average daily mental hospital populations in the USA declined dramatically from 600,000 in 1955 to 100,000 in 1980"(P.61). Palermo et al (1992) situate the period of deinstitutionalization "particularly from 1965-1980". The authors cited agree on this period of greatest momentum.

The effects of deinstitutionalization are misrepresented when discussed only in terms of massive reductions in stable daily institutional populations. The term evokes images of wrongful hospitalization and patients subsequently released who should never have been hospitalized, or advances in healing technologies, or changed definitions of competence, or increased tolerance toward or support for mentally ill persons in the community. Authors and advocates have criticized the validity of these

images. Many now labelled homeless, derelict, vagrant, nuisances, are former patients or current outpatients. Many have had multiple admissions but few remain long in psychiatric facilities. Szasz (1990) describes "thousands of persons being not only forcibly incarcerated in hospitals, but also forcibly evicted from them"(P.562[316]). Cohen (1985) describes an increase in non-offender mentally ill populations outside of institutions, and their difficulty in obtaining mental health services. In their review of statistical studies on this topic, Palermo et al (1992) refer to the deinstitutionalized mentally ill as "pseudo-offenders" who

overcrowd the jails (...) roam the streets, sleep in alleys, stations, and other buildings (...) invaded libraries and court house halls and corridors, intrude upon (...) shops and department stores (...) churches and public places (...) from street to jail and from jail to street, as through a revolving door.(P.59)

While stable daily institutional populations were reduced, Szasz (1990) cites Roth's (1989) "most recent national data" to demonstrate that the number of involuntary admissions in the United States continued to be high in 1980. Roth reported 1,176,558 inpatient admissions in all institutions, 26% involuntary (noncriminal), but "more than 51% of admissions to state and county mental hospitals" are involuntary(P.135). The average length of hospitalization appears to be about one month. This was approximately the

average length of stay at Ottawa's regional facility¹ at the time of the study; these continue to decline.

Cohen (1985) states that "the crime-like notion of dangerousness is increasingly used to decide on committal standards"(P.61) as a result of deinstitutionalization. He also describes an increase in forensic psychiatric populations since deinstitutionalization. Rice's (1985) study of inmates incarcerated under a *Warrant of the Lieutenant Governor* confirms increased stable forensic psychiatric populations in Oak Ridge (Ontario's provincial institution for the criminally insane) and provincial and regional psychiatric hospitals, despite decreased average lengths of incarceration since the 1960s. The findings reflect an increase in the number of persons charged with crimes, but judged criminally insane or not fit to stand trial, in Ontario.

Most of the literature on deinstitutionalization concerns the United States, but findings are as relevant in Canada. There have been reductions in institutional resources, staff number, and bed availability in psychiatric wards and facilities throughout Canada. In Ontario, mental health services had been greatly reduced at the time of this research and continue to be reduced during the three years since police officers were interviewed for this study.

¹Average lengths of stay were obtained: for 1992-93, 33.4 days; for 1993-94, 30.4 days; for 1994-95, 27.0 days.

KNOWLEDGE CONCERNING POLICING

Police studies involving rural detachments are few, and comparative studies are rare. Concerning literature on policing, Lundman (1980) states:

Studies have typically been concerned with a single police jurisdiction thereby limiting the generalizability of the results. (...) [E]xisting studies have generally focused on large, urban departments with a corresponding loss of knowledge of patrol activities in suburban and other types of police jurisdictions. Finally, comparative data have only infrequently been reported within the confines of a single study. (P.52-53)

An examination of rural and urban perceptions of policing will provide rare knowledge from rural detachments; the comparison will facilitate or refute generalizations concerning police behaviour or perceptions.

Authors and researchers who have studied police work report a large proportion of activities not concerned with prevention, control, or apprehension. Some describe the proportion of non-crime related activities as far more important, others as far less defined, than crime-related activities. Perrier (1978) writes:

Contrary to popular belief, much less time is spent on crime detection and the apprehension of offenders than on other phases of police work. (...) [T]he function of peace-keeping, which takes up the majority of police duties, is less clear and largely undefined. (P.211)

Bittner (1980) also noted a lack of definition of police activities, and the arbitrary quality of a police officer's perception of the need for intervention and the intervention required:

[W]e are often told that the role of the police is to centre around law enforcement, crime control, and peacekeeping (...). Such statements of function are abstract and do not restrict the interpretations that can be given to them.(P.2)

Bittner's well-known studies "Police discretion in emergency apprehension of mentally ill persons" (1967) and "The police on skid-row: a study of peace keeping" (1969) are important to any examination of policing, but particularly to this study, which like Bittner examines police perceptions.

Bittner's research for the 1967 article, conducted from July 1963 to June 1964, is important despite being conducted when institutional populations were still high. His study provides some of the themes explored in examining police perceptions, and an undefined area of "psychiatric first aid" which this thesis will explore in a chapter concerning interventions.

The criteria by which officers in Bittner's (1967) study decided to make emergency apprehensions of mentally ill persons are summarized as follows: when the person attempts suicide, when signs of a "serious psychological disorder" are present, when "signs of serious psychological disorder are expressed in highly agitated forms", where persons are creating "a nuisance in a public place", and where information is received from persons "in some sort of instrumental (professional) relationship to the person, requesting aid"(P.283-284). Bittner qualifies persons in instrumental relationships to the apprehended person, on

whose information police officers will act, as "physicians, lawyers, teachers, employers, landlords, and so on"(P.284). Family members, friends, roommates or neighbours, whose requests "are not usually honoured", are excluded by Bittner from the instrumental designation.

Currently the Mental Health Act does not permit officers to act on information from others. Police may, without observing disordered behaviour, take a person into custody upon an order by a justice or a physician, and from other officers. Officers transport patients of psychiatric forensic units to and from clinics, courtrooms, other facilities; custody is transferred to and accepted from authorities in such locations. Rather than instrumental relationships, such persons are in relationships of authority toward the apprehended person. For most of Bittner's range of instrumental relationships, the Mental Health Act requires police intervention to be determined by observation of behaviour.

Policing styles have changed since Bittner's articles, which describe foot patrols; currently vehicle patrols are more common. Foot patrols have been reinstated in some Ontario communities, including urban communities, but are not the norm for the urban (municipal) or rural (provincial) forces studied. Mental health knowledge has changed, but police are not issued updated versions of illness definitions and their assessment criteria may not conform

with those of doctors or psychiatrists. Their discretion to act is reduced, and the institutional resources available to them are fewer since Bittner's (1967) study.

Bittner found that officers in his study applied "psychiatric first aid" to avoid referral to formal services, that police "are quite reluctant to invoke" laws which authorize "apprehensions of the mentally ill", and that they "will try to avoid taking him to the hospital". For the officers in Bittner's study:

[I]t is not enough for a case to be serious in a 'merely' psychiatric sense. To warrant official police action a case must also present a serious police problem. (P.279)

This thesis will compare rural and urban officers' reluctance or readiness to refer persons to psychiatric facilities, and whether such referrals represent serious police problems.

KNOWLEDGE CONCERNING MENTAL ILLNESS

Literature survey

The University of Ottawa's PsychLit database at the time of this research provided two default periods: 1974-86 and 1987-92. The dates covered the period of changes in legislation and mental illness treatment prior to the research period, and seemed suitable for an examination of knowledge and perceptions, interactions among authorities, and interventions under mental health legislation.

A computerized literature search was conducted to

determine production during those periods, using various probes. The greater proportion of literature production concerns mental health or mental illness; considerably less was related to policing. Results are summarized in a table:

Table 2: Literature survey

Probe	1974-86	1987-92
psychiatric	24,492	21,232
mental disorders	4,532	411
police	1,378	963
mentally disordered	101	114
policing	45	36

Several probes were made for articles on the combined topic of policing and various descriptors of mental illness; production on combined topics was much lower. The most fruitful descriptors were the combination of "police" with "psychiatric"; other probes did not produce additional articles. Most addressed the use of mental illness as a defence; some addressed mutual interests of police and mental health authorities; a number addressed mental illness labelling as a variable in arrest rates, offense rates, weapons charges, violence and its prediction. Some criticized the data collection procedures and conclusions of other articles. Few were relevant to this study of police perceptions and interventions with persons perceived as mentally ill.

The journals in which relevant articles appeared demonstrate a low production in Criminology: thirty-five

articles in Psychology, Psychiatry, Psychiatry and Law, Nursing, or related Health journals addressed policing; four in Criminology or Police journals addressed questions of mental health for the period preceding the research.

Demographics of police intervention with mentally ill persons

A number of studies addressed demographics of police emergency psychiatric referrals: frequency of admissions; age, gender, and severity of symptoms of persons accompanied by police. Despite differences in findings, most implied that police referrals to emergency wards of psychiatric and other hospitals were common.

The range of findings was wide. Adityanjee et al (1988) found a "significant proportion" of police admissions in a hospital in India. Sheps (1974) study found 90% of emergency admissions in a Harlem hospital brought in by police. Cohen & Marcus (1990) study of a number of hospitals in New York city found a 69% increase in police admissions from 1983 to 1989. McNeil et al (1991) found 33.6% of emergency admissions "in an urban psychiatric emergency room" accompanied by police. By contrast, Steadman et al (1986) found that only 7.1% of 196 evaluations (not admissions) in an unnamed hospital setting were police referrals. Reported rates varying from 7% to 90% suggest either great differences in norms of police

behaviour, or in facilities studied. Information concerning referral frequency, for one month during the year of the study, was acquired from the regional facility that serves the area.

Table 3: Referral sources for emergency presentations²

Referral source	number	per cent
Self	203	49 %
Police	60	14 %
Family	57	14 %
Community contacts	36	8.5 %
Ambulance	24	6 %
Internal (from ward)	17	4 %
Other hospitals	10	2.5 %
Other sources	9	2 %
Total admissions	416	100 %

On average, police referred two of approximately fourteen admissions per day during the month reported. The number of referrals per officer may be low, but police remain an important source of emergency referrals for the area's regional facility.

Studying age, McNeil et al (1991) found that most persons referred by police were typically older (mean age 40.5) than those referred by other sources such as self or family (35.9). Steadman et al (1986) found police referrals younger (33.8), with a similar mean age for other referrals

²October 1993 Report to Community Advisory Committee of Outreach and Emergency Program of an Ottawa facility. The report does not differentiate between rural or urban referrals.

(36.1). Moodley & Perkins (1991) study of a London (UK) hospital found persons referred by police even younger (under 30). Studying gender, Steadman et al (1986) found significantly higher numbers of female police admissions, while Adityanjee et al (1988) found twice as many male as female police admissions in India. With respect to severity, Sales (1991) reported that police referrals were the most severely ill while Steadman et al (1986) reported police referrals as no more disordered than other admissions. Reported demographics of emergency police admissions to hospitals are inconsistent; differences may reflect variations in local behaviour norms, community tolerance of behaviour, police training, medical practices, data collection, or evidence on which conclusions are based. Local data do not specify age, gender, or severity in reports that include numbers of police admissions; local data concerning police referrals that do not result in admission were not collected.

Literature concerning mental illness and policing

Literature concerning police and mental illness was inconsistent with respect to frequency and demographics of emergency admissions. Studies using mental illness as a variable of violence seem equally inconsistent. Abstracts are summarized and contrasted:

Table 4: Knowledge comparison

Authors	Summary of findings
Menzies et al (1982)	No evidence of higher levels of violence as a result of mental disorders (forensic mental patients)
Sholom et al (1989)	"[U]nstable personality structures" and alienation among "impulsive violent subjects", but not among other violent subjects (violent prisoners)
Whiteford & Westmore (1991)	Violence associated with "limited frontal and temporal brain damage" (brain damaged subjects)
Hillbrandt et al (1988)	Violence associated with "the absence of temporal lobe damage" (brain damaged subjects)
Lindqvist & Allebeck (1990)	Crime rates among males with diagnosis of schizophrenia similar to that of general male population; crime rates among females with diagnosis of schizophrenia double that of women offenders, four times higher than of women in general (police data)
Philips, Wolf & Coons (1988)	Very low numbers (0.2-2.0%) of persons with diagnosis of schizophrenia arrested for violent crimes; very low representation (1.1-2.3%) among violent crime arrest data (police data and clinical records)

Inconsistencies result when different questions are asked, or when different data are studied. Conclusions regarding mental illness and violence cannot be drawn from an examination of these findings. The table serves to provide a potential "knowledge concerning mental illness" base, available to officers at the time of this study.

In other journals, Cooke & Goldstein (1989) compared violent FBI index crimes with nonviolent crimes and found correlations between violence and variables related to mental health: isolation and failure to communicate. Kuhlhorn's (1990) study similarly found correlations between violence and a mental health issue: the tendency to

misinterpret situations. Copello & Tata (1990) found a correlation between police perceptions of violence and their perceptions of hostility. Mental illness and weapon use was also addressed. Norton (1988) linked the presence of firearms to violence by mentally ill persons, but countless studies have linked violence among the general population to the presence of firearms. Steadman & Felson (1984) found mentally ill persons involved in a high number of weapon incidents compared with rates among the general population, but without correspondingly higher rates of injuries.

Differences may be expected among police perceptions of weapon use, in a study that compares urban and rural policing. Rates of rural and urban firearm ownership differ considerably. Regulations governing firearm acquisition provide more rural than urban criteria. Urban residents may own firearms for self-protection, the need for which is difficult to demonstrate. Rural residents may own firearms for the purposes of pest control and hunting; they may depend on firearms to supplement diet, protect livestock and gardens, or pursue certain lifestyles or trades. The threat of harm to self or another by a firearm, where the presence of firearms is greater, is potentially greater in rural than in urban areas.

Dispositions

Articles identified four alternative dispositions in police interventions with mentally ill persons. First, police preferred to resolve problems immediately by providing some form of assistance, according to Pogrebin (1987), and to leave mentally ill persons in the care of relatives or friends rather than accompanying them to institutions. His findings suggest the application of "psychiatric first aid" described by Bittner (1967).

The second preference appears to be referral to mental health services in the community. Sheridan & Teplin (1981) found community referrals more numerous than institutional ones: 293, compared to 163 to a state mental institution. The study found a more positive long-range impact for referral to community resources than to psychiatric facilities: subsequent rates and lengths of hospitalizations were higher after the first hospitalization. Hoult's (1986) British study found persons referred, and their families, more satisfied with community referrals. Hoult found no increase in police interventions with mentally ill persons left in the community, but Borzecki & Wormith's (1985) Canadian study found increased rates of criminalization correlated with insufficient resources to meet the needs of persons left in the community. Abram & Teplin (1991) also found correlations between arrest of mentally ill persons and lack of treatment alternatives, a finding with which

Pogrebin & Poole (1987) agree.

The third outcome alternative is referral to psychiatric facilities, or psychiatric wards in general hospitals. Bittner (1967) found that police referrals were "relatively rarely turned down by admitting psychiatrists" (P.281), and that a very high level of police activity resulted in psychiatric referrals:

Despite the strong reluctance of the police, emergency apprehensions of mentally ill persons are quite frequent. Indeed, officers of the uniformed patrol make them about as often as they arrest persons for murder, all types of manslaughter, rape, robbery, aggravated assault, and grand theft, taken together; and more than one fifth of all referrals to the receiving psychiatric service of the public hospital come from this source. (P.282)

Other studies found police to be important actors in psychiatric emergency processes. Barton (1983) found police ranked as an important resource for rescue personnel and psychiatric facility emergency teams. McClelland (1983) found police, as well as paramedics and general emergency staff, an important non-psychiatric resource for psychiatry teams.

One study contradicted the foregoing findings. Peterson (1984) found poor relations between police and staff of psychiatric facilities, and recommended greater reliance on courts, administrative processes, and advocates to obtain access to psychiatric services. The fourth disposition is thus introduced: arrest or other criminal justice processing of mentally ill persons. Cohen (1985)

describes deinstitutionalized patients being arrested as nuisances or vagrants, for causing disturbances, or for other minor charges "because the police can think of nothing else to do with them"(P.62). Criminal justice processing was found by most authors to have negative consequences for mentally ill persons, the impact of arrest being a topic of several articles. Steadman & Felson (1984) found the likelihood of arrest similar for ex-patients and ex-offenders. Melick et al (1979) studied mental patients with arrest records prior to hospitalization, and found higher subsequent arrest rates for violent crime than among persons who had never been hospitalized.

Training

Several articles in health journals concerned police training by mental health professionals. Drucker & Goldstein (1983) describe training to improve police judgment and empathy toward mental patients; Janus et al (1980) describe training to improve police attitudes toward, ability to assess, interest in, and sympathy for persons with psychiatric problems. Zealberg et al (1992) found collaboration between police and psychiatric workers in the community: police provided security for mental health workers; the latter were a resource when officers intervened with mentally ill clientele. Health articles recommended that police and other stakeholders be considered when

developing training programs for emergency intervention with mentally ill persons. Criminology or Police production included studies by Strentz (1986) describing collaboration, and by Laroche et al (1974) describing the benefits of collaboration. All studies involved urban police officers.

Assessment

Some articles addressed police assessment of mental illness or other mental health related factors. Holley & Arboleda-Florez (1988a) examined police dispositions with persons perceived as mentally ill and persons perceived as using drugs: clients were referred to psychiatric facilities rather than arrested in the first case, and arrested rather than referred to a facility in the second. The same authors (1988b) measured the reliability of police assessments of mental illness using two groups, one which had previously received formal diagnosis or treatment, and one identified as normal. Assessment of mental illness by officers was equally likely in both groups. While police assessment cannot from such a study be described as reliable, agreement with their assessment by mental health authorities represents conformity of police perceptions with current mental health knowledge.

The state of knowledge concerning mental illness may generously be described as inconsistent and less than satisfactory. The ability of police or mental health

authorities to judge the presence of a mental disorder, based on such knowledge, will be questionable.

KNOWLEDGE FROM SOCIAL PSYCHOLOGY

Attribution Theory

Research from Social Psychology has found practical application in many fields, including those related to mental health and criminal justice. Areas of research focus on management of human resources, dynamics in human interactions, human behaviour in groups and in various social situations, and control of human behaviour. Within this field, Attribution Theory examines the attribution of cause to behaviour, primarily with respect to internal (personal traits) or external (situational) factors. Errors or bias are a by-product of internal attributions. Practical application of research concerning attributions in the assessment of human behaviour has not been widely pursued.

Attributions may be examined in the context of Criminology. Psychological positivism is the only theory which attributes behaviour to internal factors; its solution is internal correction, or treatment. Classical theory provides external causes of criminal behaviour. Opportunity and the potential for detection are external ingredients of the cost-benefit calculation involved in choosing to commit a crime; deterrence is exposure to new external factors that

affect the calculation. Newer criminological theories, despite important variations, attribute deviance or criminal behaviour to external factors: human interactions, reduced opportunities, results of labelling, legal criteria, location, models, other influences, economic imperatives, survival needs, and other external factors rather than to the nature of the offender.

Various components of Attribution Theory are summarized in Baron & Byrne (1987). Of particular interest to studies of perceptions of mental illness are the sources of error and bias. A table constructed to summarize these errors, and to facilitate future reference, follows:

Table 5: Sources of error and bias in attributions

Author/bias	Explanation
Fundamental attribution error Johnson et al (1984)	[O]ur tendency to explain others' actions in terms of dispositional rather than situational causes. [W]hen we observe another person's behaviour, we tend to focus on his or her actions; the context in which these occur often fades into the background. [We] notice situational factors, but fail to assign them sufficient weight (cited in Baron & Byrne, P.57).
Actor-observer effect Nisbett et al (1973)	[The] tendency to attribute our own behaviour to external or situational causes but that of others to internal ones. [W]e are quite aware of the situational factors affecting our own behaviour, but less aware of these factors when we turn our attention to the actions of others. [I]f we <i>empathize</i> with another person -- try to see the world as he or she does -- our attributions about his or her behaviour become more situational in nature (cited in Baron & Byrne, P.58).
The self-serving bias Miller & Ross (1975); Baumgardner et al (1986)	[O]ur tendency to take credit for positive behaviours or outcomes, but to blame external causes for negative ones. [P]articipants [who viewed themselves either as effective or ineffective at solving personal problems] demonstrated a self-serving bias: they tended to attribute success to internal factors such as their own ability, but failure to external factors such as luck or task difficulty (cited in Baron & Byrne, P.59).

Fundamental Attribution Error results when behaviour is attributed to a persons' internal characteristics rather than to the external situation, or when external factors are not given sufficient weight. The Actor-Observer Effect occurs when recognizing external causes of one's own behaviour, but attributing the behaviour of others to internal causes; work on the Actor-Observer Effect provides a description of empathy: "to see the world" from another's point-of-view. The Self-Serving Bias relieves one of

responsibility for failure, and permits one to take credit for successes.

In a study by Quinsey & Cyr (1986) the assessment of mental illness by psychiatrists and laypersons is examined. Assessment by both groups was correlated with case histories that suggested internal or external causes of behaviour. Research subjects assessed the likelihood of mental illness where internal causes were described. Internal causation is the foundation of medical models of mental health and illness. Officers who attribute behaviour to internal causes, implied in interventions under the Mental Health Act, risk making the errors defined.

This thesis will explore various themes addressed by Bittner (1967) and suggested by the literature survey: referral demographics, the state of police knowledge and training, assessment of mental illness, assumptions concerning mental illness and violence, situations in which mental illness is perceived to be a factor. The attribution of cause of disturbed behaviour, among rural and urban officers, will be compared. Intervention methods and disposition preferences will be examined and compared, as well as differences in perceptions of the outcomes of intervention, among rural and urban officers.

CHAPTER 3

RESEARCH METHODOLOGY

RESEARCH METHODOLOGY

Reinharz (1979) and Keller (1980) criticized the demand for quantifiable data, arguing that qualitative work provides deeper insights concerning the subjects studied. This research is qualitative, meeting the first criticism of traditional sociological research. The actors in the interactions studied were all male; interventions described and attitudes or opinions expressed were all by men. Identification of this limitation meets Cain's (1986) criteria that research should be "gendered". Gelsthorpe (1990) demands that researchers "locate themselves within their work" in order to "hold up to scrutiny" the "notion of subjectivity"(P.93). The development of my interest in the research topic will be described; my bias and some incidents that affected that bias will be identified, as well as reasons for not using a hypothesis and for the choice of research topic.

SOURCES OF SUBJECTIVITY

Personal bias

Goffman influenced my original intention to study the experience of institutionalization. My interest in institutions became an interest in psychiatric institutions during a challenging student placement as "outreach worker" with a "consumer-survivor" organization. My role included supporting efforts to obtain access to social services, pensions, other income, housing and education subsidies, retraining programs, alternative treatments to pharmacological psychiatry, as well as greater access to formal psychiatric services, and compensation for perceived harms. A number of clients sought redress for experiences perceived as coercive or abusive, and encounters with police were discussed. Two reports of police interventions follow; both occurred in the same area where the urban portion of the research was conducted.

In the first account, police were called by friends of a man with a psychiatric history. They were told that a person with a history of violence was in the "manic" phase of his "manic-depressive disorder". The person who called police described an officer "slapping his night stick in his hand" while discussing "what they would do when they found him". The image of the "burly" male officer anticipating an opportunity for violence was presented. This account did not surprise me.

The second account, involving a woman, differs from the first. The account was disturbing; the intervention by officers was not. Police were called by a downtown business owner who considered the woman a nuisance. When they arrived, she undressed and offered to perform fellatio for the older officer. He responded by picking up her clothing and telling her to get dressed. Her complaint concerned physical restraint, not by the officers who transported her but by staff at the hospital to which she was conveyed.

