

Athabasca University  Master of Arts - Integrated Studies

AN ISSUE OF PERCEPTIONS:  
MENTAL ILLNESS, THE POLICE AND THE MEDIA

By

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## ABSTRACT

Since 1988, Toronto police officers have shot and killed 13 persons who were in crisis due either to mental illness or mental illness in combination with some other factor; the police had perceived a threat of grievous bodily harm or death. These and similar fatal encounters across North America led to countless inquests and studies, most of which have concluded that the police require more mental illness training. Amendments to police 'use of force policies' and mental illness training have created some progress, yet fatal outcomes continue. The shootings, consequent investigations and eventual recommendations are all reported in the media. While this informs the public, media reports can influence and heighten public fears regarding mental illness. A new multi-disciplinary approach, relevant to both police and media, is offered.

**KEYWORDS:** *mental illness, media, training, police, use of force, perception*

Sir Robert Peel (1788-1850) was credited with the Metropolitan Police Act in 1829, a statute that in essence created the police as they are known today. He stated: *The police are the public and the public are the police; the police being only members of the public who are paid to give full time attention to duties which are incumbent on every citizen in the interests of community welfare and existence.* That has not changed in the past 180 years, with the exception of the training the police receive that the public of course does not. But does that training always differentiate between the police and the public, particularly in the case of perception and reaction to persons with mental illness?

The deinstitutionalization of persons with mental illness began about 50 years ago and created an environment that would find many of them face to face with the police. A neoliberal notion that these persons would be better served by leaving them in the hands of various community health networks, as well as their families, was well-intentioned.<sup>1</sup> But what was unintended was the disproportionate numbers of the mentally ill who would find themselves institutionalized instead in the nation's correctional facilities. Somehow having a mental disorder became associated with having a criminal or violent nature. This widely held view is shared not only amongst the public in general, but also amongst police officers. This association is a consequence not only of a lack of education but also from exposure to an omnipresent media that too frequently presents the mentally ill in a negative fashion.

Police training regarding mental illness, at both the recruit level and as ongoing in-service training, has educated the officers but how effectively? Studies have shown that police officers receive widely disparate hours of training and the methods of training are also inconsistent (Cotton, 2008, p. 2). When the police encounter a person in crisis, their response can be as varied as the personality of the officers involved. Although training provides some understanding toward a procedural response, the inconsistency and insufficiency of the training can also result in over-reaction. This can lead to a mental health apprehension, a criminal arrest or, in some cases, a use of force. The level of force is expected to be appropriate to the threat. Is it perception or misperception that explains a use of force that results in death?<sup>2</sup>

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<sup>1</sup> Sealy (2004) however found that the inconsistencies between the provinces in how they report data (and how much is actually reported) and transinstitutionalization (replacing psychiatric institutional care with general hospital care) creates difficulties for analysis and policy considerations.

<sup>2</sup> (In the United States, a Court of Appeal even ruled that a "municipality may be sued for failing to train officers to recognize the signs of mental illness" (Lurigio, p.8). It is curious to think such a matter need to be heard in so high a court.

Numerous studies examine police encounters with the mentally ill. Despite being conducted from a variety of disciplines, most suggest that the police require more training in the area of mental illness. To provide an integrated response to the problem, this training should extend also to journalists (Philo, p.260). The media influence on the public is overwhelming and is probably the greatest educational tool available when reaching out to the public. The studies also recommend a better co-ordination between the police and mental health communities and agencies (Steadman, 2000, p.649). Unfortunately, this suggestion has been repeated for 40 years, since the “criminalization” of the mentally ill (Abramson, 1972). The result is a seemingly slow response from the police, the criminal justice system, the community health organizations and the media. To be fair, some factors beyond the control of the police impede a more advanced progress. The well-intentioned reasons behind deinstitutionalization, including constitutional protections of due process, a less restrictive environment and a freedom from involuntary treatment (Patch, p. 25), have created an environment that makes the police a de facto mental health response unit (Cotton, 2008, p.2). But police do not always feel that this function is their job (p.15).

