

Issue Brief

CMHSR

Copping an Attitude?

Assessing Police Attitudes about Persons with Mental Illness

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“In the case of dealing with the mentally ill, there is particularly good reason to be concerned about attitude because the generally negative opinion of the public toward individuals with mental illnesses has been well documented, and it is widely accepted that stigma remains one of the biggest barriers to successful community integration of those with mental illnesses.”¹ It is a common perception that if police officers believe there is a heightened sense of risk among persons with mental illness (often referred to as Emotionally Disturbed Persons or EDPs) they may respond more aggressively in situations involving EDPs, escalating the situation and evoking unnecessary violence.² But is this really the case?

Findings

Several research studies have not supported this conclusion. Deane et al.³ surveyed departments across the nation in 194 cities with populations greater than 100,000 to identify the strategies police used to obtain input from the mental health system about dealing with mentally ill persons. Despite 96% of those departments stating that they had no specialized response for dealing with the mentally ill, two-thirds of those surveyed (even those with no specialized response program) rated themselves as being *moderately or very effective* in dealing with mentally ill persons in crisis. Similarly, Cotton¹ found that police had attitudes very similar to those of the general public, neither punitive nor isolationist toward the mentally ill, and that the majority of officers expressed an interest in obtaining more information on working with and understanding persons who are mentally ill.



These studies suggest that police have embraced this role of social service agent, and that many departments feel that they are handling these situations well. Green et al.⁴ found that many police officers, with no specific training in dealing with mentally ill persons, believed they could tell if someone was seriously mentally ill. His study revealed that the major problem for officers in dealing with the mentally ill was gaining access to the mental health system.

Development of the MHASP

The Massachusetts Mental Health Diversion and Integration Program at CMHSR trains police to resolve issues related to EDPs effectively. In addition, we are interested in examining police attitudes toward EDPs, and whether or not our training curriculum has any effect on their attitudes. This led to a search for an appropriate measure of police attitudes toward the EDPs they are likely to encounter in their daily work. However, a review of the literature revealed only a few measures of community attitudes toward persons with mental illness, and none specifically designed to assess police attitudes. The scale most commonly used to assess attitudes toward the mentally ill is the Community Attitudes Toward the Mentally Ill (CAMI) scale developed by Taylor and Dear.⁵ Unfortunately, the CAMI was not designed specifically to assess police attitudes. Therefore, it does not capture questions related to



police work involving persons with mental illness. This led us to develop our own scale that could be used to measure police attitudes toward EDPs – the Mental Health Attitude Scale for Police (MHASP).

The 35-items composing the MHASP scale come from a variety of studies examining attitudes toward the mentally ill.^{1,4,5} The majority of items come from the CAMI scale, from which we selected only those items that correlated highest within each of four scale dimensions:

- authoritarianism – reflecting a view of the mentally ill as an inferior class requiring coercive handling;
- benevolence – a paternalistic, sympathetic view of the mentally ill based on humanistic and religious principles;
- social restrictiveness – viewing the mentally ill as a threat to society; and
- community mental health ideology – a medical model view of mental illness as an illness like any other.

We revised the wording of these items in order to incorporate police terminology regarding offenders with mental illness (e.g., instead of persons with mental illness, we use “emotionally disturbed persons” or EDPs).

We also included 6 items created by Cotton¹ to inquire about police views of the current situation of persons with mental illness in the community and the role police have in their management.

We developed several additional items to ascertain whether or not:

- police feel they have adequate knowledge to interact with emotionally disturbed persons (EDPs);
- they feel confident in the current mental health system and in their own ability to handle EDP calls; and
- they believe that they have been adequately trained or are in need of specific training to handle situations involving EDPs.

Finally, we included items to assess results found by Greene,⁴ who discovered that police deal with many more calls involving EDPs than is officially reported. He found that 72% of police involvement with EDPs, who violate the law, was nonofficial and resulted in no-action dispositions. He attributed these findings to institutional pressures officers felt from both their own police departments and the emergency room personnel to deal with these types of calls on an informal basis that resulted in neither arrest nor hospitalization.

Future Directions

It is our hope that this scale, once validated, can be used to determine the effectiveness of mental health crisis training, as well as the extent to which police officers need to be trained. We plan to pilot the MHASP in our Boston Police Study, which will be comparing two different models of police training at two downtown Boston police districts and a control police district that will not receive any specialized training. All three districts will have access to a new mental health crisis triage protocol that will allow officers a no-refusal drop-off location to which to divert EDPs. In all studies that report success in diverting persons with mental illness from the criminal justice system and into the mental health system, the key component appears to be an effective mental health triage access point or resource for officers to divert such persons.⁶ In addition, it does not appear that any of the police mental health crisis training models assessed baseline measurements of police attitudes before or after such trainings. Given the fact that so little is known about police attitudes and their impact on their interactions with EDPs, we may need to reconsider the amount of mental health crisis training that police actually need in order to positively effect change in police encounters with EDPs.

References

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