I questioned my respondent; she reported that the younger officer had laughed, but by no other means demonstrated disrespect (according to her definition or mine). A lawyer to whom I referred her case reacted the same way; he questioned her concerning police behaviour, assuming this was the reason for her complaint. He was similarly surprised at their respectful conduct.

Our reactions to those accounts demonstrate our bias. Disrespect and even coercion by police, of persons considered mentally ill, was anticipated. A hypothesis of coercive authority by police toward vulnerable populations would have examined police behaviour from the point of view of that population. A description of police activity based on such findings would be questionable, as described by Scraton (1990): "if the premises of the analysis are flawed, then it follows that the understanding derived from the research also is flawed"(P.19).

Research hypothesis

Prior to this study, I conducted a research project as an assignment for a methodology course. This research sought evidence of coercion in therapeutic relationships, to support the hypothesis that "patients do not consult psychiatrists as a matter of free will". A judicious selection of quotations would have supported the hypothesis. The use of a hypothesis, in an exploration of police perceptions and actions, would have been similarly limiting. Harding (1987) supports conducting research without formulating a hypothesis:

[F]eminist empiricism argues that the 'context of discovery' is just as important as the 'context of justification' for eliminating social biases that contribute to partial and distorted explanations and understandings(...).(P.183)

This research will not proceed by formulating a hypothesis. It will explore information not available in current literature, and thereby add to criminological knowledge. It will explore notions concerning mental illness, and perceived need for intervention as well as actual interventions and their outcomes, without the formulation of a specific hypothesis to be examined concerning differences in the data obtained.

Research topic

Gelsthorpe (1990) demands that researchers "be open and honest about the research process"(P.93), which includes determination of a research topic, and selection of a research population and sample. This study was influenced by various opportunities which arose from my affiliation with the department of Criminology at the University of Ottawa, and with various mental health authorities at the area's regional psychiatric facility. My attention was drawn to the call for submissions concerning community policing by a professor in the department; I responded by proposing an article entitled "Police intervention in the psychiatric community". The Canadian Police College of the Royal Canadian Mounted Police contracted my services to write this article for the *Canadian Police College Journal*, and provided a grant to cover material costs and expenses for transportation and transcription of interviews. My connection with the department and the mandate from the police college facilitated my obtaining permission to interview police officers and emergency psychiatric personnel; interviews were immediately approved by municipal police chiefs and district police superintendents, and by authorities at the regional facility. Authorities who provided permission for the research to be conducted approved the questions to be examined. Commanding officers in stations and detachments selected the respondents with

whom interviews would be conducted; for two interviews the predetermined respondent was elsewhere engaged and replaced by an officer present.

RESEARCH TOOLS

Interviews

Structured interviews are frequently conducted by various authorities in regular information gathering activities: job interviews, driving permit interviews, hospital admission interviews, social service interviews, psychiatric interviews, police interviews. The reliability of data from such interviews depends on respondents' willingness to disclose their truths.

Freud promoted the interview as a clinical tool at the beginning of the twentieth century. The image of a Freudian therapist, effortlessly listening to a client (on a couch, talking) is misleading. A psychiatry textbook by Othmer & Othmer (1989), concerning how to conduct clinical interviews, quantified interviewing skills: "three spontaneous self-disclosures [information volunteered without direction] in a thirty-minute interview" are a standard. Highly skilled interviewers elicited this rate "in eight out of nine cases". Interviewers "who ignored their patients' emotional signals elicited three spontaneous self-disclosures only in six out of twenty-seven cases" (P.23).

Interviews were less frequently used than other research tools in most of the student projects observed¹ during two research courses. Expectations of low data production (such as the described psychiatric standard of one disclosure per ten minutes of interview) and the potential of complete failure to obtain data from subjects unwilling to talk, may have deterred their use. Rules of ethics governing interview use may also explain a low rate of use of interviews. There are far fewer restrictions on data collection methods not using human subjects.

The non-directive interview

Rogers (1945; 1947) devised the non-directive clinical interview, with techniques to facilitate self-disclosure, in a system which became known as "client-centred therapy". The techniques are summarized by Burger (1986): therapists may establish rapport with clients by ... showing "genuineness, warmth, and empathy", and disclosure is facilitated by demonstrating "unconditional positive regard". Judgmental reactions prohibit disclosure; unconditional acceptance establishes a safe environment for communication in which subjects (clients) are "free to express and accept all parts of themselves"(P.264). When respondents speak freely, without fear of disagreement or disapproval, information is less general, less conforming to

¹Personal observation.

institutional viewpoints, and more disclosing of personal experiences and attitudes. Unconditional positive regard was practised during each of the interviews. Disclosures, according to Rogers, will reflect what officers have discovered to be true, rather than what they have been taught to believe; the reliability of their information will increase.

Bertaux (1980) describes a variety of early sociological interview applications, first in the Chicago School where a strict focus on deviance development limited its development as a research tool. Development of the non-directive technique has allowed "more than information" to be provided: a social context is revealed, a "window" to a "unity of meaning"(P.213[trans]) that human beings construct to make sense of their experiences, and to the "little known social universes"(P.216-217[trans]) within which they function. Bertaux (1980) describes interviews as a means to discover the contradictions and uncertainties of human experience, to understand subjects' social rapport and dynamics, to learn their language(P.221[trans]).

Kandel (1972) provides guidelines to ensure non-directivity: the interviewer should intervene only to investigate a particular area in greater depth, or where meanings are unclear. She echoes Rogers, stating that interview data reflects respondents' views only if an interviewer's interjections are minimal, since the wording

and delivery of questions provide cues by which respondents may infer desired answers. Listening rather than asking questions permits unanticipated information to be volunteered, and questions to be addressed rather than merely answered.

Gelsthorpe (1990) emphasized recognition of the contribution of participants who act as research subjects; they "have power and knowledge which researchers need, and the power to withhold it"(P.92). Bertaux (1980) describes interviews as ethically progressive in that their use presumes respect for a respondent as a provider of information, rather than as an object of study or diagnosis. Studies of policing, especially in the area of mental health interventions, are few; such knowledge is lacking. Officers provided knowledge not available from any other sources or by any other means.

While some respondents may be reluctant to provide information, Kandel (1972) found that the reverse may be true during a study with a sample of subjects in mental health settings who demonstrated a willingness to participate without expectation of gain or benefit, in order to contribute to some "collective or individual benefit"(P.30[trans]). Officers were generous with information, anecdotes, descriptions, and with their personal time; there were no possible benefits or gains to encourage cooperation by respondents other than an increase

in knowledge. The experience of conducting interviews for this thesis confirms Kandel's (1972) findings.

Kandel (1972) described limitations of interviews related to the non-egalitarian relationship between dependent subjects and researchers who represent universities, institutions, other authorities. The context of the interview is controlled by the researcher, even when conducted in an environment controlled by the research subject. Differences in social status that favour the interviewer result in adapted descriptions of the "field", often with the intention of helping a researcher to obtain desired results. Oakley (1981) refers to this effect, pointing out that questions used in interviews may not be relevant to the experience of respondents.

It should not be inferred from the quantity of information provided by officers that interventions under the Mental Health Act constitute an important proportion of police activity, since the data does not flow from a general description of police activity. The purpose of the study was identified by letter and recaptured in questions during the interviews. Within the limits of the proposed research, officers responded without direction. Their anecdotes and opinions reflect their own definitions, assessments, observations, attributions, perceptions of the need for intervention, actions and interactions.

RESEARCH PROCESS

Sample selection

The potential population from which the sample could be drawn consisted of all the officers at all the detachments within a sufficiently large geographical area to permit examination of both rural and urban detachments, but sufficiently narrow to keep competing variables to a minimum. Exhaustive sampling and saturation through number, as suggested by Bertaux (1980), with sampling from interviews based on subsequent criteria of representativeness, would have been impossible. Pires (1983) suggests obtaining saturation through diversity of respondents; this was attempted by interviewing police officers, civilian police employees, psychiatrists and psychiatric nurses. Their views differed considerably, and were not a reliable measure of the quality of police interventions. Pires (1983) also suggests that, while a researcher may have a predetermined goal concerning the number of subjects to be interviewed, flexibility is also important. Limiting data to police interviews demonstrates such flexibility, and acknowledges the value of data collected from this unique source.

The size of the research sample was limited by time, geographical, and other constraints. Pires (1983) recommends that where random or exhaustive sampling is impractical, empirical saturation can be achieved and may be

assumed when no new information arises from new data collected. A degree of empirical saturation was assumed as similarities arose among the insights expressed in interviews. One or two rural and urban interviews might have been sufficient to provide information for a comparison, but surplus data to achieve empirical saturation not only increases the validity of data collected, but also affirms the reliability of respondents' accounts. Saturation compensated for technical shortcomings, such as the loss of some citations when the interviewer failed to notice immediately that a side of tape was completed.

Official approval granted through a network of authorities facilitated access to respondents. The study could not have been conducted without official approval and official participation in the sample selection. Officers were preselected by commanding officers on the basis of their experience, or at random on the basis of availability. A "top down" selection facilitated finding officers most likely to have a viewpoint on the topic of intervention with persons perceived as mentally ill.

The field

Canada's capital region, Ottawa-Carleton, includes the three municipalities studied. Various features in addition to their population density meet criteria for definition as urban centres. The neighbouring districts

readily meet the primary criterium to qualify as "rural": sparse population density even in the towns and villages where populations are somewhat more concentrated. Rural populations have fewer employment opportunities, reduced economic activities, more agricultural activity (both subsistence and commercial) than urban populations; they participate in more outdoor activities such as hunting than their urban counterparts.

Officers in rural districts have access (limited by distance and lack of public transportation) to the same resources as officers in the urban area. The urban area and neighbouring rural counties share a severe climate (Ottawa is the second coldest national capital in the world)² that aggravates problems of vagrancy or homelessness. Like eastern Ottawa-Carleton, the rural district to the east is bilingual and primarily French-speaking; like the west end, the rural district to the west is more culturally heterogeneous, and primarily English-speaking. These similarities reduce the potential for competing variables not related to rural-urban differences including language, a variable frequently assumed to be important in Eastern Ontario. The same Ontario Police Services and Mental Health Acts are in effect. Language, climate, resources, and the legislation under which officers intervened were identical for both the rural and urban forces.

²Ulan Bator, in Mongolia, is first.

Data collection

Commanding officers of the police forces studied (Gloucester, Nepean, Ottawa, and Districts 10 and 11 of the Ontario Provincial Police) received written requests and were subsequently contacted by telephone for approval of this project, and permission to approach stations and detachments to interview police officers. Interviews were approved for a detachment to the west of Ottawa (Killaloe), and three detachments to the east (Winchester, Casselman, and Hawkesbury). Chiefs and superintendents provided names of staff sergeants and sergeants, who suggested respondents and provided individual permissions for interviews. Letters written to the heads of each detachment, with copies forwarded to appropriate superintendents and chiefs of police, defined the topics to be addressed as follows:

- . from whom are requests for assistance or referrals received? (agencies, families, observers, other)
- . what types of requests for assistance or referrals are received? (violence, nuisance, danger to self or others, incapacity to manage own affairs, etc.)
- . what criteria are used to determine whether interventions should be made?
- . what types of interventions are made?
- . to whom are mental health clientele referred? (hospitals, agencies, families, police custody, etc.)
- . what follow-up if any is made after referrals?
- . what resources or specialized training would facilitate your police force's interventions among this clientele?

Permissions were granted by staff sergeants, sergeants, acting sergeants of provincial (rural) detachments, and by

chiefs of police, personnel supervisors, and staff sergeants in municipal (urban) forces.

One interview at each detachment or station was the target, but the recommendations of persons authorized to grant interviews were followed. Permission was difficult to obtain for one detachment where the chain of command was in the process of changing. A similar unit was suggested by the superintendent, and interviews subsequently conducted at both locations. Some station commanders arranged one interview; some two. Two station commanders (one rural, one urban) participated in interviews and also arranged an interview with a constable. A group interview, suggested by a rural station commander, proved impossible to arrange. Some interviews arranged by station commanders were with civilian actors, responsible for victim assistance, counselling, and training. Material from non-police interviews was not analyzed for this study.

Ethical concerns

Guarantees were made in writing to commanding officers, at the time interviews were first requested, as follows:

No information will be solicited on specific cases, nor will names be required. I will, however, credit anyone who is willing to be credited for his or her assistance or cooperation. I would appreciate any reflections, anecdotes, or experiences that officers wish to relate which might typify differences in urban and rural policing.

A copy of this letter is appended. Each of the respondents cited as a contributor to this thesis agreed to be recognized by signing a permission form to that effect. Respondents confirmed their willingness to be interviewed, the absence of coercion toward cooperation, and their right to refuse to answer any or all questions in a permission form signed by each respondent, a copy of which is appended.

Following the interviews, personal letters were mailed to each respondent, supervisor, district commander, chief of police, and hospital authority, thanking them for their participation. A sample of these letters is appended. Some of the officers requested information concerning resources which was provided following completion of the research. A copy of the article intended for publication in the *Canadian Police College Journal*³, outlining the major findings of the research, was mailed to each of the respondents.

Studying a population with power and authority resolves ethical issues that arise and limit reliability of data in interviews with vulnerable populations such as prison inmates, psychiatric patients, students, persons with public lives discussing private situations, etc.

Interviewing research subjects in a position of authority eliminates acculturation effects (see Kandel, 1972).

³The study was commissioned for a special edition of the *Canadian Police College Journal* concerning community policing, cancelled due to funding cutbacks.

Respondents determined dates and times of interviews, which were conducted in private at their stations, at their convenience. Officers set time limits for interviews, and ended interviews when they wished to do so.

A departure from non-directive interviewing occurred in the three interviews with women: a psychiatrist, a psychiatric nurse, and a victim assistance worker. Female respondents demanded information concerning the research project, its possible uses, and its progress. A case might be constructed that research subjects may expect answers as forthcoming as those they provide. Male respondents asked only for clarification of research questions and whether I had enough information; one rural officer also asked for more information concerning nearby urban psychiatric services.

Data selection

Fourteen persons were interviewed, eleven men and three women. Among social workers and psychiatrists, both men and women were interviewed. Mutual disclosure only occurred in interviews with women. All interviews with women, or with persons other than police officers, were in urban locations. Since all of the interviewed officers were male, limiting data to police interviews eliminated both gender and professional outlook as competing variables, and balanced the urban and rural representation.

From the remaining three urban and six rural interviews, the seven of best technical quality were transcribed. All three urban, and four rural interviews provide data for analysis. Five interviews -- three rural and two urban -- are with constables. Two of three rural constables were preselected by commanding officers and interviewed by appointment; one rural and both urban constables were selected by commanding officers when I arrived at the station. The two commanding officers, an urban sergeant and a rural staff sergeant, volunteered interviews which were conducted by appointment. All respondents had experience with interventions under the Mental Health Act.

All rural officers had experience as community officers or community relations officers; two of the urban officers had served at urban community substations. Among urban officers, two had fifteen years or more of experience and one had five years of experience, in the municipal force where they were interviewed. Rural officers all had fifteen years or more of experience, and all had served at least ten years at the detachment where they were interviewed. Length of time at a particular location, a potential variable in studies conducted with provincial (or federal) officers who may be transferred to different areas of the province (or country) throughout their careers, did not differ sufficiently to act as a competing variable.

Urban perceptions were provided by municipal officers from three detachments currently united as the Ottawa-Carleton regional police force. Rural perceptions are from the provincial officers of Districts 10 and 11 who patrol a semicircle up to 200-kilometres from the Ottawa River, from Algonquin Park to the Quebec border, the area surrounding the regional municipality.

Conducting the interviews

Rural interviews were conducted from October to December 1992. Urban interviews were conducted from December 1992 to February 1993. Interviews were conducted during winter months and road conditions were often hazardous. One snow storm made arrival on time (by bus) impossible for an urban interview; becoming lost on the highway prevented my arrival on time at one rural detachment. Another snow storm led to an urban interview being conducted with a different officer from the one with whom an appointment had been arranged.

In each case I introduced myself and was referred to the station commander, to whom I provided a copy of the letter which had been earlier mailed. The same letter was subsequently shown to other respondents, which all but one officer remembered reading. In one urban detachment the staff sergeant introduced me and explained the purpose of my interview to a constable who had not read the letter, with

whom an interview was subsequently conducted. A private room was provided for each interview.

Most of the officers appeared comfortable with interview conditions and positive about participating. One rural officer appeared reluctant, claiming that his everyday experiences really were not "all that interesting"(B); he nevertheless disclosed useful information which contributed greatly to this study.

Time restrictions were identified prior to commencing interviews. Interviews were recorded using a professional quality Bell & Howell tape recorder borrowed from the University of Ottawa's Audio-Visual department. A microphone on a stand was kept within officers' view at all times during each interview. Each respondent provided at least 45-minutes of interview data (one side of a 90-minute tape); two rural and one urban respondent filled both sides of a 90-minute tape. My late husband transcribed the interviews which I proofread and punctuated. Transcriptions show long passages without interviewer interruption, supporting definition of the interviews as non-directive.

Interview content

The opening consignment (or prompt) used for each interview was either as follows or a variation thereof:

I would like you to describe for me your personal experiences with the psychiatric community, and perhaps we could start by your telling me about a typical situation in which the police might be called to intervene.(author)

The expression "the psychiatric community" was confusing; the first response to the prompt was: "Okay, but first off, Marian, would you define for me what the psychiatric community is?"(A). Urban ghettos near psychiatric facilities and group identification of persons diagnosed with mental illness, or "psychiatric communities", are not apparent in rural areas.

The demanded explanations included "users of mental health services" and

Persons labelled psychiatric, whom you observed behaving in a way that indicated the presence of a psychiatric problem, who identified themselves as psychiatric patients, or who were so identified by the person requesting assistance.(author)

The vague definition proved useful in several ways. First, it placed officers in a position of control of the interview; secondly, officers referred to their own definitions of mental illness and perceptions of persons who are mentally ill. Whether their actions may formally be defined as intervention "under the Mental Health Act" was less important than whether officers perceived the presence

of a mental illness. Situations examined represent officers' perceptions of mental illness, regardless of outcome of intervention or other assessments.

Sub-prompts were as indicated in the introductory letter, given in the preceding section and appended in full. Most of the officers had read and remembered seeing this letter. Officers were at times asked to expand, or to illustrate experiences related. Each officer was thanked for his time and participation, summarizing and affirming the value of their information as suggested by Legras (1972), in recommendations concerning comfortable termination of interviews. Several officers, at the end of interviews, expressed an interest in making their knowledge available to other officers, who might encounter similar challenges in interventions with the population of interest.

Data analysis

Three years elapsed between the collection and final analysis of research data. Interviews were completed in 1993; the thesis was completed in 1996. References to legislation or policing guidelines reflect those current at the time of the research. Readers might anticipate that officers' perceptions would change with changes in legislation, but none of the changes affect the criteria by which officers may assess the need to intervene.

Five principal themes were determined. The first,

referral information, concerns the information with which officers are provided, directly or via a dispatcher, or which they observe in the absence of a report prior to any decision to intervene. This theme includes perceptions of frequency, demographics, referral sources, why police are called, and by whom. The second group of citations could broadly be defined as knowledge, including police assumptions, learning, training, experience, and familiarity. Differences in knowledge and sources of knowledge concerning mental illness, mental health concerns, mental health issues, psychiatry, psychiatric interventions, and psychiatric treatment were explored. The third theme explored concerns perceptions of settings, persons involved, behaviours, causes of behaviour, and other features of situations observed by officers. The fourth theme became intervention: all of the actions by police to assist a person suffering from a mental disorder, or to protect others or themselves, prior to decisions concerning disposition. The final theme, concerning interactions, is explored within a framework of potential outcomes. Interactions with community, medical, and legal authorities are explored. Dispositions in this chapter include community referrals, institutional referrals, and a final disposition, criminal justice processing, which concludes the chapter and the data analysis.

Actual citations will be provided as data, using

officers' descriptions of interventions under the Mental Health Act to explore the world in which they exercise their duties in this context.

The information provided by officers seems exceptional in quantity and quality, as may be anticipated from non-directive interviews conducted with Rogerian "genuineness, warmth, and empathy". The "Actor-Observer Effect" describes empathy as an understanding of the external factors to which persons attribute their actions. A perception of empathy may result from requesting explanations of actions and descriptions of circumstances. Attention to the context of interventions, and uncritical acceptance of officers' perceptions, created an atmosphere that facilitated disclosure.

Criteria concerning ethics, validity, and reliability were met and qualified by the choice of research subjects, topics, themes, tools, and methods. Many research decisions were made *ad hoc*, respecting the needs of research subjects. Criticisms based on research norms have been addressed. The reader is provided with sufficient information to determine, on examination of the data, whether its exploration contributes to knowledge production in Criminology.

CHAPTER 4

REFERRAL INFORMATION

REFERRAL INFORMATION

This chapter explores how referrals are made to police that may require intervention "under the Mental Health Act". Demographics and frequency of such referrals will be examined, as well as sources of referral and reasons for referral. Differences in rural and urban officers' perceptions will be highlighted.

DEMOGRAPHICS

Bittner (1967) described a common perception among the officers he interviewed that few calls resulted in referral for mental health services. Questioned concerning how often he might see a person who appeared mentally ill, an urban officer stated "that's something that an urban police officer would see pretty much every day"(E). Another urban officer explained that while many persons are referred whose behaviour signals a mental illness, "actual calls that require arrest, or some kind of enforcement under the Mental Health Act, is very minimal"(G). Rural officers' perceptions were similar: mental health interventions were perceived as rare although "there's a lot of people out there that are considered crazy"(A) and "quite a few people that act a little bit strange"(B).

Emergency admission statistics for the regional psychiatric facility (provided in the theoretical framework

of this thesis for October 1993) rank police as the second most important source of referrals at 14% of emergency psychiatric admissions (following self-referrals at 49%). Despite the high ranking of police referrals compared with all referrals to the psychiatric emergency service, according to officers' perceptions the ranking of such interventions compared with all police activity would be low.

There was little variation with respect to age and gender of persons referred for police intervention under the Mental Health Act. Two rural and two urban officers each described one referral involving a woman; all other referrals and interventions concerned men. One rural officer described frequent referrals and interventions involving young persons; all other descriptions, both rural and urban, concerned adults.

SOURCES OF REFERRALS

Urban officers described calls coming through a dispatcher, who receives the original referral:

Switchboard takes the calls and the communication staff generate a case. And they would dispatch us. We are on a mobile data terminal system, so all our calls are computer dispatched. (...) At the top part of the call is, there is a narrative portion which gives us a brief outline as to what is going on. (...) If I'm not clear on what the content of the call is, I'll ask the dispatcher to, the dispatcher to either call back and get more information, or we'll ask for a member of the family. (...) And then

they are changed to what we call a ten-fifty-nine code, which is a mental person. (...) A mental, mental health call would be what we'd call a ten-fifty-nine or a ten-fifty nine call. (Officer F)

Rural officers did not mention dispatchers or identifying number codes for such calls.

Sources from whom police (rural) or dispatchers (urban) receive referrals were identified. These calls may be categorized as familiar, coming generally from family members or near neighbours; instrumental, coming from mental health or other community authorities; and anonymous, coming from an unidentified source or a person not familiar with the person referred. For rural officers, familiar referrals were the norm:

Mostly intervention is, is done because somebody, somebody from a home will call and say, "Ah, my husband, my brother, my son, or whatever is acting crazy." (Officer A)

Usually [it's] the family member that calls, or a person next door if the family's not immediate. (Officer B)

Urban officers described both familiar and anonymous referrals as the norm, with a majority of familiar referrals:

They basically come from two, two camps. One would be that the family members, those closest to them, to this person, saying that, "I believe he needs help. I believe that he hasn't been taking his medication. He's becoming more aggressive, more violent, more hostile," whatever, wanting us to, to help out. The other might be a type of call where it's anonymous. It's someone on the street has noticed somebody doing something and feels that that person is a danger.