It is difficult to narrow down the issues for an effective examination from the perspectives of only one or two disciplines because so many agencies (disciplines) see the problem from their point of view, but suggest that the solution is someone else’s responsibility. Is the person with mental illness a patient, a victim, a criminal, a pariah, a liability, a threat, a burden or a just a person suffering from a disorder, not unlike someone with arthritis? It depends who is asking the question. A multidisciplinary approach is required that at the least addresses the interests of health and law officials (Reuland, p.4).

Why consider police officers a resource for dealing with the mentally ill? Study after study concludes that the police are repeatedly either ill-equipped or ill-trained to effectively respond to the mentally ill (Borum, p. 394). It is confounding that the police are so frequently the agency called upon to help. It is often a family member who initially calls the police, so it makes little sense that the first responder would be someone who might know little about the issues of a person in crisis. If a person falls from a tree and suffers a broken arm, he/she taken to hospital by a family member. If instead that person suffers a broken back, the police as well as the fire department and paramedics will attend, in a tiered response, with the intention that at least some medical attention can be given. But if a person suffering a psychotic episode clutches a pair of scissors, the family does not take the person to the hospital, nor do they call the family doctor or summon a neighbourly firefighter<sup>3</sup>. The police are called and the police response is to “protect,” because that is what they are trained to do<sup>4</sup>. That protection could be the protection of the officers themselves as much as the family who called the police or the person actually in crisis.

The media is a powerful influence and newspapers, television and radio news, and television dramatizations are the primary source for what the public knows about how the mentally ill behave (Steadman, p. 311). A 1990 survey found newspapers the major source of knowledge about psychiatric disorders for 74% of survey respondents (Wahl, p.1594). It was also noted that the newspapers reported few stories of recovery or accomplishments regarding the mentally ill, focusing more on either dysfunction or disability than on community contributions (Wahl, p. 1597). In a 2002 study, more than half of all print items examined “depicted the mentally ill person as dangerous...in marked contrast to research showing very

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<sup>3</sup> Cotton found police knowledge of mental illness was not very different from what firefighters knew (2003, p .1).

<sup>4</sup> Ron Hoffman, Mental Health Co-ordinator, Ontario Police College, as quoted by Marc Lalonde, The Chronicle.

limited associations between mental illness and violence” (Coverdale, p. 698). Conversely, a subsequent 2004 study found less than 6% of stories about mental health were in the context of crime and that policy or program initiatives were most dominant at 29% (Francis, p.541).

All mental illnesses are not equal, but researchers have found that “undifferentiated classifications of mental illness such as ‘psychiatric patient’ or ‘mentally ill’ were predominant, which is consistent with findings from television dramas” (Coverdale, p. 700). It is no surprise that the negative press coverage that involve the mentally ill or incidents involving them create unfavourable images in the public mind.<sup>5</sup> The mainstream public impression is that the mentally ill are unpredictable, likely to be violent and dangerous (Angermeyer, p.469). The essence of the stigmatization of the mentally ill is simply fear (Steadman, p. 314). This public fear is reinforced when mental illness is only a sideline in a typical crime story but gets prominent coverage when the story is spectacular and negative (Angermeyer, p.476). Angermeyer also found that news releases about mental illness discoveries and treatment advances were the second most frequent media items regarding mental illness and health (behind crime related stories). But these positive notes were typically short, in small print and not prominent. Still, “people are not simply blank slates on which messages are written. The media exist within developing social cultures. They do not create the whole social world or how we think about it” (Philo, p.278). The media however is a part of the process to construct meaning (Granello, p. 98) but for many people, the media is the meaning and there is no other construction.