(...) I think basically the majority of calls would come from someone of -- a family member or close friend that's seeking some assistance. (Officer E)

Calls from business persons may be anonymous, or from persons who are familiar with the person referred. Such calls suggest nuisance rather than threat. One urban officer describes anonymous referrals:

A lot of the calls that, like I say, the people from [residential facility] will be down in [shopping centre] and somebody will call and say, "there's this really weird looking lady standing in front and she's gawking in my window and she hasn't moved for an hour. I want her out of here." (Officer F)

A rural officer describes similar referrals, clearly not as anonymous:

Business people will oftentimes call and say, "hey listen, you know so and so is causing a real problem. Maybe they're acting out." Not that -- the proprietor is not looking to cause this person any problems. He's not looking to get him arrested or anything like that. He's just saying, you know, "this person is being a nuisance; it's your responsibility as a policeman to come take this guy away." (Officer A)

An urban officer summarizes that "the majority of calls that we take relate to those within a family type atmosphere, where that black sheep is causing problems" (E).

Referral sources fitting Bittner's (1967) description of persons "in some sort of instrumental (professional) relationship" to the referred person were also reported. Both rural and urban officers described

being called by hospital staff for assistance with a patient. A rural officer described a possibility:

If we get a referral it'll be the likes of a night nurse at the hospital saying, "Hey, we've got this person here who is totally uncontrollable. Will you come in and help us secure this individual?" That's the kind of referral we would get from an agency. (Officer A)

An urban officer described a regular occurrence:

We have a very good relationship with the [general hospital with a psychiatric ward], which is the only psychiatric unit here in [town]¹. And yes, we get there. Their staff are trained but as of late, they have been calling us when they have a violent patient and because their security -- they have, I think they have only one secure bed, and it's just a room like this, it's a locked unit. (Officer F)

A rural officer described police as more likely to refer persons to mental health authorities than to receive referrals from them: "very seldom do we get a call from an agency; agencies get calls from us" (A). The officer described relations of mutual referral and assistance; officers may provide security for community mental health workers:

If they [mental health workers] have to go over and visit a client that they're a little leery of, they will call us on occasion. (...) Just for their security, for their peace of mind. (Officer A)

Child protection authorities were a source of referrals for both groups, as described by an urban officer:

¹The names of all cities, towns, or villages will be replaced with "town".

We have more problems with the Children's Aid Homes. Because we have a lot of kids in there that have an awful lot of psychiatric problems. (...) The foster homes, or the residential care units, emergency care units and that. These kids are -- a lot of those kids are very violent. (Officer F)

A rural officer states: "we work very close with Children's Aid"(C); another provides several accounts in which youths in foster homes are involved. One rural incident involves a teacher, but does not result in an intervention under the Mental Health Act.

Sources of instrumental referral differed among officers in this study and those studied by Bittner (1967). Bittner's range of instrumental relationships was greater; officers in this study did not report lawyers, employers or landlords as a source of referrals. The greatest source of instrumental referral in urban accounts were institutional health authorities; in rural accounts community health authorities were the most frequent source of instrumental referral.

Interventions under the Mental Health Act may also be the result of self-referral, although no urban examples were provided and one rural officer discounts this source: "like, it's not the person themselves that calls and says 'I need some help', it's never that way"(B). Two other rural officers described three incidents of self-referral. One officer describes a self-referral from "a gentleman that used to phone me from a nursing home"(D), whom he collects

and takes along to deliver a summons, and one from a youth in a foster home: "he phoned me, and he's whispering on the phone that he's really mad at the people keeping him and he wants to kill them"(D). Another officer describes the third self-referral: "If J... hadn't of walked in, within five minutes I would have had calls from all over town because this guy was around"(A). Rural references to "calls from all over town"(A) resemble anonymous urban referrals from "someone on the street"(E) who "has noticed somebody doing something"(E).

REASONS FOR REFERRALS

Bittner (1980) states that "police work consists of coping with problems in which force *may have to be used*"(P.138) (emphasis in original). An urban commanding officer concurs:

Most of the time people don't want to get into physically restraining people, and they rely on us. They feel that that's our training, that's our job.

Int Mm-hmm.

Res To physically restrain.(Officer F)

A rural commanding officer also describes the perception that the use of force is part of the police mandate: "people feel better with the police because they feel, 'the police - - well they're just there to uphold the law, or enforce the law'"(C). When force must be used, or is perceived necessary, only police are authorized to employ it.

According to a rural officer: "when people get

scared, who do they call? They call the police"(A). Fear frequently motivates familiar referrals, according to an urban officer: "you never think of a member of your family becoming violent"(F), but when they do "they've become afraid, and then they back off, and they call us"(F). It motivates anonymous urban referrals:

They're not really doing anything, but they certainly look dangerous: "they look the part of someone I should be afraid of (...) and perhaps the police should be aware of this person, and get involved."(Officer E)

It motivates the less anonymous rural referrals of "people that didn't fit within what people call normal, and because they're not normal, they tend to frighten people"(A). Officers provided fear as the foremost reason persons will call the police, rather than managing situations themselves.

Annoyance is also a frequent reason for referral.

Annoyance referrals are described by an urban officer: "quite often it can be something as simple as walking down the street and talking to themselves, and being an apparent nuisance"(E). Rural officers described annoyance referrals from neighbours: "this individual was playing his music too loud"(A). Urban officers also reported annoyance referrals by neighbours: "we just get calls because the neighbours were tired of hearing the fights and that"(F).

"Lost persons" were described as a reason for referral by both rural and urban officers. A rural officer describes referrals from a shopping mall: "they'll get lost,

or they'll need help and people don't understand them, and we get called"(F). Rural lost person descriptions involved family referrals: "if he took the wrong turn then he'd be lost (...) his wife would call us"(D).

Police were frequently requested to intervene because persons with mental illnesses failed to follow their regular medication regimes:

The family members don't know how to deal with it because they can't tell that person to take more medication (...). They're aware of what could happen if this person doesn't start to take his medication again (...). Maybe they know from previous experience that this person could become a danger suddenly, if he doesn't get back on medication. So I think maybe that might be the basic type of calls we would take.(Officer E)

Perceptions concerning the importance of medication will be discussed further in the section concerning police knowledge.

An urban officer provides escalating violence as a reason for a familiar referral:

The parents were of the old generation that they could look after everything themselves, didn't need police intervention. The boys could fight inside the house all they wanted. (...) Finally, the day came when one of the brothers got mad enough he picked up a steak knife. Well, they thought maybe they couldn't handle that one, so they called us.(Officer F)

A rural officer describes violence as a reason for a familiar referral in a case of behavioral change: "he has not been acting rationally lately, and he's violent toward

his wife"(A). Behavioral change that does not include violence may provoke similar concern, according to the same officer:

[T]he family realized this right away, like, "what's the matter with F..., he's so quiet and withdrawn (...). What's the matter with him? He hasn't been drinking, what's going on?"(Officer A)

Violent behaviour was cited as a reason for referral by both types of officers; referrals that did not involve violence were more frequent in rural accounts. Suicide attempts figured more strongly as a reason for referral in rural than urban accounts. One of many rural examples involves a referral from a friend: "he phones a friend to say goodbye - a very intuitive friend"(A). A rural officer adds that the referral source is: "usually a family member in case of suicide"(B).

This chapter has examined the perceived frequency of calls for intervention where persons referred to police appear to be suffering from a mental illness: officers described frequent encounters but claim a low proportion resulting in intervention under the Mental Health Act. Rural officers report direct referrals; urban officers are alerted by a dispatcher. Most such calls concern adult males.

Most referrals were familiar but urban officers also described anonymous referrals as frequent. Allusions to the

lack of rural anonymity have been made and will be further addressed in the following chapter. Only rural officers reported self-referrals. Urban officers received more frequent requests for assistance than rural officers from hospital authorities. Urban officers did not describe referrals from community mental health authorities, frequent in rural interviews; only rural officers described self-referrals. Both groups described child protection authorities as a source of referral, as well as institutional mental health authorities.

Reasons for referrals were similar for both rural and urban officers. Police assistance under the Mental Health Act is requested when force is required and when persons are unable or unwilling to manage situations themselves, as identified by Bittner (1980; 1967). Although the Mental Health Act limits intervention to circumstances where due to a disorder or incapacity a person threatens to harm him/herself or another, intervention may be demanded when persons are afraid, or merely annoyed rather than threatened. Urban officers did not include threats of suicide, a frequent reason for rural referrals, except in circumstances where other factors were also involved. Urban officers described escalating violence and rural officers provided unusual behaviour, violent and non-violent, as a reason for referrals.

CHAPTER 5

***TRAINING, KNOWLEDGE
AND FAMILIARITY***

TRAINING, KNOWLEDGE, AND FAMILIARITY

Knowledge may be expert, from learned sources, or experiential. In the context of police intervention under the Mental Health Act, expert knowledge may be learned through training, study, and contact with mental health or other experts. Experiential knowledge is learned through experience during other interventions -- under the Mental Health Act or another authority -- or through some other association with the person who is the object of referral or intervention. Knowledge will be examined to determine officers' means of assessing the need to intervene under the Mental Health Act.

POLICE TRAINING

Interviews were examined for references to training. A rural officer explained that training is an incomplete source of guidance in how to intervene: "It's fine and dandy to say, 'the book says if you do this and this and this and this', but there's always something that the book forgets to tell you"(B). The officer states that every situation is different:

Every time you go to a situation where there's an attempt suicide or a mental person, you always learn from it. (...) There's always that one thing that might be different. And you'll say, "well next time I'll know; I'll do this." And you learn

from experience. And that's the only way you do learn, is from experience. (Officer B)

Rural officers described only regular police training, applicable to all types of interventions. A rural officer stated: "we don't really get training in how psychiatric people, you know, the different conditions, how will they react and what they do" (A).

Urban officers described various types of training. At one station, a commanding officer described sources of mental health training:

About once a year we get a, we end up going to, through, some sort of a retraining session on mental health. Not necessarily the Criminal Code or the Mental Health Act applications, but we normally have the nurse come in, or doctor. And last year we spent a full day with the staff from the [regional facility]. And they just reviewed some of the things to look for, some of the behaviour problems to look for in schizophrenics. (Officer F)

Urban respondents (an officer at one urban station and a social worker at another) provided material from a program delivered by a national mental health agency, to which officers in two of the three urban areas had been exposed. The program¹, which is in widespread general use, teaches recognition of suicidal behaviour and the interventions appropriate for such cases.

The urban commanding officer described training

¹The *Alberta* or *Foundation* model is copyrighted training for suicide intervention, delivered across Canada by various licensed health and education professionals.

specific to intervention under the Mental Health Act as "quite adequate at this point"(F). He states that "we teach officers safety is the number one priority"(F), emphasizing that "when you're dealing with a mental patient you want both parties to come out of it without being hurt"(F). The officer suggested more time could be usefully spent "to get practising communication skills"(F). He qualifies this recommendation, however, stating that "nobody reacts the same way as in the classroom presentations"(F). This being so, the officer considers experience more important than training: "there's nothing like experience."(F).

Both types of officers described training in interventions but only urban officers had received training specifically related to interventions involving mental illness. Rural discourse concerned only regular police training. Training was described in both groups as inadequate for interventions involving mental illness; both groups emphasized the importance of experience.

POLICE KNOWLEDGE

Police officers' expert knowledge determined by training was shown to have shortcomings. Other sources of knowledge received equal credit from an urban officer: "intuition, common knowledge, interpersonal skills: it all clicks in"(G). "Common knowledge" may represent current social assumptions about mental illness, as described by

Bittner (1967):

[T]he views and knowledge of the police about mental illness are in close agreement with the views and knowledge of the public in general. Policemen, like everyone else, appear to have a correct conception of the nature of mental illness, in terms of standards of modern psychiatry (...).

Current knowledge concerning mental illness, as demonstrated by the examination of literature in the theoretical framework, varies considerably among experts. Disagreement among learned authors parallels disagreement among psychiatrists with respect to the need for intervention, as well as diagnosis and appropriate treatment for a single patient's pathology, in medical venues. It is reflected in disagreement among expert witnesses from that field with respect to a person's fitness to stand trial or to be released, in criminal justice venues. Psychiatry is not an exact science; its practice is subjective. Officers' knowledge similarly varies. Social or individual behaviours of mentally ill persons and characteristics associated with or mistaken for mental illnesses were described.

Social characteristics

Social behaviours typical of persons perceived as mentally ill were described. A rural officer explains that urban mentally ill persons "who have psychiatric problems tend to ghettoize around the facility"(A). The officer describes persons "living in subsidized areas or they're

living on welfare or whatever, and they really have, don't have a lot to their name"(A). Most such persons have the capacity to look after themselves, according to an urban officer:

They're people who under the proper medication can deal with their lives somewhat effectively, although certainly not the same as may you or I. But they can deal with the day-to-day basics of life.(Officer E)

The urban officer describes an excluded group: "they tend to stick, stick to themselves"(E); its members have communication difficulties: "who knows what they're thinking -- they don't seem to be sharing it with anyone"(E). Other activities were also described:

They're just doing what they normally do, and they're just taking their time, you know. They may just be, maybe appreciating what they're looking at, something a lot of people, a lot of us don't get, can't do because we live in the fast lane.(Officer F)

Speech and mannerisms were key indicators of mental illness:

You can tell by a number of ways: maybe by the way they're speaking to themselves, maybe they're, they're not very hygienic in appearance. And perhaps their, just their mannerisms, might indicate to you that they're having problems.(Officer E)

Assaults without provocation are included: "for no reason, somebody has gone off and assaulted somebody"(F), states an officer. "They tend to pick on people they don't know"(F), he adds, and contrasts normal behaviour: "you and I, if we get mad, we get mad at something for a reason"(F).

From citations drawn from rural interviews, an

episodic quality of mental illness may be inferred. Some of the persons with whom officers intervened were well for long periods, and experienced intermittent periods of mental health problems known in mental health jargon as an "episode". In one example, the episode was related to time:

She'd be all right for six months and then (...) she'd have a breakdown (...) We brought her in to the hospital, on the Form-One, and she'd be in there for a few days. She'd come back out, and she'd be normal again for six months. (Officer C)

An episode may be the result of a stressful social situation:

He had a history of psychiatric problems, okay? And he was also violent. And he freaked out at his sister's wedding and started attacking people. (Officer A)

Memories of severe trauma may surface and provoke an episode:

She keeps on having flashbacks, and going back to the time of the Second World War (...). She's there pounding on the door. (Officer B)

Each of the rural interviews provide citations such as "we always have this cycle"(D); "he gets violent from time to time"(D). In a single instance where an urban officer had more than one intervention with the same person, the single urban instance of intervention with a woman, episodic variations in behaviour are also described: "somewhat of a pendulum swing"(E).

Particular disorders

Rural officers made few generalizations; urban officers frequently provided characteristics associated with particular mental illnesses. One officer provided traits associated with schizophrenia:

If the guy's good at hiding his emotions -- if he's good at conniving, and he knows how to manipulate people and that, and I think that's one thing about schizophrenics, is that they can be very manipulative. (Officer F)

and some behaviours:

Somebody's having a seizure or he's having an episode from schizophrenia and he'll be talking to himself very loudly, and you know you have a schizophrenic person on your hands. (Officer F)

Some conditions are more visible than others:

Somebody with Down's Syndrome, you can pick them out of a crowd fairly quickly. But there are a lot of older adults that are handicapped -- er, not handicapped, excuse me, wrong term -- that are suffering from a disability that, that you would know once you start talking to them. (Officer F)

Persons with some disorders, according to the officer, require different treatment from persons with other disorders:

Manic-depressives are really a bit different. You have to be very very patient with them. And you have to allow them to come back at their own speed. You can't force a manic-depressive to -- if they're at the last stages of the depression, where they don't have any emotions left, or they feel that the only way out -- you have to, you have to work with them to bring them back. (Officer F)

Some disorders were confused: "it was very obvious that he had severe schizophrenia, and he was working split personalities"(F). The only rural generalization, also made with respect to schizophrenia, concerns medication (the topic of the following section): "I guess it's a trait in some paranoid schizophrenics to hoard medication"(A).

Medication

All of the respondents discussed medication. Faithful adherence to a medication regime was considered by officers to be essential to maintaining the mental health of persons diagnosed as mentally ill. Episodes and reoccurrence of symptoms are generally attributed to failure to take medication. An urban officer states: "most of the calls dealing with that are people who are schizophrenic, or off medication"(F). A rural officer describes observing whether a medication regime is followed: "I can tell -- oops, he's off his medication"(D). An urban officer states: "once they've decided that they don't need the medication anymore (...) it just snowballs into a problem"(E). The pattern of taking and not taking medication is described by several rural officers. "When he takes his medication he feels better and when he feels better he stops taking it"(D). Abuse of medication is considered common and persons threatening suicide may be anticipated to accumulate medication. A rural officer describes an incident: "we were

concerned that this person had, had a cache of medication (...) that he could take all at once to do extreme harm to himself"(A).

Violence (including domestic violence)

The threat of violence is a frequent theme in all interviews. An urban officer states in general: "the possibility of violence is always very strong"(F), and in describing a particular assessment: "he might be, just at this point, just very psychotic and given the opportunity, kill anybody"(F). Urban officers associated mental illness with violence. Generally, familiar calls are generalized as involving persons "acting in a violent or an aggressive way towards the family"(F). Rural officers not only did not associate violence with mental illness, they associated mental illness with an absence of violence: "they're a little off centre, but they're not a danger. If they're a danger to anyone, they're a danger to themselves"(A). Precautions were taken in the event of violence, and violence anticipated in particular cases, but no general association of violence and mental illness was made in rural interviews. Despite accounts of specific incidents in which violence occurred or was threatened, a rural officer states of mentally ill persons in general: "I've been here for eleven years and I haven't really come across any real violent ones"(B).

Mental illness was frequently linked with domestic violence in both types of interviews. A rural officer stated that referrals due to domestic violence involve a mental disorder "30 to 40% of the time"(B); an urban officer also attributes domestic violence to mental illness: "we find out that the domestic is the result of a person with a condition, whether it be schizophrenia or something like that"(F).

Suicidal behaviour

Suicidal behaviour is frequently associated with depression. Urban accounts provide depression as a reason for suicidal behaviour, and consider threats more frequent than previous attempts:

There have been people present. They say the person has been very depressed lately, but they've never tried it before or they've spoken about it somewhat and never been believed. I think that maybe those are the types of encounters that we get, and the types of responses we get. As opposed to, "yes, he's tried this before and before and before." I think that normally it's maybe been the other way: depressive and, and maybe speaking about it somewhat.(Officer E)

A rural officer includes alcohol: "suicides, attempt suicides, it's alcohol and depression"(B).

Officers described frequent experiences with suicide attempts and suicidal behaviour. Urban officers minimized suicide attempts: "the person could have tried a little harder and been successful"(E), states one, and another: "he

was an attention seeker, he was mentioning many times that he was going to kill himself that night"(G). One urban officer claimed to be more familiar with completed than attempted suicides, explaining: "my experience has been the number of suicide-type calls that I've been to have been successful suicides"(E). Concern regarding attempted suicide is more evident in a rural officer's description, an argument with a doctor concerning the need for intervention: "there is his suicide note, there is his rationalizing for shooting himself, and you're telling me that there's nothing wrong with this guy?"(A) He explains:

People don't do that kind of stuff, you know. They don't put a shotgun to their heads, they don't, you know, as a bluff or a threat. They will maybe say: "if you do this" or, you know, "if you won't do this, then I will do this." But they don't actually go through with it, as a bluff. So there's something wrong with this guy's head, at least temporarily there was.(Officer A)

Rural officers acknowledge suicide attempts more readily than urban officers. Whether this is an outcome of urban training may be debated.

Suicidal behaviour, by which a person may cause harm to him or herself, is a criterium for intervention under the Mental Health Act. It frequently appears as a topic of officers' discourse concerning intervention under the Mental Health Act. It represents what Bittner (1967) calls a serious psychiatric problem. Completed suicides are investigated by police and therefore represent what Bittner

(1967) calls a serious police problem. Bittner (1967) states that both must be present for police to intervene with mentally ill persons; ironically this seems to be the case in urban interventions for the behaviour that is most clearly defined in each of the Mental Health Acts.

Physical strength

Urban officers associated mental illness with such stereotypes as unusual strength and inability to feel pain: "their pain thresholds aren't anywhere near what ours are"(F), states one officer. One officer describes common assumptions that support the stereotype of extraordinary strength.

It seems to be a well-known fact that people who are suffering somewhat tend to be, to be able to give a lot of pain. They tend to be quite strong quite often. They don't know their own strength, and they may not know what they're doing, and they may tend to strike out at the people who are trying to help them.(Officer E)

Extraordinary strength is particularly associated with schizophrenia; the officer claims this assumption as specialized knowledge:

As you're probably aware, schizophrenics can have a tremendous amount of strength! And we find that, sometimes what looks like a wrestling match, we're being thrown away. I have seen young men in good shape that are schizophrenic, at the last stages of severe schizophrenia, and they could pick me up and throw me across, across the room, and I -- there'd be nothing I could do about it, you know. Their strength is just tremendous and the general public don't, don't realize

that. And until you've been involved in something, if you've ever been involved in, a nurse or a doctor involved in that part of the health care system, you know well in advance how strong these people can be. (Officer F)

Rural officers associated extraordinary physical strength with drug use, rather than mental illness.

Drugs (including alcohol)

Officers in both categories explained that drug use caused behaviours similar to those associated with mental illness. As stated, a rural officer attributed extraordinary strength to drug use:

The old days -- the early seventies -- all these mind-bending drugs, all these hallucinogenics (...) like L.S.D. and speed (...) Those were scary days. The strength that these individuals had was incredible -- absolutely impervious to pain. (Officer A)

An urban officer contrasts disturbed behaviours related to the use of cocaine and to schizophrenia. Cocaine causes people to "bounce off the walls for an hour and then they'll lay down and in the morning they'll wake up hurting" (F). By contrast: "the schizophrenic at some point in time will [only] give up the behaviour for a short time" (F).

Their behaviour is ongoing. They can spend a whole night standing, going back and forth, exhibiting signs of the behaviour. Like, you know, they just don't slow down. (Officer F)

Both types of officers associated episodic disturbed behaviour with the use of alcohol, and rural associations of

alcohol and suicide have been cited. In general, urban officers explained that "alcohol plays a big part here"(F), and that alcohol makes mental illness more difficult to manage: "you cannot effectively communicate with them if they are, if they have a high level of alcohol in them, or medication in their system"(F). Problems caused by alcohol abuse and mental illness are similar, and mutually aggravating:

The people they refer to as scary are sometimes alcoholics like those, the street bums, for want of a better term. And whether or not those people are, like I said, suffering from any kind of mental problems or whether it's, you know, what came first, the alcohol or the mental, or the mental or the alcohol, or whatever? It's hard to say. (...) I'm not sure if it's the alcohol that's deteriorated them or not. (Officer E)

A primary distinction between rural and urban officers concerns training: rural officers described no training in mental health problem recognition; urban officers described such training delivered by institutional mental health personnel. This difference may have contributed to a difference in police knowledge, with urban officers making generalizations concerning mental illness with far greater confidence than rural officers.

FAMILIARITY

Analysis of the material related to familiarity with clientele demonstrates that background information is valued by both types of officers. An urban officer states: "we've tried to get as much background information as we can"(F). Discoveries of a prior psychiatric history are frequent.

Any calls that we really get for a "mental person call", as we classify it, most of those are the straight, the straight-forward, the more simpler of the type. They've already had intervention with the hospitals.(Officer G)

Discovery of a prior criminal justice history is also frequent, and much background information may be obtained from fellow officers. An urban officer describes consultation among officers:

When you go to that call, "I was there last week", "I was there a couple of months ago and this guy did this or this, and this guy implied this or this", or whatever the case may be. Like, I think that quite often you're going to have a situation where somebody may have knowledge of this person. And that knowledge is shared with the officers (...) there's going to be somebody within that grouping that's going to know what they're talking about.(Officer E)

Information is also shared among rural colleagues: "you have a little bit of background from the office"(B), who also take advantage of police files: "the first time I ever came across that situation, then I got all the files out and I looked at everything"(D).

Information concerning the referred person may be obtained from the victim, and such incidents were described

by both types of officers. An urban officer qualifies the degree of reliability of such information, however, based on "how well that person knows the individual who seems to be having a problem"(E). Family information was valued by the urban officer above that provided by other informants:

If it's a mother calling about her son, who's not taking his medication, or has suddenly gone off on a tangent of some sort, obviously she's going to be able to explain the situation and what's happening, and what kind of medication he's on, and you know, that sort of thing.(Officer E)

Many patients are the object of multiple mental health and police interventions, and urban officers obtained knowledge already on file from both police and psychiatric records, concerning persons with whom they intervened. In urban areas with large numbers of police officers, each intervention may have occurred with a different officer. In rural areas, one officer may have many interventions with the same person.

Rural officers also obtained information from victims and family members, fellow officers and files, but more frequently indicated immediate personal familiarity with their clientele. Knowledge concerning such persons' situations or natures may result from previous interventions: "if you have to deal with these people on a second or third time, then you realize the process of psychiatric problems or a history there"(A). Another officer describes persons with whom he frequently intervenes

as "recidivists"(D): "these people that over the years, you know who they are"(D). Only the rural commanding officer provided an exception to the rule of rural familiarity: "except for the one incident that I can relate to, I've never had it where I had to deal with a person that was out of the area"(C).

Only one urban officer provided an example of familiarity:

I know that my first years here, she was always in trouble and you could call her by first name; many of the policemen would call her by first name. She would call some policemen by their first name, 'cause she knew them so well. But I think that's more or less an exaggerated case, rather than the norm. But that kind of thing does exist. But I wouldn't suggest that it exists, you know, to that degree.(Officer E)

The same urban persons may be frequently observed: "you may have seen them almost on a daily basis if they're residing in the area in which, in which you're working"(E). The officer explains that urban officers work for periods of "a year or two years at a time"(E), or even several years in the same area of the city: "there's four districts in the city of [town] and each one of those districts has a number of car areas"(E).

You can appreciate that this person does know the people that are living in his area. Certainly, maybe the bad guys, or maybe the facilities within his area, or in some cases the people who are suffering from some sort of mental disorder.(Officer E)

The urban commanding officer described being "fairly

familiar" with a "fair share out here", most of whom did not "qualify for the police to take custody and take to the hospital"(F). Knowledge obtained as a result of multiple interventions with the same person is rare: "you can't attend on every call and you can't be expected to know everybody"(E). He adds that officers would "know something about the situation" if incidents involving the same person occurred on a "daily, weekly, monthly, whatever"(E) basis. In the case of a person frequently observed, the urban officer reported familiarity only with the problematic behaviour: "I'd heard his name before and many times after, but I haven't spoken to him on a normal basis"(G).

Police in rural areas are generally familiar with their clientele. One rural officer explains that "you may know that individual, by having dealt with him before or just by his reputation in town"(A), but accounts of incidents commence with "this is another person that I've known for a long time"(A). Another rural officer states, "a lot of the history is usually known to us"(B). Rural accounts emphasized behavioral changes as signalling mental health problems or episodes of illness; personal familiarity permits such a comparison of behaviours: "I knew him when he was healthy, and now I know him when he's not(D)". Direct personal knowledge may account for rural officers' greater concern for suicide attempts, previously described: "this one really freaked me, this is a fellow that I know

very well, a well-known business person"(A).

Mutual familiarity between officers and members of rural communities may also have drawbacks. While rural officers benefit from their knowledge of their clientele, "you know most of the people"(B), they are themselves also known "you walk down the street and everybody knows who the hell you are, what you do"(B).

Rural officers may be consulted while they are not on duty. There is no "time off" for a rural officer who is the only officer in the community: "I gave them my phone number at home"(D). Rural officers' accessibility may be voluntary, or just a feature of rural life where residents of small towns know their neighbours. Persons with disturbed behaviour also know their officers:

I don't know if he'll come. If it comes, I know it'll be really annoying, because he might come to my door at two in the morning. But we'll deal with that then.(Officer D)

Middle of the night calls are the norm: "It's not at two o'clock in the afternoon on a sunny day in the week, you know, when the doctor's in his office. No, it never happens that way"(A).

Clients may prefer one officer to another, and request help from a particular officer rather than consulting the officer on duty. While this may be inconvenient, rural officers attempt to accommodate such requests. Such a situation may have advantages, and may also be annoying at times:

You've been there before, you know what the background is. And a lot of the people don't like some of the policemen around here so they pick and choose whoever they want, and everybody bends over backwards for them. So what can you do?(Officer B)

A rural commanding officer acknowledges the situation described by the previous officer: "they'll wait for him to be on duty if he's off for the weekend, if it's not urgent. They'll wait 'til Monday to see him"(C). He considers responding to citizen demands an investment:

It's a sacrifice on the officer's part, but the sacrifice that he does is rewarding at the end because he works closely with them. Information is received that you'd never receive before.(Officer C)

Mutual familiarity reduces barriers which the officer identifies with authority: "that barrier -- authority or whatever it is -- is gone, it's eliminated"(C). The officer's discussion of barriers that result in authoritarian relationships complement Kandel's (1972) discussion concerning the need for an egalitarian relationship between persons interviewed and interviewing (see Chapter 3).

If a communication has got to be good communication that goes back and forth, that barrier has to disappear. If it doesn't the communication is one way. And that's the police officer, telling the other person what to do. (...) The respect for you as an officer is there, but this, the person on the street or the party that we talk to, is not afraid to come out and say, "[name of officer], I can tell you a certain thing," or "I've got a certain problem." And they're more open to you. If you don't have that breakdown, they're on the defensive.

"You tell me what I did wrong because I don't know nothing." Whereas the other people, they're open; they come to you and they tell you what's going on. (Officer C)

Increased familiarity may result in some inconvenience, but features that improve communication between officers and their clientele also improve clients' confidence in the police and thus their willingness to inform police of problems. Increased familiarity thus makes the officer's job easier.

Rural and urban officers received similar police training, but urban officers have more specific training opportunities, provided by mental health personnel, who taught officers how to recognize characteristics of mental illness and how to intervene. Urban officers' discourse relies on "common knowledge", and a variety of pseudo-scientific and negative assumptions were provided concerning mental illnesses, and persons diagnosed with particular conditions. The only reference to a particular condition by a rural officer involved an association of the hoarding of medication with symptoms of schizophrenia. Urban officers associated mental illness with violence in general; despite frequent accounts involving violence, rural officers did not. Both types of officers associated domestic violence with mental illness.

Urban training included training in suicide intervention, but urban officers showed less concern than

rural officers regarding suicide attempts. Urban training neglected communication skills; their importance was emphasized by an urban commanding officer. Rural officers attributed excellent communication between officers and citizens to community policing and a reduction of authority barriers. Rural officers' described various types of inconvenience that resulted from increased familiarity with members of their communities.

While admittedly both rural and urban officers develop some degree of familiarity with their clientele, experience in a group of small communities, with close relations such as family ties among its members, provides greater familiarity than a period ranging from one to several years patrolling the same area of the city.

CHAPTER 6

CAUSES OF DISTURBED BEHAVIOUR

CAUSES OF DISTURBED BEHAVIOUR

The previous chapter explored officers' perceptions of mental illness and persons with mental health problems; this chapter will analyze officers' descriptions of incidents of disturbed behaviour. Opening with descriptions of how officers feel about "attending"(F) such incidents, descriptions of what they saw and heard will follow. Because the sounds of weapons discharging is prevalent in rural description, descriptions of actual incidents will commence with a look at weapon use in rural and urban environments. Incident descriptions will be organized according to criteria provided for intervention under the Mental Health Act.

The reasons officers use to explain the behaviour of others and their own actions, directly or as inferred by the details provided in descriptions of incidents, will be examined in the light of Attribution Theory (for a description see the theoretical framework of this thesis). The cause of or reason for all behaviour is either internal -- because of the way a person is, or external -- because of the circumstances in which the person finds him or herself. Three types of attribution errors are described, based on the differential assignment of internal or external causes. The greater likelihood of rural or urban officers to make such errors will be analyzed.

PERCEPTIONS ON APPROACH

Self-perceptions

The officers interviewed were not as confident in interventions under the Mental Health Act as in other police work. The urban commanding officer reports that "probably about eight-five per cent [of officers] don't like going"(F) while adding that such incidents "don't bother me, that's a part of our job"(F). As a first reason for discomfort, he cites "fear of the unexpected"(F). Another urban officer notes that "you always have to be somewhat on your guard"(E). He relates discomfort to the type of person, rather than the type of incident; it is "just the uncertainty of someone who suffers from a mental disorder"(E), and the fact that "you don't know where this person is coming from"(E). The stereotype of extraordinary strength comes into play: "officers are hurt on occasion with people with psychiatric problems, or mental problems, or whatever you wish to phrase it"(E). A rural officer uses similar descriptors: "and so you're going to be a little leery (...) you're going to be overly cautious"(A).

Officers questioned whether the interventions studied should be a police responsibility. A rural officer comments that these interventions are in the category of peacekeeping: "if we're out there to preserve the Queen's peace, maybe it is our responsibility"(A). As with other forms of peacekeeping, described as undefined and arbitrary

by Bittner (see the theoretical framework of this thesis), officers described a lack of clarity in the Mental Health Act as compared with the *Criminal Code*. Some discomfort may be related to not knowing what to do in such circumstances.

[The Mental Health Act] sets out only certain conditions. A lot of them feel that they'd be criticized for their actions down there, because it's not broad enough. (Officer F)

Other authorities may not agree with officers' interpretation of the Act, decision to intervene, or means of intervening. If help is found, family members are pleased: "you always feel good if you can come out of one of those situations too, and you've resolved it to somebody's satisfaction"(F), states an urban officer.

None of the officers indicated distress or reluctance to act, but all described some discomfort with work on an unfamiliar terrain or with people whose reactions were unpredictable, and in an area where opinions differ so greatly among mental health authorities, and between mental health and criminal justice authorities. Differences among authorities will be discussed in the final chapter concerning interactions.

Visual perceptions

Rural officers provided frequent descriptions of what they saw; the only description provided by an urban officer is of a rural setting. This difference among officers suggests a greater visual impact of rural settings, or a lack of attention to such details by urban officers.

Rural descriptions suggest perceptions of exposure: "another one of these lo-ong stairways this time, you have to walk up"(A). The perception of exposure is common in all the rural interviews:

Holy Jesus, I'm telling you, whenever you've got to go into a situation like that there's never a tree to hide behind. You've got to get to that residence, you've got to walk up an open driveway. It always seems that way.(Officer A)

In the only urban interview description of a setting, parents called an urban detachment to report their son who had hidden in their rural home. The sense of forbidding prevails: "he had boarded all the windows up, he had closed all the curtains, he had put boards against the doors"(F).

Not all settings are as forbidding. Pleasant descriptions of settings are rare, however, and when provided they are used to provide a contrast between appearances and actualities. It is not expected that people have mental health problems in "a nice home (...) on a lake, a very nice posh place"(A). It is a surprise that a person with a serious mental illness whose "house is spic'n'span"(B) would be able to maintain standards of

cleanliness.

While rural officers more frequently provided observations concerning the environment in which interventions occurred, it is premature to conclude that they pay more attention to external factors than urban officers.

Auditory perceptions

Only rural officers provided a description of what they heard. The first citation suggests that mental illness may be determined by how a person sounds: "we hear this "HO-oohh yes?" And so he, from the tone, just the way he replies you realize, yeah, this guy's not all there"(A).

Rural officers provided frequent references to the sound of firearms. The sound of firearms signals the need for a cautious halt: "if you pull up to the house and you hear a bang, well, you're not going to go rushing in"(B). Even a low-powered firearm causes concern in what seems an otherwise routine call:

I go to the door, and as we're approaching the door, I hear a sound that I think is, sounds like somebody shot an air rifle off, you know. Now, that's very strange. You know, you're not thinking about danger or anything like that. You're just thinking of your normal knock on the door, and say, "hey guy, turn the radio down, will you? People are being disturbed, give us a break, see you later." That's what you're thinking about.(Officer A)

Urban officers provided no descriptions of sounds heard when

approaching the scene of an intervention, again suggesting less attention to situational details.

DESCRIPTIONS OF INCIDENTS

The presence of firearms and other weapons

A first consideration of rural officers is to determine "if there's firearms or if they're violent"(B). For rural officers, firearms are a frequent threat.

The people we are dealing with up here, if they're in any residence at all, there's gonna be firearms, so you always have to be aware that there's always a possibility of firearms being involved. And in just about any incident that's involving violence, or threats of violence, firearms are gonna be used up here.(Officer A)

When it is known that there are firearms in the residence, one rural officer determined the degree of threat by the amount of time elapsed: "I guess if he had wanted to shoot somebody he would have shot them by now"(A)". Another rural officer describes concern for the person with a mental health problem, rather than a potential victim, that "they'll do themselves right there, then and there, right, soon as you approach"(B). Despite precautions, encounters in which rural officers' lives are threatened by firearms are frequent: "I walk around the corner, and well, there's a guy holding a gun on us now. Ba-a-a-ad scene. Nobody likes that kind"(A).

Firearms were rarely mentioned in urban anecdotes, although one officer described urban firearm use as

increasing. Other weapons were frequent: "in less than three months I've been confronted with two people with weapons"(F). Knives or other blades were most frequent. The officer reports handling "a serious high risk call, a person with a knife trying to kill somebody"(F), and in another case: "he picked up a steak knife and he started running around the house after his other brother"(F). Threats using knives are increasing, and a peculiar threat to cut peoples' heads off:

That is a reoccurring thing, when you're dealing with mental patients, this thing about cutting peoples' heads off. That's one thing I've noticed, anyways. I think that there's probably been five or six events that I've been to, that what they want to do is cut peoples' heads off.(Officer F)

Knives were also frequent in rural accounts. In an incident involving self-referral by an adolescent, the caller threatens to use a knife on the foster parent:

He says, "I hear her walking upstairs."
 (...) He says, "If she comes down here, downstairs, I'm gonna stab her. I'm gonna kill her", the lady. And he obviously had all his equipment. So I phoned the C.A.S., and I said --
 Int What do you mean?
 Res He had his knife, and all that. So he could have, he had the means to do what he wanted to do.(Officer D)

While some young persons in rural environments may have the same ready access to firearms as adults, a ward in a foster home is unlikely to have such access. Knives were generally the more likely weapon in incidents involving youths.

The theme of weapons reoccurs throughout the interviews; how officers respond in the presence of weapons will be examined in the following chapter. For both types of officers, the presence of weapons of any kind ensures an intervention, potentially under the *Criminal Code* as well as under the Mental Health Act.

Threats of harm to self or another

The presence of others may help to defuse incidents, as in one rural anecdote in which "the friend comes out with a firearm"(A). The presence of others more often than not creates greater problems for officers to consider: "we really don't know who else is in the apartment, and we don't really know what's going on"(A):

All of a sudden we've got a situation where we have an armed and depressed individual in a residence with another person, and we don't know, really, whether it's a hostage situation, or what not.(Officer A)

The presence of others was a reason for increased concern by all officers.

Differences in rural and urban reactions to suicide attempts have been previously discussed, with rural officers taking such situations far more seriously. This may be related to the more frequent rural presence of firearms. In all rural accounts of suicide attempts, firearms were involved:

The boom that they heard, was him not really knowing how, in his drunken state, whether

the gun was loaded or not and he put a round off through the ceiling. (...) There is a suicide note, you know, saying goodbyes, like all the goodbyes that people will do that. They say: "Goodbye, I love you, this is not your fault, it's my fault," and on and on and on. And this thing, this big long dissertation of why people are justified in shooting themselves.(Officer A)

Danger of harm to self is aggravated in the presence of firearms, which may explain why rural officers are more likely to intervene under the Mental Health Act in cases of attempted suicide.

Imminence of harm

In order to intervene under the Mental Health Act, officers must judge a threatening situation to represent the possibility of imminent harm. Some threats reported by potential victims did not result in any intervention; others were taken seriously and the person making them apprehended. Two examples follow in which officers decided not to intervene. In the first case, a rural incident, the threat occurred in the past: "You hear about it: 'oh, he threatened to kill me'. You know: 'that was -- when was that?' 'Two years ago'"(B). In an urban incident, the officer also judges a threat to harm both self and others as not imminent:

He was mentioning many times that he was going to kill himself that night, that he had step-parents and the grandmother, and he was going to take a bus tomorrow morning, and he was going to shoot her, and -- continuous. And then he's telling his

concerns about some of his problems, and why he feels so hostile to the police, to society, and why he's trying to kill himself and he had made many, many attempts. (Officer G)

The officer describes the observed person as "definitely" (G) having a mental illness, but decides not to intervene because "he was an attention seeker" (G). Threats made in the past and not carried out, and threats made merely to challenge officers, were not judged by rural or urban officers as imminent.

The threat of harm to self becomes more imminent when firearms are involved. Missing firearms may provoke concern, as in the following rural incident, "there's always a shotgun hanging on the wall, and this shotgun's not on the wall" (A), and a weapon in someone's hand is more imminent than a statement concerning a weapon: "he says, 'I've got nothing to live for', and all of a sudden, now the gun is no longer pointed at -- at me, it's, it's pointed here [gestures to his chest]" (A). Threats without the means to carry them out, or reports of past threats, are not sufficiently imminent to engage other authorities, either of the Criminal Justice or Mental Health Systems.

Incapacity

A provision of the Mental Health Act requires intervention when a person is no longer capable of caring for him or herself. Based on their observations and in the absence of a specific threat to harm self or another, officers are required by the act to judge whether behaviour indicates incapacity. Descriptions of situations where this judgment was made were examined. One urban officer indicates that this judgment is not difficult: "It doesn't take a rocket scientist to know if somebody's acting abnormal"(F). Testing is simple: "little things, you know; if they're not sure about date and time"(F). Another urban officer also qualifies incapacity as obvious:

And obviously he was, he was, I don't know him from other than that particular evening but, obviously he was suffering, and he was starting to lose control of his ability to, to deal with daily life.(Officer E)

The urban commanding officer provides three behaviours that indicate incapacity: shoplifting and unmotivated fighting, getting lost, and obsessive interest:

At the malls, the major malls, somebody will go down and they will be suffering from depression. And they will decide that they're going to get into a fight, or that they're going to shoplift, and part of the shoplifting is that they'll fight.(Officer F)

And they're out at the intersection. They're in an adult work program, where they leave during the day. And they can, they get on buses and they go through, and they go down to [name of mall] and sometimes they'll get lost.(Officer F)

They'll be talking about completely off-the-wall stuff to you, or they will show a very keen interest in one particular aspect of what you're doing, and nothing else.(Officer F)

While incapacity may be inferred from rural anecdotes, few general indicators were included. One rural generalization seems to contradict urban findings: "ninety-nine per cent of the time, you know, the guy will answer the door"(B), and "by the time that we do respond the people seem quite normal"(B). Where urban officers seemed confident in their ability to make judgments of incapacity, rural officers were reluctant to use such qualifiers.

CAUSAL ATTRIBUTION

Attribution Theory examines the causes to which we attribute our own and others' behaviour. The type of cause to which we attribute behaviours provides information about ourselves (empathy, perspective, bias), as well as about the incident described. The theory is fully explained in the theoretical framework.

Attribution Theory categorizes causes in two groups: internal and external. Data analyzed in this section did not arise in direct response to the questions submitted. In the first interview, a rural officer described settings and circumstances which, according to the officer, precipitated disturbed behaviour. In urban interviews no such information was volunteered. Urban officers generally

attributed disturbed behaviour to internal factors: "why is this person acting in such a way or particular way? And it's usually because of the mental illness"(G). Spontaneous differences in the attribution of cause prompted this analysis.

Fundamental attribution error

The tendency to attribute the actions of others to their nature is the source of *fundamental attribution error*. It is explained as the tendency to explain the behaviour of others in dispositional terms. Details that would provide a context or background for the behaviour may be ignored or considered important.

As demonstrated in the description of perceptions at the beginning of this chapter, urban officers paid little attention to situations in which behaviour occurred. Invariably, when a mental health problem is identified it is perceived as the cause of the behaviour: "we find out that the domestic is the result of a person with a condition whether it be schizophrenia or something like that"(F). In another example, external causes are not given sufficient weight. It is the way the person "takes it":

It could be any, any situation. They could be sitting there watching television or chuckling when he's heard something funny, and then the individual that I am with would take offense to that and start -- you know, "he's laughing at me", or whatever, he'll take it a different way. (Officer G)

With one exception, urban officers consistently attributed behaviour that required intervention to a mental state: "the tension of not knowing where he was, or not knowing how to deal with what was going on in his mind"(E) or "because of the aggravation that they're feeling"(E). In the single urban anecdote where behaviour was not attributed to a mental illness, it was nevertheless attributed to an "internal" cause: "he was a cocaine user (...) he had some substance within an hour of our intervention with him"(G).

Only one of three urban officers interviewed, the commander of his detachment, referred to a person's situation. The context of the person's actions is provided:

It was a man of about fifty years of age, and he walked away from the [hospital]. He was dying of cancer and he was so stressed out that he didn't want to sit in the hospital, and die, so he decided he would go home. (Officer F)

Actions were attributed to a mental state, however: "as part of the stress reaction he was unable to comprehend a lot of things"(F).

Because situational explanations were provided in the first interviews, they were expected to appear consistently. A lack of assignment of external causes was considered an oversight and officers were prompted to provide descriptions of situations. The question was misunderstood. When the term "situation" was replaced by "extenuating circumstances", an urban officer responded:

I don't think that, that the extenuating

circumstances are always as much of a help, as they could be a hindrance. I mean you don't really know, just knowing, having the face value knowledge doesn't always help you. (...) And it might be a means towards their end. They might say, "Well, the reason I am doing this is because of this." You know, it's almost like a scapegoat answer for them. And maybe they've used it for thirty years, you don't know that either. (Officer E)

The officer considered examination of "extenuating circumstances", the situation or context in which incidents occur, not only not helpful but redundant.

A lack of interest in external causes results from paying attention only to the person's actions, another quality of fundamental attribution error. In all examples where rural officers described actions, a variety of external causes were also included. Most frequently, family dynamics were involved: "what has happened is that he's not getting along with his wife"(A). In an example where internal causation might be inferred: "this guy takes this big depression and he's gonna shoot himself"(A), an external cause is nevertheless attributed:

I think what happened was this guy, this guy he's married, he's got grown up kids, and that's one of the things that triggered things, that these grown up kids, they're not going to bring the grandchildren up, because he would have, had been acting flakey. And the wife was just fed up with him crying in his beer, type of thing, and left. (Officer A)

Even where a mental state is identified ("it was just in his mind"(A), external factors are also provided:

He was having marital problems and there was some accusation that he or his wife, fooling around. (...) There was some event happening in the man's life. It was an anniversary or something like this, and there was lots of family around and drinking and all this stuff. (Officer A)

This trend is constant in rural interviews. Whatever the condition described, external causes are provided:

A person was travelling through the province and ran out of funds on the highway and became depressed and slept in her car. At that point, we didn't know, until we brought her in the office we didn't know what was wrong with her. And then we found out, through her information, that she was depressed on account of what she was doing; she had to go west and there was no way out. (Officer C)

For each incident described, rural officers provided the external causes -- some real, some imagined by the client -- to which actions could be attributed. Behaviour was not attributed to external causes in any of the urban descriptions, and officers even emphasized that these were unimportant: "information overload, you know; it might not help you, knowing more" (E). Urban officers were more likely than rural officers to be subject to fundamental attribution errors.