This same media influences the communities within which the community’s officers are raised. Recruits were exposed to a lifetime of negative stories, labels and confusion regarding

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<sup>5</sup> Rusch found the public perception of mental illness ranged from severe substance abuse and depression up to psychiatric disorders like schizophrenia (p. 642).

mental illness<sup>6</sup> and deprogramming may be necessary to achieve a neutral or unbiased opinion. It has been cautioned however that “over-exposure to the topic might actually have a negative rather than positive effect on new officers” (Cotton, 2008, p.23), possibly creating more bias. The recruit officer is expected to overcome any bias toward mental illness and “serve and protect” a community that anticipates the officer will share and retain its community beliefs. How much training will an officer require to overcome biases and community pressures? Will training remove or override the biases of some officers? What if these biases are systemic, throughout the community and, by extension, its police services?

Some media reports and bias involving the mentally ill come from the police themselves (Angermeyer p.471). A biased officer who is interviewed or writes a media release can reinforce an already biased perspective. If this in turn reinforces the community’s perspective and the officer serves that community, a cycle is created that is difficult to overcome. Researchers argue that media accounts of mental illness often use aggressive and derogatory terminology (Angermeyer, p. 484). McAfee found throughout the training materials of 49 US police academies, only 3 used “preferred person-first terminology” (persons with mental illness instead of mentally ill persons) that emphasizes the individual’s humanity instead of the disorder (McAfee, *CJR*, p.60).

The Diagnostic and Statistical Manual of Mental Disorders IV (DSM) notes violent behaviour as a key diagnostic *behaviour* or associated *feature* for a number of psychiatric disorders but not as a *symptom*. This has led to the suggestion that “manifestations of violence may increase the likelihood that these disorders will be diagnosed” and this in turn causes a

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<sup>6</sup> Granello found that 72% of prime-time television characters who presented mental illness either hurt or kill someone (p.99).

“confounding by definition” (Public Health Agency of Canada, p.2). Additionally, if persons with a mental illness appear more frequently violent than those who do not have a mental illness, it can often be attributable to the lapsed or non-use of prescribed medication, or the uses of alcohol or other drug abuse. Often the presence of alcohol or drugs can mask the symptoms of mental illness (Morabito, p.61). A comorbid condition of addiction and mental illness complicates both a police and health response. In a violent encounter with the police, the existence of a mental illness will drive the media’s story, not the victim’s addictions.

Police use of force is relatively rare. Yet it receives a disproportionate amount of attention (Morabito, p.60). Even though police may respond to mental health calls no differently than they would to other calls, the problem arises when police command and control techniques are ineffective with someone in crisis (Morabito, p.71). “Officers are trained to be authoritative and immediately get control of a situation, but with those suffering psychiatric problems, such tactics often serve only to ratchet up tension” (Morrow, 2012). Toronto Police Association president Mike McCormack states, “The mental health issues sort of take a back seat when our officers are exposed to people with weapons and violence. The priority at those calls is dealing with the immediate threat” (Mills, 2012). Perhaps it then becomes a matter of *how* the threat is perceived, when some officers bring preconceived notions of mental illness to their radio calls. Where one officer might feel he can talk down a distressed person, another officer might feel his or her life is in danger (Parent, p.61). One study found that officers consider a ‘call for service’ involving a person with mental illness coterminous with a fight call or someone committing a robbery (Ruiz, p.369), perhaps because officer attitudes are “typically viewed as one-dimensional and homogeneous” (Patch, p.30). The attitude an officer has toward either mental illness or the mentally ill will largely affect the officer’s response although there are no actual

measures for officer attitude (Clayfield, p.742). One survey found that 50% of officers believe persons with mental illness take up too much police time (Cotton, 2010, p.302) and others feel they are street corner psychiatrists (Lamb, 2002).

Regardless of the contributing factors of a person's violent episode, a call to the police results in a high(er) priority response and then often some degree of force to control or restrain the person in crisis. Yet one US study found that only 1 in 59 assaults on officers and 1 in 42 officers killed were by "mentally deranged" assailants whereas persons with a severe mental illness were 4 times more likely to be killed by the police (Cordner, p.3). If these statistics are accurate, why is there such a perceived risk in dealing with persons in crisis? Does a person waving a knife pose a greater threat when the officer is told that a mental illness might exist? When de-escalation commands are unheeded, does the officer feel threatened or just ineffective? Is a show of force a remedy for ineffectiveness? Is this what "ratchets up" the encounter? "Backing off is counter to the way they operate," states retired Moose Jaw police Chief Terry Coleman, a Mental Health Commission of Canada consultant. That might explain why a third of Canadian police shootings which end in injury or death involve someone with a suspected mental illness (Tapper, 2011).