The Actor-observer effect

The second identified source of error is the actor-observer effect, which is defined as a differential tendency when describing one's own, or others', behaviours. One's own behaviour is generally attributed to external or situational causes; the behaviours of another are more likely to be assigned an internal cause. Officers without exception justified their own actions using external factors. In no case where an intervention was described did the officer attribute his actions to fear, for example, and most denied being afraid in such interventions despite descriptions of fear of the unknown, or concern with the described unpredictability of such cases.

A difference arose, however, in degree of flexibility between rural and urban officers. The senior rural officer described the change to community policing from a previous provincial police ideology that "strict is fair"(C). He describes a change from this position as "a good thing"(C). An urban officer maintains the former position, emphasizing the need to be "fair and firm"(F). In incidents of interest to this thesis, the officer described having no choice but to intervene: "when they're at that level, I know that I'm going to have to take a firm, probably a very quick, response to this person"(F). The type of incident does not allow for flexibility: "you can't take a position and then change that position with somebody

that's schizophrenic(F)".

While officers similarly attributed their own actions to external causes, urban and rural officers differed, as shown in analysis of fundamental attribution errors. The tendency by rural officers to include situational descriptions and causes is relevant to analysis of the actor-observer effect, which includes a description of empathy. Empathy is the ability to understand how a person perceives his or her situation, whether real or imagined. Whether being able to see another's situation results from empathy, or empathy is an effect of being able to see "reality" as another sees it, rural officers demonstrated empathy and urban officers did not. The following rural anecdote, with a complete situational explanation, demonstrates such empathy:

There's a kid, last year in school. He comes from a broken family. He had a big hopes and he moved back with his dad. And, things didn't pan out and you could tell. At one point he was sabotaging everything around here, because it was gonna be such a great life over there.(Officer D)

The ability to see external factors and the ability to experience empathy varies with knowledge of a situation. Direct personal familiarity as a result of close social networks makes such knowledge available to rural officers. There are too many programs and too many people in urban centres; urban officers cannot be familiar with the situation of most of the persons with whom they intervene.

Urban officers appear more likely than rural officers to err in terms of the actor-observer effect.

Self-serving bias

The third attribution error described is the *self-serving bias*, the tendency to attribute positive actions or outcomes to one's personal qualities, and to provide situational causes for negative outcomes. Successes were generally attributed to internal causes and failures to external causes, by both types of officers.

An urban excerpt blames external factors for a negative outcome. The officer explains that a client's behaviour was not related to police intervention; it "didn't necessarily mean that we had to do anything or anything, we never touched the man"(E). The officer, who earlier described consideration of situational causes as "information overload"(E) did not consider police presence as an external source of aggravation. The urban commanding officer, however, acknowledged a potential impact of police presence:

Sometimes a uniform can be a calming experience; other times it can be a final fuse or the final straw that sends him right off the edge.(Officer F)

The senior officer was better able than urban constables to recognize that police intervention may be an external factor that affects behaviour. Rural officers generally acknowledged the effect of police presence. One officer

provides an example from an incident of threatened suicide: "maybe now that he knows you're coming he's going to do it before you have a chance to intervene"(A).

An excerpt from an account by the senior urban officer again provides the exception. The officer attributes failure to understand (although not a failed intervention) to a lack of knowledge: "because you're not a doctor, because you're not someone who, generally speaking, is able to understand the complex mind"(F). Only one example of a failed intervention is provided, by a rural officer, in which a suicide occurs. He explains that there is no time to intervene, an external factor:

Bang! and that was it. (...) All of a sudden you see movement and you prepare yourself, like. You know, you're gonna take cover. But by the time you take cover, then, Bang! it was over. What else could you do?(Officer B)

In general, officers provided examples of successful interventions and attributed their successes to a variety of internal factors. The primary reason an officer is successful is experience. The senior rural officer provides his considerations when interventions involve mental illness:

We try to assign officers that has quite a bit of experience, or has had some experience with this type of occurrence. It seems to make the job easier for everybody.(Officer C)

The success of interventions may be attributed to personal style. A rural officer, with twenty-three years of

experience, describes intervention styles as individualized; what works for one officer will not work as well for another: "if he tried that, maybe they will not work for him"(B). He adds: "but it's worked for me"(B). A rural officer, perhaps humorously, attributes his success to his "charm"(A) in a discussion concerning the importance of being able to communicate.

Urban officers credited their successes more directly to internal qualities. In the following example, these are described as general among officers:

Most policemen take pride in the fact that they have a good sense of logic, a good sense of reason. And with the experience of dealing with large volumes of people on a daily basis, I think this is what they set their guidelines by.(Officer F)

Another urban officer suggests, again in general, that officers rely on intuition -- "gut feeling"(G) -- and common sense, rather than training:

You see so many people. You have an idea how somebody reacts, you'll get a gut feeling from -- can't be necessarily training. Training has a play in it, but it is not the essential thing. Common sense kicks in and this is the thing that's going to get you through the street, and keep you alive, and you could be a book whiz, but it's not going to cut it out there.(Officer G)

He confirms a need for communication skills, but describes such skills as innate rather than acquired:

If you don't know how to interact with the people, then it's not going to, you might as well sit in and have a desk and push papers, because it's not going to work for you.

Intuition, common knowledge, interpersonal skills: it all clicks in. (Officer G)

Another urban officer attributed successful interventions to police knowledge: "our knowledge of human nature", which results from experience: "just from day to day of who we meet, and we meet the spectrum of personalities" (E).

Both rural and urban officers attributed their successes to internal causes and their failures to external causes, with few exceptions provided by senior officers. The urban commanding officer recognized that police, not being doctors, lacked real knowledge of mental illness. The rural commanding officer, in stating that experience made interventions easier for everyone concerned, inferred that failures may be attributed to a lack of experience. With these exceptions noted, rural and urban constables are equally likely to err in the direction of self-serving bias.

This chapter explored officers' observations, the information used to assess the need for intervention. Officers of both groups approach these situations with mixed emotions. Officers suggested that an inability to predict what a person might do made such calls uncomfortable. Descriptors such as "tentative" and "leery" were frequent. "Fear of the unexpected" was cited, but in no instance was fear admitted.

Officers intervened when they judged a threat of imminent harm to self or others. This threat appeared

imminent in the presence of weapons, particularly firearms in rural incidents. The danger of firearms was a constant threat for rural officers; other weapons were increasingly threatened in urban incidents. Threats to others were a greater problem than threats to self alone; victims and potential hostage situations complicated interventions.

Within the definitions provided by Attribution Theory, rural officers demonstrate more empathy; urban officers demonstrate more bias. Rural officers consistently provided observations concerning situations and external causes; only one senior urban officer provided such observations. Urban officers provided more descriptions of actual behaviour, and generalized more concerning the behaviour of mentally ill persons, than rural officers. A shortage of urban descriptions of settings of interventions further suggests a lack of attention to external factors.

CHAPTER 7

POLICE INTERVENTION

POLICE INTERVENTION

Previous chapters have established the context of interventions under the Mental Health Act: the nature of referrals that suggest to officers that mental health is a concern; the reasons persons call the police instead of managing situations and the implication that force will be needed; what officers know -- or assume -- about mental illness or clientele with mental health problems; and in the previous chapter, what do officers think about it all. In this chapter, the thesis examines what officers do when they intervene.

PREPARATION

Being prepared depends on having some knowledge of the situation and what to expect. Rural officers may call the referred person for more information: "'this is [name of officer] I understand there's a problem here tonight'"(A). Specific preparation is difficult for circumstances described as unpredictable, and which may require simply "going down there and saying, 'hey, cool it for awhile'"(B). In circumstances which involve mental health problems, an effective response depends on the ability to make the right decisions to ensure public safety, and their own: "when you're dealing with these psychiatric people, you're trying

to protect yourself as well"(A).

Risk assessment

The first step in an intervention is a risk assessment. For both rural and urban officers, the first question in a risk assessment is clearly whether there are weapons in the house. Urban officers note that the location of the referred person in the house is important to this question, since "there's an awful lot of weapons available in the kitchen"(F). The same precaution is important in rural circumstances, where "every residence"(A) has a firearm. A rural officer asks:

Are there any firearms in the house? No, there aren't any firearms, no. Has he got any weapons of any kind on him? No, there's not, no. Does he keep a baseball bat behind the door? No, there's nothing there. So you know that. He doesn't have a gun, he doesn't have a bat, he doesn't have a knife.(Officer B)

In rural accounts, most of which involve weapons, there is an implication that weapons are surrendered without argument: "he throws it down, the gun at the couch"(A), states the officer in one incident; in another incident a friend intervenes: "eventually the guy comes, the friend comes out with a firearm"(A). Urban accounts are similar: "he was instructed to come out with his hands up and to surrender to the officer coming at the door, and that worked, that particular case"(F). None of the officers specifically described means of disarming mentally ill

persons who were armed, although interventions will be examined where force was used.

When intervening in residences or institutions, officers described putting away their own weapons. A rural officer provides the roots of this practice, from "the days when we had the old holster that would open by itself and fall, and the gun would fall out on the floor"(D). Although the current model "is pretty safe"(D), officers continue to disarm to prevent having their weapons used against them: "I don't want him to take it away for me, in case that's what it comes down to"(D). Rural officers also described securing articles such as flashlights and batons. Urban officers described disarming when entering an institution or agency; securing of other equipment was not described. One urban officer described wearing 22-lbs of equipment, current additions have increased this number¹.

Backup

In most interventions, officers work in pairs. According to a rural officer "the policy is clear on that, we don't respond to those calls alone, for safety purposes"(D). Working as a team is the rule in urban forces as well: "there's always two officers (...) there's always

¹From information provided in 1993. An officer at a 1996 meeting of a psychiatry community advisory committee presented information concerning pepper spray (referred to as O.C. spray for *olio capsicum resin*). When asked whether equipment still weighed 22-lbs, he replied, "oh, much more than that now".

two that respond to that sort of a call"(F). In rural situations where further intervention may require taking the person some distance, two officers are required: "specially in a transport situation, there are two of us"(A). In urban situations several officers may be dispatched: "if there's indications that violence is happening, we would normally send more than two cars"(F).

Officers work in pairs to provide each other with mutual protection. A rural officer elaborates:

One looks after the other, eh? Like, you never turn your back on the person. If one goes ahead the other will stay back and he'll be watching the room, like, for knives and stuff like that. So you protect each other.(Officer B)

The quality of protection "depends on whom you work with"(B). Inexperienced officers may take unnecessary risks: "I'm not going to shoot this guy. My partner might. He's just a young lad, he's got no family, and he's bigger and he'll stop a bullet for me"(A).

The team situation is an ideal that cannot always be met, however, as both types of officers admitted. The help of other authorities may be readily available to urban officers: "quite often with calls of this nature you're also going to have people from the ambulance services there"(E). Rural officers may need to be more creative in recruiting help: "there's always gonna be somebody around that's gonna be able to, to assist you"(A).

Working as a team facilitates officers' approach. A

rural officer describes sending his partner "to look through the windows"(B) while talking to the person on a cellular telephone. When working alone, the officer described reliance on his training for self-protection:

You don't go run up to the door, and stand in front of the door, even though that you know a person's not a violent type. You always just stand off to the side. It's in the training movies. You don't go running up; you don't, you make the smallest, the smallest target of yourself as possible, until you're inside the door.(Officer B)

Approach cautiously, find out as much as possible about the situation, and make a small target: each of the respondents, in all of the interviews, concurred on the theme of taking precautions to protect their own and others' safety.

Public relations

Officers described public safety as their first consideration. Family members have already been identified as the primary source of referrals for both urban and rural officers; they may still be present when officers arrive. An urban officer describes asking the family member to come out, not only for their protection but also to provide information:

If the person is in the actual mode of being violent, we'll ask for the member of the family to leave the house, and come out and brief us outside (...) we will try and find out from the member of the family what's the best way to calm him down, in other words do they have any ideas that can help in approaching this person.(Officer F)

Officers of both groups expressed the importance of family members to defuse potentially dangerous situations. The officer describes asking "has he had contact with the police, how does he respond to the police officer?"(F) A family member may provide background that facilitates the officer's work considerably. Rural officers will, whenever possible, "find out who the next of kin is, family around the area"(B) to determine "whether the person is dangerous. We find out from them what these people are really like"(B).

The presence of family members, or of the community in general, may affect the way police intervene. In this regard, Lundman (1980) states: "a meaningful portion of police behaviour occurs in response to the actions of the citizens present during an encounter"(P.10). For rural officers the presence of others acts as a constraint, raising the question of an officer's reputation: "what kind of reputation would the force get, if you started beating on helpless people?"(A) Community approval is particularly important for officers who may need to recruit help when no backup is available; as one officer indicates, "there's always gonna be somebody around"(A), to provide assistance as well as to observe the intervention.

The ability and willingness of family members to help may permit officers to avoid transporting a person to a psychiatric institution. A rural officer prefers to take the person home, "get the family to do something about

it"(B). The senior urban officer describes police officers acting as backup for family members willing to take responsibility for transportation:

We were able to convince the parents that (...) it would be less, not frustrating, less problematic for the parents, for them to transport him down for the meds, and an assessment at the same time. And then we said that if the son refused or got out of the car, or that if he felt there was a problem, he should just pull over to the side of the road -- he had a cell phone in the car. Call us and we would then convey him from that, whatever, point on. (Officer F)

Transportation by family members will save considerable time, and avoid a situation that is generally inconvenient for both rural and urban officers.

TAKING CONTROL

On engaging in any intervention, officers must take control of the situation. In interventions under the Mental Health Act, taking control requires the exercise of greater discretion than in criminal matters. When a crime has been committed, the officer's authority is clear; when behaviour appears disturbed a variety of judgments must be made before intervening.

Officers are not always confident that their assessment of the need to intervene is correct. A rural officer describes an intervention under the Mental Health Act in which senior officers were present:

There was my staff sergeant, the detachment

commander, okay, and a sergeant. Okay. We were all involved with this occurrence and I am, I'm gonna end up doing it because I know it's my turn to do it. Sergeants don't work, right, they just push paper and they correct, they don't initiate work unless they have to. So I'm deciding, I'm trying to second-guess these guys. If I do this, are they gonna go along with it or they going to criticize?(Officer A)

Control must be demonstrated in a manner that precludes confrontation, according to an urban officer: "you cannot take a challenging position with them"(F). To challenge is to give "permission to do the thing they feel that they have to do"(F). The first step is always based on a concern for safety; a rural officer provides the drill: "this person is searched to make sure there's no weapons, or nothing they can use as a weapon against you"(A).

Control, once achieved, must be maintained. A rural officer describes the consequences of being overconfident, and not maintaining control: "a guy goes wandering off to the bedroom, you don't know what's in the bedroom, he could come out with a gun"(B). He describes losing control in another intervention: "we learned that from experience too, like, one guy jumped out the window and left"(B).

Communication

The senior urban officer has already described a need for training in communication skills. All officers operate under time constraints, however. For urban officers, talking to a person to defuse a situation requires a greater investment of time than taking him or her to a psychiatric facility: "it's not always feasible that you're going to sit down and talk to this person for five or six hours"(E).

For rural officers, intervention begins with communication. In some situations, the first approach is not successful. To the officer's question, "how are things?"(A), he receives a reply:

"Well what do you think? I'm sitting here on a couch with a gun stuck between my knees here. Here's my suicide note there. How do you think things are tonight?"(Officer A)

Communication is not always immediately successful: "he's telling us to get out"(A), states the officer in one account. Rural interviews provided frequent examples of successful communication with mentally ill clientele. Demanding coffee or tea was an important technique in opening a communication: "'where's your coffee pot?' I always use that; it works so well, eh?"(A) In another example, "I tried the old 'put the kettle on' ploy, there. So he puts the kettle on then we go in there"(A). This social interchange allows the officer to take control of the situation: "I've got him working for us now"(A), he states

of a person who makes tea. Engaging the person in such an action may also be a means of disarming him or her: "he's going to have to put this rifle down if he's going to put the pot, the pot of tea on for us, eh?"(A)

Transportation is less convenient for rural officers, who provided frequent accounts where "talking" was sufficient as an intervention: "you can con these people, you know, into just about any kind of situation as long as you've got the time and the patience to do it"(A). A peaceful resolution may follow the cup of tea:

We talked for about five minutes and I'm saying, "God, you know, things can't be that bad, J..., there're no problems in this world that are so big that you can't find an answer for 'em." I heard [a motivational speaker] say that once on a tape, okay?(Officer A)

The officer brings to mind Bittner's (1967) reference to "psychiatric first aid".

The senior urban officer describes using communication to simulate familiarity. This is not always equally successful:

His first name was my first name as well and I used that as my approach to get him to converse with me. (...) Some of them, some of the older patients would say, you know, "Well, you're demeaning me. I want to be called by my name. It's Mister Jones to you." Well, then you treat them as Mister Jones. Until then, almost all the people I deal with, in domestics and that, I ask to call them by their first name.(Officer F)

The senior urban officer made fewer references to communication than rural officers, but agreed that

conversation was important even where communication was impossible:

I'll be talking about one thing and she's talking about another, but it's still important that I continue to communicate with her, even though we're not, I'm not communicating. (Officer F)

As in rural interviews, communication may be a complete intervention in less serious urban incidents: "they'll let me in, and we'll have a chat, and we're able to bring it down to that level"(G).

Even where the outcome of the intervention was referral to a psychiatric facility, communication facilitated cooperation with transportation. An urban officer describes speaking to a client "for some twenty minutes or so"(E), after which the person "voluntarily got into the ambulance"(E). Another urban officer uses the same technique: "once I intervened, chatted for thirty-five, forty minutes, the time we finished he agreed to accompany me in the cruiser"(G). He attributes the success of this intervention to communication: "I guess I just struck him the right way, that he was able to communicate"(G).

Communication skills remain an important asset in defusing hostility, reassuring frightened clients or family members, reducing disturbed behaviour to facilitate further intervention, and even as a complete intervention.

Attempting to communicate, according to an urban officer, is appropriate only when the person is not violent.

Officers will attempt to solve the person's immediate problems: "that's about what we would do if the person was at that time nonviolent. We'd establish a line of communications with him"(E). Communication is important in rural circumstances, even in a violent incident: "when somebody's pointing a gun at you, you know, you're -- whew - - yeah, you're doing a lot of talking"(A).

In a rural account of a family threatened by a parent's former employer, an example that represents both excellent communication and "psychiatric first aid", an intervention known to mental health workers as "joining", is described. The officer is familiar with the person's problems and his approach, "he reads the Bible to you"(D), states the officer. The officer uses metaphors to which the person may be expected to respond:

I talk to him like he talks to me, basically. You know, he says that he works for the Lord, and I say, "well, I do too". (...) He says, "well, you think you got all the strength", and I tell him, "yes, I have all the strength because I work for the Lord". And then he buys that, and then he settles down. (...) He always wonders, "how come he knows?" And I tell him, "well, I know because of my inner strengths. They tell me I am assigned to protect them. Whenever you go, I know".(Officer D)

"Psychiatric first aid" seems to be effective for managing various situations, and was widely practised by all of the rural officers. The officer who provided the above example wished for greater authority to deliver such assistance. He observes the person's progress, and "sometimes I feel like

stopping by and saying, 'did you take your pill today?'"(D) He explains that such preventive interventions are not within the mandate of a police officer.

Managing violence

In the light of Kuhlhorn's (1990) study which found correlations between violence and the tendency to misinterpret situations, communication may defuse or avoid violence. At times, however, there is no apparent opening for communication. The potential for danger in situations involving firearms has been highlighted. A rural officer, providing an account in which a search for a man ends in his suicide, describes concern for his fellow officers as well as for himself: "we were just thankful that he didn't take anybody with him. (...) And it would have been quite easy for him to, you know, take somebody with him"(B).

Urban officers anticipated violence in the presence of a mental illness even if the person were unarmed. An officer describes an "aggressive stance"(E), characterized by speaking loudly and "getting closer to people as he spoke"(E). A gesture described as "pointing the finger type thing"(E) suggests to the officer "that feeling that he could go over that boundary at any time"(E). Another urban officer suggests that anyone may become violent. A person who is "just very psychotic"(F) may, "given the opportunity, kill anybody"(F). Where violence is anticipated, urban

officers' "have no other choice but to take into custody"(F) if the threatening behaviour continues. This is described as "giving the alternatives (...) with the hope that you don't end up getting into it with him physically"(F).

When persons do not respond to communication, coercion becomes necessary. At the time of this interview, physical force would be the most likely intervention. The urban officer explains:

It was either into a wrestling match, or striking them with a baton. And in some cases, they even escalated it into them being shot. So, patients being wounded. So hopefully this O.C. spray, when we get into a level where we have to become involved the O.C. spray will be to our advantage. We've seen some awfully good things with the O.C. spray, where we've prevented officers and patients alike from being hurt.(Officer F)

At the time of this writing, "pepper spray" (oleo-capsicum resin) has been added to the enforcement paraphernalia on an urban officers' equipment belt.

Most rural accounts of violence involved danger to self, by the referred person, rather than danger to others. This is clearly a criteria for intervention under the Mental Health Act. A rural officer's description, when intervening in a case where suicide was threatened, demonstrates concern for the referred person:

If I had any thoughts of trying to grab this gun away from this guy, I'm not gonna, you know, I'm not going to have it on my conscience that I pulled his gun and he shot himself, or I'm not going to have it on my conscience that I rushed him and, you know, he shot himself because I was gonna rush

him.(Officer A)

Suicide attempts cannot always be prevented, however cautiously officers proceed. A rural officer describes one such incident: "the guy shoots himself in the armpit a couple of times, you know, using a 22. And what do you?"(B)

In addition to threats to self, or to an officer, disturbed behaviour frequently involves threats to others. One rural officer explains: "he wasn't violent towards me, but he had just tried to knife his wife"(A). Situations of violence between spouses were so frequently described among those requiring intervention that they merit a separate section.

Domestic and sexual assaults

The most frequent rural examples of actual or potential interventions under the Mental Health Act involving violence were domestic incidents. Domestic incidents were rarely described by urban officers, but the senior urban respondent provided one incident of domestic violence and his direction of a successful intervention. Despite a general association of domestic violence with mental illness, officers are required by law to choose criminal justice processing for such complaints. Examples will be provided in the following chapter concerning the "fourth disposition"; this chapter will only examine some of the actual interventions prior to arrest or taking into

custody.

While rural officers discussed the requirement to take persons responsible for domestic disputes into custody, this disposition was not inevitable when officers perceived the presence of a serious mental health problem. This may be inferred from an account that ends with: "he stayed down there at [provincial facility] for four weeks and then, then he was in as an outpatient for quite a while"(A).

A rural officer who stated that "the book"(B) didn't provide officers with everything they need to know, discusses the need to observe both partners in a domestic dispute. He provides evidence for the assertion by both urban and rural commanding officers that experience makes a better officer than training:

Before we used to sit at the table and talk, have the husband here and the wife there, but that didn't work. A lot of people were doing it that way. So 'till you finally did separate them and say, "hey, I learned something from that". You know, I didn't have to fight with both of them.(Officer B)

Separating a fighting couple is the first step in an intervention:

So you go in there and you say, "okay, can I see you outside?" "No, I don't wanna go outside." The other one will say, "Yeah, I'll go outside." So you got them separated. Once they're separated, the fighting's done, because they're not fighting with you. They're fighting with each other, you see, and once you get them separated, the problem is over.(Officer B)

Using experience to augment training permits the officer to

intervene more effectively in situations of spousal violence. Police awareness of a potential situation, according to the rural officer, may itself deter further violence:

They can say, "I was in touch with the police." (...) The wife would say, "I called the police, the police were here, I told them everything" and that settles their problems.(Officer B)

Officers discussed an increase in reporting, rather than an increase in domestic incidents. With respect to sexual assault, the senior rural officer described a similar change in attitude toward reporting:

Child abuse, you could see it in the last few years. Child abuse, sexual abuse in children has come wide open. And that's through the campaign that went through. We have to report it. We've gotta take it serious.(Officer C)

The rural officer who intervenes frequently with young persons described preventive work with teenage women to prevent sexual assault. His account provides a further example of rural "psychiatric first aid", delivering a message that seems more likely to come from a psychologist or social worker than from a police officer:

In the high schools, I tell the girls, "hey, you don't have to put up with it; you don't have to put up with anybody pinching your ass." They laugh. I say, "it's funny, but --". I said, "do you, do you young girls walk around doing it to the boys? The boys don't put up with it, and neither do you. It's wrong, wrong, wrong, period." (...) "It's your body. Nobody touches it unless you say it's okay. No means no".(Officer D)

He demonstrates concern that resembles the concerns of social workers: "a young lady that I knew, well, she's pregnant (...) I keep an eye on her"(D). He also intervenes directly, with young men, meting out warnings that complement his lecture to the female students:

Young ladies that have been molested by boyfriends. (...) I stop the guy on the street, "Hello, how are you, why don't you stop by my office for a minute?" And then when I'm in my office, I tell him point blank: "Remember what happened, that day, at that time, at that place? (...) Well, it's gonna have to come to a stop. No means no, and if I can convince that young lady to give me a statement, I'm gonna put you in jail" -- "Aa-aah" -- "Well, smarten up. No means no. Period".(Officer D)

His intervention is effective. He follows up with the victim and is informed: "he quit bothering me"(D).

The use of restraints

Both types of officers who addressed the matter of restraints -- a topic not to be missed in any discussion of intervention under the Mental Health Act -- indicated that their use was minimal. The rural officer described his attitude toward restraints, but suggests this may not be a widespread viewpoint:

And throwing the cuffs on, and the whole, you know, the whole nine yards. But now, you don't want to deal with people like that, that way. At least, I don't.(Officer A)

The type of restraints used were described by an urban officer: "in [town] we're using the regular handcuffs"(E).

The officer associated handcuffs with arrests and indicated that nylon cuffs were not used. He states further, however, that in interventions under the Mental Health Act "the option"(E) to use restraints "is probably more prevalent there, or certainly the chance of it happening is there"(E). Neither group admitted or endorsed the frequent or widespread use of restraints when intervening under the Mental Health Act. All officers claimed they rarely or never used restraints, but could not speak on behalf of other officers.

Follow-up, feedback, and outcome

To conclude this chapter, the issue of obtaining feedback or follow-up will be addressed. Only rural officers described outcome, feedback, or follow-up after interventions. Their access to outcome data may again be attributed to their characteristic familiarity.

The rural commanding officer provided the only example of an intervention by rural officers with an unknown person, in which the person's problem was solved by providing monetary assistance. Even from this single incident of intervention with a "stranger", outcome data was available:

She wanted my card when she left, and I told her my name and my address at the office, and we received a real good letter, that her only problem was financial. (Officer C)

Generally speaking, obtaining feedback requires some follow-

up action by the officer: "I had time to go in and drop in on the farmer, and have a coffee with him"(C). Such follow-up is almost automatic, since the same officers continue to be involved with the same clientele. The senior officer recounts the continuing history of persons with whom he has intervened: "I was involved with her for about three years, and finally she met someone. They lived together, and they're still living in town"(C). The same officer follows up on community service work assignments, inspired again to demonstrate an understanding of psychology and social work, in this case the importance of learning through some form of consequences: "this person won't come back and paint another fence; (...) you're not going to deal with him no more"(C). The officer who provided several accounts concerning youths echoes the message of learning from consequences. He observes that a new boy, coming into the community where another youth has been a bully, is not afraid; this will benefit the youth who has been the subject of previous interventions: "it's not that unhealthy for him not to get away with it again"(D).

Following up and obtaining feedback are inevitable in communities where social interactions occur between officers and clientele. Two rural examples are provided by another officer. In both cases, he calls the person with whom he has intervened: "if I call J... there and say, 'hey, I need my snow machine fixed', J... 'll say, 'no problem,

bring it up'"(A). In the second case, the actions are similar although the context is different: "if I phone E... and say, 'got any fish, E...', E...'ll say, 'no, but I'll go catch some, [name of officer]'"(A). The continuing social interaction allows officers to observe and control their communities: "everybody was happy (...) there's been no recidivism"(A).

The familiarity enjoyed by rural officers is denied to urban officers: "sometimes you'd like to call the family"(F), states the senior urban officer, but this is rarely an option:

We never get any feedback that way. And we're, you know, in all, in all honesty, we're busy enough that -- sometimes there's the occasional case we'd like to know how they made out, but we normally take it that if we don't get called back to the residence, that everything worked out.(Officer F)

Rural familiarity permits officers to obtain feedback concerning their clientele; for urban officers the incident is completed when they leave the person in a psychiatric facility, in a cell, or at the scene of the intervention.

Many of the rural examples involving violence between spouses included reports of following up. An urban officer describes having little contact with persons following the intervention:

The only time I have an intervention with somebody after that would be if I'm picking up a witness statement, or getting the person the next day because they're a little too intoxicated that night to give me a

statement of what took place.(Officer G)

When intervention is minimal, rural officers may also report a lack of follow-up:

"Thank you for telling me what was going on, and I will talk to the other half and see what his problem is, and we'll see what we can do." You know, 99% of the time it works. You never hear of them again.(Officer B)

By contrast, another rural officer completes an account: "he got back with this girl that he was having problems with and -- lovey-dovey"(A).

Rural officers may report to a family on the outcome of transportation to a facility: "after the person is left there, we usually go back and see the family, and talk to them, and tell them what we did"(C). Urban officers more frequently report families not wanting officers to intervene further: "we'd go down there and, 'need our help?' 'Nope, the boys can look after themselves'"(F). Being able to call the family, or to call on the family, may become part of a rural officers repertoire of preventive interventions:

You make it a point that, when you're in that area, to drop in and out, and have a cup of coffee. But, but don't bring up their problems or anything like that. (...) Because if you're there long enough, either the wife will say, "can I see you for a minute before you leave?" or stuff like that.(Officer B)

The difference in follow-up or outcome information between rural and urban interview content is consistent with the difference in degree of familiarity: urban officers do

not become familiar with the majority of their clientele's lives; rural officers know their communities and are familiar with outcomes whether or not there is feedback from the persons involved.

Officers described differing intervention styles. With respect to actions prior to the intervention, both types of officers either disarmed or disabled their sidearms; rural officers also secured other items that could be used as weapons. Caution was described by both types of officers, to protect themselves and others who might be involved with the person referred. With respect to the actual interventions, the first step for both types of officers was to determine the types of weapons available and to disarm the person. Rural officers described reliance on personal resources, such as their "strength and agility"(A), urban officers mentioned the use of batons and looked forward to being permitted to use "pepper spray", which has since become important in their arsenal of equipment for such interventions.

Officers described generally working in pairs; the quality of back-up was attributed to fellow officers' experience, except where superior and commanding officers accompanied a rural officer and watched, rather than participated in, the intervention. Officers described recruiting other assistance when necessary, from ambulance

drivers and other medical personnel in urban accounts, and from family members and neighbours in rural accounts. Community relations and reputation were considered extremely important for rural officers, but were not mentioned by urban officers.

When engaging in interventions, officers followed the rules of their training and adapted their training to the needs of the situation. Suitable interventions were determined in consultation with fellow officers, victims, family members, and community authorities. Communication was considered an important aspect of intervention for both types of officers, but it appeared in rural interviews as the most important feature. Both types of officers described communication as a means to defuse situations, to assess the need for further intervention, and to facilitate transportation. Urban officers described the importance of communication, but rural officers provided countless examples of interventions in which communication and communication style played a key role in the outcome. The use of restraints in such interventions, by either group, was reported as rare.

Rural officers and one urban officer described interventions where violence occurred between spouses; for urban officers this appeared to be entirely a criminal justice matter while for rural officers, spousal violence was frequently perceived within a context of mental health

problems and thus included in descriptions of interventions under the Mental Health Act. One rural officer, the only officer to describe numerous interventions with youth, described interventions aimed at preventing sexual assault or harassment. Rural officers enjoyed continuing interactions of one sort or another with persons with whom they had intervened; urban officers were rarely aware of the outcomes of their interventions.

CHAPTER 8

***POLICE INTERACTIONS
IN FURTHER INTERVENTIONS***

POLICE INTERACTIONS IN FURTHER INTERVENTIONS

There are four possible outcomes of police intervention in situations where a mental health problem is suspected. The first, "no further intervention", includes cases where officers do not take complaints seriously or manage whatever intervention is required. In such circumstances urban police involvement ends until such time as another report is received. Rural officers may attribute the disturbed behaviour to a situation which they resolve by explaining matters to the person, or by involving his or her family members, friends, neighbours, or other personal supports. Warnings may be issued; other solutions may be implemented such as the case in which money was made available to help a person on her way. Follow-up to receive feedback on outcomes may occur, or voluntary feedback may be received. Such incidents are completed within the chapter on police intervention: police do not consider that the person's behaviour sufficiently threatens self or others with imminent harm to require further criminal justice or mental health interventions.

A police decision that a person needs psychiatric help does not predict the final outcome of an intervention. Such help may be found within the community, or community authorities may disagree with police recommendations.

Further interventions under the Mental Health Act involve a wide range of other actors, some with equal or greater authority, who may accept or reject the officer's signalling of a mental disorder or report of disturbed behaviour.

Where the officer's perception is rejected, where serious harm has occurred, and under particular legislations, criminal justice processing may be a preferred or a default option.

COMMUNITY INTERVENTION

Community authorities who may become involved in interventions, at police request or as a matter of course, include mental health workers, child protection workers, adult protection workers, volunteers such as members of Alcoholics Anonymous and similar programs, school authorities, and local medical authorities. Where there is disagreement with community authorities who are not also medical authorities, the officer's authority is greater.

In rural accounts, the great variety of persons with whom officers interact form the group described by Bittner (1967) as "instrumental". In urban accounts child protection workers are the only non-medical persons with whom officers describe collaborating in interventions. Their failure to mention other urban community health or social agency suggests few interactions.

Mental health resources

Rural detachments in the eastern and western districts described many interactions, but differed in the number of services available and the types of interactions they had with their local authorities. In the rural district to the east of the urban centre, a "resource bank" was developed of persons to whom officers may refer clientele: "we had a booklet made up of all the agencies we could contact for any help, including psychiatric help"(C).

Community options were preferred to institutional referral. The senior rural officer described familiarizing new officers with these resources; knowledge of such resources facilitated police intervention:

We have the facilities; we utilize them to the maximum. The constables are more than willing to help anybody. (...) He just don't pass it off and say, "it's the doctor's problem". We deal with it. And again, I repeat, it's got to be due to the facilities being available to us.(Officer C)

Persons perceived as mentally ill may contact resources voluntarily; having referral information to provide eliminates the need to "charge somebody for the sake of charging someone"(C). Referrals may be made to the local doctor, who may refer the person for further assistance: "the local doctor will communicate with somebody, 'eh, you'd better go and have a talk with this person, he needs help'. (...) We get people that'll come out to homes"(C).

Again, police intervention ends with the referral:

"it's left alone, with some feedback from the person that interviewed this or tried to help. (...) We're satisfied, we close an occurrence; the incident report is therefore closed"(C). The process includes immediate feedback from the mental health worker or other professional who becomes involved, and the officer describes "a closer network of people working together"(C). All of the rural officers preferred community solutions to urban psychiatric referrals, but the rural commanding officer would prefer to have specialized psychiatric services come to the community: "the people could come out to the community and work within a community"(C).

In the rural area to the west of the urban centre, officers also refer persons to community authorities, particularly doctors at local hospitals, and case workers in health units. With the latter, there is an agreeable level of cooperation: "if they feel that yeah, this person is really bad, well they'd look after it"(B). As in the other rural detachment, officers may not be required to engage in further interventions: "we just make a referral to them and let them look after it"(B). Mutual assistance is the norm:

[The mental health worker] could call today and say: "Hey listen I've got to go this afternoon and see so and so. And he's -- geeze, I don't know -- I was talking to him on the phone and he was acting, or he's sounding, a little violent or a little weird there. Could one of the guys go out with me?"(Officer A)

Officers try to accommodate such requests: "we make that

accommodation, because it's important"(A). All of the rural officers valued cooperative relationships with community workers. Such services are extremely limited, however: two mental health units in the district to the west of the city, with minimal staff, were the only agencies described as resources. Even those resources were in jeopardy, according to the officer, at the time of the interview:

You'll hear that they're gonna be cutting back on social programs and all of a sudden these people are starting to wonder whether they're gonna have a job tomorrow or not. (...) It's just a crying shame 'cause these people still fill such an important function out there. Those gals are so busy. (Officer A)

Such cutbacks have occurred since this research was conducted.

Rural officers demonstrated considerable respect for community workers, and indicated that "it would be nice to have two or three times the number of outreach workers"(A). Rural officers from this district excluded doctors from their otherwise unqualified report of cooperative relationships with community mental health workers.

Volunteer resources

Alcohol is frequently involved in mental health issues, and a number of urban alcohol or other addiction programs are managed through the outpatient department of the regional psychiatric facility. Rural officers meet the needs of alcoholic clientele through cooperation with

members of the local chapter of Alcoholics Anonymous.

Persons are may be referred to such programs: "these other programs that have worked for other people, why don't you try it?"(C). These volunteers assist rural officers by providing direction or acting as a resource:

The trained people that are on these programs, I have all the confidence in them because that's what they do. (...)
Volunteers in no matter, no matter in what field in the community, it's A-one. A.A., Alcoholics Anonymous.(Officer C)

Residential care facilities

Relationships with community volunteers and mental health workers, extremely important according to interviews from both rural detachments, received no mention in urban interviews. Urban officers were called to act as a resource within adult residential facilities, but did not draw on such experiences to demand assistance for clients. Often they are "called to respond to a home or to a facility"(E), according to an urban account. The senior urban officer describes frequent interactions with the residents of "several adult residential care facilities"(F), outside of the facilities and not in response to requests by staff. Another urban officer described looking for persons and consulting with residents of the Salvation Army hostel, but did not mention any cooperation between officers and their staff. The relationships described are with the clientele of the organization, rather than with its workers. To a

question concerning available resources, an urban officer demonstrated little familiarity with community agencies. He described a "drop-in centre"(E) that provides services which he was not able to identify, and interactions between officers and the centre's clientele but not with its staff.

Resources for youth

Children and Family Services, to which officers referred by its former name, ("C.A.S.", or the Children's Aid Society) was the only community agency mentioned by both rural and urban officers. An urban officer describes intervening at foster care facilities, suggesting interventions with violent children: "sometimes they can get pretty broken up from the kids going on rampages and that"(F). A rural officer also describes cooperation with workers of this agency: "we work very close with Children's Aid"(C). Another rural officer in the same district cites examples of disagreement with child protection workers: as stated, the officer's opinion prevails:

I said, "this child cannot stay here" (...) and then she asks us, "well look, we're in charge of the child". I said, "That's good; I'm very pleased to hear that. However, my mandate dictates that I must protect people, the person keeping him, as well as the child. And that kid is not staying here tonight."(Officer D)

He is sympathetic to the constraints under which staff of the agency work: "C.A.S. is caught in the same situation, they have nowhere to turn (...) they have no place to keep

him, or the places are full"(D). He regrets the lack of services for older youths: "C.A.S. don't want him, because he's too old. The parents don't know what to do with him. (...) What do you do with him?"(D). The excerpt underlines a general shortage of community mental health support services, particularly for young people, in rural areas.

The same officer describes frequent interactions with authorities at the local high school. Incidents of cooperation were reported in which two students report a "bomb threat"(D), and in which a teacher with a difficult student (already the subject of intervention) asks for assistance. The officer is disillusioned with education authorities: "the school says, 'it's not our responsibility'; the teacher says, 'I'm not there to discipline'"(D). The officer describes acting as a resource for the school, and an extensive involvement: "I go to the school a lot"(D). He supervises some activities: "last year, I went camping with the kids for three days"(D). His familiarity permits him an unusual participation in their "criminal justice" education:

They know me. And when I go to their class, I don't tell them their rights; they already know more than enough about that. I tell them, "my rights". (...) And I tell them, "your rights stop exactly where mine start".(Officer D)

Not only does the education system fail to guide or to discipline, according to this officer, it also fails to educate: "the only thing they are eligible for is go to

university and get a degree in basket weaving"(D).

MEDICAL INTERVENTION

Rural interviews commenced and predominated in the previous section; they will predominate in this section which commences with excerpts from urban officers although references to general practitioners were few. Urban reference to general practitioners is in a different context from that provided by rural officers. Police may recommend that patients or their parents consult their family doctor directly to make arrangements for admission to a facility: "there has been no need for us really to be involved, other than perhaps as an ear for the, for the parent to get some more advice"(E). References in urban accounts involved requests for consultation with a doctor by persons charged with offenses. Generally, officers cooperate by calling a doctor; doctors cooperate by adopting the officers' prognosis that "he doesn't need a doctor"(F):

We'll call a doctor and we'll say, "we've got J... in here again. Is he on medication? What's your charts tell us? Is there anything we should know? Do you want to talk to J...? Do you want us to bring him down?" And, "no, J... 's just a pain. Just leave him there. Tell him to lie down. Give him a glass of water; he'll be fine."(Officer F)

Immediate assessment

Rural and urban officers are bound by the same regulations in such interventions, the 1987 Ontario Mental Health Act at the time of this research, which require that a person signalled as having a mental illness be taken for immediate examination by a physician. Urban proximity to psychiatric facilities permits this examination to be made by the doctor in charge of emergency services at the facility.

The greater the distance from incident to facility, the more frequently rural officers described negative interactions with doctors. In the nearer rural district to the east, where interactions were described as cooperative, a client may be referred to a doctor to avoid removal from the community: "the doctor that we worked with was a local doctor, and very familiar with the patient"(C). The proximity of the medical centre to the detachment (it is located in the neighbouring building) may be a variable in the quality of interactions: "we have a good relationship with our doctors, here especially"(C). The officer may simply transfer responsibility to the doctor: "we don't have to take that person to hospital, but she's referred by the doctors to somebody"(C). Transferring responsibility relieves the officer of the providing transportation. To avoid transporting a client, officers may refer the family to a doctor:

We used to take them in on a Form-1 -- on our authority for evaluation, but now we mostly depend on either the parent or the husband or the wife, to go to the doctors and have the doctors sign the Form-1, and go that route rather than us bring him in forcefully. (Officer C)

The "Form-1" is an application "for a psychiatric assessment of the person", completed by a doctor based on his or her observations, or "on the basis of facts revealed by others". This is the authority required "to take the subject of the application in custody to a psychiatric facility, to detain the person in the facility, and to restrain, observe and examine the person there for not more than 72 hours" (citing the *Guide to the Mental Health Act*).

A community officer of the same eastern district provides accounts of transportation for psychiatric assessment. In an example involving a young person, consultation with a doctor was not described. Child protection workers, mandated in Ontario to act as the child's guardian, may provide the necessary authority; obtaining the young person's consent would not be necessary. Proximity may also be a variable: the eastern detachment is a 45-minute drive as compared to the 2-hour drive from the western detachment to the nearest psychiatric facility. Transportation from the nearer detachment may qualify as sufficiently "immediate".

Rural officers from the western detachment require such authority to transport a person, without his or her

consent, to a psychiatric facility. Their greater dependence on medical cooperation to exercise their mandate results in contrasting views from those expressed in urban accounts and the other rural accounts. A shortage of doctors is the first concern: "they're lucky to get a doctor in [town 20 kilometres distant]"(B), more frequently "either you're gonna run them to [towns 60 and 70 kilometres distant]. "Its only half an hour run"(B), he adds, from the community station 40 kilometres distant. When doctors are on duty at the nearest hospital, the officer describes them as "usually"(B) cooperative.

Doctors around here are pretty good with suicide, attempt suicides. They'll sign a Form-1 and off they go and get themselves examined. (...) But if he's been before a doctor and the doctor says, "oh yeah, no, he's not crazy", you know, you see, our hands are tied. (Officer B)

Another officer from the western district described the lack of cooperation from local doctors as "the biggest problem we have"(A). There are some exceptions, willing to act "on the basis of facts revealed by others"(A) as authorized by the Mental Health Act:

Some doctors I can call up and say, "Hey I've got a problem with so and so. This is what he's supposed to be doing. We're going to pick him up now. Make me up a Form-1." (...) You leave the guy out in the car with your partner and you go upstairs, pick up the Form 1 and you're gone. (Officer A)

More frequently, doctors disagree with officers.

Several reasons for refusal to authorize

transportation were provided. First, some doctors seem genuinely reluctant to invoke the Mental Health Act or any agency of social control that will deprive a person of liberty:

The first big problem we have around here, when you're dealing with that type of person, is finding a doctor that's got the balls to listen, okay, and act upon the Mental Health Act, okay? Actually "Form 1" somebody. (...) If you're a doctor, and you put a Form 1 on somebody, you're depriving the person of their, their liberty, and most doctors -- ah I shouldn't say though, they don't have the balls, I think they don't -- yeah, I guess that's the proper term. They don't want to take that responsibility. (...) "I don't know about taking this guy's liberty away from him." (Officer A)

Some doctors may have a vested interest in not authorizing transportation:

If these people are not violent then they're going to go by ambulance. And so now the doctor's thinking, "am I going to risk having my ambulance away from my hospital for five or six hours?" (...) So he's, he's saying: "Well, I've tried. I'm not going to Form-1 him, guys. There's nothing wrong with him". (Officer A)

Some doctors do not want to take on the work required to comply with an officer's request: "once you get a doctor to give you a Form-1, then the doctor has an obligation. He's going to start phoning around"(A). Authorization to transport is dependent on access to resources: "A lot of times a doctor will resist the urge to Form-1, if he can't find a bed that's readily available"(A). The officer suggests that doctors should have increased power to command

a bed:

What has to happen is that these doctors have to have a number where they can phone and say: not "is there a bed available?" but "when can my client come in for an assessment?"(Officer A)

Doctors were also described who were unwilling even to come to the hospital when not on duty:

Problem number one is getting a doctor that'll even come, in the middle of the night. (...) On the weekends, on Saturday night, when there's no doctors around. This is usually when you're dealing with these individuals.(Officer A)

Transportation

Officers attempted to avoid transportation. All officers preferred enlisting the assistance of others to transport a person who is not violent, or having him or her transported by ambulance. The person transported by an officer will either have threatened violence, or no doctor has been consulted (urban incidents), or no ambulance is available (rural incidents). In urban areas, persons who are not dangerous will probably be left to their own devices: "he's not going to hurt himself and he's not going to hurt a soul. And it's, "have a nice day" (...) we don't do anything under the Mental Health Act"(G). Officers may accommodate requests for transportation: "we will take the person to the hospital if they request"(E).