Police training remains an issue. Across North America, the training that police officers receive on mental illness ranges from one hour to an entire week. There is no common curriculum and no standard best practice toward instruction (Cotton, 2008, p.2). Most police services have increased the hours devoted to training, as well as using a co-operative teaching model that involves mental health professionals in delivering the material (Cotton, 2008, p.16). The Crisis Intervention Team (CIT), based on the "Memphis model," is becoming an industry standard and CIT training is a positive response to the problem (Steadman, 2000, p.646). Police

officers team up with mental health professionals and respond to calls that involve persons in crisis. This integrated approach to the response for help is a positive step. But officers have a duty to protect life and property. This could mean protecting everything other than the person seen as the threat. This is not to imply that an officer would not attempt to protect the life of a threatening mentally ill person, but how is the officer's primary instinct of protection measured? How do competing values affect an officer's judgment?

The communication skills an officer has will vary from officer to officer but the tactics required and used to defuse a situation are or should be less variable. But despite appropriate training, officers respond differently to threatening situations and when a problem of communication is also present, the encounter can become deadly.<sup>7</sup> Would more intense and life-like simulation training help manage threatening situations? Not unless the simulation made the officer truly feel like his or her life was in immediate peril. Without that "peril," it may be impossible to know how an officer would actually respond to a real-life situation. Unfortunately, some situations are ultimately 'on the job' training.

What causes the police to respond in a manner contrary to the purpose for which they were called? : To "do something" (Cotton, 2004, p. 143). Before considering a lack of training as a possible answer, what factors may pre-exist in an officer's mind? Some officers do not consider a call for service regarding a person with mental illness 'real' police work (Coleman, p.53) and there is an underlying culture that only 'real' police work is measured or rewarded (Godfredson, p. 193). Are there cultural or societal attitudes toward mental illness instilled in the

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<sup>7</sup> Four RCMP officers encountered angry Polish immigrant Robert Dziekanski at Vancouver airport, October 13, 2007, the day he arrived in Canada. Dziekanski spoke no English and the officers knew no Polish. They tried to calm him down but within half a minute of the officers arriving on scene, Dziekanski was on the floor after five deployments of a Taser and he died minutes later. See Braidwood.

officer before he or she became an officer? Are those attitudes detectable in pre-hire screening and if so, are they of concern or commonplace? If a potential recruit expressed a bias, during psychological testing, against other races or the opposite sex, that should raise concern toward the candidate's suitability; no police service would willingly hire a racist or misogynist. Should the same flags alert the recruiter if a bias toward the mentally ill was detected?

The officer 'type' may also be a factor in how the mentally ill are treated during an encounter (Cotton, 2004, p.136). One study identifies four officer types: the enforcer (who, in keeping with public sentiment, feels something needs to be done, often an arrest), the idealist (who seeks resolution through placement of the mentally ill person into a place suitable for appropriate treatment), the realist (who would see the situation as hopeless and that a revolving door system is ineffective; this officer will take the easiest route by avoiding arrest and paperwork and escort the mentally ill person aside) and finally the optimist (who would avoid the warehousing of ill persons and prefers remedy, encourages them to seek help) (Patch, p.32). Cooper (p.298) however notes that individual officer characteristics and their influence on encounter outcomes have not been specifically researched. It may be a necessary step to identify officer type before commencing mental illness awareness training to adjust the training methodology toward a more effective outcome. Stress may too be a factor. Officers with a higher education (college and above) report lower stress levels (Gershon, p.280) and while debate continues about the difference a university education makes for an officer, evidence leans toward lesser educated officers making an arrest instead of a referral (Coleman, p.60).