Transportation for psychiatric assessment requires a considerable investment of police time and manpower, even

for urban officers, due to the general rule that "two officers shall go"(B) and the Mental Health Act provision that requires officers to wait until an authority at the hospital assumes custody of a person unwilling to enter voluntarily. A person unwilling to be transported may require the intervention of two or three officers:

Failure to comply, well then you have to take him into physical custody. Most of the time the presence of two or three officers will, you'll be able to take him into physical custody without too much of a struggle.(Officer F)

A rural officer explains that officers have little choice but to provide transportation: "it's our responsibility to transport violent and psychiatric patients"(A).

The decision to transport is not frivolous. Having made the decision, "you suck it in and you go down and you try to get the person into your cruiser"(A), the rural officer relates. The client is no less reluctant to be transported than the officer is to transport. Transportation to a facility is preferable to transportation to a rural jail cell: "then I guess he, he looked at his options and decided that he was going to go along"(A). Transportation to a facility may be perceived by other officers, or by members of the community, as preferential treatment:

My boss or whoever knows my association with this individual, and they're gonna say, "well if that had been so and so he would have just been thrown in jail, and that's all there is to it, but because so and so knows [the officer] they've gone this route".(Officer A)

Having succeeded in persuading or coercing a person into the police cruiser, urban officers take him or her directly to a psychiatric facility. Rural officers generally take the client to a doctor, as addressed in the previous section, and subsequently to the psychiatric facility. Urban officers call the facility to prepare for their arrival:

A lot of the times we'll say, "well I have somebody here and we're heading to this hospital", and they'll call ahead. (...) They'll either send us off or they'll say, "okay, fine, keep on going".(Officer G)

In most cases, making arrangements is the responsibility of the doctor:

They'll phone [town, 3 hours distant]; they'll phone [town, 2 hours]; they'll phone [town, 2 hours], they'll phone [town, 2 hours] to find a facility that'll take this individual, just for an assessment. Just for the assessment, because that assessment is good for a hundred and twenty hours or something like that, something like that or five days. But to find a bed for this individual! So this doctor, that night, he phoned all over the place and he found a bed that was available at [a general hospital]. I guess they have a psychiatric wing down there.(Officer A)

Sometimes the officer is required to make those arrangements: "at three o'clock in the morning, he's [the doctor] not phoning (...) trying to find a bed, you know, and getting some grouch on the other end of the line down there saying: 'we got nothing for ya'(A)". Shortage of beds is equally a problem for urban officers: "we were told by all the health care facilities, 'there are no beds'"(F):

We need more beds for psychiatric patients.

I mean that's -- it's a disgrace, for the way the beds are being shut down. There is a much greater demand for inpatient beds, and a different way of handling patients. When the police bring them in, there's got to be some sort of, "hi, here you are". (Officer F)

To have local beds designated psychiatric was a demand frequently made by rural officers: "in an area like we are right now, there has to be a guaranteed bed"(A) or a wing "with four or five beds"(A). The decision to transport may depend on access to services; lack of resources makes condition or need a secondary concern.

Reception

Transportation is not completed upon arrival at a psychiatric facility. The Mental Health Act requires that the officer remain in charge:

[A] constable, or other peace officer, or anyone else who takes a person in custody to a psychiatric facility shall remain there and retain custody until the facility accepts custody of the person. (...) The peace officer's duty is to remain until effective control of the person has been transferred to the facility. (Page 9, *Guide to the Mental Health Act*)

In contrast to the previous sections, references to psychiatric facilities and interactions with emergency room personnel were frequent in urban accounts.

Officers first concern is the lack of a triage system for psychiatric emergencies. An urban officer describes: "you take your numbers. If you're the tenth

person in there, the doctor will see you after he sees the next nine"(G). The demand for triage is reiterated by another urban officer, who suggests that a person "taken down by the police"(F) should "be handled separately than the mainstream person coming off the street"(F). Officers, like accompanying family members or friends, are told to "get in line"(F). Related to this lack of triage is a concern, articulated by the senior urban officer, regarding a complete lack of interest by emergency room staff in the officer's observations:

Policemen are never spoken to, at the hospital. Very, very seldom will the nurse or a doctor come to you and say, "I want to be briefed on why you have this patient here". Why not? They ask the ambulance attendants, when they come in, "what happened while you were en route to the hospital? What did you see? What were your observations?" (...) I might have taken mental patients down a hundred, two hundred times, in the more than twenty years I've been here, and I could probably count on one hand the number of times a doctor's come out and said to me, "What were your observations?"(Officer F)

The public nature of most of the waiting areas was a concern in urban general emergency facilities. The person transported by officers waits with other patients "between two big burly policemen (...) in a big open room"(F). Their presence may upset patients in specialized emergency facilities as well, who "come in and there's two big burly policemen sitting there with a patient, and they start screaming"(F). A smaller general emergency facility

provides officers with a separate waiting area, although the "first come, first serve" rule holds:

You're still going to be waiting (...) and there would be no doctor seeing you any sooner, but you're in your own little environment and it's easier to control (...) we're disturbing a lot less people, like if he's still acting up, and there's less distractions for him to play off of. (Officer G)

An urban officer calls the wait "lengthy, but it's not like it used to be" (G). He describes an improvement from "three, four hours, easy" (G). Another urban officer suggests that waiting periods vary: "in my most recent experience, they decided to take that person in, within probably half an hour" (E). On other occasions: "I've certainly sat in hospitals (...) in excess of three hours" (E).

The person who has been transported may also find the wait lengthy. This may work to the officer's advantage:

The longer we were at the hospital, the more violent he became, the more aggressive he became towards the staff to the point that they decided, "yes, we are going to admit this person". (Officer E)

Rural officers reported the opposite. The person's behaviour was no longer disturbed by the time of arrival at the facility:

After he gets talking, after he gets to the psychiatric facility, and they start (...) a proper assessment, all of a sudden (...) the individual, the patient, is not feeling like he's being manipulated, he's being pushed around, or he's a prisoner. Then all of a sudden he's starting to feel like he's a patient! And these people are here to help him, and there's a feeling of trust, and all

of a sudden it's not an involuntary situation anymore. The doctor will say: "I would like you to stay here for a couple of days, while we do this and while we do that. What do you think?" and probably, nine times out of ten, the guy will say, "sure, no problem", you know. Not always, maybe nine times out of ten, maybe seven times out of ten. (Officer A)

When the physician at the facility sees the client, urban officers may leave. Whether the client is admitted or sent home, custody is transferred to the attending physician and involvement by urban officers' is completed. Custody is not transferred when transported rural clients are seen by the physician. The Mental Health Act actually requires officers to remain until the physician's diagnosis is completed, and a determination by the attending physician that the person is not in need of emergency psychiatric care places the officer in the position of having transported a person many miles from home without a means of returning. Rural officers continued to find the waiting period long following the time the person is seen by the doctor:

It's a long wait. (...) They just take the person and off they go and we don't see them until either they're kept or they're released. And we're obliged to hang around until, you know, the interview is done. (...) Sometimes two hours, while you're sitting in a little room waiting and waiting and waiting. (Officer B)

Rejection/admission at a psychiatric facility

Officers and authorities at psychiatric facilities frequently disagree on the need for intervention. An urban officer suggests that doctors and police operate under the same constraints: "if the doctor's not satisfied that it's happening, right then and there, his authority [to act] is gone just as ours [is]"(F). This is not consistent with the Mental Health Act. The *Guide* states the following:

The Act gives a physician latitude in forming an opinion based on his or her belief, either through his or her observations or on the basis of facts revealed by others. On the Form-1, however, it must be clearly indicated which facts were observed by the physician and which were observed by others. (...) [The Form-1] must state that the physician who signs it personally examined the person and made careful inquiry into all the facts necessary to form his or her opinion of the nature and quality of the mental disorder. (P.4, *Guide to the Mental Health Act*)

The Mental Health Act permits a physician to act on the basis of information received. As described by officers in the previous section, however, their information was rarely solicited. As suggested by the rural account, the senior urban officer also found that prospective patients were calmed down by the time of arrival at the emergency facility: "the doctor doesn't have the opportunity to go back to the house, and talk to the family (...) the doctors don't get a chance to go that far"(F). Another urban officer maintains the stereotype that psychiatric patients are manipulative: "a lot of times they've been through this

doctor, or the medical facilities and they know exactly what answers to give to their questions"(G). He is more sympathetic toward the doctors: "he just has his program of answers that he is providing the doctor (...) if I heard it, and I didn't see the actual situation (...) I would, too, probably release him"(G).

A recovery of normal functioning is not always the reason for disagreement. A frequent complaint is the lack of time physicians take to make an assessment: "[officers] get in their car and the patient's at the taxi, at the taxi stand calling for a taxi"(F). Rural officers report arguing with doctors, and requesting a second opinion:

After interviewing him for about five minutes and he says, "there's nothing wrong with him, officer, you can take him away". Whoa! Just a minute! Heh heh. I'm saying to this doctor, "ah, this guy is staying here. I am not taking him back with me". "Well what do you want me to do?" And I'm saying, "give the guy an assessment, give the guy an honest assessment". "Well I just did."
 "Well I don't agree with what your, what your assessment is. Let's bring somebody else in for a second opinion." "Well, there's nobody else to give you a second opinion."(Officer A)

Two rural officers described threatening to leave the client at the facility. "You tell me, as a doctor, that he's fine? Fine. Goodbye. You're on your own"(D) is provided by one rural officer, and from another:

I'm saying, "Listen, I'm gonna leave this guy out in your waiting room. If you think he's not a threat to anyone then I'm gonna leave him in your waiting room, 'cause I'm

not driving him back to [town]. I'm telling you, I just drove two and a half hours down here with this guy and I'm not driving back with him."(Officer A)

While the threat may not impress the doctor, the client may decide to enter voluntarily:

I got the piece of paper, the form authorizing me to do it from the doctor up here, and he's down there, he don't want to be down there. (...) He's now heard the cops say, "I ain't taking you nowhere". So now J... 's got a big decision to make. Because J... 's gonna be involuntary or he's gonna be voluntary. If he's gonna be voluntary, then fine, he can stay there.(Officer A)

Voluntary admission is a desirable solution for medical authorities and an acceptable one for officers, provided a bed is available. Since this is a rural example, an available bed was confirmed by telephone prior to the transportation.

Clients who are known by the facility will be more readily admitted than new clients;

It may be that that person is already attending at that facility on an outpatient basis or perhaps, or perhaps they're well-known at that facility, in which case you shouldn't have many problems in dealing with or speaking to somebody who's aware of this, or they can pull the files and assist that person.(Officer E)

When a person is not a previous patient "it may be that much more difficult to get that person the help that they may need"(E). Known clients are more easily assessed and treated:

They're already aware of what that person is suffering from. (...) If there's medication

that's required, they're aware what that person is already taking, or should be taking, and they're aware of the medication and whether or not that medication would maybe perhaps need to be changed or increased.(Officer E)

A rural officer attributed differential treatment to varying hospital policies:

Luckily there was an assessment available down at the [regional facility]. Well geeze! The [regional facility]! What a super place! You know what I mean? Always they are willing and available to help you. You never ever have to truck anybody away from there.(Officer A)

Other officers, rural or urban, did not express variations in opinions concerning different hospitals, with the exception of the urban officer's appreciation of the small general hospital's provision of a separate waiting room.

The standard procedure following a decision to admit is to sedate or otherwise medicate the person so that he or she may be taken to a ward. An urban officer expressed surprise at the patient's tolerance to medication: "he took two full vials of that before he even started to come down"(F); a rural officer expresses surprise at the quantity of medication administered: "I think they pumped enough drugs into this guy, you know, to kill an elephant"(A). Urban officers may assist doctors in subduing a person who is involuntarily admitted:

The doctor could use as much force as necessary to sedate a patient, in other words, if it takes five or six attendants to forcibly hold a person down, until medication is given. Sometimes we can go

and do it with just one or two of us,
because we have the experience to handle
that.(Officer F)

Even if admitted, officers complained that persons were not kept in hospital for a long enough period to provide sufficient treatment. In addition, the time allowed by the Mental Health Act is insufficient to protect persons who are threatened by transported individual: "they hold him for thirty-six or seventy-two hours, and then let him go. And that doesn't solve the situation here"(D).

CRIMINAL JUSTICE INTERVENTION

Attempts to have a person admitted to a psychiatric facility, despite arguments and threats by officers and the perceived needs of the client, are not always successful. If an infraction has occurred, an officer has the option to initiate criminal justice processing. Persons may be detained in cells in the police station: "we have six cells here. He would be lodged here for the night, and then he would go to what we call a 'show cause' hearing the next morning"(F). Most officers considered arrest and detention in a jail cell inappropriate for persons with mental health problems: "A police station is not an adequate place for a person that is mentally disturbed, or has a mental illness"(G), states an urban officer. Another urban officer agrees, and explains:

From what you saw in the cells, they aren't
the rooms designed for that. (...) They're

not padded. And we have seen more than one fellow trying to do a nose dive off into the toilet, off of the top of his cell.(Officer F)

A rural officer questions whether detention is appropriate in most cases:

He's roaming about, and then when he does something wrong, we pick him up and we penalize him. And that's only through the penal system that the correction takes place. But is it a correction?(Officer D)

He describes a preferred solution:

What I'd do is, order a Victoria nurse, that could go by and say, "Did you take your pill today?" It would be cheaper maybe, in the long run, that, than go through the whole judicial process to handle that situation.(Officer D)

Detention when treatment is not available

Officers mentioned using criminal justice resources when no means were available to obtain treatment. Various types of reasons may be used. Persons may be detained and held in custody based on failure to comply with previous court orders: "he has 'fails to appear' from previous [incidents], or he has outstanding indictable offenses, the judge, justice, may order him detained until another hearing"(F). Officers may press minor charges in order to detain the person until a court appearance: "I started by charging him with trespassing"(D), and "I charged him for causing a disturbance, and I locked him up"(D). Pressing charges may seem completely inappropriate, despite a record

of similar offenses: "you just don't take somebody in for a show cause on a 'disturbing the peace'"(D).

To press charges may not be an option in cases such as threatened or attempted suicide: "if I counsel you to commit suicide, I'd be committing an offence, but if you attempted suicide yourself, it's not an offence"(B). For some offenders, including mentally ill offenders, criminal justice processing is considered the only effective deterrent:

There's always the hard timers (...) that just won't do it. There's no corrective measures that we can take to try and correct them. We try our best, we can go two, three times with this procedure that I just mentioned. And once we find that there's no reaction to it, no adjustment to better himself, or to get on the right track, then I think we have to go to the legal system.(Officer C)

Detention as a preferred option

Where there is a threat of imminent harm to another person, officers may hold a person in custody until an assessment can be made by a court appointed physician:

They've done something criminal and they have to be charged for it. (...) We would (...) hold them overnight if it's the night time, hold them over for court in the morning and have that person see the court psychiatrist to have him determine whether or not that person is in need of any further care.(Officer E)

A rural officer concurs that the same procedure is used by provincial officers, despite the perception of mental

illness as a factor:

He's going to have to go to jail. He's gonna have to go through a bail process. The court is then gonna have to find -- or his defence lawyer, whoever -- is then going to have to go through the process of finding him a psychiatric assessment to see whether in fact he is suitable, you know, whether he had the mental capacity to appreciate the nature of the crime. (Officer A)

In the case of grievous bodily harm to another, criminal justice intervention is the rule. Officers provided situations in which they felt they had no choice but to press charges: "the act they're doing may be a criminal act; it may be an assault or something like that"(A). The senior urban officer provides several incidents in which persons committed murder, and were processed through the Criminal Justice System rather than the Mental Health System, despite apparent mental health problems. In one incident, a young girl "had been bludgeoned to death"(F). The person was arrested, tried, and eventually detained in a provincial psychiatric facility under a *Warrant of the Lieutenant-governor*.

Psychiatric custody is not the only final outcome of arrest and trial, even in a case where officers intervene to find the person "laying on the bed with the shotgun in his mouth"(F). The person "was charged with murder [later] that day"(F), tried and imprisoned despite mental health problems that threatened imminent harm to self: "he was down there a month or two months, and he committed suicide. So he would

have been in Kingston. [location of federal penitentiary]"(F).

One rural officer provided a serious case, in which a person who had committed rape subsequently killed himself rather than be arrested, in the context of mental health interventions.

Domestic assault policies

In the case of assault between spouses, in spite of perceived mental illnesses, officers had no discretion whether to press charges under legislation current at the time of this research. The senior rural officer explains that "every incident that comes in, of a woman or wife being battered, must be in the court system"(C). Exceptions to this policy were not made, as explained by the senior urban officer:

The spousal assault policy that we're on, there are an awful lot of shocked husbands in here on a Friday and Saturday night. (...) It hasn't reached a lot of them, especially the middle-income, the middle and higher-income people. (...) I won't say they feel they're above the law, they just feel spousal assault doesn't apply to them; that spousal assaults apply to low-rental, low-whatever, you know low-income people or people that are on welfare. (...) It doesn't work, everybody gets treated identically. (...) You can have a long criminal record and you beat your wife up, you come in here first, and you stay 'til the morning. You can be a first-time "punch your wife in the mouth", be making two hundred thousand dollars at home, and you stay here 'til morning. (Officer F)

A rural officer provides the perception that attitudes toward spousal violence are changing: "women are a little bit smarter now, too. They know they can get help"(B). All of the officers who discussed domestic violence attributed increased referrals to a change in attitude, rather than to an increase in violence. Domestic violence was the only situation with frequent mental health concerns where officers described having no option but to lay charges, although rural officers did report incidents where persons were transported for further mental health intervention without being charged.

Criminal justice processing

Appropriate sentences were addressed. Officers may request a light sentence, particularly in the cases of young persons. A rural officer describes such a situation: "I'm gonna talk to the Crown and say, 'maybe fifty hours of community work and a suspended sentence' so that they don't have a record"(D). Probation was considered appropriate for a mentally ill person, although unlikelihood that conditions would be met argued for a harsher sentence in one incident:

He was released with conditions. I know we say, "well, the conditions are good for nothing because he's mentally ill." But my point of that was that, short of that, there is nothing in the system that protects that victim.(Officer D)

Driving privileges may be suspended but an urban officer explains that this prohibition is also difficult to enforce:

We knew he was driving on a regular basis. We had also alerted the towing compounds, because his car was constantly being towed, that if he came back and got the car and got in it and drove, to call us. (Officer F)

Some rulings are severe, as in the case of a person who was acquitted but nevertheless detained for ten years: "he actually, he was found [not] guilty by reason of insanity. I think he's still at [provincial forensic facility]" (F).

A criminal record may be considered a burden, in the case of young persons, or a learning experience that is necessary consequence to persuade that person to change his or her behaviour. While a record of criminal justice intervention may be a severe outcome for a young person, it may be seen as an inevitable and deterrent consequence from which a person learns that his or her actions were not acceptable:

At that point, the judge supports what we're doing, and he may order community work. But he's went through the process, criminal system. At that point, it's documented. And the kid knows, the young offender knows, or that person knows, that he's got a record. (Officer C)

Where it has acted as a deterrent, having a record is not considered too great a cost: "there was no great consequences other than a record" (A).

An extremely common outcome described in rural interviews was the loss of a person's right to own firearms. Recourse to prohibition of firearms is frequent, and a variety of examples are provided: "do you seize his firearm?

You put a prohibition against him, that's it"(B); "you submit the report through the firearms prohibition"(B); "he wasn't charged with anything; he was put on a firearms prohibition"(A); "he didn't get thrown in jail; he wasn't given a big heavy fine; you know, his right to use firearms was taken away from him"(A).

In many cases, rural residents consider this outcome to be severe. A rural officer describes a person previously referred for psychiatric treatment, in an incident involving a firearm. When he requests a Firearms Acquisition Certificate: "I didn't believe he was an appropriate candidate so I refused him"(A). The officer adds that a person "has a right of redress"(A) when denied a certificate, although generally the restriction is not disputed: "very few people do that, but this individual decided that (...) he still wanted his F.A.C."(A).

An appeal of a firearms restriction, made for mental health reasons, is difficult for officers. First, officers do not qualify as experts on mental health or mental illness:

And obviously when I go to court, they ask you for an opinion, you give it and then they say, "are you a doctor?" "No, I am not." And then, "well, then, keep your opinions to yourself".(Officer D)

Secondly, information that the person has been diagnosed and received treatment for a mental illness may not be admissible: "we couldn't get any of this stuff in"(A). The

information is considered "hearsay evidence (...) the judge couldn't do anything with it"(A).

If we wanted to introduce the fact that he was taken to psychiatric facilities (...) we would have to subpoena the psychiatrist from the facility to come up here to give testimony in court.(Officer A)

The officer emphasizes that "I sure as heck couldn't give him an F.A.C."(A), and intervenes by having the individual "write a letter, addressed to the court, that he had changed his mind"(A) by threatening to have the psychiatrist brought to court:

"Aw, [officer], do you have to do that? Do you have to do that? I'm gonna be so embarrassed. Everybody's gonna hear it."
"Yeah, that's right. Yep, anybody who's in court that day is gonna hear exactly what happened that eve -- that morning. And they're gonna know the circumstances. And I guess that's part of the consequences of your actions."(Officer A)

This type of persuasion resembles earlier "psychiatric first aid" interventions; it was highly successful in a rural area but might not have worked as well in a context of urban anonymity.

A major difference between rural and urban dispositions was related to the distance officers must travel in order to obtain psychiatric services for their clientele. Rural officers avoided transportation whenever possible and referral to community mental health workers, volunteers, and sometimes doctors were the preferred rural disposition; further referrals may occur without police intervention in rural areas.

In situations where officers determine that further mental health interventions are required, authority is shared with health authorities. For both officers and medical professionals, this type of shared authority occurs only in this situation. Only in the rural station situated next to the medical facility, where interactions were frequent, was this sharing of authority comfortable and reported as generally harmonious. Both local doctors for rural officers, and psychiatrists at urban facilities for both types of officers, were seen as stumbling blocks to finding the care and treatment necessary to help persons with mental health problems. Both rural and urban officers described threatening to leave clients at hospitals, and rural officers reported arguments with authorities in order to have persons transported and admitted at facilities.

Where treatment at a psychiatric facility was refused, behavioral problems might be considered too threatening or harmful to permit the client's remaining in

the community without treatment. Criminal justice processing was at times initiated in order to obtain another psychiatric evaluation. Criminal justice processing was described as inevitable for incidents of domestic violence, and when officers were unable to ignore seriously threatening or harmful behaviour. Officers did not describe the quality of criminal justice processing as more effective than mental health processing in determining treatment of mental health problems, but expressed the opinion that it frequently deterred further criminal behaviour.

CHAPTER 9

SUMMARY AND CONCLUSIONS

SUMMARY AND CONCLUSIONS

The thesis has demonstrated similarity in the types of problems encountered, similarity in the type of referrals received, similarity in reliance on formal psychiatric interventions and in viewing access to such services as the ideal outcome of interventions. Officers similarly resorted to criminal justice processing where situations could not be defused by the officer, and when mental health authorities refused assistance. Both types of officers described criminal justice processing as a deterrent of criminal behaviour, if an inappropriate mental health intervention.

Differences were more frequent, particularly in type of knowledge, sources of knowledge, and subsequently in intervention styles. Despite a far greater threat of weapons use, rural officers did not associate mental illness with danger of violence; for urban officers violence was consistently implied. Differences in attitudes and attributions were demonstrated, and related to variations in training and types of knowledge.

The quality of interactions between officers and clients differed from rural to urban settings, and all officers acknowledged the impact of comfortable interactions in reducing crises and in reducing the need for further intervention under the Mental Health Act. Differences arose

in access to resources, use of resources, mutual cooperation with authorities, and demands for assistance from institutions or community workers. While a lack of rural resources made intervention more difficult for rural officers, it has resulted in a more personal intervention style. Officers' intervening to solve problems was also related to distances from psychiatric facilities, which required rural officers to meet additional criteria -- examination by a local doctor -- for transportation as well as making transportation even more inconvenient than for urban officers. This difference, and rural officers' familiarity with their clientele and their communities, caused a reduction in referrals for psychiatric treatment whenever it was perceived as avoidable. Psychiatric treatment remained preferable, for both groups of officers, to criminal justice processing.

Finally, the demand for greater consultation by emergency room staff concerning officers' reasons for transportation has been the subject of much discussion at a Community Advisory Committee meeting for the General Psychiatry program of the regional facility, on which an urban officer sits as a member. He reports that this source of frustration has been greatly reduced; psychiatric emergency nurses and doctors now consult officers more often, if not consistently.

From officers' accounts, three "officers" can be

constructed: police officers in general, urban officers and rural officers. Their images will be addressed separately.

SUMMARY OF SIMILARITIES

In general, police officers had frequent encounters with persons perceived as mentally ill, but a minimum of interactions that resulted in intervention under the Mental Health Act. Where intervention is requested, most referrals are from persons familiar with the client. Officers generally find interactions with other authorities, involved on a regular basis in a person's life, both positive and cooperative. Reasons for interventions generally concerned suicidal, irrational, and violent behaviour. Medication was considered extremely important, and the manifestation of mental illness symptoms was associated with not taking medication, too much medication, or combining medication with illicit drugs and alcohol. Domestic violence was associated with mental illness, and suicidal behaviour was associated with depression.

Knowledge concerning particular cases was acquired from referral sources, familiar persons (friends and family members), colleagues involved in previous interventions, or available based on officers' previous interventions, general familiarity, and police files. Background information was invariably considered important. All officers considered mentally ill persons unpredictable, and various similarities

were described between symptoms of mental illness and symptoms of illicit drug use.

Comfort with interventions was related to general police training, general experience of mental health interventions, and personal qualities that facilitated communication. Most approached such interventions with mixed emotions due to "fear of the unexpected". Officers intervened when imminent harm was judged to threaten the client him/herself, or others. Judgments of imminence depended greatly on whether weapons were present, and threats to another posed a greater problem than threatening harm to oneself. Victims and potential hostages complicated interventions. Officers described increased awareness of spousal violence and sexual assault problems as a result of more frequent reporting, rather than an increased number of incidents.

The presence of a "uniform" may defuse a situation of crisis involving mental illness, but negative reactions to authority were described as frequent. "Safety first" was a general motto and officers proceeded with caution in mental health interventions. Officers' first step is to disarm the person; the second to open communications if possible. Officers generally work in pairs or more, and recruit assistance from emergency personnel or community members when no officer was available for back-up. Officers augmented police training with personal experience to ensure

successful interventions. Communication was considered an important aspect of intervention: to defuse situations, to assess the need for further intervention, to facilitate cooperation with transportation. The use of restraints was reported as rare by all the officers interviewed.

A separate space to wait in emergency areas was appreciated, since officers acknowledged the effect of a police escort for the client, and of police presence on other waiting patients. Officers desired increased communication with and from hospital staff and encountered frequent disagreement from mental health authorities when assessing severe problems and the need for psychiatric treatment. Officers considered many rejections to be due to a shortage of psychiatric beds and expressed a desire that more hospital beds be so designated. The need for a system of triage at hospitals was indicated, in which officers would be served more quickly than voluntary or family referrals. Admission by a hospital was considered a satisfactory outcome, but clients admitted were generally not kept long enough to ensure sufficient treatment or to prevent harm from occurring in the community.

Serious offenses resulted in criminal justice processing, although all of the officers considered a jail cell not a suitable place for a person with a mental disorder. Where detention occurred, however, officers hoped for and even anticipated a positive outcome. Domestic

violence generally resulted in charges; attempted suicides were not considered criminal behaviour. Charges were laid and minor charges constructed to incapacitate persons who were considered a serious threat to others, and at times following suicidal behaviour. Where no violence or danger of harm was judged, the laying of minor charges was avoided. Driving prohibitions were difficult to enforce. Probation was considered suitable even though conditions were rarely followed. Detention resulted when no alternatives existed, when behaviour seemed more criminal than disturbed, and when psychiatric services were refused. Generally, detention represented a lack of other options and the gravity of the incident investigated. Detention was frequently considered the only effective deterrent even for behaviour perceived as being caused by a mental illness.

In the analysis of attributions, all officers were found to be equally likely to attribute successful interventions to personal qualities, and difficult interventions to characteristics of the clients with whom they intervened.

SUMMARY OF DIFFERENCES

Urban perceptions

Urban officers were alerted by dispatchers of the need for intervention, and referral sources were frequently anonymous. Requests for assistance from hospital authorities were described as frequent.

Urban officers associated mental illness with violence, and with social and personal isolation, with an adequate if relatively poor quality of life, with unhygienic appearance, unusual behaviour, and unprovoked assaults. Schizophrenia was associated with the hiding of emotions, being conniving and manipulative, having seizures, talking loudly to oneself, having unusual physical strength, and symptoms that were continuous or intermittent rather than time-limited. Characteristics of mental illness were considered obvious, visually determined (Down's syndrome), or apparent following interactions. Officers described a constant danger of violence in interventions with mentally ill persons.

Urban officers received specific training by mental health personnel to recognize symptoms, "the things to look for"(F). Officers appear to internalize medical definitions of mental illness, and to focus on negative characteristics. Specific training was also provided in the area of suicide intervention, resulting in reduced concern regarding suicide attempts and the association of suicidal behaviour with

attention seeking. "Common knowledge" was valued and resulted in pseudo-scientific assumptions concerning mental illness and persons with particular diagnoses. Training in communication skills was described as neglected and its importance emphasized by urban officers. Communication was considered important, but not a complete intervention in crisis situations.

Background information was obtained from records, as a result of public knowledge, and from other officers. Second hand information resulted in increased generalization concerning the traits and behaviours of mentally ill persons. Some familiarity with clients resulted following one to several years of patrolling same area. Weapon use, including firearms, was increasing.

Material from their interviews analyzed in the light of Attribution Theory suggests a high degree of bias. Urban officers provided few descriptions of settings or situations and paid more attention to the actions of clients, which were attributed to mental illness rather than to the context in which actions occurred.

With respect to interventions, urban officers unloaded their sidearms before entering facilities where they were requested to intervene. Interventions with facility residents generally occurred in public, and in response to reports by mall business persons. Officers had little or no information concerning the outcome of their

interventions, and returned for follow-up only to complete records of incidents. Urban officers rarely drew on community resources, or cooperated mutually with resource persons, or made demands of community doctors. Officers described a degree of cooperation with hospital staff, from whom calls for assistance were at times received. They found that persons known at facilities were more readily admitted. Officers described a requirement for high dosages of medication to sedate clients, but related such doses to patient needs rather than medical excesses.

Where referred persons were not admitted, urban officers left them at the facility unless charges were to be laid. Action was taken to ensure compliance with driving prohibitions and other conditions, and permanent detention (in a provincial psychiatric facility) was considered a necessary and desirable outcome. Domestic violence was generally considered to be a criminal justice matter.

Rural perceptions

Referrals for intervention under the Mental Health Act are directly received by rural officers; persons frequently ask the police for assistance with their own mental health problems, and there is no rural anonymity. Requests for assistance may occasionally, but not frequently, come from hospitals; more frequently they are received from community mental health authorities with whom

officers enjoy a mutually cooperative relationship.

Mental illness is associated with a non-violent population although incidents of violence were frequently reported. Both schizophrenia and suicidal behaviour were associated with the hoarding of medicine, and suicide threats were associated with mental illness.

Rural officers enjoyed considerable background information due to their familiarity with persons' histories (both normal and disturbed), and more information was received from referring parties. Familiarity may be a liability as officers are called at home, by telephone and in person, at any time of the day and more frequently at night. Personal knowledge, resulting from familiarity with referred persons and improved communication, provides an understanding of the client rather than the illness. Personal knowledge and knowledge based on experience are more specific to particular clients, and less generalized to mental illness. Rural officers are less able -- or willing -- to diagnose the presence of mental illness of persons with whom they are familiar.

Colourful setting descriptions are provided and observations concerning external causes of disturbed behaviour are frequent. In light of Attribution Theory rural officers have more empathy; their accounts also indicate greater compassion. Frequent interventions involving spousal violence were described, and spousal

violence is frequently considered to be related to a mental health problem. Proactive interventions were described to prevent sexual assault. Feedback and follow-up are the norm, and officers maintain contact with and observation of the persons with whom they intervene under the Mental Health.

All weapons (including batons and flashlights) were secured to prevent their being used against the officer. Rural officers also looked through windows and telephoned reported persons prior to confrontations. Rural officers describe reliance on personal resources such as "strength and agility". The presence of superior officers was described as inhibiting. Community relations and reputation are important, and communication between officers and citizens was described as excellent. Communication has improved as a result of community policing ideals and a perceived reduction of authority barriers. Communication skills were the most important factor in a successful intervention, and communication was often a complete intervention in crisis situations.

The nature of interventions was determined in consultation with fellow officers, victims, family members, community authorities such as teachers, community mental health workers, volunteers, and in one detachment with doctors. Reciprocal cooperation was described with community mental health workers and volunteers; there are no

residential facilities. Interactions with other community agencies (children's protective services or schools) were generally but not always cooperative. Friendly interactions continued with persons following interventions. Wherever possible, problems were resolved within the community, without formal psychiatric intervention, with help from various community actors and family members and friends.

Cooperation with doctors depended on relations independent of requests to authorize transportation in custody under the Mental Health Act. A lack of cooperation from local doctors was attributed to unwillingness to deprive persons of liberty, to tie up single ambulances, or to take responsibility for arranging a bed in a psychiatric facility. Rural officers avoided transportation to urban centres whenever possible. Distances to facilities were frequently cited as a problem, and rural officers described a need for local beds and visiting nurses to monitor treatment compliance.

Rural officers argued and threatened to "force" psychiatrists to admit clients, or clients to enter voluntarily; if unsuccessful officers were required to return with clients to their communities. Officers described cooperation with doctors and other staff as varying among hospitals. Officers described treatment, when administered, as excessive.

The most common form of criminal justice processing

involved firearms prohibitions, and officers acted to ensure compliance with firearm prohibitions. The high proportion of firearms in rural interventions were described as a constant threat to officers, to clients themselves, and to bystanders. Criminal records were considered a deterrent but a handicap, and community service and other alternatives were preferred. Officers found little respect from courtroom actors, and encounter difficulties in submitting evidence of previous psychiatric interventions.

CONCLUDING REMARKS

The academic analysis of police perceptions of mental health interventions provides a framework for understanding what officers do. The foundation of this intervention is not an authority, however, but the people with whom officers intervene.

It is the same people, with the same problems, that rural and urban officers encounter. They are troubled human beings whose behaviour does not fit behavioral norms. They have problems in relationships, problems controlling their emotions or impulses, frequently problems managing their finances. Some, with conditions such as Alzheimer's disease, have problems remembering who, or where, or why they are. Many, according to statistics and current psychological theories, because of trauma associated with pain and abuse, develop counterproductive coping mechanisms

and provide themselves with irrational explanations in order to live with who, where, and why they are as they are. Some are legitimately, since birth or due to accident, illness or trauma, incapable of adding two and two to arrive at four. Most are occasional and some are frequent residents of acute or chronic or forensic psychiatric facilities. They are the long term clients of mental health, social, outreach, child protection, residential care facility, shelter, corrections and other workers, and of medical, criminal justice, and other authorities.

Research found no differences among rural and urban clientele, rural and urban referral sources, urban and rural reasons for requesting intervention. The same family members or strangers called officers to intervene under the Mental Health Act (MHA) for the same reasons -- fear or annoyance -- in cities, and in villages or at farms in remote rural areas across Ontario. Why then do rural and urban officers perceive these persons so differently, describe them so differently, explain their behaviour and interact with them, so differently?

At first glance, urban officers have the advantage of specialized training which ostensibly should better prepare them to execute mental health interventions than their rural counterparts. That their knowledge is not particularly coherent is not to their discredit. Examination of the quality of psychiatry diagnostics equally

reveals an absence of coherence. There is no consistency, accuracy, or even kindness in these diagnoses, and psychiatrists -- particularly those of different generations -- rarely agree.

Psychiatry has evolved within living history and many can remember the horrors of mental hospitals, documented recently in various books concerning practices in facilities such as the Allen Institute in Montreal. Such practices were not exceptional, and it is only in the last three decades that much of what was barbaric -- if not all -- has been replaced by pharmacologically induced oblivion, or at best contentment and tranquillity. As recent as the horror era of psychiatry is known to be, there continues to exist a widespread trust in its current "rightness". This belief applies for officers as well, despite recognition by both urban and rural officers that the doctors and psychiatrists they encounter are as unpredictable in their reactions to the officers' requests, as are the persons delivered into their care and keeping.

Urban officers are at a disadvantage precisely because they adopt the attitude that psychiatry promotes toward this clientele. The client does not present a person, he or she presents an illness and displays an array of symptoms fitting somewhere in a constantly shifting collection of patterns, in the several times revised diagnostic manual (currently *DSM-IV*). His or her disease

has a name which is altered as the manual changes, changed as new features of behaviour are defined as inappropriate, revised whenever the person changes doctors. He or she has no name.

The urban officer is as nameless as his clientele. He is a uniform; various characteristics are assumed and internal causes (because he is a police officer) attributed to who he is and what he does. His label also varies according to the education, social status, and criminal justice status of the person describing him.

For the rural officer, the person has a name. He or she remains the same person although psychiatric definitions change. The rural officer, like his clientele, also has a name. His clients know where he lives and his phone number. His children go to school with the children of his clientele; they may even play in each other's yards. If he is single, he may take them camping. His clients may become angry if he interferes with their activities, but their anger is with him, personally, not with what he represents. And he interferes with them personally, not with what they represent -- an unknown and unknowable quantity with which the Mental Health Act authorizes him to intervene.

When behaviour causes problems or danger for others, the rural officer knows what has stimulated that behaviour. It may be an event or a memory, a thought or a sound or a vision. It may appear of no consequence to the officer; it

will invariably be something to which nobody "in their right mind" would react as strongly, but the reason for the response, real or perceived, is known.

A person who is intervening in such circumstances may focus on one of two things: the stimulus or the response. Attributing the response to the person's level of functioning requires urban officers to stop the person. Attributing the response to the stimulus requires rural officers to stop, remove, or manage the stimulus by explaining why it does not merit such an extreme response. Urban officers are trained to examine the response, and do not know the stimuli. Rural officers know most of the stimuli in most of the lives of the persons who are their neighbours, or the relatives and friends of their neighbours. They are no less aware that the response is inappropriate, but they are far more aware that a rationale -- even if based on imagination -- exists.

The response must be stopped, of course. Urban officers use force. This is their training, and a role in which they are immensely capable. Rural officers talk. They use each of the tactics that a neighbour would use. They demand a cup of coffee or tea. Attention to these routine duties, the execution of familiar movements, reestablishes the person's competence.

On the surface, distances from resources and limited access to resources required rural officers to work harder

to defuse or resolve situations; urban officers are more readily able to transfer responsibility to medical authorities. In both cases, persons with whom officers intervened continued to need help to control their responses, from persons who come forward or are sought out when control is lost. The need for help is real. In cities, others provide this help. In rural areas, the police officer may be the only available resource.

Senior officers concurred in emphasizing the importance of experience, affirming that skills accrue. Where more is required, more skills develop. From their descriptions, the skills of rural officers resemble the human interaction skills that family members, neighbours, friends learn in order to comfort, restore competence, and even restrain. They barely seem qualifiable as skills; they become automatic in a context of familiarity.

Beneath the surface, familiarity is the keystone of rural officers' ability to see, hear, understand situations, know what to do. The key to managing a situation involving mental illness is not to know what kind of mental illness the person has, but to know the person and what provoked the response. The key to a successful intervention is to treat the person as an equally human being.

To teach human interaction skills, and compassion, is not within the repertoire of medical authorities' skills. Learning about the manifestation of illnesses does not teach

the urban officer to intervene confidently, competently, and compassionately "under the Mental Health Act".

It has become increasingly apparent during my career in mental health education that a person who has experienced mental illness is eminently suited to teach another person to understand life with mental health problems. This type of education is available through some psychiatric facilities. Rural officers obtain this education by observing human nature more closely, more intimately, in more frequent interactions with members of their communities than urban officers can have, in circumstances that do not permit a separation of the person from the context of his or her actions, and from his or her name. Urban officers cannot duplicate those opportunities to increase their awareness of particular individuals, but their sensitivity and understanding can be increased to humanize their interactions with clients with mental health problems. They could learn from the clients of psychiatry, far more effectively than from its practitioners, how to defuse hostility, how to gain cooperation rather than resistance, how to recognize and manage those situations that can be managed. From contact with any of their clientele, the person emerges a human being; their situations become familiar and those who intervene learn compassion and empathy.

In a climate of disappearing resources, urban

officers must be prepared to take greater responsibility in such interventions. To do so effectively, they will need to see the persons with whom they intervene as real persons. They will need to look beyond behaviour to see the actor as well as the action, the stimulus as well as the response. This can only be learned through direct, personal, normalizing interactions, in respectful social situations rather than during a crisis, with persons who have had, or continue to have, mental health problems.

Medical authorities must also learn to respect and support the work that officers do. It is their responsibility, on behalf of their clients, to take the initiative in creating opportunities for officers to learn, from those clients, how to intervene effectively.

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APPENDICES

APPENDIX 1: LETTER OF PERMISSION

October 21, 1992

Marian Crow
Criminology Department (Master's Program)
University of Ottawa
1 Stewart Street
Ottawa ON K1N 6N5

Superintendent
District Commander
District Headquarters
Ontario Provincial Police

Dear Superintendent :

Attached you will find a copy of a letter from Mr. Donald J. Loree of the Research and Program Development Branch of the Canadian Police College, with respect to a research proposal to write a publishable paper on the subject of leadership in community policing as related to policing in the psychiatric community, for which I have been engaged as an independent contractor. The study, a comparison of rural and urban approaches in Eastern Ontario, is being undertaken with the aim to provide a training program for personnel. I will be pleased to make a copy of my contract available for your examination.

So that I may interview officers in your jurisdiction, I would be grateful for your assistance in determining whom I should contact. I would also appreciate your assistance in facilitating this study by informing the officers that I will be calling to arrange appointments for interviews.

I hope to interview police personnel at the detachment in Ontario, and would appreciate your recommending a detachment in your area which has a similarly rural clientele. I will telephone toward the end of next week to discuss the matter further with you.

I hope to complete the interviews before Christmas, to allow time for transcription, analysis of data, and writing the paper before the March 12, 1993 deadline.

I will be asking questions such as the following:

- . from whom are requests for assistance or referrals received (proportions from agencies, families, observers, other)?
- . what types of requests for assistance or referrals are received (proportions violence, nuisance, danger to self or others, incapacity to manage their own lives, other)?
- . what criteria are used to determine whether interventions should be made?
- . what types of interventions are made?
- . to whom are mental health clientele referred (for example: hospitals, agencies, families, custody, other)?
- . what follow-up is made after referrals?
- . what resources or specialized training would facilitate your police force's interventions among this clientele?

XX

No information will be solicited on specific cases, nor will names be required. I will, however, credit anyone who is willing to be credited for his or her assistance or cooperation. I would appreciate any reflections, anecdotes, or experiences that officers wish to relate which might typify differences in urban and rural policing.

Thank you for your cooperation in this study.

Yours very truly,

Marian Crow

msc

Att.

APPENDIX 2: LETTER OF INFORMATION

Marian Crow
Criminology Department (Master's Program)
University of Ottawa
1 Stewart Street
Ottawa ON K1N 6N5

Police Services
Street
Ontario

Dear :

Attached you will find a copy of a letter from Mr. Donald J. Loree of the Research and Program Development Branch of the Canadian Police College, with respect to a research proposal to "write a publishable paper on the subject of leadership in community policing as related to policing in the psychiatric community", for which I have been engaged as an independent contractor. The contract for this study describes "a comparison of rural and urban approaches in Eastern Ontario", being undertaken with the aim "to provide a training program for personnel".

I will be asking questions such as the following:

- . from whom might requests for assistance or referrals be received (hospitals, agencies, families, observers, other)
- . what types of requests for assistance or referrals are perceived as possibly involving persons with psychiatric disorders
- . what criteria are used to determine the type of intervention that should be made (custody, referral, no intervention, other)
- . to whom are clientele referred (for example: hospitals, agencies, families, custody, other)
- . is it customary for follow-up to be made after referral to other agencies
- . what resources in the community, or what types of specialized training, would facilitate your police force's intervention in such situations

I am interested in officers' reflections, anecdotes, and experiences but do not, of course, expect information on specific cases, nor will any names be required. I will be pleased to credit any persons assisting with this study, as per the enclosed form.

Yours very truly,

Marian Crow
Graduate Student
Criminology Department
University of Ottawa

APPENDIX 3: LETTER OF CONSENT

From M Crow
Criminology Department (Master's Program)
University of Ottawa
1 Stewart Street
Ottawa ON K1N 6N5

To All participants in the Canadian Police College Study: Policing in the Psychiatric Community: A Comparison of Rural and Urban Approaches

Subject Anonymity, Confidentiality, and Recognition

I will guarantee anonymity and confidentiality of information by altering any personal names or identifying features of situations discussed in interviews. I would appreciate your perceptions of the interview, however, and I would also like to recognize the time and courtesy extended by all the participants who provided ideas, information, and personal experiences.

I ask, therefore, that you complete and return this form at your earliest convenience so that I may recognize your contribution by name when this study is published.

- | | | |
|---|-----|----|
| 1. Did you feel constrained to grant this interview? | Yes | No |
| 2. Did you feel that refusal to grant an interview would have negative consequences? | Yes | No |
| 3. Did you feel free to refuse to answer any questions? | Yes | No |
| 4. Did you feel that refusal to answer any questions would have negative consequences? | Yes | No |
| 5. Do you wish to have your name recognized as a contributor to this study, for purposes of publication of an article in the police journal in which it will be published | Yes | No |
| 6. Do you wish to have your name recognized as a contributor to this study, in the event that any parts thereof are included for publication of a Master's thesis | Yes | No |
| 7. If there are any conditions under which you would like your name or any part of the interview to be included or excluded, other than the guarantees described above, please describe these conditions below: | | |

Thank you for your participation in this study

APPENDIX 4: LETTER OF RECOGNITION

Marian Crow
Criminology Department (Master's Program)
University of Ottawa
1 Stewart Street
Ottawa ON K1N 6N5

February 19, 1993

Constable

Ontario Provincial Police
Division
Street

Dear Constable :

I would like to thank you for your time and courtesy in granting me an interview, as well as for the insights and experiences which you shared in our mutual aim of facilitating effective police practices with a difficult clientele.

I have written to your sergeant and to the OPP Superintendent in to thank them for their cooperation, and to mention your contribution to this study.

I include a form which I am sending to all the contributors and participants, in order to recognize your contribution. Please return this form to me at your earliest convenience.

This study has greatly increased my understanding of the difficulties and advantages of rural policing, and of the dedication and sensitivity of rural police officers.

Yours very truly,

Marian Crow

Encl.