Socioeconomic factors affect many persons with mental illness. The mentally ill often reside in poorer or socially disadvantaged neighbourhoods. These neighbourhoods witness increased violence (Scott, p.405) as persons having a mental illness are more vulnerable to

victimization (Watson, 2004, p.3). It is speculated that certain police precincts (or divisions, attachments) appeal to certain officers (Patch, p.33). If certain districts of a town or city are home to more persons with mental illness than other districts, the officers who patrol there might require a higher level of training or at least be subject to a form of assessment to see if they are suited to work in a more sensitive and demanding community. Cooper (p.299) notes that race too should be examined when looking at encounters between the police and the mentally ill. Similar socioeconomic factors force many minorities into those same neighbourhoods and combining race with mental illness within arguably violence-prone neighbourhoods can further escalate encounters with the police.

Since racial tensions involving the police always seem present to some extent, does a person of a racial minority who may also have a mental illness face a different outcome when encountering the police? There is some evidence of that, considering that of the 13 fatal Toronto police shootings involving a suspected mentally ill person since 1988, 7 victims were Black, one was Asian, one was Native and the others were of Eastern European background.<sup>8</sup> Studies in fact have shown that African Americans have a higher incidence of schizophrenia than Caucasians (Cooper, p.305) but can that finding account for the number of racial minority shootings witnessed in Toronto?<sup>9</sup> Add alcohol or drug abuse to this situation and a responding officer's reaction might be as unpredictable as the victim's.

An overrepresentation of fatal shootings involving suspected persons with a mental illness led to a reform of police policies and practices in Victoria, Australia. This in fact led to a reduction in overall fatal police shootings but oddly no reduction in shootings involving the

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<sup>8</sup> Kennedy, thestar.com; Adam, Ottawa Citizen.

<sup>9</sup> One study found that Taser use or deployment is mainly on "recent European immigrants, blacks and Aboriginals, the mentally ill and drug addicts" (Oriola, p. 74).

mentally ill (Kesic, 2010, p.467). It seems Victoria police continued to rely on deadly force when confronting the mentally ill.<sup>10</sup>

Some research finds police training programs “are probably not harmful and may be helpful...there is good reason to believe that they are not sufficient to fundamentally change the nature of police encounters with mentally ill people in crisis (Hails, p.53). This study found a median of 6.5 hours and a mode of 4 hours was devoted to recruit training on responding to persons with mental illness. Cotton found no research that showed additional training or education would even lead to a better outcome (2008, p.16). Training alone may only inform or educate officers. But it is necessary to transform them (Coleman, p.48). A systems approach is required to improve police interactions with persons with mental illness. Perhaps it is not how much training but how integrated is the training.

What of the perspective of the person with mental illness? Watson found generally negative perceptions and expectations of the police (Watson, 2008, p.452). There were feelings of vulnerability to police brutality, false arrest, and relief or satisfaction when not being abused. Officers often told them “they were just doing their job.” Participants wanted the police to know that they were human beings too, to be patient and calm with them, and to recognize or ask about mental illness (p.455). The question presents ethical dilemmas. For example, the officer’s duty is to the community but a health professional’s duty is to the patient (Coleman, p.44). How the officer treats someone may indeed be a function of what the community wants instead of what it needs. Who makes that decision?

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<sup>10</sup> Victoria has racial tensions which may be an element of their police shootings (Bourne).

The stereotypes and stigmatization associated with mental illness continue to complicate and frustrate police officers, health workers and community members alike. Progress is slow in recognizing the person with a mental illness as a victim and not a criminal, and further distorted by media misrepresentations. The media is not completely at fault. The public seems to want stories that sensationalize yet continue to marginalize the mentally ill. The police are community members too, subject to the media and a reference for it. Despite training and other initiatives, neither the public, nor the police nor the media seem anxious to educate themselves about mental illness. To address the multiplicity of affected organizations, research and subsequent recommendations need to come from a variety of disciplines with an interdisciplinary effort that recognizes the problem and sees ways toward a common solution. Until then, mental illness will remain fatal.

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